Walter W. Tom, M.D., F.A.C.S.
Surgeon & Medical Director
MAUI COSMETIC SURGERY
a medical corporation

PATIENT CONCERNS QUESTIONNAIRE

Patient Name: _____ Date: _____

Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply.

Leg Veins
Skin Care Products
Facial Fullness/Drooping
Facial Injectables/Fillers
Facial Fat Transfer
Thin Lips
Facial Veins
Blotchy Skin
Facial Redness
Skin Care Advice
Facial Fine Lines/Wrinkles
Brown/Age Spots & Freckles
Tired, Dull Skin
Length/Fullness of Eyelashes
Rough Texture of the Skin
Facial/Peel Treatments
Acne
Unwanted Hair
Cellulite
Breast Size
Bikini Tummy Tuck
Body Contouring
Abdominal Area
Hips
Thighs
Neck/Jawline
Vaginal Concerns

Other:

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PERSONAL HISTORY

Name _____Date_____
Date of Birth_____Occupation_____
Home Address_____
City_____State_____Zip Code_____
Home Phone (__) _____Work Phone (__) _____Cell Phone (__) _____
May we call you at work? __yes __no
E-mail address: _____
Emergency Contact Name_____Phone (__) _____
How did you hear about us?
Which of the following best describes your skin type? (Please circle)

I Always burns, never tans
II Always burns, sometimes tans
III Sometimes burns, always tans
IV Rarely burns, always tans
V Brown, moderately pigmented skin
VI Black skin

MEDICAL HISTORY:

Do You Smoke? Yes ( ) No ( )
Are you presently under the care of a physician? ( ) Yes ( ) no name_____
Are you presently under the care of a dermatologist? ( ) yes ( )no name_____
Do you have any of the following medical conditions? (Please check all that apply)
( ) keloid scarring ( ) skin disease/skin lesions ( ) Rosacea
( ) Herpes simplex or cold sores ( ) respiratory problems
( ) diabetes ( ) high blood pressure ( ) heart disease
( ) cancer ( ) Hepatitis/liver disease ( ) kidney diseases ( ) seizure disorder
( ) allergy to cold environment, Raynaud's disease, lupus, or other autoimmune diseases
( ) hormone imbalance ( ) thyroid imbalance ( ) blood clotting abnormalities
( ) any active infection ( ) history of consulting a psychiatrist or counselor
( ) personal or family history of anesthesia problems ( ) panic attacks ( ) fainting
Description of any of above problems _____
_____
Do you have any other health problems or medical conditions? Please list: _____
Medications: ( ) Accutane ( ) birth control ( ) hormones
( ) others, please list:_____
( ) homeopathic Rx (i.e. St. John's Wort, Gingko) _____
Do you take any pre-medication for dental or other procedures? (i.e. antibiotics)
__yes __no

Have you ever used Accutane? ( ) Yes ( ) No If yes, when did you last use it?_____

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What topical medications or creams are you using?
( ) Retin A ( ) others, please list _____
Any recent tanning or sun exposure that changed the color of your skin? ( ) Yes ( ) No
Have you used any self-tanning lotions or treatments? ( ) Yes ( ) No
Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma ( ) Yes ( ) No If yes, please describe _____
_____.
Do you form thick or raised scars from cut or burns? ( ) Yes ( ) No
FEMALE PATIENTS
Are you pregnant or trying to become pregnant? _yes _no
Are you using contraception? __yes __no
Are you breast-feeding? __yes __no

ALLERGIES:

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced.) ( ) food ( ) latex ( ) cosmetics
( ) aspirin ( ) lidocaine ( ) hydrocortisone ( ) hydroquinone or skin bleaching agents
( ) other medications: _____

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, nurse or doctor of any current medical or health conditions and to update this history as current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature_____Date _____

I understand that professional services provided by Dr. Walter Tom and his staff will not be covered by medical insurance. I agree to take full responsibility for payment of the charges incurred.

Signature_____Date _____

Advanced Directives: *ALVC respects your right to participate in decisions regarding your healthcare. However, the policy of the Center is that all patients undergoing procedures will be considered for life sustaining treatment.* ***ALVC does not honor advanced directives****. ALVC will always attempt to resuscitate a patient and transfer that patient to a hospital in the event of deterioration.*

Signature_____Date _____

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HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for an office procedure may require that your relevant protected health information be disclosed to the health plan to obtain approval for the visit.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Initial____

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We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your provider is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**
Health & Human Services in Napa 2261 Elm St., Napa, CA 707-253-4279. **Initial_____**

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Patient's Responsibilities:

Participate in, and follow agreed-upon plan of care.

Fully participate in decisions involving their own health care.

Cooperate with physician and ask questions if not understanding instructions or information.

Provide physician with a complete and accurate history about illnesses, hospitalizations, medications, and other matters related to your health.

Notify facility if there is any problem or dissatisfaction with care or services.

Treat personnel with respect, consideration, and dignity.

Give timely notice when canceling an appointment.

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____	_____	_____
Print Name	Signature	Date

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PATIENT'S RIGHTS AND RESPONSIBILITES

PATIENT'S RIGHTS:

- Exercise these rights without regard to sex, cultural, economic, educational, or religious background.
- Patients are given equitable, unbiased, considerate, and respectful care.
- Patients are provided appropriate privacy regarding medical records and during interviews, examinations, treatment, and consultation. Medical information will not be released without patient's written consent.
- Patients are given the opportunity to participate in decisions involving their care.
- Patients are in receipt of sufficient information in advance, if feasible, to allow a patient to give informed consent or to refuse any proposed treatment or procedure.
- Patients are provided, to the degree known, complete information concerning their diagnosis, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
- Patient should have knowledge of the name of the physician primarily responsible for care, and the names and roles of any other physicians/nurses involved in their care.
- Patients, prior to treatment, are informed of their financial responsibility and are provided with a receipt and explanation of their bill, regardless of source of payment.
- Patients have ability to have their complaints addressed, and to receive an appropriate response.
- Facility should provide information to patients and staff concerning:

1. Services available at the facility
2. Provision for after-hour and emergency care
3. Fees for services and payment policies
4. Methods for expressing grievances and suggestions to the facility

PATIENT'S RESPONSIBILITIES:

- Participate in, and follow agreed-upon plan of care.
- Fully participate in decisions involving their own treatment.
- Cooperate with physician and ask questions if not understanding instructions or information.
- Provide physician with a complete and accurate history about illnesses, hospitalizations, medications, and other matters related to your health.
- Notify facility if there is any problem or dissatisfaction with care or services.
- Treat personnel with respect, consideration, and dignity.
- Provide a 24-hour cancellation notice prior to your scheduled appointment date, otherwise there will be a charge of $150.00.

_____	_____	_____
Print Name	Signature	Date

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CANCELLATION AND NO-SHOW POLICY

We would like to thank you for being a patient in our office. We value all of our patients and strive to provide the best patient care possible in the most comfortable and safe environment. Please understand that when we schedule your appointment, we are reserving time for your particular needs. We kindly ask that if you must change an appointment, please give us at least 24 hours' notice. This courtesy makes it possible to give your reserved time to another patient who would like to be seen in our office.

We understand that occasional missed appointments can occur for a variety of reasons. A "No Show/Late Cancellation" is defined as missing an appointment without cancelling at least 24 hours before your scheduled time. There will be a charge for a missed or non-cancelled appointment in the amount of $150.00.

_____	_____	_____
Print Name	Signature	Date