

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

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically records contain your symptoms, examination, test results, diagnosis, treatment and a plan for the future or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
 - A means of communication among the many health professionals who contribute to your care
 - Legal document describing the care you received
 - A means by which you or a third party payer can verify that services billed were actually provided
 - A tool in educating health professionals
 - A source of data for medical research
 - A source of information for public health officials charged with improving the health of the nation
 - A source of data for facility planning and marketing
 - A tool in which we can assess and continually work to improve care we render and outcomes we achieve
- Understanding what it is in your record and how your health information is used helps you to:
- Ensure its accuracy
 - Better to understand who, what, when, where and why others may access your health information
 - Make more informed decisions when authorizing disclosure to others

YOUR HEALTH INFORMATION RIGHTS

The information in the health records we maintain belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by **45CFR 164.52**
- Obtain a paper copy of the notice of information practices upon request
- Inspect and copy your health records as provided in **45CFR 164.524**
- Amend your health records as provided in **45CFR 164.528**
- Obtain an accounting of disclosures of your health information as provided in **45CFR 164.528**
- Request communications of your health information by alternative means or at alternative locations
- Revoke authorization to use or disclose health information except if that action has already been taken

OUR RESPONSIBILITIES

This organization is required to:

- Maintain the privacy of your health information
- Provide you with legal duties and privacy practices regarding information collected and maintained
- Abide by the terms of this notice
- Notify you if we are unable to agree to requested restriction
- Accommodate reasonable requests you have to communicate health information by alternative means.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will notify you if we change our practices.

- We will not use or disclose your health information without your authorization, except as described earlier.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

- If you have questions and would like additional information, you may contact our office at (318) 221-1629
- If you believe your privacy rights have been violated, you can file a complaint with our office manager or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS

We will use your health information for treatment. **Example:** information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record used to determine the course of treatment that could work best for you. Your physician will document in your record his expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observation that way the physician will know how you are responding to treatment.

We will use your health information for payment. **Example:** a bill sent to your third party payer. Information (or with) the bill may identify you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations. **Example:** Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

OTHER DISCLOSURES

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the Emergency Department and Radiology, certain Laboratory tests, and a Copy Service we use when copies are made of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third party payer for services rendered. So that your information is protected, however, we require business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to the members of the clergy and, except for religious affiliation to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

Communication with Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers of an institutional Review Board that has reviewed the research proposal and has protocols to ensure privacy of your health information has approved their research.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders of information about treatment alternatives or other health related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): Disclose to the FDA health information relative to adverse events with respect to foods, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers Compensation: We may disclose health information to the extent authorized by necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information necessary for your health, and the health and safety of other individuals.

Law Enforcement: Disclose health information required by law, or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

FORREST P. WALL, M.D.

Patient Name _____ Date of Birth _____ Age _____
Address _____ City _____ State _____ Zip _____
Home # _____ Cell # _____ Email Address _____
Social Security Number _____ Patient's Employer _____
Address _____ City _____ State _____ Zip _____ Work # _____

Circle Gender: Male or Female **Circle Martial Status:** Minor Single Married Divorced Widowed Separated

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

Name _____ Relationship _____ Phone # _____

RESPONSIBLE PARTY

Person responsible for this account _____ Relationship to patient _____
Address _____ City _____ State _____ Zip _____
Phone # _____ Date of Birth _____ Social Security Number _____
Employer _____ Address _____
City _____ State _____ Zip _____ Work # _____

Please list the family members or other persons, if any, whom we may inform about your general medical condition and diagnosis. (Including treatment, payment and health care options).

Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____

Please print the address of where you would like your postcards and/or correspondence from our office to be sent if other than your home address. _____

Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL"
Circle One: Yes No

Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, and other health care information if other than your home telephone number. (____) _____

Can confidential messages be left on your telephone answering machine? Yes _____ No _____

INSURANCE INFORMATION

Primary Insurance _____ Policy # _____ Group # _____
Claims Address _____ Phone # _____

Policy Holder Name _____ DOB _____ SSN _____

Relationship of Insured to Patient: Self _____ Spouse _____ Parent/Guardian _____

Secondary Insurance _____ Policy # _____ Group # _____
Claims Address _____ Phone # _____

Policy Holder Name _____ DOB _____ SSN _____

Relationship of Insured to Patient: Self _____ Spouse _____ Parent/Guardian _____

Patient/Guarantor Signature _____ **Date** _____

FORREST P. WALL, M.D.

