PATIENT REGISTRATION FORM

Today's Date: _____________________ Date of Injury:_______________________

Reason for today's visit: ____

Name: ____
Last First MI Ms. Mrs. Mr. Dr.

I prefer to be called: ____

Birthdate:______________________________Age:____________SS#:____

❐ Single ❐ Married ❐ Divorced ❐Widowed ❐ Separated

Home Address:____
apt/condo #

____
city state zip

Home#: (________)____________________________________ Cell (_________)_________________________________

E-Mail :____
(Would you like to be excluded from mailings and email promotions? ❐ Yes ❐ No)

Employer:____ Occupation:____

Wk #: (________)_______________________________________ ❐ Full time ❐ Part time # of years employed:_________

Student: ❐ Yes ❐ No Where: ____ ❐ Full time ❐ Part time

When is the best times to reach you?____

How did you hear about us? ____

Spouse or Parent Information

Name:____ SS#:__________________________ Birthdate:_________________

Relationship: ❐Parent/Guardian ❐ Spouse ❐ Other (please identify)____

Address: ____ Phone:(________)____________________________________

Employer: ____ Work Phone:(________)_______________________________

Responsible Party (Guarantor) Information

Check one: ☐ Self ☐ Spouse ☐ Parent

Name: ____ Work Phone:(______)________________
Last First MI

Relation: ______________________________________Home Phone:(_______)________________________

Billing Address: ____ SS#:______________________

Employer:____

Employer's Address:____

Insurance Information

ALL PATIENTS- please fill out this section, even if your procedure/treatment will not be covered. This information may be necessary when ordering laboratory or other tests.

Primary Insurance:_________________________________ Plan name:___________________________

Claims Office Address:____
(street or P.O. Box) city state zip

Claims Office Phone #:__________________ Group #:___________________Policy #:___________________

Policy Holder Name:____ Co-pay Amount $:____________

Insured's SS#:_____________________________ Insured's Birthdate:_______________________________

Insured's Relationship to Patient: ❒ Self ❒ Spouse ❒ Child ❒ Other______________________________
____

Secondary Insurance:_______________________________ Plan name:___________________________

Claims Office Address:____
mailing address (street or P.O. Box) city state zip

Claims Office Phone #:__________________ Group #:___________________Policy #:___________________

Policy Holder Name:____ Co-pay Amount $:____________

Insured's SS#:_____________________________ Insured's Birthdate: _______________________________

Insured's Relationship to Patient: ❒Self ❒Spouse ❒Child ❒Other______________________________

Do you have Medicaid? ❒Yes ❒No Which state? ____

IN THE EVENT OF AN EMERGENCY, WHOM SHOULD WE CONTACT?

Name:___________________________ Phone: (_______)_______________ Relationship________________

Medical History

Name: ____ Date: __________________________

Confidential Record: The information you provide will help us make the best decisions regarding your medical care and is only released according to HIPAA regulations as noted in our Notice of Privacy Practices.

What is your Height?______ft _______in Weight? __________lbs

Allergies: (including Drugs, Foods, Latex, Other) ❒ yes ❒ no ____

____

Type of Reaction: ❒ Hives/Rash ❒ Anaphylaxis (Severe Reaction with difficulty breathing) ❒ other _______________

Medications: (name, dosage, and frequency)

Prescription: ❒ yes ❒ no ____

Non-prescription: ❒ yes ❒ no ____

For Women:				
	Do you take Birth Control Pills?	❒ yes	❒ no	
	Are you pregnant?	❒ yes	❒ no	Week #:_____________
	Are you nursing?	❒ yes	❒ no	

Have you EVER had:

