



17300 North Outer 40 Road, Suite 300
Chesterfield, MO 63005
636.530.6161

Welcome To Our Office

(Please Print)

Name: _____
Last First Middle

Home Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: () _____ Cell Telephone: () _____

Work: () _____ Other: () _____

At which number do you prefer to be contacted? _____

We make appointment reminders, would you like to be contacted by phone or e-mail? (Circle)

E-mail Address: _____

Would you like to receive our e-newsletter: Yes _____ No _____

Birth date: ____/____/____ May send information to my home? Yes _____ No _____

SSN: _____ Sex: Male Female Occupation: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Employer Phone Number: () _____

Responsible Party: _____

Relationship to Patient: _____ Insurer's birth date: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Which procedure(s) would you like to discuss today on your visit?

How did you hear about us? _____

(If radio, please specify which station)

Emergency Contact

Name: _____ Relationship: _____

Home Phone.: () _____ Work: () _____ Cell: () _____

Signature: _____ Date: _____

Due to the HIPAA (Health Insurance Portability and Accountability Act) all information must be completed on this form and the following forms. If you have any questions regarding this, anyone in our office will be glad to help you.

Thank you for choosing St. Louis Cosmetic Surgery!



*I am also interested in learning more about:
(Please circle)*

Facelift

Tummy Tuck

Forehead Lift

Liposuction

Eyelid Surgery

Body/Thigh Lift

Nose Surgery

Hair Transplant

Ear Pinning

Collagen

Laser Resurfacing

Botox

Lip Augmentation

IPL Photofacial- *for sun damage, dark spots, rosacea and fine lines*

Chin Liposuction

Microdermabrasion

Cheek Lift

Laser Hair Removal

Mini Facelift

Skin Care Products
Sold only by Physicians

Breast Augmentation

Thermage

Breast Lift

Massage

Breast Reduction

Facials

PAYMENT POLICY

We strive to provide all of our patients with prompt and excellent medical care and to assist you in the handling of your bill. In order to maintain your account in good standing, our requirements for payment of your account are as follows:

- A. PAYMENT IS EXPECTED FOR ALL OFFICE VISITS, SERVICES, TREATMENTS, AND PRODUCTS AT THE TIME OF EACH VISIT.
- B. ALL CHARGES ARE DUE AND PAYABLE THE DATE THEY ARE INCURRED, regardless of the status of your insurance claim. If your insurance does pay, you will be issued a refund for the amount they pay.
- C. We do not accept the theory that legal cases should be settled before payment of the fee is due. ALL CHARGES ARE DUE AND PAYABLE THE DATE THEY ARE INCURRED.

Because our services are rendered to YOU, you are responsible directly to us for settlement of your account within the time limit set, regardless of the status of your insurance claim. Please feel free to discuss your bill or charges at an early date, to avoid misunderstandings.

It is understood that failure to comply with this agreement would leave St. Louis Cosmetic Surgery, Inc. no alternative but to seek collection action.

The fees or charges on our bill are for THE DOCTOR ONLY. YOU WILL BE BILLED SEPARATELY FOR ANY HOSPITAL, X-RAY, LABORATORY, ANESTHESIA, PATHOLOGY, OR SURGICAL CENTER CHARGES.

COMPLETING AND FILING OF INSURANCE FORMS

We will be happy to fill out and mail your insurance forms AFTER receiving the insurance form with the claimant's side filled out AND the "authorization to release information" and "authorization for payment directly to the physician" are signed.

WE ALSO REQUIRE THE ADDRESS OF YOUR INSURANCE COMPANY OR YOUR EMPLOYER. It is our policy to send the completed insurance form directly to the insurance company of the employer and NOT back to the patient. If you feel the need to have the insurance form mailed back to you, we will be happy to do this after the bill is paid in full.

We will file a secondary insurance when we have the explanation of benefits from the primary insurance. The explanation of benefits is sent from the primary insurance company indicating what was billed and what amount was paid by the primary insurance company. We MUST have this to file the insurance. I have read the above and agree to the terms of this payment policy.

Signature

Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND TO PAY BENEFITS TO ST. LOUIS COSMETIC SURGERY, INC.

