PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care 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 records and will do all we can to secure and protect that 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 your 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 your 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 disclosure 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 to 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 objections to this form, please ask to speak with our HIPAA 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:_____ Signature:_____ Date:_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR 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 you to know that all of 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 (HIPAA) 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 use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this 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 this 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. APSC Staff.

ARTISTIC PLASTIC SURGERY CENTER
Khash Dehghan, MD. PhD, FACS
Certified American Board of Plastic Surgery
American Society For Aesthetic Plastic Surgery

Date _____
Referred By: _____
Dr. Phone No. _____
Preferred Language _____
Social Security# _____

Name: _____ **Date of Birth:** _____ Age: _____
Email: _____ Mr. ____ Ms. ____ Mrs. ____ Miss ____ Other ____
Home Phone: _____ **Cell Phone:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Employer: _____ Work Phone: _____
Address: _____ State: _____ Zip: _____
Emergency Contact: _____ **Phone:** _____ **Relation:** _____

PLEASE FILL IN THE BELOW PORTIONS IF APPLICABLE

Spouse's Name: _____ Date of Birth: _____ SSN: _____
Employer: _____ Work Phone: _____
Father's Name: _____ Date of Birth: _____ SSN: _____
Employer: _____ Work Phone: _____
Mother's Name: _____ Date of Birth: _____ SSN: _____
Employer: _____ Work Phone: _____

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative or other individual to the extent necessary to help with your health care or with payment for your health care. List below individuals to whom we MAY NOT release personal health information:

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

INSURANCE INFORMATION

Primary	Secondary
Plan Name:	Plan Name:
Subscriber:	Subscriber:
Address:	Address:
City/State/Zip:	City/State/Zip:
ID: Group:	ID: Group:
Co-Pay: $ Phone:	Co-Pay: $ Phone:

On the job injury? ☐ Yes ☐ No Claim No. _____ Date of injury:
How did the accident occur? _____ Where? _____

RELEASE OF INFORMATION

I hereby authorize Artistic Plastic Surgery Center, Khash Dehghan, MD, PhD, FACS, or their designee, to take any required photos and to release said photos as well as all medical information accumulated during my examinations from the date of my initial office visit until the date of the conclusion of such treatment to those individuals who, in Dr. Dehghan's sole determination are required to receive such information, either for the purpose of medical treatment, medical quality assurance or peer review.

I also understand that these records shall be available to my insurance company if they should request them.

I hereby authorize any medical facility or physician's office to release my medical records, including photos, x-rays and lab reports to:

ARTISTIC PLASTIC SURGERY CENTER, PLLC
Khash Dehghan MD, PhD, FACS
3515 South 15th Street, Suite 101
Tacoma, WA 98405

Signature: _____ Date: _____

CONCENT FOR BLOOD TESTING

This facility is governed by the laws of the State of Washington and deems to be in compliance with them. In the event that an employee should receive a needle stick during your surgical procedure, it will be necessary that a sample of your blood be drawn and tested for HIV and Hepatitis B. Appropriate counseling will be provided prior to obtaining a blood sample. This is done in strictest confidence and the results will not be released to anyone without your written permission. There will be no charge to you or your insurance company for this procedure.

I hereby give my consent to this procedure should it become necessary.

Patient Signature: _____

Witness: _____

Date: _____

FINANCIAL POLICY

Thank you for choosing us to provide your medical care in the field of Plastic and Reconstructive Surgery. The following is a statement of our financial policy, which we ask that you read, agree to, and sign prior to any treatment.

If reconstructive surgery is planned, our office staff will contact your insurance company to determine eligibility and make certain that benefits are available for your planned surgery. However, even though eligibility has been confirmed with your insurance provider, and pre-certification has been obtained, it is possible for your insurance company to deny benefits after the surgery. For this reason we suggest that you also check with your insurance company.

Your insurance policy is a contract between you and the insurance company. Your insurance may cover none or only a portion of the charges. You should be aware that **you are responsible for the balance of the bill.** If your claim is denied, you are responsible for the entire charge. You as a patient are responsible for all surgical, hospital, lab, or other costs and fees unless you have arranged and confirmed insurance coverage before the operation(s) and your insurance pays for all services.