Y N
- ❒ ❒ Heavy Scarring/Keloids
- ❒ ❒ Hepatitis/Jaundice (skin or eyes turned yellow)
- ❒ ❒ Prolonged bleeding or excessive bruising
- ❒ ❒ Trouble with bleeding with surgery or Wisdom teeth
- ❒ ❒ Family member with bleeding problems
- ❒ ❒ Hemophilia
- ❒ ❒ Blood clots in the legs, lungs/Thrombophlebitis
- ❒ ❒ High blood pressure
- ❒ ❒ Murmur: Type: _____________________________
- ❒ ❒ Mitral Valve Prolapse
- ❒ ❒ Echocardiogram exam of the heart
- ❒ ❒ Irregular heart beat or palpitations
- ❒ ❒ Anemia/Sickle cell disease
- ❒ ❒ Chest pains or Angina
- ❒ ❒ Heart attack; year(s)__________________________
- ❒ ❒ Congestive heart failure
- ❒ ❒ Artificial joints, implants, valves _______________
- ❒ ❒ Neck problems or neck surgery
- ❒ ❒ Rheumatic fever or rheumatic heart disease
- ❒ ❒ Pacemaker
- ❒ ❒ Liver disease
- ❒ ❒ Kidney problem

Y N
- ❒ ❒ Sleep apnea/Severe snoring or use CPAP Mask
- ❒ ❒ Asthma or emphysema
- ❒ ❒ Do you use an inhaler
- ❒ ❒ Taken Cortisone/Prednisone/Steroids in past year
- ❒ ❒ Shortness of breath on exertion
- ❒ ❒ Bronchitis
- ❒ ❒ Cough up blood, loss of appetite, night sweats
- ❒ ❒ Trouble breathing when lying flat
- ❒ ❒ Diabetes; # of years _________________________
- ❒ ❒ Difficulty healing wounds
- ❒ ❒ Unexplained weight loss /Fever/Chills
- ❒ ❒ Severe /Frequent headaches
- ❒ ❒ Stroke
- ❒ ❒ Epilepsy/Convulsions; last seizure____________
- ❒ ❒ Psychiatric problems
- ❒ ❒ Gastrointestinal bleeding/Ulcers/Colitis
- ❒ ❒ Cancer/Chemotherapy; Type__________________
- ❒ ❒ Cold sores/Fever blisters
- ❒ ❒ Glaucoma
- ❒ ❒ Mononucleosis; year_________________________
- ❒ ❒ Drug/Alcohol abuse

(Please complete reverse side)

Patient: ____

Any other Medical Conditions: (past & present) ❒yes ❒no
____

Previous Surgeries: ❒yes ❒no
____
____

Have you EVER smoked tobacco? ❒yes ❒no (# of packs per day: _____ # of Years____ Year Quit: _______)

Have you ever had any difficulty with anesthesia? ❒yes ❒no (explain :_________________________________)

Have **any family members** ever had any difficulty with anesthesia? ❒yes ❒no (explain :_________________)

Have you ever had a blood transfusion? ❒yes ❒no (what year(s): ____________________________________

Have you ever had an AIDS/HIV test? ❒yes ❒no (what year ________, results? ❒negative or ❒positive)

I hereby state that the information given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status.

____ ___________________________
Signature Date

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I have verbally reviewed the medical information with the patient named herein. Initials: _______Date:__________________

MEDICAL HISTORY UPDATE

1.) ❒ No changes in my medical history. Signature:________________________________Date: __________________

2.) ❒ No changes in my medical history. Signature:_______________________________ Date: __________________

David F. Pratt, M.D. FACS PS

Certified by the American Board of Plastic Surgery

Cosmetic & Reconstructive Plastic Surgery

Patient: ____ Date: _______________

□ **I do NOT request further information**
□ **I would like to discuss improvement of the following with Dr. Pratt during my consultation:**

Aging appearance of my:

□ Skin
□ Face
□ Eyes
□ Lips (thinning or down turned corners)
□ Neck
□ Low brow
□ Sad, baggy or puffy eyelids
□ Heavy jowls
□ Double chin or weak chin
□ Facial folds and creases
□ Fine lines and wrinkles
□ Sun damage
□ Skin tone
□ Loss of facial fullness

Breast:

□ Size
□ Shape
□ Position, sagging
□ Symmetry between my breasts
□ Areolar or nipple size
□ Inverted nipple(s)

Facial appearance / proportion of my:

□ Eyes
□ Nose
□ Ears
□ Cheeks
□ Lips
□ Jaw
□ Chin

Body:

□ Arms
□ Back
□ Breast
□ Chest
□ Upper abdomen
□ Lower abdomen
□ Buttocks
□ Hips
□ Inner thighs
□ Outer thighs
□ Legs
□ Excess fat deposits
□ Exaggerated curves
□ Lack of defined curves

Other:

□ Irregular scars
□ Moles, skin tags or other growths

Injectibles / Fillers:

□ BOTOX
□ Restylane
□ Collagen
□ Juvaderm

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Cosmetic & Reconstructive
Plastic Surgery

Payment Policy for Cosmetic Surgery Procedures

A non-refundable deposit of one thousand five hundred dollars ($1,500) is required to schedule a surgical procedure.

