Elliot M. Hirsch, MD

PLASTIC & RECONSTRUCTIVE SURGERY

5363 BALBOA BLVD #237, ENCINO, CA 91316
201 S. BUENA VISTA ST. SUITE 325, BURBANK, CA 91505
OFFICE: 818-825-8131 FAX: 818-616-1044

PATIENT REGISTRATION FORM

PATIENT INFORMATION			
LAST NAME	**FIRST NAME**		**M.I.**
ADDRESS	**CITY**	**STATE**	**ZIP CODE**
HOME PHONE	**WORK PHONE**	**CELL PHONE**	
SOCIAL SECURITY #	**SEX** M F	**DATE OF BIRTH**	**AGE**
EMAIL ADDRESS	**PLEASE CIRCLE THE BEST WAY TO CONTACT YOU** EMAIL HOME WORK CELL		
MARITAL STATUS	□ **SINGLE**	□ **MARRIED**	□ **DIVORCED** □ **WIDOWED**
EMPLOYER	**OCCUPATION**		
PRIMARY CARE PHYSICIAN	**PHONE**		
REFERRED BY	**PHONE**		
EMERGENCY CONTACT / RELATIONSHIP	**PHONE**		

INSURANCE INFORMATION		
INSURANCE TYPE (CIRCLE)	**MEDICARE PPO POS EPO HMO WC SELF PAY OTHER**	
PRIMARY INSURANCE	**Group# / ID#** /	**RELATIONSHIP TO INSURED** SELF SPOUSE CHILD OTHER
SECONDARY INSURANCE	**Group# / ID#** /	**RELATIONSHIP TO INSURED** SELF SPOUSE CHILD OTHER

INSURED INFORMATION (IF OTHER THAN PATIENT)			
INSURED LAST NAME	**FIRST NAME**		**M.I.**
SOCIAL SECURITY #	**DATE OF BIRTH**	**RELATIONSHIP TO INSURED** SELF SPOUSE CHILD OTHER	

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Elliot M. Hirsch, MD, Inc. to use and disclose my individually identifiable Protected Health Information ("PHI") for the purpose of diagnosing, treating, consulting, and referral. I hereby authorize the disclosure of my PHI to insurance carriers and/or its representatives for processing claims. I understand that my PHI may be re-disclosed by the person or entity receiving it and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such re-disclosure by the person or entity receiving my PHI. I voluntarily agree to this authorization, and I understand that my health care will not be affected if I do not sign this form.

ASSIGNMENT OF BENEFITS

I hereby authorize payments to be made directly to Elliot M. Hirsch, MD, Inc. for surgical and/or medical benefits, if any, otherwise payable to me for professional services rendered. I understand that I am financially responsible for the charges not covered by this Authorization. I further agree, in the event of Non-Payment, to bear the cost of reasonable legal fees should this be required. A photocopy of this Assignment shall be considered as effective and valid as the original.

SIGNATURE X _____ DATE _____

IF MINOR, PARENT/GUARDIAN MUST SIGN

_____ DATE _____

PLEASE PRINT PARENT/GUARDIAN NAME

FINANCIAL POLICY

Thank you for choosing Elliot M. Hirsch, MD, Inc. as your health care provider. We are pleased to be able to render services in the evaluation and treatment of your condition. Please understand that you will be financially responsible for charges that are not covered by your insurance. If you have any questions regarding your financial account with our office, please contact our billing department during normal business hours, at 818-825-8131.

Your clear understanding of our Financial Policy is important to our professional relationship.

- We need a current copy of your insurance card in order to bill your insurance directly for the charges and services rendered.
- If you do not provide us with a current insurance card or do not have insurance, full payment is due at the time of service. We accept cash, check, or credit card (Visa, MasterCard, or Discover).
- For cosmetic procedures, full payment is required 2 weeks before surgery unless other arrangements have been made. If you have not paid in full 2 weeks prior to surgery or have not made other arrangements, you may lose your surgical reservation.
- Please notify us immediately if there are any changes to your insurance plan or your coverage.
- Co-payments and Deductibles are an agreement between you and your insurance plan, are your responsibility, and are not something we can negotiate.
- Medical records or copies of records can be provided at your request; please allow up to 5 (five) business days for records to be compiled. There may be a nominal fee for record copying.

SELF PAY

We expect full payment at the time of service unless prior arrangements have been made.

MEDICARE

We accept Medicare assignment. There are some services and supplies that are not covered by Medicare. We will advise you if there are any non-covered charges prior to that service being provided.

