



Jain Plastic Surgery, PC
COSMETIC SURGERY CENTER

JAIN PLASTIC SURGERY, PC

SUMMARY OF PRIVACY PRACTICES

This summary of privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice is in the HIPAA Compliance Plan Notebook.

Date of Last Revision: 03/18/2003

This information is made available upon request by a patient

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail, please refer to the Notice of Privacy Practices that follows this summary):

- for medical treatment;
- to obtain payment for our services;
- in emergency situations;
- for workers compensation programs;
- to run our Practice more efficiently; and to ensure our patients receive the best of quality care;
- for research;
- to avert a serious threat to health or safety;
- for organ and tissue donation;
- for appointment and patient recall reminders;
- in response to certain requests arising out of lawsuits or other disputes.

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- the right to inspect and copy;
- the right to amend;
- the right to an accounting of disclosures;
- the right to request restrictions;
- the right to a paper copy of this notice;
- the right to request confidential communication.

For more information about these rights, please see the detailed Notice of Privacy Practices that follows this summary.



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PATIENT CONSENT FORM

Acknowledgement and Receipt of Privacy Practices Summary

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information and information about your treatment, payment or healthcare operations in order to provide healthcare treatment that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to use the disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice or to request restrictions and revoke consent in writing after you have received our privacy notice.

Print Name: _____ Signature: _____ Date: _____

Compliance Assurance Notification for Our Patients

This misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practices never contribute in any way to the growing problem of improper disclosure of PHI. As a part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that any event compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.



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FORMS COMPLETION POLICY

While disabled from working, many of our patients and/or family members ask that their doctors assist them in the completion of special forms which cover payments for credit cards, car payments, mortgage payments, insurance, short-term or long-term disability income and Family Medical Leave Act, etc. The staff at Jain Plastic Surgery, PC is happy to assist with the completion of these forms, however, due to the growing number of forms that need completion and the time involved in their completion, our office is forced to implement the following policy. Please read the following information carefully.

1. Should you require assistance completing the above referenced form(s), there will be a minimum charge of \$25.00 per form.
2. Forms are completed only after payment is received.
3. Forms are completed in the order they are received. Once the form and payment are received, please allow 7 to 10 business days for completion by our office. We cannot interrupt patient care to fill out forms. Please make sure to plan accordingly.
4. The forms cannot be completed until the physician(s) note from your most recent office visit is transcribed. On average, this takes 24 to 48 hours from time of appointment.
5. No forms are completed on an emergency or rush basis as our clinical and surgical schedules do not allow this.
6. Forms should be given to the support staff in the front office. Our physician cannot receive any forms during your examination. If you need a form filled out, these forms can be dropped off with payment at the front desk, or they can be mailed with payment to 2522 Warm Springs Road, Columbus, GA 31904. Please do not fax any forms to our office.
7. If you are unable to pay the fee for the completion of the form, you could seek to gain the same information from a copy of your medical record. Please inquire about this option with our front office staff.
8. Forms received without payment will not be processed and will be returned to you uncompleted.
9. If you are a patient under Workers Compensation, these forms are not covered and are considered a personal expense.
10. Due to Federal Privacy guidelines, these forms can only be faxed or mailed to the patient. We are unable to fax or mail these forms to any other entity.

Thank you for your cooperation.
Jain Plastic Surgery, PC

I have read and understand the policy listed above.

Patient or Guardian Signature

Date



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PATIENT INFORMATION FORM

PATIENT INFORMATION

Patient Name: _____
First Middle Last

Address: _____
Street & Apt. # City State Zip

Home Phone: _____ Mobile: _____ Other: _____

Are there any restrictions for contacting you? Yes If yes, what are they: _____
 No _____

Age: _____ Date of Birth: _____ SSN: _____ - _____ - _____

Marital Status: Single Married Divorced
Name and telephone number of spouse: _____

Employer: _____ Occupation/Title: _____

Employer Address: _____ Phone: _____

Emergency Contact: _____ Telephone: _____

Relationship to Patient: _____ Telephone 2: _____

MEDICAL INFORMATION & MEDICAL HISTORY

Please list all surgeries you have had: _____

Have you had any problems with anesthesia: Yes If yes, please explain: _____
 No _____

