JESSICA BELZ, M.D.
PLASTIC SURGERY

Name _____ DOB _____ Age _____

Reason for today's visit _____

Procedure(s) interested in _____

Have you had previous plastic surgery? *(please circle)* YES NO

If yes, what type? _____

Were you satisfied with it? *(please circle)* YES NO

**CURRENT MEDICAL CONDITIONS**

To your knowledge, do you **have** or have you ever **had** any of the following? *(please circle)*

AIDS
Anemia
Anxiety
Arthritis
Asthma
Autoimmune Disease
Bleeding Disorders
Blood Clots
Blood Transfusion
Bone Fractures
Breast Cancer
Bruise/Bleed Easily
Cancer
Caps/Dentures/Bridges
Chest Pain/Tightness
COPD
Crohn's Disease/Colitis
Depression
Diabetes
Eczema
Emphysema
Facial Fractures
Fainting Spells
Frequent Nosebleeds
Head Injury
Headaches/Migraines
Heart Attack
Heart Disease
Heart Failure
Heart Murmur
Hepatitis
Herpes
High Blood Pressure
High Cholesterol
History of Radiation
HIV Positive
Hives
Irregular Heart Beats
Kidney Stones
Liver Disease
Loose/Missing Teeth
Lupus
Lyme Disease
Mitral Valve Prolapse
Multiple Sclerosis
Obesity
Pacemaker
Phlebitis
Polio/Meningitis
PTSD
Psoriasis
Pulmonary Embolism
Rashes
Rheumatic Fever
Rheumatoid Arthritis
Scoliosis
Seizures
Shortness of Breath
Skin Cancer
Skin Disease
Sleep Apnea
Stroke
Thyroid problems
Tuberculosis
Ulcers
Urinary Tract Infection
Weight Loss
Other _____
_____

Name _____ DOB _____

**SURGERIES/MAJOR HOSPITALIZATIONS** □ If none, please check.

*(please list all, including dates)*

_____

_____

_____

_____

_____

**MEDICATIONS & DOSES** □ If none, please check.

*(please list all medications with dosages, including prescription & over-the-counter medications, vitamins and herbal supplements)*

_____

_____

_____

_____

_____

**ALLERGIES TO MEDICATIONS** □ If none, please check.

| Name of Medication | Reaction |
|---|---|
| | |
| | |
| | |
| | |

Are you allergic to **Latex**? *(please circle)* YES NO

Are you allergic to **Adhesive**? *(please circle)* YES NO



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Name _____ DOB _____

**FAMILY MEDICAL HISTORY**

Have any family members suffered from any of the conditions listed below? *(please circle)*

| Condition | Relation to You |
|---|---|
| Bleeding Disorder | |
| Blood Clots | |
| Breast Cancer | |
| Cancer (please specify what type) | |
| Diabetes | |
| Heart Disease/Stroke/Heart Attack | |
| High Blood Pressure | |
| Lung Disease/Asthma/Emphysema | |
| Mental Illness | |
| Reaction to Anesthesia | |
| Other | |

**SOCIAL HISTORY**

Marital status *(please circle)*: Single Married Separated Divorced Widowed

Number of pregnancies: _____ Number of children: _____

Occupation: _____

Does your job require heavy lifting? _____

Do you consume alcohol? *(please circle)* YES NO

If yes, type and amount per week _____

Do you currently smoke cigarettes or use tobacco products? *(please circle)* YES NO

If yes, how many cigarettes per day? _____ How long have you smoked? _____

If no, have you ever smoked or used tobacco products? *(please circle)* YES NO

When did you quit? _____

Do you or have you ever-used IV or other street drugs? _____



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Name _____ DOB _____

**REVIEW OF SYSTEMS**

*Do you **now** have or have you **had** any of the following conditions within the last year? Please circle all that apply.*

| | | |
|---|---|---|
| Weight Gain | Sinusitis | Chronic Constipation |
| Weight Loss | Shortness of Breath | Painful Urination |
| Headaches | Wheezing | Leakage of Urine |
| Depression | Chronic Cough | Leg Cramps |
| Fainting Spells | Chest Pain | Joint Pain |
| Blurred Vision | Heartburn | Backaches |
| Eye Pain | Breast Pain | Easy Bruising |
| Dry Eyes | Breast Lump | Insomnia |
| Double Vision | Nipple Discharge | |
| Difficulty Hearing | Abdominal Pain | |
| Nosebleed | Chronic Diarrhea | |

**FEMALE PATIENTS ONLY**

Age period began _____

Age at first childbirth _____

Date of last period _____

Date of last mammogram _____

Age of menopause _____

Do you have breast implants? _____ Size/type? _____

Are you pregnant?_____

Are you breastfeeding? _____

Patient's Signature _____Date _____

*The effort you have made in filling out this form is greatly appreciated. Thank you!*



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Name _____ DOB _____

**PATIENT INFORMATION**

Patient Name: _____ □Mr. □Mrs. □Ms. □Miss □Dr.