All elective or cosmetic surgery is payable in advance. Financial arrangements for elective and cosmetic surgery are entirely the patient's responsibility. In certain uncommon circumstances, health insurance companies may pay for some or all of certain types of procedures. If you feel that insurance may help with your medical costs, it is your responsibility to confirm this prior to scheduling your surgery. Regardless of whether insurance is involved, it is the patient's responsibility to pay all costs related to his/her surgery.

Emergency surgery will be handled on an individual basis.

If no insurance is available for reconstructive surgery, payment is expected at the time of the service. For your convenience we accept personal checks, cash, and most major credit cards.

This office takes assignment on Medicare patients as well as the individual contracted insurance companies. Finance charges of 1.5% per month will be added to outstanding accounts that remain unpaid after 60 days.

I hereby agree to full responsibility for all expenses incurred by or on the account of

Patient: _____

I authorize my insurance company to pay directly to ARTISTIC PLASTIC SURGERY CENTER, PLLC for services rendered. I agree that I will pay any remaining balance no later than 30 days following the insurance payment.

Signature: _____ **Date:** _____

ARTISTIC PLASTIC SURGERY CENTER, PLLC
3515 South 15th Street, Suite 101
Tacoma, WA 98405

Concerns & Complaints

If you believe your rights have not been respected or you are not pleased with the way you are treated you have the right to...

- Register a complaint with any staff member and get a prompt response from management
- Speak with management directly about your concerns
- Initiate a formal grievance

We encourage you to speak with any staff member or the practice manager to resolve concerns Promptly. The Practice manager will also be available to assist with the clinic's grievance process. To reach the Practice Manager:

Please call: 253-756-0933 ext: 107

Email: KellyL@artisticplasticsurgery.com

The Practice Manager is available Monday through Friday, 9:00 a.m. to 5:00 p.m. Outside these hours please leave your name and phone number. Your call will be returned within 24 hours during the week or 48 hours over a weekend or holiday. We will try our best to resolve all problems with care, compassion and conscience decisions.

Artistic Plastic Surgery Center, PLLC

3515 S. 15th (& Union)
Suite 101
Tacoma, WA 98405

Phone: 253-756-0933
Fax: 253-759-6553
www.artisticplasticsurgery.com

If you require to voice your concern and or complain further than APSC, you may contact the Washington State Department Complaint Service at: 360-236-4700

How to file a complaint: Use these contact options to file a complaint about a laboratory, hospital, pharmacy, other licensed facility, or licensed professionals.
Complaint Hotline: 1-800-633-6828,
available 24 hours a day, 7 days a week
Phone: 360-236-4700
Fax: 360-236-2626
Mailing Address:
PO Box 47857
Olympia, WA 98504
Email Address:
HSQAComplaintintake@doh.wa.gov

2019 Novel Coronavirus Outbreak (COVID-19)

If you have questions about what is happening in Washington, or how the virus is spread, please call :

1-800-525-0127 and **press #** from 6 a.m. to 10 p.m. Monday - Friday, and 8 a.m. to 6 p.m. Saturday - Sunday and observed state holidays. Language assistance is available. Please note that this call center cannot access COVID-19 testing results. For testing inquiries or results, please contact your health care provider.

Text the word "Coronavirus" to 211211 to receive the latest information on COVID-19, including county-level updates, and resources for families, businesses, students, and more.

Who may I contact?
State COVID-19 Assistance Hotline
1-800-525-0127
6 a.m. to 10 p.m. Monday-Friday
8 a.m. to 6 p.m. Saturday and Sunday, and
observed state holidays
Language assistance is available. Please note: The call center cannot access COVID-19 testing results. For testing inquiries or results, please contact your health care provider.

You may also text the word "Coronavirus" to 211-211 to receive information and updates on your phone wherever you are. You will receive links to the latest information on COVID-19, including county-level updates and resources for families, businesses, students and more.

Patient Rights & Responsibilities

It's All About You!

ARTISTIC PLASTIC SURGERY PLLC

253-756-0933

Patient Rights & Responsibilities

When you come to our practice as a patient, your rights will be respected.