HMO/PPO

We are providers for many insurance plans, but are not all plans. You are responsible for verifying that we are providers for your plan. If you are an HMO member, you must have a current referral at the time of your visit in order to be seen, and for the visit to be covered under your plan. Without a proper referral, you may be responsible for charges incurred.

If you are a PPO member, you are responsible for co-payments, deductible, and co-insurance. Please confirm with your insurance that we are providers covered under your plan.

WORKERS' COMPENSATION

If you are consulting with us regarding a work-related injury, we require information for both your personal insurance coverage as well as your employer's Workers' Compensation insurance. Prior to being evaluated in our office, we need to have a letter or statement from Workers' Compensation carrier authorizing your treatment. The letter should include the claim number, address, adjuster's name and phone number. Your employer's human resources office should be able to assist you with obtaining this information. If payment is not received from these third parties within 90 days, we reserve the right to bill you directly.

HOSPITAL AND SURGERY CENTER CHARGES

In the event that you undergo surgery in a hospital or outpatient surgery center, separate charges will be made by the facility. Elliot M. Hirsch, MD, Inc. may be part owner or have financial interest in a surgery center where you will be having surgery.

UCR (USUAL AND CUSTOMARY RATES)

We are committed to provide the best treatments possible for our patients. Our fees for services rendered are usual and customary for our geographic area. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance companies' arbitrary determination of UCR rates.

FINANCIAL AGREEMENT

I understand that I am financially responsible for all charges not covered by my insurance. I guarantee that the balance will be paid by cash, check, or credit card. Past due balances may be subject to additional fees.

I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed in a timely manner, to ensure that payment for services rendered. I understand that I am ultimately responsible for payment of all services.

PATIENT OR GUARDIAN NAME (PLEASE PRINT):	
SIGNATURE:	**DATE:**

Medical and Surgical History Form

Date of Appointment: _____

Name: _____ Age: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female Current Height: _____ Current Weight: _____

Please describe the reason for your visit with Dr. Hirsch: _____

Please list all surgical procedures that you have previously undergone, including date and location:

Surgery	Date	Location

Please list all medical conditions for which you are currently treated by a physician:

Please list all medications (including herbal supplements) that you are currently taking:

Medication Name	Dose	Frequency	Reason

Are you allergic to Latex?: ☐ Yes ☐ No Please list all allergies or sensitivities: _____

For female patients: Are you currently pregnant? ☐ Yes ☐ No

Please list the number of pregnancies and dates. Please note if children were delivered through C-section:

When was your most recent mammogram and what was the result? _____

Do you use or have you previously used any of the following:

Tobacco: ☐ Yes ☐ No If yes, how much and how often? _____

Alcohol: ☐ Yes ☐ No If yes, how much and how often? _____

Drugs (including marijuana): ☐ Yes ☐ No If yes, how much and how often? _____

Have you ever had or been exposed to any of the following:

Tuberculosis: ☐ Yes ☐ No If yes, please explain _____

HIV/AIDS: ☐ Yes ☐ No If yes, please explain _____

IV drug use: ☐ Yes ☐ No If yes, please explain _____

Mental Illness: ☐ Yes ☐ No If yes, please explain _____

Blood Transfusion: ☐ Yes ☐ No If yes, please explain _____

MRSA bacteria: ☐ Yes ☐ No If yes, please explain _____

Problems with bleeding: ☐ Yes ☐ No If yes, please explain _____

Problems with anesthesia: ☐ Yes ☐ No If yes, please explain _____

Do you have a family history of any illness, bleeding problem, or problem with anesthesia:

☐ Yes ☐ No If yes, please explain _____

Please note if you have experienced any of the following in the past 6 months:

General: ☐ Fever ☐ Chills ☐ Unexplained weakness ☐ Diabetes

Other symptoms: _____

Head: ☐ Dizziness ☐ Loss of consciousness ☐ Visual disturbance ☐ Headaches ☐ Anxiety

Other symptoms: _____

Heart: ☐ Palpitiations ☐ Chest pain ☐ Murmur ☐ Unexplained heart racing ☐ High blood pressure

Other symptoms: _____

Lungs: ☐ Shortness of breath ☐ Cough ☐ Difficulty breathing ☐ Asthma ☐ Cold or flu

Other symptoms: _____

Abdomen: ☐ Nausea or vomiting ☐ Unintentional weight loss ☐ Abdominal pain ☐ Loss of appetite