Address: _____

City: _____ State: _____ Zip code: _____

Home phone: (___)-_____ Work: (___)-_____Cell: (___)-_____

*Please circle the number you prefer us to call and leave a message if needed.*

Email address: _____

SSN: _____ Birthdate: _____ Age: _____

Gender: □Female □Male

Marital Status: □Single □Married □Separated □Divorced □Widowed

How did you hear about us? □Physician referral □Former patient
□Website/Internet □Friend
□Hospital □Other: _____

Who may we thank for referring you? _____

Employer: _____Work phone: (___)-_____

Employer Address: _____

City: _____ State:_____ Zip Code: _____

**Emergency Contact**: _____ Phone: (___)-_____

**Responsible Party** (*Please fill out ONLY if different from patient information above)*

Name: _____ SSN: _____ Birthdate: _____

Relation to patient: _____

Employer: _____ Work phone: (___)-_____

Employer Address: _____

City: _____State:_____ Zip Code: _____



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Name _____ DOB _____

**Insurance Information**

Primary Insurance Company: _____

Address: _____

City: _____ State: _____ Zip code: _____

Insured's Name: _____ Insured's Birthdate: _____

Insured's Relation to Patient: _____ Insured's SSN: _____

Insured's ID/Policy Number: _____ Group Number: _____

Secondary Insurance Company: _____

Address: _____

City: _____ State: _____ Zip code: _____

Insured's Name: _____ Insured's Birthdate: _____

Insured's Relation to Patient: _____ Insured's SSN: _____

Insured's ID/Policy Number: _____ Group Number :_____

**Physician Information**

Primary Care/Family Physician: _____Phone: _____

Referring Physician: _____ Phone: _____



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**Initial** **POLICIES AND CONSENTS**

_____ **CONSENT FOR GENERAL TREATMENT**

I request and authorize healthcare services to be provided by Dr. Jessica Belz and members of her clinical staff.

_____ **CONSENT FOR COMMUNICATION**

I agree to receive appointment reminders and other communications from Dr. Jessica Belz' office via text messaging, email, and/or phone.

_____ **NO REPRESENTATION OR GUARANTEES**

I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no oral or written representations or guarantees have been made to me as to the results of any diagnosis, treatment, and medical care that I (or the patient, if a minor) may receive as a patient of Dr. Jessica Belz.

_____ **RELEASE OF INFORMATION**

I hereby authorize Jessica M. Belz, M.D., PLLC, her agents, and employees to release copies of my medical records, including information from prior treating physicians, X-rays, reports, and information about substance abuse treatment, mental illness, HIV, AIDS, sexually transmitted infections or TB.

a) to any governmental agency, medical service organization, insurance company, auditing agency engaged by Jessica M. Belz, M.D., PLLC, or a third party payer, employer or physician for the purpose of processing any claims for benefits.
b) To any physician or health care facility to which I, the patient, may be referred to, for the purpose of continued patient care.
c) To the physician/facility who has referred me to Dr. Jessica Belz.

_____ **PAYMENT POLICY**

All professional services rendered are charged to the patient. Necessary forms may be completed to help expedite insurance payments. However, the **patient** is responsible for all fees, regardless of insurance coverage. **Payment is expected when services are rendered.** FMLA and Disability forms will gladly be completed for an additional fee of $25. In the rare event of a complication, the **patient** is responsible for all fees related to said circumstances, including, but not limited to: anesthesia, facility, emergency room, laboratory, pathology, radiology, and other consultant fees.

_____ **INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS**

I authorize release of any information concerning my (or my child's) healthcare, advice and treatment for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of Insurance benefits otherwise payable to me, directly to the doctor. I understand that I am financially responsible for any amount not covered by my insurance. I also understand that Dr. Belz may or may not participate with my current insurance carrier.

**I hereby certify that I have read this form, or it was read to me, and that I fully understand the contents of this form.**

_____ _____

Patient Signature Date



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# PATIENT PHOTOGRAPH CONSENT

Photographs are considered to be an integral part of your plastic surgical care. Photographs are required and nearly always taken prior to and after any procedure. Photographs may also be taken during procedures as deemed warranted. This is a generally accepted practice amongst plastic surgeons. Photographs are useful as a patient educational tool, are a critical part of surgical planning, and are a means to accurately assess results.