The total payment for surgery is due a minimum of 14 days prior to the surgery date.

Acceptable forms of payment include cash, personal check, cashier's check, money order, Master Card, Visa and Care Credit. There is information available regarding financing. A 3% convenience fee will be added to your credit card transactions for procedures totaling $1,000 or more, based on the full procedure fee.

Failure to comply with this payment schedule will result in forfeiture of the deposit and cancellation of surgery. If the date of surgery is changed by the patient, the deposit is forfeited. Rescheduling surgery on another date will require an additional deposit.

<u>Cancellation of surgery by the patient within 14 days of the surgery will result in the forfeiture of the Surgery Booking Fee, which equals 50% of the entire surgery fee.</u>

I have read the above payment policy and understand its contents.

Patient's Signature: ___________________________________Date: ____________________

Patient's Printed Name: ____

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Kirkland, WA 98033

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4005 Colby Avenue
Everett, WA 98201

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COMMUNICATION OF MEDICAL INFORMATION

You have the right to have your medical information kept confidential. You also have the right to designate whom we can share this information with. Please complete the information below. Place your initials on the line to indicate your preference.

_____ I authorize that information may be left on my home voice mail system.

_____ I request that you contact and speak with me only.

_____ I request that you call the following number(s) only:

(First choice:)_____________________ cell/home phone/work phone/other (please circle one)

(Second choice:)___________________ cell/home phone/work phone/other (please circle one)

You may leave information with the following person(s):

Name:_________________________ Relationship:_____________ Contact #:__________________

Name:_________________________ Relationship:_____________ Contact #:__________________

Name:_________________________ Relationship:_____________ Contact #:__________________

*****Please indicate whether you authorize receipt of e-mails from us.*****

❑ I authorize e-mail communication. ❑ I decline e-mail messages.

Your e-mail address:____

E-mail should not be used for urgent or time-sensitive exchange of information. *For urgent or time sensitive matters, please contact us by phone or in person only.* At the discretion of this office, if the message is deemed sensitive to time and content, we will contact you by phone (see above.) If you initiate communication with us using e-mail for other matters, we may reply using e-mail. Please note that e-mail messages may become part of your medical file.

I understand I can change any of this information in the future as necessary.

Signed:_______________________________ Date:________________

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Notice of Privacy Practices

David F. Pratt, M.D. FACS/Pratt Plastic Surgery

Our office understands the need for protection of our patient's confidential medical and financial information and we have always maintained sensitivity to the distribution of this information. We are cautious when speaking within the office and comply with accepted standards regarding the release of information. HIPAA (Health Insurance Portability and Accountability Act) is the new federal ruling, applicable to all facilities and business entities having access to private health information. This states all patients must be informed of the office's privacy practices, and also outlines your right as a patient to receive copies of your health information.

Please read the following, sign, and date at the bottom. Do not hesitate to ask the office staff if you have any questions upon your request or would like a copy of this notice.

1. Charts and medical information: We can only release information to individuals or offices upon your written, signed and dated request, unless it assists in your medical care (such as the hospital or therapist), is required by your insurance (such as sending an operative report or incident report,) or is to be given to a government or law enforcement agency. Charts are maintained so that access is only by staff members. We give utmost care when faxing and copying records. Unneeded information, such as a duplicate operative report, is shredded.

2. Financial records: These records are maintained confidentially- both by speech and in writing. No one may access your information except by your written release, except insurance companies working on your current claim, or as permitted by law
(such as a current spouse.)

