LIVINGSTON PLASTIC SURGERY
REGISTRATION FORM

DATE: _____ Email Address: _____

PATIENT INFORMATION:

Patient Last Name:_____ Patient First Name:_____ Middle Init _____

Patient Address:_____City/State/Zip:_____

Home Phone: _____Cell Phone: _____Work Phone: _____

Patient SSN: _____ Patient Date of Birth: _____Age: _____

Marital Status: _____ Driver's License No: _____ State: _____

Employer: _____Occupation: _____Phone: _____

In Case of Emergency:

Name of local friend/relative: _____Relationship: _____ Contact Phone:_____

For Child Parent/Guardian: (If patient is a child, please list both parents/guardian contact numbers):

Mother/Guardian: _____ Father/Guardian: _____

Home Phone: _____Cell Phone: _____Work Phone: _____

Insurance Information: (*Please give insurance card to receptionist for copying)*

Subscriber's Name:_____ Subscriber's SSN:_____DOB: _____

Name of Carrier:_____ Policy/ID #: _____Group#:_____

Insured Relationship to patient: _____

Referral Information:

How were you referred to Livingston Plastic Surgery?

Patient Referral _____ Friend _____ Colleague _____ Internet Search Engine _____ Yellow Pages _____

Our Website _____ Emergency Room _____@_____ Magazine _____ Dr. _____

Acknowledgement:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance.

Patient (or Parent/Guardian) signature:_____

LIVINGSTON PLASTIC SURGERY

COSMETIC, HAND AND RECONSTRUCTIVE

PATIENT MEDICAL HISTORY

Reason For Visit _____

Primary Care Physician _____

Referring Physician (if applicable) _____ Advance Directive ○ Yes ○ No

Medical Problems	Treating Physician

Previous Surgical Procedures	Surgeon	Month/Year

Current Medications (dose and frequency — continue on back as necessary)	Ordering Physician
Do you take Aspirin or any blood thinners? ○ Yes ○ No	

List all medication allergies

Social History

Tobacco – packs per day: How long? Quit/When? Alcohol – number of drinks per day/week:

Do you or have you used illicit drugs ○ Yes ○ No Which drugs? How long and how much?

6410 FANNIN, SUITE 927 | HOUSTON, TEXAS 77030 | P: 281-501-1812 | F: 281-888-9948

WWW.DRCHRISLIVINGSTON.COM

LIVINGSTON PLASTIC SURGERY

COSMETIC, HAND AND RECONSTRUCTIVE

Marital Status	Please check one
Single	☐
Married	☐
Divorced	☐
Widowed	☐
Weight	
Height	
Brassiere Size	
Waist	
Personal Physician	
Physician's Phone	
Date of Last Physical Exam	
Date of Last Skin Exam	
Pregnant	Please check one
Yes	☐
No	☐
Date of Last Menstrual Period	
Birth Control Pills	Please check one
Yes	☐
No	☐
Other Birth Control	Please check one
Yes	☐
No	☐
Do you have children?	Please check one
Yes	☐
No	☐
How many?	
Did you breast feed your children?	Please check one
Yes	☐
No	☐

6410 FANNIN, SUITE 927 | HOUSTON, TEXAS 77030 | P: 281-501-1812 | F: 281-888-9948

WWW.DRCHRISLIVINGSTON.COM

LIVINGSTON PLASTIC SURGERY

COSMETIC, HAND AND RECONSTRUCTIVE

PATIENT MEDICAL HISTORY

Family Medical History: (Please note **M**other, **F**ather, **B**rother or **S**ister next to each item)

○ Hypertension ___ ○ Kidney Disease ___ ○ Colon Cancer ___ ○ Skin Cancer ___ ○ Stroke ___ ○ Ulcerative Colitis/Crohn's Disease ___

○ Heart Disease ___ ○ Liver Disease ___ ○ Breast Cancer ___ ○ Ovarian Cancer ___ ○ Sickle Cell Anemia ___ ○ Diabetes ___

