Spalding Drive Cosmetic Surgery & Dermatology
120 South Spalding Drive, Suite 315
Beverly Hills, CA 90212
310.275.2467

Welcome to our Practice!

As a courtesy to our doctors and their time we would like to take a moment to make you aware of the following:

- Payment is due in full for any cosmetic procedures or products purchased on the date of service. If we are billing your insurance company we must have a copy of your current insurance card at the time of service.

- Please also allow at least 24 hours notice if you have to cancel or reschedule an appointment with the doctors or the estheticians. We will charging a $300 Consult fee for Dr. Nassif. All no shows or late cancellations will be charged $300 (Non refundable). There will be a $100 cancellation fee Dr. Amron.

- If you are arrive more than 15 minutes late for an appointment we may either work you into the schedule that same day (which may involve a wait) or we may have to reschedule your appointment for a different day.

Thank you for your cooperation

We look forward to a successful and rewarding relationship

Spalding Drive Cosmetic Surgery & Dermatology, A Medical Corp.
120 S. Spalding Dr. Suite 315 Beverly Hills, CA 90212
(310) 275-2467 FAX (310) 275-6651

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____Phone Number_____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birth date _____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____ Email:_____

Please tell us how you learned about us: _____

Whom may we thank for referring you: _____

In case of an emergency who should be notified: _____ Phone: _____

Personal Physician _____ Physician's Phone _____

RESPONSIBLE PARTY INFORMATION

Relationship to Patient _____ Phone _____

Address _____

PRIMARY INSURANCE

Subscriber Name _____ Relationship to Patient _____ Birth date _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by: _____ Business Phone _____

Insurance Company _____ Soc. Sec. # _____

Policy # _____ Group # _____ Subscriber # _____

SECONDARY INSURANCE

Subscriber Name _____ Relationship to Patient _____ Birth date _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by: _____ Business Phone _____

Insurance Company _____ Soc. Sec. # _____

Policy # _____ Group # _____ Subscriber # _____

ASSIGNMENT AND RELEASE

I authorize treatment of the individual named as Patient. I understand that Spalding Drive Cosmetic Surgery & Dermatology, A Medical Corp. will file with my primary insurance for services rendered and I authorize payment of medical insurance benefits to be made to my treating physician. I also understand that I am financially responsible for any services that are not covered under the terms of my policy.

I authorize Spalding Drive Cosmetic Surgery & Dermatology, A Medical Corp. to release or obtain any medical information related to its treatment of Patient. A photocopy of this authorization shall be considered as effective and valid as the original.

I fully understand and comply with this policy:

Signature of Patient or Responsible Party Date

HAVE YOU EVER HAD:	YES	NO
Eye diease, including glaucoma and “dry eye”?	☐	☐
High Blood pressure?	☐	☐
Kidney disorder?	☐	☐
Diabetes?	☐	☐
Bleeding Disorder?	☐	☐
Lung or respiratory disease?	☐	☐
Arthritis or joint disease?	☐	☐
Depression or anxiety?	☐	☐
Hepatitis?	☐	☐
Thyroid disease?	☐	☐
AIDS or AIDS related complex?	☐	☐
A reaction to anesthetic?	☐	☐
Cancer, including skin cancer?	☐	☐
Stomach trouble, ulcers?	☐	☐
Do you smoke? How much?_____	☐	☐
Do you drink alcohol? 1. How much?_____	☐	☐
Do you have difficulty breathing through your nose?	☐	☐
Do you have frequent nosebleeds or bruise easily?	☐	☐
Do you scar easily or excessively?	☐	☐
Do you have any skin disease, i.e. cold sores, herpes, eczema psoriasis, acne, fever blisters, dermatitis?	☐	☐
Are you allergic to adhevesive tape, iodine or any cosmetics?	☐	☐
Are you allergic to any medications? Please List:_____	☐	☐

	YES	NO
Do you require treatment for hayfever or other allergies?	☐	☐
Have you ever had an injury to your head, face, or neck?	☐	☐
Do you plan to gain or lose more than 10 pounds?	☐	☐
Current Wt:_____ Wt. one year ago:_____	☐	☐
Do you exercise regularly?	☐	☐
Have you ever received local anesthesia from a doctor or dentist?	☐	☐
How long have you been thinking about having plastic surgery?	☐	☐
Have you had plastic surgery before?	☐	☐
If yes, what was done and when?_____ _____		
Were you happy with the results?	☐	☐
Have you ever had any other surgery to your head, face, or neck?	☐	☐
How do you think plastic surgery will benefit you?	☐	☐
Do you think plastic surgery will significantly change your life?	☐	☐

Which of the following features/problems are you interested in changing/improving?

☐ Nose ☐ Hair
☐ Breathing ☐ Appearance ☐ Scars
☐ Chin ☐ Acne ☐ Other
☐ Eyelids ☐ Ears
☐ Forehead ☐ Wrinkles
☐ Face (facelift) ☐ Facial blemishes (moles, etc)
☐ Other: _____

WOMEN:

Do you suspect you might be pregnant?	☐	☐

Last menstrual period_____

Please explain any “yes” answers: _____

Please list your current medications, including dose, if possible. (Remember to include aspirin, Advil, birth control pills and hormones, steroids, heart and asthma medications, vitamins, and blood thinners.)

I, _____, a patient at Spalding Drive Cosmetic Surgery & Dermatology, A Medical Corp. do hereby voluntarily give consent to the taking of photographs of me under the following conditions:

1. The photographs may be taken only with the consent of my physician or by an assistant or photographer approved or designated by my physician.
2. The photographs shall be taken by my physician or by an assistant photographer approved or designated by my physician.
3. The photographs or other visual materials may be released to other physicians or insurance companies when necessary.
4. The photographs will be used for medical records and may be published in professional journals or medical books, or used for other purposes which may be deemed proper in the interest of medical education, knowledge or research.
5. Although I have given permission to the publication and use of details and visual materials concerning my case, it is specifically understood that I will not be identified by name.

_____ _____
Signature (Patient, Parent, or Guardian) Date

_____
Witness

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COMPLIANCE ASSURANCE NOTIFICATION FOR OUT PATIENTS

To our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want to know that all our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way the growing problem of improper discloser of PHI. As part of the plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect! Because of the fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

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PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical and will do all we can to secure and protect your privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support you full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or discloser of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request too refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:_____ Date:_____

Signature:_____

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Patient Name: _____ Date: _____

You may be contacted by Spalding Drive Cosmetic Surgery and Dermatology to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

May we contact you at home? ***Y/N*** *Tel. (___) _____ Ok to leave Voice mail* ***Y/N***
May we contact you at work? ***Y/N*** *Tel. (___) _____ Ok to leave Voice mail* ***Y/N***
May we contact you via cell phone? ***Y/N*** *Tel. (___) _____ Ok to leave Voice mail* ***Y/N***

Comments: _____

Can a message be left with our Center's name and what the call is in reference to? ***Yes/No***

Is there anyone we can leave a message with? ***Yes / No*** *(If yes, please list first and last names)*

_____ _____

_____ _____

Would you like to authorize an individual as you personal representative? This person would have the authority to schedule, confirm or change appointments only. Yes / No (If yes, please list first and last names)

_____ _____

_____ _____
Patient Signature Date