AS A PATIENT AT OUR PRACTICE, YOU HAVE THE RIGHT TO:

- Patient Care.
- Receive treatment and/or procedures that are available and medically indicated, regardless of your race, beliefs, sex, age, national origin, or ability to pay.
- Be treated with consideration and respect.
- Be an active participant in the decision making process regarding your care.
- Receive counseling and support about your medical condition.
- Refuse treatment as allowed by the law.
- Decide to leave the recovery area. If you do this against the medical judgement of the doctor , we will ask you to sign a release.
- Be informed about the outcomes of care, including unanticipated outcomes.
- Complain about the care you experience here without fear of retribution.
- Receive appropriate assessment and management of pain.

Emergency Services:

Anyone who requests an examination or treatment for an emergency medical condition will receive an appropriate medical screening examination within the capabilities of the practice. Our practice participates in the Medicare program.

Information:

- Understand what people tell you. If you need an interpreter, we will provide one for you.
- Receive help in obtaining access to protective services
- Have your physician provide you or another appropriate person acting on your behalf with a complete explanation of your condition in understandable terms.
- Understand all choices for treatment including alternatives, risks, and benefits.
- Obtain another doctor's opinion.
- Be informed of and give written consent to participate in any medical services.
- Know the names and qualifications of those caring for you.
- Give legal orders about how you wish to be treated or who will make decisions for you if you become unable.
- Decide whether to be transferred to another facility and to understand what the choices are.
- Review, amend, and request copies of your medical records.
- Obtain a detailed explanation of your bill.

Privacy: Receive care in reasonable privacy and have informational records read only by people directly involved with your care or monitoring its quality, unless you provide written permission.

A Safe Environment:

Be cared for in a safe and secure environment.

Be free from all forms of abuse, neglect or harassment.

Receive help obtaining access to protective and advocacy

As a patient at our practice, you have the responsibility to:

1. Tell your care providers everything you know about your health, and to let someone know if there are changes in your condition.
2. Make known when you have advance directives and provide documents describing your preferences.
3. Ask for explanation and information if you do not understand what you are told.
4. Participate in your health care by helping make decisions, following the treatment plan prescribed by your physician, and accepting responsibility for your choices.
5. Demonstrate respect and consideration for other patients and medical personnel.
6. Follow practice rules and regulations about safety and patient care during your treatment such as those about visitors, smoking, noise, privacy, etc.

Signature

Printed Name

Address

Date

Witnessed: Medical Personal (Sign & Date)

Artistic Plastic Surgery Center, PLLC

3515 S. 15th (& Union)
Suite 101
Tacoma, WA 98405

Phone: 253-756-0933
Fax: 253-759-6553
www.artisticplasticsurgery.com

PRIVACY PRACTICES ACKNOWLEDGMENT

A copy of our Notice of Privacy Practices will be provided for your review upon request.
By signing this form, you are consenting to our use and disclosure of your Protected Health Information while carrying out treatment, payment activities and healthcare services on your behalf.

You have the right to revoke this consent at any time by submitting to our office a written notice of your revocation. Please understand that revocation of this consent will not affect any action we took before we received your revocation. However, we may elect to discontinue providing healthcare services to you if this consent is revoked.

I wish to be contacted in the following manner (please check all that apply):

Home Telephone
_____ Leave message with detailed information
_____ Leave message with callback number only

Mobile Telephone
_____ Leave message with detailed information
_____ Leave message with callback number only

Work Telephone
_____ Leave message with detailed information
_____ Leave message with callback number only

Written Communication
_____ Mail to my home address
_____ Email to this address - _____
_____ Fax to this number - _____

Other _____

I hereby give permission for Artistic Plastic Surgery Center, PLLC to disclose information regarding my treatment to:

① Name _____
Address _____
City/State/Zip _____

② Name _____
Address _____
City/State/Zip _____

I consent to the above:

Print Name: _____ Today's Date: _____

Signature: _____ Date of Birth: _____

MEDICAL RECORD

Name: _____ Date of Birth: _____ Age: _____

Referred by: _____

Have you or a family member been seen in the office before? ☐ Yes ☐ No

If yes, please list the name of the person and their relationship to you: _____

What brings you to our office today? _____

When did the problem start? _____

Have you consulted another physician for this or other related problems? ☐ Yes ☐ No

PAST MEDICAL HISTORY

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please describe any current health problems: _____

Height: _____ Weight: _____ Weight loss/gain in past year? _____

Date of last medical exam: _____ Doctor's name: _____

EKG? ☐ Yes ☐ No Chest X-Ray? ☐ Yes ☐ No Lab Tests? ☐ Yes ☐ No

Please list all medications you are presently taking and the dose (mg.):