I hereby authorize the release of any medical information necessary to process this claim and request payment of benefits to the party who accepts assignment below. I also authorize payment directly to the undersigned Physician of the surgical and/or medical benefits.

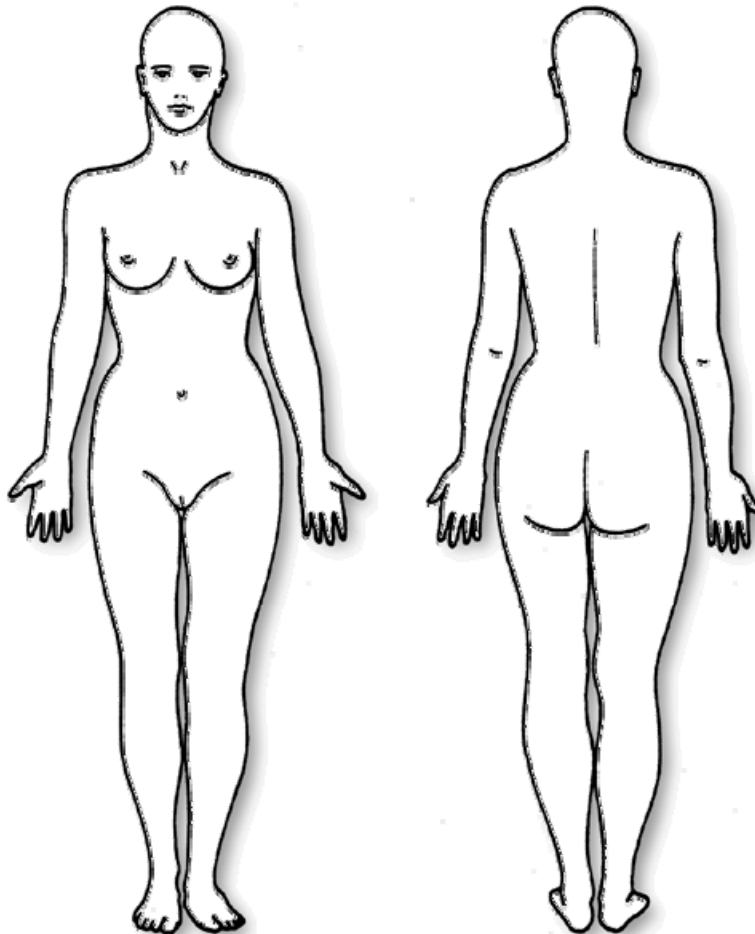
Signature

Date

If any areas of your face bother you, please circle those areas.



If any areas of your body bother you, please circle those areas.



St. Louis Cosmetic Surgery
17300 N. Outer 40 Road, Suite 300 Chesterfield, MO 63005
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.

The Health Insurance Portability and Accountability Act of 1996 (“HIPPA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used.

“HIPPA” provides penalties for covered entities that misuse personal health information.

As required by “HIPPA” we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

- **Treatment** means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Healthcare Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communication of protected health information from us by alternative locations.
- The right to inspect a copy of your protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of legal duties and privacy with respect to protected health information.

This notice is effective as of April 1, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post, and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our Privacy Officer, or upon request we will supply you with the address of the Department of Health & Human Services, Office of Civil Rights to file a written complaint. We will not retaliate against your filing a complaint.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

St. Louis Cosmetic Surgery, Inc.

17300 North Outer Forty Road, Suite 300
Saint Louis, MO 63005

Phone: 636-530-6161
Fax: 636-777-7500

I understand that, under the Health Insurance Portability & Accountability Act of 1966 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the above address to obtain a current comp of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

CONFIDENTIAL COMMUNICATIONS

I request that all communications to me (by telephone, mail or otherwise) by St. Louis Cosmetic Surgery, Inc., and/or its staff be handled in the following manner:

For written communications, send to:

For oral communications, call:

Telephone Number

If you are unavailable at this number, may we leave an answering machine or voice mail message?
 Yes No

Do we have permission to disclose your health information with another person other than yourself?
 Yes No

If yes, Name: _____
Relationship

Patient Signature: _____

Date of birth: _____ Date: _____