○ Lung Disease ___ ○ Thyroid Disease ___ ○ Lung Cancer ___ ○ Uterine Cancer ___ ○ Bleeding Disorder ___ ○ None

Medical Problems: (Check ALL that apply)

General Symptoms

○ Fever ○ Chills ○ Nausea/Vomiting ○ Easily Fatigued ○ Recent Weight Loss _____ lbs ○ None

Head and Neck

○ Headaches ○ Dizziness ○ Neck Masses ○ Facial Drooping ○ Previous Head Injury ○ Sleep Apnea ○ None

Eyes and Ears

○ Blurring ○ Double Vision ○ Hearing Loss ○ Sinus Problems ○ Glaucoma ○ Temporary Blindness ○ None

Endocrine

○ Heat Intolerance ○ Cold Intolerance ○ Infertility ○ Irregular Menses ○ Thyroid Enlargement/Pain ○ None

Breasts

○ Pain ○ Tenderness ○ Lumps ○ Nipple Discharge ○ Asymmetry ○ None

Respiratory

○ Bronchitis ○ Asthma ○ Shortness of Breath ○ Chronic Cough ○ Lung Blood Clots ○ Use of Home Oxygen ○ None

Cardiovascular

○ Chest Pain ○ Heart Murmur ○ Heart Failure ○ Previous Heart Attack ○ Claudication (pain in legs when walking) ○ None

Gastrointestinal

○ Reflux (heartburn) ○ Bleeding Ulcers ○ Blood in Stool ○ Diarrhea ○ Constipation ○ Changes in Stool ○ None

Genitourinary

○ Painful Urination ○ Groin Hernias ○ Incontinence ○ Blood in Urine ○ Frequent Urination ○ Flank or Pubic Pain ○ None

Hematologic/Lymphatic

○ Bleeding Disorder ○ Anemia ○ Blood Clots ○ Easy Bruising ○ Previous Transfusions ○ Enlarged Lymph Node ○ None

Musculoskeletal/Neurologic

○ Joint Pain ○ Joint Swelling ○ Seizures ○ Tremors ○ Weakness/Paralysis ○ Syncope (fainting spells) ○ None

Psychiatric

○ Depression ○ Mood Changes ○ Nervousness ○ Sleep Disturbances ○ Bipolar Disorder ○ None

Skin

○ New Lesion ○ Changing Lesion ○ Rash ○ Bleeding Lesion ○ Itchy Lesion ○ None

6410 FANNIN, SUITE 927 | HOUSTON, TEXAS 77030 | P: 281-501-1812 | F: 281-888-9948

WWW.DRCHRISLIVINGSTON.COM

LIVINGSTON PLASTIC SURGERY

6410 FANNIN SUITE 927 HOUSTON TX 77030

PATIENT BILLING, PAYMENT & INSURANCE CONSENT

I understand that I am financially responsible to *LIVINGSTON PLASTIC SURGERY* for the entire cost of the services provided by the physicians and professional medical staff. I am aware that fees for professional services are set by my insurance company and that the insurance company may not provide full payment for the professional fees. I understand that *LIVINGSTON PLASTIC SURGERY* will assist me in obtaining payment. I understand that I have been given no guarantee of reimbursement for services performed and that these matters are between me (the insured) and my insurance company.

I am aware that my physician may choose to utilize an assistant during my procedure due to its complexity or to conserve my operating room and anesthesia time. My insurance company will be billed for charges on behalf of the assistant.

I am aware that all charges for what may be considered cosmetic procedures or cosmetic surgery is payable in advance and that I will be reimbursed if insurance coverage is obtained. In addition, should my insurance company delay payment I may be requested to remit in full for certain procedures.

I understand that I am financially responsible for my (and my dependants) balance within ninety (90) days and agree to honor this commitment, even when my insurance company is responsible for the delay in payment. I realize that I am required to make a deposit toward my surgical fees and any unmet deductible prior to surgery; and this in no way excludes me from further financial responsibility.