All photographs will be taken with as much discretion as possible. Care will be taken to assure they are as least identifiable as possible. Since the photos will concentrate on the area of concern, few will include the face. Your name will not be in the photograph. Your name will accompany the photos in storage. If the procedure includes the face, there will be **NO** ability to make the photos completely anonymous. Unique identifying, non-removable, body adornment such as tattoos or piercings may also preclude anonymity.

Photographs may be requested by insurance companies or others involved in your care. They may be sent through the mail, via the Internet or fax machine.

Except in an emergency, if a patient refuses to consent for photographs, Dr. Belz may choose not to proceed with the procedure.

Please indicate which photograph consent you agree to, by placing your **initials** where indicated and providing your full **signature** below.

_____**ALL MEDIA USE**

I hereby authorize, Dr. Jessica Belz and/or her assistants to take, develop, utilize, and store photographs of myself. I understand that copies of these photographs may be used for professional medical purposes deemed appropriate, including, but not limited to: any print or broadcast media, patient education, medical education, surgical planning, office photo albums, internet, practice website, television, advertising media, commercial media, social media, lay publication or during lectures to medical or lay groups. I release and discharge Dr. Belz and her staff from any and all claims or actions that I have or may have relating to such use and publications. I understand that I will not be entitled to monetary payment or any other consideration as a result of the use of these images and that these photographs will use discretion and be as confidential as possible.

_____**MEDICAL USE ONLY**

I hereby authorize, Dr. Jessica Belz and/or her assistants to take, develop, utilize, and store photographs of myself, solely for the purpose of medical care and to request authorization for surgical procedures with my insurance company, if applicable. I understand that I will not be entitled to monetary payment or any other consideration as a result of the use of these images and that these photographs will use discretion and be as confidential as possible.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

JESSICA BELZ, M.D.
PLASTIC SURGERY

# NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. Compliance with this Act is required by April 14, 2003.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.
**We may use and disclose your medical record only for each of the following purpose: 1) treatment, 2) payment and 3) health care operations.**

- **Treatment** means providing, or managing health care and related services by one or more health care providers. Examples would include information pertaining to consultation, examination, surgery, and other medical care. These are often requested by other health care providers involved with your care or entities involved in your care such as hospitals and surgery centers. Insurance companies frequently request this information to determine coverage of a particular procedure, including insurance for cosmetic surgery. They request this be sent through the mail, and/or via fax or internet (electronic). This information can also include photographs. When photographs are involved, no facial features are included unless the area of concern is located on the face. Mailings and/or appointment reminders sent to you or others may contain our business name, logo and/or doctor's name. We may send you e-mails confirming appointment and/or surgery times, and request results of needed labs, tests, procedures, or medical evaluations.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. Examples would include sending a bill for your treatment to an insurance company or other source responsible for your payment. Please be aware that although payments via check or credit card by you contain no health information, they will be deposited into an account readily identifiable by bank or card personnel as being associated with a "plastic surgeon's office."

- **Health care operations** include the business aspects of running our practice, such as conducting assessment and improvement activities, auditing functions, cost management analysis and customer service.

We may also contact you and distribute de-identifiable health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or health related benefits and services that may be of benefit to you. Reminders may be in the form of a letter, postcard or voice message on your answering machine. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to abide by that written request, except to the extent that we have already taken actions relying on your authorization.

## NOTICE OF PRIVACY PRACTICES – continued

**Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose personal health information, (PHI), including electronic, that identifies you without your written authorization.** Individual authorization is required for uses such as psychotherapy notes, PHI for marketing, sale of PHI, or fundraising. This practice does not participate in any of these practices at this time.

**You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer, Dr. Jessica Belz.**

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to family members, other relatives, close personal friends or any other person identified by you. It is our policy to be as discrete as possible at all times. We do, however, frequently need to relay information to friends and relatives pertaining to your care, such as your course during surgery or recovery. We may relay information to a significant other or answering machine about appointments or billing issues. If you do not want us to call a place of employment or home or leave messages, please notify us.

- The right to reasonable requests to receive confidential communication of protected health information, from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive any accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us on request.

- The right to be notified of any breach of unsecured protected health information, as required by law.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective of all protected information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Policy from this office.

You have recourse if you feel that your privacy protections have been violated. You have a right to file a formal complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of the policies and procedures of our office. We will not retaliate you for filing a complaint.

JESSICA BELZ, M.D.
PLASTIC SURGERY

**NOTICE OF PRIVACY PRACTICES**
**ACKNOWLEDGEMENT AND CONSENT FORM**

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can be and will be used to:

- Conduct, plan and direct my treatment and follow up among the various health care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received and/or read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to abide by my requested restrictions, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient name: _____

Relationship to patient: _____

Patient signature: _____

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OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement and consent on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____