3. Requesting medical records: You may receive copies of your medical records, upon written request. Forms are available from the staff and must be fully completed. We may also charge a reasonable fee for the costs of copying. By law, we must notify you within 15 days if the records are or are not available, or have the records available for your review during regular business hours.

   If you wish to make a change to the notations in your file, please notify o

4. Discipline: Our staff has been trained regarding office policies. The office has a discipline protocol in place should there be a breach of confidentiality. If you believe your privacy rights have been violated or have any concerns, please contact our office manager.

I certify that I have read the above information, have had the opportunity to ask questions, understand the policy as outlined above, and, if I wish, have received a copy of this form.

I ❒ request ❒ do not request a copy of this form.

Signed: ____ Date:____________________

Printed Name: ____

David F. Pratt, M.D. FACS PS Cosmetic & Reconstructive Plastic Surgery
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Medication Refill Policy

In order to properly handle your request for medication refills, we require at least **48 hours**. (On Friday afternoons, please call before 3:30 pm to allow time to verify the refill request and call in to your pharmacy.) At the time of calling, please give your name, contact phone number, the name of the medication, and the pharmacy name and phone number.

Completion of Forms

Forms, such as those from your employer, workman's compensation, automobile insurance, etc. will take an average of three (3) to seven (7) days to complete. These forms are usually forwarded to the address and fax number listed on the form. (Please check the form for this information.) A copy is kept as part of your records. If you wish to pick the form up from our office, please inform us; we will notify you when it is ready. Please leave a daytime contact number with our office staff.

Request for Medical Records and Photographs

You must complete an authorization to release information form prior to these being sent to any office, except in certain cases as outlined by the law. For medical records, by law, we have 15 days to notify you of the availability of the records, though we will do our best to accommodate the request sooner, if possible. In some cases, there may be a small charge.

No Show/Cancellation Policy

Our office requires a minimum of 48 hours (2 working days) to cancel an appointment. If there is a no show or a failure to cancel within 48 hours it may result in a **charge equal to, but not greater than, the visit fee, per occurrence.** This charge cannot be billed to your insurance; you will be responsible for this amount.

Cell Phones

We respectfully request that you turn off your cell phone upon entering the building. The clinic has sensitive medical equipment which is affected by cell phones.

I certify I have read this form and understand its contents. I have had the opportunity to ask questions and these have been answered to my satisfaction.

Signed: ____ Date: ______________________

Printed Name: ____

If signed by someone other than the patient: Relationship: ________________________

Witness: ____________________________Date:______________________

❒ Patient has requested and received a copy of this form.

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Explanation of Billing Policy

Many managed care companies and insurance companies today contract with physicians and are accustomed to reimbursing physicians at discounted rates. We do not currently contract with your insurance company or managed care company. As a courtesy to you, we will bill your insurer directly, for all the treatments rendered to you.

Any outstanding balance remaining 30 days past the due date will be billed directly to the patient and is the patient's responsibility.

The fee amounts billed to your insurance company are standard fees derived from a recently updated list of Usual and Customary Fees charged by physicians practicing Plastic and Reconstructive Surgery in the Greater Seattle region. Our staff will be glad to assist you if problems should arise, so feel free to call us at any time.

Some insurance companies require the patient to pay a co-pay at the time of service. Please have this co-payment available for collection by our office staff prior to being seen by Dr. Pratt.

Some insurance companies require a referral from the patient's primary care provider prior to being seen. It is the responsibility of the patient to make sure the referral, in writing, is at the office by the time of the visit.

It is also the responsibility of the patient to have full, current medical insurance information available at the time of the visit, so our office may do timely, appropriate billing. If this information, or the referral, is not with you or received by our office upon your arrival, we ask that you reschedule your appointment.

If you have any questions, please check with your insurance company prior to being seen by Dr. Pratt.

1. I authorize the release of information to my insurance company for claim processing.
2. I authorize payment of medical benefits directly to David F. Pratt, M.D.
3. I understand the above information and acknowledge that payment for the medical surgical services rendered by David F. Pratt, M.D. is ultimately my responsibility. I agree to pay any outstanding balance not covered by my insurance company.

Further, I understand that this agreement shall not be amended orally.

Patient or Parent's Signature: ____

Printed Name: ____

Date: ____