ELLIOT M. HIRSCH, MD
PLASTIC & RECONSTRUCTIVE SURGERY

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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		

The section below is for insurance patients only			
INSURANCE TYPE (CIRCLE)	MEDICARE PPO Covered CA EPO HMO IPA SELF PAY OTHE		
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 AND MIDDLE INITIAL	DATE OF BIRTH OF INSURED

OFFICE USE ONLY

Plan:_____ Location:_____

Ins:_____ Tentative DOS:_____

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. Please notify us immediately if there are any changes to your insurance plan or your coverage.
- 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, CareCredit, or credit card (Visa, MasterCard, or Discover).
- For cosmetic procedures, full payment is required 1 week before surgery unless other arrangements have been made. If you have not paid in full 1 week prior to surgery or have not made other arrangements, you may lose your surgical reservation.
- Co-payments and Deductibles are an agreement between you and your insurance plan, are your responsibility, and are not something we can negotiate.

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.

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, 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.

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, billing, and referral. I hereby authorize the disclosure of my PHI to insurance carriers and/or its representatives for processing claims, and in the event of a dispute I hereby authorize the disclosure of my PHI to relevant credit card companies and banking institutions. 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.

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.

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

NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGEMENT AND DISCLOSURE

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

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

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. 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 _____

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.

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 _____

Medical and Surgical History Form

Name: _____ 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

Do you have any allergies or sensitivities to medications? ☐ None ☐ Yes, please list _____

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 last mammogram and what was the result: _____

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

Tobacco: ☐ Currently using ☐ Previously used, date stopped:_____ ☐ Never used

Alcohol: ☐ Currently using ☐ Previously used, date stopped:_____ ☐ Never used

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 ☐ HIV/AIDS ☐ IV drug use ☐ Blood Transfusion ☐ MRSA bacteria

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 _____

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

Patient signature:_____Date_____