Ambay Plastic Surgery
27716 Cashford Circle, Suite 102
Wesley Chapel, FL 33544
813-406-4448

Patient Information Form

Patient Name: ______________________ Preferred Language: ______________

Address: ______________________ City: ______________ State: ______ Zip: ______

Home Phone: ____________ Cell Phone: ____________

Social Security Number: ______________ Email Address: ______________________

Employer Name: ______________ Address: ______________________

Occupation ______________________ Work Phone: ______________

Who is your primary care physician? ______________________

How did you hear about us?

- ☐ Real Self
- ☐ Radio
- ☐ Google
- ☐ TV:
- ☐ Patient Referral: ____________
- ☐ Friend: ____________
- ☐ Dr. Referral: ____________
- ☐ Billboard

What is the nature of your visit? ______________________

Patient Demographics

Height: ______ Weight: ________ DOB: __________ Age: ________
Gender: ________ Race: ____________

Emergency Contact

Name: ______________________ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: ________

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Primary Insurance

Name: ______________________ Policy #: ____________ Group ID: ____________

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Secondary Insurance

Name: ______________________ Policy #: ______________ Group ID: ______________

Assignment and Release

I, ________________________, have insurance coverage and assign all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

________________________________ ________________

Signature of Insured / Guardian Date

Section I: Surgery and Anesthesia History

1. Have you ever had surgery?

☐ No ☐ Yes, please describe and list the month/year:

____

____

2. Have you ever had a blood clot?

☐ No ☐ Yes, if yes when: ______________________________

3. Have you had ANY anesthesia complications?

☐ No ☐ Yes, please describe: ______________________________

4. Are you aware of any family members that have had anesthesia complications or blood clots?

☐ No ☐ Yes, please describe: ______________________________

____

____

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Section II: Specific Medical History

		No	Yes	Description
1.	Are you pregnant?	☐	☐	________
2.	Emphysema	☐	☐	________
3.	High Blood Pressure	☐	☐	________
4.	Asthma	☐	☐	________
5.	Heart Trouble	☐	☐	________
6.	Hepatitis or Liver Trouble	☐	☐	________
7.	Kidney Trouble	☐	☐	________
8.	Diabetes	☐	☐	________
9.	Epilepsy or Seizures	☐	☐	________
10.	Stroke	☐	☐	________
11	Problem Scarring	☐	☐	________
12.	Cancer	☐	☐	________
13.	Bleeding Tendency	☐	☐	________
14.	Repeat Infections	☐	☐	________
15.	Tuberculosis	☐	☐	________
16.	Severe Allergies	☐	☐	________
17.	Arthritis	☐	☐	________
18.	Mental Illness	☐	☐	________
19.	Convulsions or Fits	☐	☐	________
20.	Migraine Headaches	☐	☐	________
21.	Gout	☐	☐	________
22.	Thyroid Trouble	☐	☐	________
24.	Obesity	☐	☐	________
25.	Have you been advised to or had psychiatric care?	☐	☐	________

26.	Others Not Listed:	

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Section III: Social History

1. Do you smoke? ☐ No ☐ Yes, how much? ______________

2. Do you drink? ☐ No ☐ Yes, how much? _______________

3. Do you do recreational drugs such as marijuana? ☐ No ☐ Yes, when? _____________

4. Do you do IV drugs? ☐ No ☐ Yes, when? ____________

5. Do you take pills for dieting? ☐ No ☐ Yes, what? _________________ when? __________

Section IV: Family History

Have any blood relatives had any of the following?

		No	Yes	Description
1.	Emphysema	☐	☐	____________________
2.	High Blood Pressure	☐	☐	____________________
3.	Asthma	☐	☐	____________________
4.	Heart Trouble	☐	☐	____________________
5.	Hepatitis or Liver Trouble	☐	☐	____________________
6.	Kidney Trouble	☐	☐	____________________
7.	Diabetes	☐	☐	____________________
8.	Epilepsy or Seizures	☐	☐	____________________
9.	Stroke	☐	☐	____________________
10	Problem Scarring	☐	☐	____________________
11.	Cancer	☐	☐	____________________
12.	Bleeding Tendency	☐	☐	____________________
13.	Obesity	☐	☐	____________________
14.	Repeat Infections	☐	☐	____________________
15.	Tuberculosis	☐	☐	____________________
16.	Severe Allergies	☐	☐	____________________
17.	Arthritis	☐	☐	____________________
18.	Mental Illness	☐	☐	____________________
19.	Convulsions or Fits	☐	☐	____________________