Other symptoms: _____

Genitourinary: ☐ Kidney stones ☐ Pain with urination ☐ Difficulty with urination

Other symptoms: _____

Extremites: ☐ Muscle ache ☐ Joint pain ☐ Muscle weakness ☐ Injury

Other symptoms: _____

Any other relevant comments regarding your past medical history:

I hearby state that I have answered the above questions truthfully and have given all information pertinent to my medical history:

Patient signature: _____ Date _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from a civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation**: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect**: This agreement shall be intact from the date of first medical services rendered (including, but not limited to emergency treatment)

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY THE NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR A COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By:_____ _____
Patient's or Patient Representatives Signature Date

By: _____ _____
Physician's or Authorized Representatives Signature Date

By:_____
Print Patient's Name

_____
Print or Stamp Name of Physician,
Medical Group, Or Association Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGEMENT

Note: A copy of our privacy policy is available in the office or at: http://www.hirschplasticsurgery.com/f/Privacy_Policy_Hirsch.pdf

I acknowledge and agree that I have had an opportunity to review the Notice of Privacy Practices for Elliot Hirsch, M.D., Inc. and agree that I have reviewed the Notice of Privacy Practices in its entirety and been given the opportunity to ask any questions regarding the use or disclosure of my protected health information and my associated rights. I acknowledge and agree that I have had all my questions answered to my satisfaction.

PATIENT (OR REPRESENTATIVE) SIGNATURE _____DATE _____

PRINTED NAME _____

DISCLOSURE AUTHORIZATION FORM: FAMILY & FRIENDS

As described in the Notice of Privacy Practices, any disclosure of your protected health information can only be made with your written authorization. It is our practice not to disclose any information to a person, regardless of their relationship with you, unless you have specifically authorized them to receive such information.

I authorize the physicians and staff of Elliot M. Hirsch, MD, Inc. to disclose my protected health information to those individuals listed below:

Name: Relationship

_____

Please note any limitation to disclosure of my PHI to the person(s) described above: _____

PATIENT (OR REPRESENTATIVE) SIGNATURE _____DATE _____

PRINTED NAME _____

This authorization will be in full force and effect for two years from the date of signature unless indicated.

ADDITIONAL RELEASE OF MEDICAL RECORDS

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

PATIENT (or Representative) SIGNATURE _____DATE _____

PRINTED NAME _____

PHOTO CONSENT:

Dr. Hirsch is an active researcher in the field of plastic surgery and therefore may publish the results of his procedures in scientific journals and on the internet for the use of patient education. Whenever possible, we will de-identify photographs before publication. In order to publish your photographs, it is necessary to have your consent.

Consent:

I hereby irrevocably consent to and authorize the use and reproduction by Elliot M.Hirsch, MD, Inc. and its affiliates, or anyone authorized by any of them, of any and all photographs, electronic images or video footage of me taken that Elliot M. Hirsch, MD, Inc. has in its possession, provided either by me or by a third party (collectively, Images) for the purpose of informing the medical profession and the general public about plastic surgery and plastic surgery procedures and techniques without compensation to me. Such use shall include, but not be limited to, distributing the Images via print, visual and electronic media, specifically including the Elliot M. Hirsch, MD, Inc. website and social media sites such as YouTube, Facebook, RealSelf, Loveyourlook, and Twitter. The Images (including any photographic negatives) shall be the sole property of Elliot M. Hirsch, MD, Inc.

I hereby waive any right to inspect or approve the finished product, photograph, video, DVD, CD-ROM or matter that may be used in conjunction therewith or to the eventual use that it might be applied. I hereby release, discharge and agree to hold harmless Elliot M. Hirsch, MD, Inc. and affiliates and their respective representatives, assigns, and employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and name and the reproduction thereof as stated above, including any claim for payment in connection with distribution or publication of the video and/or photographs.

I hereby warrant that I am over twenty-one years of age, and competent to contract in my own name insofar as the above is concerned. I have read and understand the foregoing release, authorization and agreement, before signing my name below, and enter into it knowingly and voluntarily.

PATIENT (OR REPRESENTATIVE) SIGNATURE _____DATE _____

PRINTED NAME _____

For patients under 21 years of age: I have read the above Release and Authorization. I am the parent, guardian, or conservatory of _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization in the interest of public education and scientific research.

PATIENT (OR REPRESENTATIVE) SIGNATURE _____DATE _____

PRINTED NAME _____