Name: _____ Dose/Frequency: _____

List all medications to which you are allergic and please give the reaction:

_____

Previous surgery? ☐ Yes ☐ No

Type: _____ Date: _____

Type: _____ Date: _____

Type: _____ Date: _____

Did you have comp ications following surgery? ☐ Yes ☐ No If yes, please explain: _____

DO YOU HAVE A:

Family or personal history of complications with local or general anesthesia?	☐ Yes ☐ No
Family history of unexpected Death(s) following general anesthesia?	☐ Yes ☐ No
Family history of unexpected Death(s) following exercise?	☐ Yes ☐ No
Family or Personal history of Malignant Hyperthermia?	☐ Yes ☐ No
Family or Personal history of neuromuscular disorder?	☐ Yes ☐ No
Family or Personal history of high temperature following exercise?	☐ Yes ☐ No
Personal history of muscle spasm?	☐ Yes ☐ No
Personal history of dark or chocolate-colored urine?	☐ Yes ☐ No
Personal history of unanticipated fever immediately following anesthesia?	☐ Yes ☐ No
Personal history of unanticipated fever immediately following serious exercise?	☐ Yes ☐ No

If yes, please explai n: _____

Please list any prior injuries:

Type: _____ Date: _____

Type: _____

Hospitalizations not shown above:

Cause: _____ Date: _____

Cause: _____ Date: _____

SOCIAL HISTORY

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Living with: ☐ Alone ☐ Spouse ☐ Parents ☐ Friend ☐ Other _____

Current Occupation: _____ Employer: _____

Who will take care of you following surgery? _____ Phone: _____ Relation: _____

What is your daily consumption of the following?

Coffee _____ Alcohol _____ Tobacco _____ Mind altering drugs _____

FAMILY MEDICAL HISTORY

Has a family member ever had the problem for which you are now coming to this office? ☐ Yes ☐ No

If yes, please explain: _____

Has a family member had:

Tuberculosis	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Blood/Bleeding Problems	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Asthma/Lung Disease	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Vascular Disease	☐ Yes	☐ No
Scleroderma	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No

REVIEW OF BODY SYSTEMS

Do you currently have symptoms of :

Fever, weight loss or fatigue?	☐ Yes	☐ No
Glaucoma or other eye problems?	☐ Yes	☐ No
Ear, hearing or balance problems?	☐ Yes	☐ No
Nose or sinus problems?	☐ Yes	☐ No
Difficulty swallowing?	☐ Yes	☐ No
Heart problems (chest pain, palpitations, irregular heartbeat, heart attack)?	☐ Yes	☐ No
High or low blood pressure?	☐ Yes	☐ No
Rheumatic fever?	☐ Yes	☐ No
Breathing problems, asthma, or lung disease?	☐ Yes	☐ No
Problems with the reproductive system?	☐ Yes	☐ No
Problems with bones, muscles, or joints?	☐ Yes	☐ No
Problems of the breasts?	☐ Yes	☐ No
Skin problems?	☐ Yes	☐ No
Neurological problems (stroke, numbness, weakness, dizziness, frequent headaches)?	☐ Yes	☐ No
Have you ever been treated for emotional problems?	☐ Yes	☐ No
Diabetes, hypoglycemia, thyroid disease, or endocrine problems?	☐ Yes	☐ No
Bruise easily or take longer than normal to stop bleeding?	☐ Yes	☐ No
Rheumatoid or other arthritis?	☐ Yes	☐ No
Vascular disease, lupus, or scleroderma?	☐ Yes	☐ No
Swelling of the lymph nodes or abnormal blood problems?	☐ Yes	☐ No
Cancer?	☐ Yes	☐ No
Does it take you a long time to heal?	☐ Yes	☐ No
Could you possibly have an infectious disease and/or MRSA?	☐ Yes	☐ No
Do you take products containing aspirin?	☐ Yes	☐ No
Do you have religious beliefs that discourage blood transfusions?	☐ Yes	☐ No

My dominant hand is: ☐ Right ☐ Left ☐ Both

What is your race? _____ What is your ethnicity? _____ Prefer not to answer _____

I certify that the above is true, correct and complete. I am aware and accept that withholding information about my medical history could result in serious injury to me or harm to those involved in my care.

Signed: _____ Witnessed: _____