Authorization for Release of Information

I _____ hereby authorize The Plastic Surgery Center LLP to release and/or receive any “confidential” health care information pertaining to my care and/or treatment.

Information to be Released/Received:

_____ Progress/Office Visit Notes _____ Lab Reports
_____ Operative Reports _____ Emergency Room Reports
_____ Medication List _____ Radiology (X-Rays)

Indicate Dates of Reports (as close as possible): _____

Purpose of disclosure:

_____ Changing Physician _____ Consultation _____ Continuing Care _____ Legal
_____ Worker’s Compensation _____ School _____ Insurance _____ Work

I understand that this authorization may only be used for the disclosure listed above, and that this document will remain a permanent part of my medical record.

I understand that I may revoke this authorization at any time by notifying our office in writing, and that it will be effective on the date notified except to the extent that action has already been taken in reliance of it.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations.

I understand that if I choose not to authorize the release of information, my healthcare and payment for my health care will not be affected.

I understand that I may see and obtain a copy of the records described in this authorization upon my request. Additionally, I may receive a copy of this authorization upon request.

I understand that The Plastic Surgery Center LLP may receive compensation for the use or disclosure listed on this authorization.

Patient/Guarantor Signature

Date

Print Name

Social Security Number

Previous Name (Maiden Name)

Date of Birth

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PATIENT PERSONAL MEDICAL HISTORY

Reason for today's visit: _____

Other Procedures I would be interested in discussing in future visits:

- | | |
|--|---|
| <input type="checkbox"/> Abdominal Lipectomy (Tummy Tuck) | <input type="checkbox"/> Liposuction |
| <input type="checkbox"/> Rhytidectomy (Face Lift) | <input type="checkbox"/> Mastopexy (Breast Lift) |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Blepharoplasty (Eyelids) |
| <input type="checkbox"/> Post-Mastectomy Reconstruction | <input type="checkbox"/> Skin Care |
| <input type="checkbox"/> Laser Skin Resurfacing | <input type="checkbox"/> Botox/Restylane Injections |
| <input type="checkbox"/> Breast Augmentation (Breast Implants) | <input type="checkbox"/> Chemical Peels |
| <input type="checkbox"/> Rhinoplasty (Nose Contouring) | <input type="checkbox"/> Other Plastic Surgery |

How did you hear about us?

- | | |
|--|--|
| <input type="checkbox"/> Metro Book | <input type="checkbox"/> Forum |
| <input type="checkbox"/> Bell South Yellow Pages | <input type="checkbox"/> Newspaper |
| <input type="checkbox"/> T.V. | <input type="checkbox"/> Friend/Family |
| <input type="checkbox"/> Seminar | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Physician Referral | Other: _____ |

Do you have a Living Will? Yes No

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I CONSENT TO THE PHOTOGRAPHS TAKEN TO BE USED FOR MEDICAL, SCIENTIFIC, OR EDUCATIONAL PURPOSES, PROVIDED THE PICTURES DO NOT REVEAL MY IDENTITY.

Signature of Patient/Parent if a Minor

Date

Name (Please Print)

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PATIENT PERSONAL MEDICAL HISTORY

Full Name: _____ Date of Birth: _____

Please answer all of the questions as accurately as possible. This is a confidential record of your medical history and will be kept in the office. If you do not understand the question, please ask for assistance.

