

Anderson Cosmetic Surgery

Stephen B. Anderson, MD

425-453-9060 · 800theface.com

PATIENT REGISTRATION

Patient Name: _____ Birth Date: _____ Age: _____
(please print) (last) (first) (middle)

Mailing Address: _____

City: _____ State: _____ Zip: _____ Social Security Number: _____

MARITAL STATUS (please circle): Single Married Divorced Widowed SEX (please circle): Male Female

I may be reached at the following number(s), and will contact you if I wish to be removed from the contact list (check preferred):

Home Number: _____ Work Number: _____ Cell Number: _____

Best Time To Call: Morning Afternoon Evening Other: _____

E-mail: _____ Fax Number: _____

Employer: _____ Occupation: _____

Spouse: _____ Occupation: _____ Phone No: _____

Person Responsible for Billing: _____

In case of emergency, who should we notify?

Name: _____ Relationship: _____

Home Number: _____ Work Number: _____ Cell Number: _____

HOW DID YOU HEAR ABOUT OUR CLINIC?

Radio Station _____ Patient Referral _____ Seminar _____ Mailing _____
 TV Channel _____ Friend _____ Return Patient _____ Other: _____
 Dr. Referral _____ Web Search Engine _____ Drove By _____

Cosmetic consultations are complimentary. There is a \$500 charge for second opinions and non-cosmetic surgery consultations, such as reconstruction due to an accident, scars, etc. Payment is due at the time of consultation. When a procedure is scheduled, a \$500 deposit is required. This deposit is non-refundable unless the procedure is cancelled 15 business days prior to the scheduled procedure. Full payment is required at the time of the pre-op appointment or within 15 days prior to surgery. Deposits for non-surgical procedures, such as Thermage, are non-refundable unless the procedure is cancelled 48 hours prior to the scheduled date. It is the patient's responsibility to provide an appropriately trained translator if necessary.

SIGNATURE: _____ DATE: _____

Fellow American College of Surgeons • Fellow American Academy of Facial Plastic & Reconstructive Surgery
Diplomate American Board of Otolaryngology

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Please let us know your concerns and interests so that we may best serve you.

- | | |
|--|---|
| <input type="checkbox"/> Facelift (lower) | <input type="checkbox"/> Laser Resurfacing |
| <input type="checkbox"/> Mid-Face Lift | <input type="checkbox"/> Botox® |
| <input type="checkbox"/> Forehead or Brow Lift | <input type="checkbox"/> Thermage |
| <input type="checkbox"/> Eyelid Procedures | <input type="checkbox"/> Injectable Fillers (Radiesse®, Restylane®) |
| <input type="checkbox"/> Nasal Surgery | <input type="checkbox"/> Scar Revision |
| <input type="checkbox"/> Ear Procedures | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> Chin Enhancement | <input type="checkbox"/> Intense Pulse Light |
| <input type="checkbox"/> Liposculpture | <input type="checkbox"/> Hair Restoration |
| <input type="checkbox"/> Other: _____ | |

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SKIN TRANSFORMATION

Please let us know if you would like information regarding the following services and procedures:

Exclusive Skin Care Products:

- Refinement (Exfoliate, Moisturize, Protect)
- Rejuvenation (Sun Damage, Wrinkles, Tightening)
- Pigmentation (Freckles, Sun Spots, Rosacea)
- Acne Control

Injectibles:

- Botox® for smoothing frown lines and wrinkles around eyes, forehead and lips
 - Fillers to enhance lips, hands and correct moderate to severe facial folds and wrinkles including Nasolabial Folds
 - Thermage** to tighten skin and diminish wrinkles on face, neck, body and hands with no downtime.
 - Prolite** for rosacea, broken capillaries and pigmentation on face, neck, hands and chest
 - Laser Treatment** for wrinkles and skin tightening around lips, eyes and face
 - Chemical Peels** and **Microdermabrasion** for sun damage, wrinkles and acne scars
-

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MEDICAL HEALTH HISTORY

Patient Name: _____ Birth Date: _____ Age: _____

Medical History:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart trouble/chest pain |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ankle swelling |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> TB exposure | <input type="checkbox"/> Asthma/wheezing | <input type="checkbox"/> Scarlet/Rheumatic fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> HIV positive/AIDS | <input type="checkbox"/> Hepatitis: TypeA,B,C |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Varicose veins, phlebitis |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Anemia | <input type="checkbox"/> Anesthesia problems |
| <input type="checkbox"/> Ulcers/Reflux | <input type="checkbox"/> Birth Defect | | |

Medical Illnesses (not listed above):

Allergies to Medications:

Current Medications (Prescriptive or Over-the-counter):

Injuries/Hospitalizations/Surgeries (Description and Date):

Have you or a family member been exposed to MRSA: _____

Primary Care Physician(s): _____ Date of last exam: _____

If currently under the care of a physician(s), please explain:

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STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment and our health-care operations. Your personal health information will never be given to anyone – even family members – without your written consent. You, of course, may give written authorization to us to disclose your information to third parties.

Our office and electronic systems are secure from unauthorized access and our employees are trained to ensure the confidentiality of your records is protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations and comply with the law. This may include your name, address, telephone number(s), Social Security, employment data, medical history, health records, etc. While most of the information will be obtained from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use your health information to communicate reminders about your appointments including voicemail, answering machines and postcards.

Patient Rights

You have the right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S.

Department of Health and Human Services.

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We thank you for being our patient. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

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ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Anderson Cosmetic Surgery. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information.

Anderson Cosmetic Surgery reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Any member of my immediate family

Spouse Only

Other (Please Specify)

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained

Provided prior to treatment?

YES

NO

Date provided:

Reason for denial:

Need more time to review statement of privacy practices.

Want to consult with another person before signing.

Other (EXPLAIN):