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20.	Migraine Headaches	☐	☐	______
21.	Gout	☐	☐	______
21.	Thyroid Trouble	☐	☐	______
22.	Have you been advised to or had psychiatric care?	☐	☐	______

23. Others Not Listed:

____

Section V: Medications

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list name and dosage:

____

____

Section VI: Allergies and Sensitivities

Are you allergic to any medications? ☐ No ☐ Yes, please list medication and symptom:

____

____

Are you allergic to Latex? ☐ No ☐ Yes, please list symptom: ______________________

Are you allergic to any Foods? ☐ No ☐ Yes, please list symptom:

____

____

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: ______________________________ ______________

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Consent to Communicate

Patient Name:

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appointment Reminders				
☐ Email Medical Information				
☐ Email Office Specials				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Message – if so, list cell carrier:			☐	-
☐ Text Appointment Reminders				
☐ Text Office Specials				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	

Signature: ______________________________ Date: ____________________

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NOTES:

If receiving Breast Augmentation, cup size: ________________________________

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Notice of Patients' Privacy Rights

The notice of privacy practices is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you or your legal dependent (as a patient of this practice) may be used and disclosed, and how you can access to your individually identifiable health information.

Please Review This Notice Carefully

1. Our commitment to your privacy:

   Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Patient's Privacy Rights ("Notice") that we have in effect at the time.

   We realize that these laws are complicated, but we must provide you with the following important information:

   - How we may use and disclose your PHI;
   - Your privacy rights in your PHI; and
   - Our obligations concerning the use and disclosure of your PHI.

   The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

2. If you have questions about this notice, please contact:

   The Privacy and Security Officer: Kristy Roelofs at security@ambayplasticsurgery.com

3. The different ways in which we may use and disclose your PHI:

   The following categories describe the different ways in which we may use and disclose your PHI:

   Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the

people who work for our practice — including, but not limited to, our doctors and nurses — may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents. Finally, we

may also disclose your PHI to other healthcare providers for purposes related to your treatment.

Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such service costs, such as family members. Also, we may use your PHI to bill you directly for service and items. We may disclose your PHI to other healthcare providers and entities to assist in their billing and collection efforts.

Healthcare Operations. Our practice may use and disclose your PHI to operate our business. As examples of the way in which we may use and disclose your information for operations, our practice may use your PHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other healthcare providers and entities to assist in their healthcare operations.

Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

Health-Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatricians' office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

Disclosures Required by Law. Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

4. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your PHI:

Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths;
- Reporting child abuse or neglect;
- Notifying a person regarding potential exposure to a communicable disease;
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition;
- Reporting reactions to drugs or problems with products or devices;
- Notifying individuals if a product or device they may be using has been recalled;
- Notifying appropriate governmental agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information; or
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws, and the healthcare system in general.

Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement;
- Concerning a death we believe has resulted from criminal conduct;
- Regarding criminal conduct at our offices;
- In response to a warrant, summons, court order, subpoena, or similar legal process;
- To identify/locate a suspect, material witness, fugitive, or missing person; and
- In an emergency, to report a crime (including the location or victim[s] of the crime, or the description, identity, or location of the perpetrator).

Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

Organ and Tissue Donation. Our practice may release your PHI to organizations that handle organ, eye,or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain written authorization to use your PHI for research purposes except when the Practice's Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following:

(i) The use or disclosure involves no more than a minimal risk to your privacy based on the following:

a. An adequate plan to protect the identifiers from improper use and disclosure;

b. An adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and

c. Adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted.

(ii) The research could not practicably be conducted without the waiver.

(iii) The research could not practicably be conducted without access to and use of the PHI.

Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials, or foreign heads of state, or to conduct investigations.

Inmates. Our practice may disclose your PHI to correctional institutions or law

enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (1) for the institution to provide healthcare services to you; (2) for the safety and security of the institution; and/or (3) to protect your health and safety or the health and safety of other individuals.

Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

5. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

Confidential Communication. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Privacy and Security Officer at: Ambay Plastic Surgery 27716 Cashford Circle Ste 102, Wesley Chapel, FL, 33544 specifying the requested method of contact and/or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to Kristy Roelofs, Ambay Plastic Surgery 27716 Cashford Circle, Wesley Chapel, FL 33544. Your request must describe in a clear and concise fashion:

- The information you wish restricted;
- Whether you are requesting to limit our practice's use, disclosure, or both; and
- To whom you want the limits to apply.

Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: Ambay Plastic Surgery 27716 Cashford Circle, Wesley Chapel, FL 33544 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed healthcare professional chosen by us will conduct reviews.

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Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: Kristy Roelofs, Ambay Plastic Surgery 27716 Cashford Circle, Wesley Chapel, FL 33544. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion (1) accurate and correct; (2) not part of the PHI kept by or for the practice; (3) not part of the PHI that you would be permitted to inspect and copy; or (4) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosures. All of our patients have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of certain non-routine disclosures our practice has made of your PHI. To obtain an accounting of disclosures, you must submit your request in writing to: Kristy Roelofs, Ambay Plastic Surgery 27716 Cashford Circle, Wesley Chapel, FL 33544. All requests for an “accounting of disclosures” must state a time period, which may not be longer than six years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of other costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact: (813) 406-4448 or Front Desk, Ambay Plastic Surgery 27716 Cashford Circle, Wesley Chapel, FL 33544.

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact: Kristy Roelofs, Ambay Plastic Surgery 27716 Cashford Circle, Wesley Chapel, FL 33544. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note we are required to retain records of your care. If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy and Security Officer at: Dr. Raj Ambay and Kristy Roelofs, Ambay Plastic Surgery 27716 Cashford Circle, Wesley Chapel, FL 33544.

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HIPAA CONSENT
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Our Notice of Privacy Practices provides information pertaining to the use and disclosure of protected health information (PHI). Ambay Plastic Surgery complies with HIPAA guidelines in regards to patient treatment, payment, and healthcare operations (TPO). You have the right to review our Notice of Privacy Practices prior to signing this consent. Ambay Plastic Surgery reserves the right to revise its Notice of Privacy Practices at any time. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of your protected health information for treatment, payment, and health care operations. You have the right to revoke this consent by submitting a written request. However, such a revocation shall not affect any disclosures we have already made in compliance with your prior consent. Ambay Plastic Surgery shall provide this form, which complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) if requested.

The patient or patient guardian understands that 1.) Protected health information may be disclosed or used for treatment, payment, or health care operations. 2.) The patient/guardian may request a copy of the Ambay Plastic Surgery Notice of Privacy Practice. 3.) Ambay Plastic Surgery reserves the right to change the Notice of Privacy Practices. 4.) The patient or guardian may revoke this consent in writing at any time and all future disclosures will then cease.

With my consent, Ambay Plastic Surgery may call my home or other designated location and speak with me, or leave a message in reference to any items that assist the practice in carrying out TPO, including appointment reminders, insurance related information, and information pertaining to patient clinical care including laboratory results.

With my consent Ambay Plastic Surgery may contact me via designated text messaging, designated e-mail, or designated address regarding any items that assist the practice in carrying out TPO, such as patient statements, collection letters, and any other correspondence or related material.

The practice is not required to agree to my requested restrictions, but if an exception is made, it is bound by this agreement.

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I may revoke my consent in writing except to the extent that the practice had already made disclosures in reliance upon my prior consent. If I do not sign this consent, Ambay Plastic Surgery may decline to provide treatment. By signing this form, I am consenting to Ambay Plastic Surgery's use and disclosure of patient's PHI to carry out TPO.

____	___________________________
Patient Name (please print)	Date
____	___________________________
Signature of Patient or Legal Guardian	Relationship

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PHOTOGRAPH
RELEASE AND AUTHORIZATION

At Ambay Plastic Surgery (APS) we take your privacy very seriously. This consent to release photos allows us to use photos that we do our best to de-identify, for the purpose of informing the medical profession, patients and the general public about plastic surgery procedures and techniques.

I hereby irrevocably consent to and authorize the use and reproduction by Ambay Plastic Surgery (APS) of any and all photographs and electronic images or video footage of me taken by APS, or that APS has in its possession, provided either by me or by a third party (collectively, Images) for the purpose of informing the medical profession, patients and the general public about plastic surgery procedures and techniques. Such use shall include, but not be limited to, distributing the Images via print, visual and electronic media, specifically including the APS website and social media sites.

I hereby waive any right to inspect or approve the finished product, photograph, 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 APS and its 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.

Signature:_____________________________________

Printed Name:_________________________________

Date:____