PATIENT INFORMATION SHEET

Name:_____ Age:_____

Height: _____ Weight: _____

Please Describe Your Reason For This Visit: _____

_____

Please Describe The Accident Leading To Your Injury (If Applicable): _____

_____

_____

Date of Injury: _____

Current Medications (Please Include Over-The-Counter and Herbal Medications):_____

_____

_____

_____

Pharmacy: _____

Allergies and Reaction:_____

_____

_____

Health Problems:_____

_____

Previous Surgeries/Injuries:_____

_____

_____

Have you ever had a wound infection? _____ If so, was it Staph? _____

Personal Physician (full name):_____

Other Physicians You Are Seeing and Why:_____

_____

_____

ALFONSO OLIVA, M.D., F.A.C.S.

TELEPHONE
509-838-1010

THE COWLEY CENTER FOR
PLASTIC SURGERY
530 SOUTH COWLEY STREET, SPOKANE, WA 99202

FACSIMILE
509-777-1070

Smoking, Second-Hand Smoke Exposure, Nicotine Products (Patch, Gum, Nasal Spray)

Patients who are currently smoking, use tobacco products, or nicotine products (patch, gum, or nasal spray) are at a greater risk for significant surgical complications of skin dying and delayed healing. Individuals exposed to second-hand smoke are also at potential risk for similar complications attributable to nicotine exposure. Additionally, smoking may have a significant negative effect on anesthesia and recovery from anesthesia, with coughing and possibly increased bleeding. Individuals who are not exposed to tobacco smoke or nicotine-containing products have a significantly lower risk of this type of complication.

Please indicate your current status regarding these items below:

_____ I am a non-smoker and do not use nicotine products. I understand the risk of the second-hand smoke exposure causing surgical complications.

_____ I am a smoker or use tobacco/nicotine products. I understand the risk of surgical complications due to smoking or use of nicotine products. I understand my surgery will be cancelled if my nicotine test is positive, or I do not quit smoking for 3 months prior to surgery.

Date:_____ Signature: _____

Plastic Surgery Northwest, PLLC

COSMETIC INTEREST QUESTIONNAIRE

Patient name: _____

Areas of interest or concern to you (please check all that apply):

- Botox® Cosmetic
- Juvederm®
- Skin rejuvenation
- Retin-A
- Acne
- Chemical peels
- Laser resurfacing
- Laser treatments
- Spider vein treatments
- Obagi skin care system
- Skincare advice
- Sunscreen advice
- Birthmarks
- Liver spots/age spots
- Leg veins
- Facials and eye treatments
- Hair removal
- Facial veins
- Brow/Eyelash Tinting
- Latisse

Other, please specify: _____

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number:

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		**True Age**		**Older Than**
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		**Somewhat Concerned**		**Very Concerned**
1	2	3	4	5

How did you hear about us?

_____

AUTHORIZATION FOR RELEASE OF PATIENT PHOTOGRAPH

Name_____

Address_____
street address *city* *state* *zip code*

I consent to the taking of photographs by Dr. Oliva or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Oliva.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of Dr. Oliva, and may be retained by Alfonso Oliva, MD's office for the limited purpose of including them in his office books of before and after results, any print or visual electronic media, **including Dr. Oliva's website**, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Alfonso Oliva.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so, it won't have any affect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below.

I understand that the information disclosed, or some portion thereof, may be protected by state law and /or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPPA").

I release and discharge Dr. Oliva, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____
Signature *Date*

I have read the above Authorization and Release. I am the parent, guardian, or conservator of _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

_____ _____
Signature *Date*

Date:_____

To Whom It May Concern:

This is an authorization to release my medical records and/or X-ray reports to:

Alfonso Oliva, M.D., F.A.C.S.
Cowley Center for Plastic Surgery
530 S. Cowley Street
Spokane, WA 99202
Tel: 509-838-1010
Fax: 509-777-1070

_____
Name (Printed)

_____
Name (Signed)

_____
Social Security #

_____
Date of Birth

ALFONSO OLIVA, M.D., F.A.C.S.

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530 SOUTH COWLEY STREET, SPOKANE, WA 99202

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ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for any balance due.

_____

Name (Printed)

_____

Name (Signed)

_____

Date

DIPLOMATE: AMERICAN BOARD OF SURGERY, AMERICAN BOARD OF PLASTIC SURGERY, CAQ SURGERY OF THE HAND
A PROFESSIONAL SERVICES CORPORATION

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review carefully.

Alfonso Oliva, M.D., P.S., respects your privacy. We understand that your personal health information is very sensitive. We will not disclosed your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment and Health Operations

For treatment:

-Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.

-We may also provide information to others providing you care. This will help them stay informed about your care.

For payment:

-We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations:

-We use your medical records to assess quality and improve services.

-We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.

-We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.

-We may use and disclose your information to conduct or arrange services, including:

- -medical quality review by your health plan.
- -accounting, legal, risk management, and insurance services.
- -audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:

-Receive, read, and ask questions about this Notice.

-Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted.

-Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice").

-Request that you be allowed to see and get a copy of your protected health information.
You may make this request in writing. We have a form available for this type of request.

-Have us review a denial of access to your health information-except in certain circumstances.

-Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.

-When you request, we will give you a list of disclosures of your health information. This list will not include disclosures to third-party payors. You may receive this information without charge once very 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.

-Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.

-Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please call: (509) 838-1010.

Our Responsiblities

We are required to:

-Keep your protected health information private.
-Give you this Notice.
-Follow the terms of this Notice.
-We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handing of your protected health information, you may call: 509-838-1010. You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

Notification of Family and Others:

-Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.
-[Hospital] Information may be provided to people who ask for you by name. We may use and disclose the following information in a hospital directory:
  -your name
  -location
  -general condition
  -religion (only to clergy)

You may have the right to object this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:

-With Medical Researchers—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
-To Funeral Directors/Coroners consistent with applicable law to allow them to carry out their duties.
-To Organ Procurement Organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
-To Comply With Workers' Compensation Laws—if you make a workers' compensation claim.
-For Public Health and Safety Purposes as Allowed or Required by Law:
  -to prevent or reduce a serious, immediate threat to the health or safety of a person or the public
  -to public health or legal authorities
  -to protect public health and safety
  -to prevent or control disease, injury, or disability
  -to report vital statistics such as births or deaths
-To Report Suspected Abuse or Neglect to public authorities.
-To Correctional Institutions if you are in jail or prison, as necessary for your health and the health and safety of others.
-For Law Enforcement Purposes such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
-For Health and Safety Oversight Activities. For example, we may share health information with the Department of Health.
-For Disaster Relief Purposes. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
-For Work-Related Conditions That Could Affect Employee Health. For example, an employer may ask, us to assess health risks on a job site.
-To the Military Authorities of U.S. and Foreign Military Personnel. For example, the law may require us to provide information necessary to a military mission.
-In the Course of Judicial/Administrative Proceedings at your request, or as directed by a subpoena or court order.
-For Specialized Government Functions. For example, we may share information for national security purposes.

Effective Date: April 7, 2003

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By signing below, I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature _____ Date _____ Time _____

Printed Name _____ Relationship (if signing on behalf of patient) _____

Member
AMERICAN SOCIETY OF PLASTIC SURGEONS

DIPLOMATE: AMERICAN BOARD OF SURGERY, AMERICAN BOARD OF PLASTIC SURGERY, CAQ SURGERY OF THE HAND
A PROFESSIONAL SERVICES CORPORATION