List any previous hospitalizations and dates: _____

List all prescription medications you are currently taking: _____

List any over-the-counter medications you have taken within the past 30 days: _____

Do you use tobacco: Yes If yes, how much and how long: _____
 No _____

Do you use alcohol: Yes If yes, how much and how long: _____
 No _____

Have you ever been diagnosed with Depression, Anxiety, Schizophrenia or any other mental disorder:
 Yes If yes, please explain: _____
 No Treating Physician: _____

Please list any allergies to medication: _____

PLEASE CHECK IF YOU HAVE ANY PROBLEMS WITH THE FOLLOWING:

Ear/Nose/Throat

- Eyes
- Ears
- Headaches
- Mouth/Teeth

Lungs

- Cough
- Coughing up blood
- Shortness of breath
- Coughing up phlegm/sputnam
- Asthma/Emphysema

Cardiovascular

- High blood pressure
- Rheumatic fever
- Chest pain
- Ankle swelling
- Heart attack(s)
- Shortness of breath
- Palpitations (rapid heart beating)
- Is your exercise tolerance good?

Skin

- Rashes
- Lesions that do not heal
- Changes in moles
- Development of thick scars

Musculoskeletal

- Arthritis
- Back Pain

Gastrointestinal

- Loss of appetite
- Increase in appetite
- Weight gain
- Weight loss
- Indigestion
- Nausea/Vomiting
- Diarrhea

Genitourinary

- Blood in urine
- Pain when urinating
- Frequent urination

Menstrual/Reproductive

- Regular periods
- Heavy periods
- Painful periods
- Date of last period: _____

Neurological

- Stroke(s)
- Seizure(s)
- Passing out

Blood System

- Low blood count
- Bleed easily from gums when brushing teeth?
- Bruise easily
- HIV/AIDS
- OTHER BLOOD DISORDER: _____

FAMILY HISTORY

Mother: Living
 Deceased Age at time of death: _____ Cause of death: _____

Father: Living
 Deceased Age at time of death: _____ Cause of death: _____

Please check any family medical issues that are applicable to you:

- Cancer
- Diabetes
- Heart Disease
- Mental Disorders
- Vascular Disease (stroke)
- Obesity

REFERRAL SOURCE

Please mark all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> Word of Mouth |
| <input type="checkbox"/> Columbus in the Valley | <input type="checkbox"/> Seminar |
| <input type="checkbox"/> Southern Views | <input type="checkbox"/> Internet/Web |
| <input type="checkbox"/> Bayonet | <input type="checkbox"/> Referring Physician |
| <input type="checkbox"/> Other | |

Name of referring physician

Please list other referral source

AREAS OF INTEREST

Facial Procedures

- Blepharoplasty (eyelid lift)
- Botox
- Brow or Forehead Lift
- Earlobe Repair
- Facial Liposuction
- Face or Neck Lift
- Lip Enhancement
- Otoplasty (ear pinning)
- Rhinoplasty (nose reshaping)
- Skin Resurfacing (laser, peel, etc)
- Soft Tissue Fillers (injections)

Breast Procedures

- Augmentation
- Reconstruction
- Breast Reduction
- Mastopexy (breast lift)
- Nipple Reduction or Inversion

Body Procedures

- Abdominoplasty (tummy tuck)
- Brachioplasty (arm lift)
- Belt Lipectomy
- Liposuction (thighs, abdomen, etc.)
- Thigh or Buttock Lift

Other Procedures

- Skin Care
- Lesions/Moles
- Telangectasia (spider veins)
- Laser Hair Removal
- Laser Tattoo Removal

ACKNOWLEDGEMENT

By signing below, I am acknowledging that the above information is true and complete to the best of my knowledge. I understand that withholding any personal or family medical information could be detrimental to my healthcare and/or surgical experience.

I understand that office visit charges are payable on the day that service is rendered.

Signature: _____ Printed Name: _____

Date: _____