ASSIGNMENT AND RELEASE: I hereby authorize insurance benefits to be paid directly to *LIVINGTON PLASTIC SURGERY* and I hereby authorize the release of medical information required to process any claims.

'NO SHOW' OFFICE VISIT POLICY: I understand that I make an appointment with Dr. Livingston knowing that the time is now mine and is no longer available to any other patient. Therefore, I understand that should I not call to cancel the appointment in advance of my scheduled appointment time and I am an established patient I will be charged a $25 fee. If I am a new cosmetic patient my credit card info will be obtained prior to the visit and I will be charged the full consult fee amount of $100

COLLECTION/ATTORNEY FEES: LIVINGSTON PLASTIC SURGERY, after having exhausted all resources to collect an outstanding balance, will hire a collection agency or attorney to collect the unpaid balance. The Patient will be responsible for charges incurred for the collection process.

CONSENT FOR USE OF CREDIT CARDS/DISCLOSURE OF PROTECTED HEALTH INFORMATION:

It may become necessary to release your protected health information to financial parties, credit card entities, banks and financing companies to facilitate your payment. Services performed that are paid with a credit card, debit card or financing third party are not eligible for payment challenges *after* services are provided. By signing this form I am irrevocably consenting to allow *LIVINGSTON PLASTIC SURGERY* to use and disclose my protected health information to any credit card entity, bank or financing company when they request such information to process an account and assist with payment.I WILL NOT CHALLENGE CREDIT, DEBIT OR FINANCING PAYMENTS ONCE THE SERVICES ARE PROVIDED. The practice encourages complete post-op care and follow up interaction to address any issues that might arise. I AGREE THAT THIS NON CREDIT CARD CHALLENGE AGREEMENT IS IRREVOCABLE. _____init.

DATE: _____ PATIENT NAME (PRINT):_____

SIGNATURE OF PATIENT/GUARDIAN:_____

SIGNATURE OF PRACTICE REPRESENTATIVE: _____

LIVINGSTON PLASTIC SURGERY

PHOTOGRAPHIC CONSENT

PHOTOGRAPHIC USE:

I hereby grant permission to *LIVINGSTON PLASTIC SURGERY* to take photographs and/or electronic images for:

1) Diagnostic/medical chart purposes – to enhance my medical record and to assist my insurance company with any claims that I might submit for my medical care. init _____

I authorize the use of illustrations, photographic and electronic images created in my case at any time during or after treatment for teaching purposes or to illustrate scientific papers, books and/or lectures if medical research, education or science will be benefitted by their use.

2) Advertising purposes – to this extent I agree that these photographic and electronic images will remain the property of *LIVINGSTON PLASTIC SURGERY.* init _____

I authorize these photographs and/or images to be used in prospective patient education and in any advertising. ***I understand that complete confidentiality of my identity is assured.***

Signed: _____ Date: _____

(patient or legal guardian, if patient is a minor child)

Signed: _____ Date: _____

(Practice Representative)

HIPAA Notice of Privacy Practices

LIVINGSTON PLASTIC SURGERY
6410 FANNIN STE 927
HOUSTON TEXAS 77030
(281)501-1812

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.

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 healthcare services to you, to pay your healthcare 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 healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home 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 and treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician'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 physician. We may also call you By name in the waiting room when your physician 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.

We may use or disclose your protected health information in the following situations with 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 of 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 the *Notice of Privacy Practices*. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician 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 (JoJo Aguilar, Front Desk Manager) of your complaint. **WE WILL NOT RETALIATE AGAINST YOUR FOR FILING A COMPLAINT.**

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 (832) 325-7611. Signature below is only to acknowledge receipt of this *Notice of Privacy Practices*

PRINT NAME: _____ **SIGNATURE:** _____

DATE: _____ **Practice Representative:** _____