Family Doctor or Internist: _____ Date of Last Exam: _____

Occupation: _____ Marital Status: _____

Height: _____ Weight: _____ Highest Level of Education: _____

Do you Smoke? _____ Type & Amount Per Day: _____

How Long? _____ If Former Smoker, Date Quit: _____

Do you use: _____ Alcohol Type & Amount Per Week _____

_____ Caffeine Type & Amount Per Week _____

_____ Street Drugs Type & Amount Per Day _____

Drug Allergies: _____

Other Allergies: Iodine Shellfish Tape Band-Aids Latex Other _____

Please list any medications you are currently taking:

PRESCRIPTION

NON-PRESCRIPTION

VITAMINS, HERBALS, ETC.

Please list all Hospitalizations, Serious Illnesses, Surgeries and the Date they occurred: _____

Please describe all Serious Accidents, Severe Injuries, Broken Bones, or Head Injuries and the Date they occurred: _____

Women: Date of Last Menstrual Period: _____ Are you Pregnant? _____

Total Number of Pregnancies: _____ Number of Children: _____

Did you Breast feed? _____ Date of Last Mammogram: _____

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PATIENT PERSONAL MEDICAL HISTORY

PAST MEDICAL HISTORY: Have you ever had the following:

Heart Disease:	Yes	No	Arthritis:	Yes	No	Rheumatic Fever:	Yes	No
Anemia:	Yes	No	Tuberculosis:	Yes	No	Diabetes:	Yes	No
Cancer:	Yes	No	Glaucoma:	Yes	No	Asthma:	Yes	No
AIDS or HIV:	Yes	No	Stroke:	Yes	No	Hepatitis:	Yes	No
Ulcer:	Yes	No	Cold Sores:	Yes	No	Fever Blisters:	Yes	No
Kidney Disease:	Yes	No	Thyroid Disease:	Yes	No	Pneumonia:	Yes	No
Bleeding Tendency:	Yes	No	Epilepsy:	Yes	No	Bronchitis:	Yes	No
Mitral Valve Prolapse:	Yes	No	Back Trouble:	Yes	No	High Blood Pressure:	Yes	No
Measles:	Yes	No	Mumps:	Yes	No	Chickenpox:	Yes	No
Shingles:	Yes	No	Genital Herpes:	Yes	No	Migraine Headaches:	Yes	No
Whooping Cough:	Yes	No	Scarlet Fever:	Yes	No	Diphtheria:	Yes	No
Venereal Disease:	Yes	No	Polio:	Yes	No	Hernia:	Yes	No
Transfusion:	Yes	No	Hemorrhoids:	Yes	No	Hives:	Yes	No
Low Blood Pressure:	Yes	No	Eczema:	Yes	No	Mononucleosis:	Yes	No
High Cholesterol:	Yes	No						

Any Other Diseases, please list: _____

Date of last Chest X-Ray: _____

Date of last Tetanus Shot: _____

REVIEW OF SYSTEMS: Do you have now or have you had within the past year:

Weight Change:	Yes	No	Swollen Feet/Ankles:	Yes	No	Seizures:	Yes	No
Dry Eyes:	Yes	No	Skin Rash:	Yes	No	Joint/Muscle Pain:	Yes	No
Chronic Cough:	Yes	No	Chronic Diarrhea:	Yes	No	Swollen Lymph Nodes:	Yes	No
Chest Pain:	Yes	No	Jaundice:	Yes	No	Easy Bleeding:	Yes	No
Rapid Heart Beat:	Yes	No	Depression:	Yes	No	Easy Bruising:	Yes	No
Breast Pain:	Yes	No	Breast Lump or Mass:	Yes	No	Breast Discharge:	Yes	No

FAMILY HISTORY:

Present age, or age at death

State of Health (good, fair, poor) or cause of death

Mother _____

Father _____

Brother (s) _____

Sister (s) _____

Children _____

HAS ANY RELATIVE HAD ANY OF THE FOLLOWING:

Cancer:	Yes	No	Stroke:	Yes	No	Tuberculosis:	Yes	No
Epilepsy:	Yes	No	Diabetes:	Yes	No	Allergies:	Yes	No
Heart Disease:	Yes	No	Anemia:	Yes	No	High Blood Pressure:	Yes	No
Bleeding Tendency:	Yes	No	Asthma:	Yes	No	Chronic Lung Disease:	Yes	No
Drug Alcohol Problem:	Yes	No	Mental Illness:	Yes	No	Leukemia:	Yes	No
Migraine Headaches:	Yes	No	Obesity:	Yes	No	Thyroid Disease:	Yes	No
Ulcer:	Yes	No	Depression:	Yes	No	High Cholesterol:	Yes	No
Glaucoma:	Yes	No	Gout:	Yes	No	Kidney Disease:	Yes	No

FORREST P. WALL, M.D.

**THE PLASTIC SURGERY CENTER LLP
385 BERT KOUNS INDUSTRIAL LOOP, BLDG. #100
SHREVEPORT, LA 71106
PHONE: 318-221-1629 FAX: 318-221-6308**

ACKNOWLEDGEMENT FORM

I _____ have received the Notice of Privacy Practices
and I have been provided an opportunity to review it.

Name (Print)

Signature

Date

BUSINESS OFFICE POLICY

The primary goal of our physicians is the provision of quality patient care. This goal can be accomplished through sound fiscal management, the practice of keeping costs contained, and having the cooperation of our patients implementing the following policies. **Please review this document thoroughly and sign below. This will become part of your file.**

CANCELLATIONS – Our goal is to provide quality medical care and in order to do that, we had to implement a cancellation policy. The policy enables us to better utilize available appointments for our patients. Please call our office **immediately** if you find you cannot keep your appointment. Cancellations of scheduled appointments must be communicated to our office at least **24 hours** prior to the scheduled appointment time. For your convenience you may leave a message of cancellation on our voice mail system. Monday appointments must be cancelled by noon of the preceding Friday. Appointments **not cancelled with 24 hours notice** will be charged at the same rate as the scheduled visit. **THESE CHARGES ARE EXCLUSIVELY YOUR RESPONSIBILITY.**

COSMETIC SURGERY – Cosmetic procedures require a 20% non-refundable deposit at the time the surgery is scheduled. Forty-Eight (48) hours prior to the surgery date, the remainder of the physician's fee is required to be paid in full. This is only payable in the form of cash, cashier's check, major credit cards or money order.

COSMETIC SURGERY CANCELLATIONS – Surgery scheduling requires careful planning and coordination between our office, the surgery center and their operating room staff, as well as the anesthesiologist, if applicable. Therefore, please understand the importance of respecting our 48-hour cancellation policy. Surgeries cancelled more than 48-hours prior to the surgery date that are rescheduled within 5 business days will be allowed to apply the 20% non-refundable deposit towards the new surgery date. Surgeries cancelled less than 48 hours in advance will forfeit the deposit.

ASSISTANT SURGEON FEES – Your physician may elect to use the services of an assistant surgeon. Although his fee will appear on your monthly statement, you will not be responsible for payment of this fee. This will be billed to your insurance carrier, and assignment accepted.

INSURANCE CLAIMS – The benefits paid by insurance companies for plastic surgery vary greatly from carrier to carrier and plan to plan. Therefore, we make every effort to determine in advance if insurance coverage exists. We will obtain your benefit information such as deductibles, coinsurance and out of pocket expenses. This will determine the amount, if applicable, that will be required to be collected prior to scheduling your procedure. We do this because we believe you need to be as informed as possible before surgery. We know you realize that you are ultimately responsible for the full payment of your account, but we have found that our knowledge and experience can be an important factor in assisting you to collect your maximum benefits.

PATIENT ACCOUNT BALANCES – You will receive monthly statements showing the patient balance and insurance balance, if any. Payments are required monthly on any patient balance. If you are unable to pay your bill in full we will be happy to arrange a comfortable monthly payment plan with you.

The Plastic Surgery Center LLP strives to provide excellent health care. We will only release information concerning you to those that are necessary and/or we have your permission. Thank you for choosing our practice to provide you medical care. Please feel free to inquire about anything we can assist you with.

Please sign that you have read and agree to our Business Policy as stated above.

Signature

Date