Patient Information

Patient's Name ____
First Middle Initial Last

Address ____
Street & Apt# City State Zip

SS# ________________________ Birthdate_________________

Race________________________ Ethnicity__________________ Preferred Language_______________________

Gender ☐ Male ☐ Female

Home phone:________________________________ Can we leave a message for you at home? ☐Yes ☐No
Phone:____________________________________ Can we leave a message for you at work? ☐Yes ☐No
Cell phone:________________________________ Can we send you a text message? ☐Yes ☐No
Email address: ______________________________ Can we send email to this address? ☐Yes☐No

Preferred method of contact: ☐Home ☐Work ☐Cell
Occupation: ______________________________________ Employer: ____

In case of emergency, contact: ________________________________ Relationship to patient: ______________________
Home phone: ________________________________ Work/Cell phone: ______________________

Complete this section only if someone other than the patient is financially responsible.
Responsible Party:____ Relationship to Patient: ____________________
Address:
Home phone:____________________________ Birth Date:______________________ SS# ____________________

Primary Health Insurance

Name of Insurance Company: ____

Secondary Health Insurance

Name of Insurance Company: ____

All Commercial Insurance - Signature on File

I request that payment of authorized benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services.

Beneficiary Signature ____ Date _________________

Medicare Patients Only - Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on her approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature____ Date ________________

Payment Policy

1 understand that office visit charges are payable on the day service is rendered. I authorize Dr. Williams, or any dually accredited associate to bill my insurance company. I agree to pay all deductible, co pay, and non-covered service amounts. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Williams and myself.

Signature: ____ Date:______________________

Notice of Privacy Policy

Patient's Name: ______________________________

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may request a revised copy from the Privacy Officer.

Please list any persons (other than insurance carriers and healthcare professionals) who are authorized to receive protected health information about you:

☐ **No one**

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all your questions regarding the contents of our Notice have been answered.

By signing this form, you acknowledge your right to revoke your consent in writing except to the extent that the practice has already made disclosures in reliance upon your prior consent.

______________________________ ______________________________

Patient Signature
(Parent/Guardian Signature if patient is under the age of 18 years)

Date

Patient Photography Authorization and Release

☐ I consent to the taking of photographs or videotapes of me or parts of my body, by Dr. Jeffrey Williams or his designee, in connection with my medical care or with the plastic surgery procedure(s) to be performed by Dr. Williams. Preoperative and postoperative photographs of my person will be used for confidential clinical record purposes only. and shall remain the property of Peak Rejuvenation.

I further consent to the release by Dr. Williams, or his designated representatives of such photographs, videotapes or case histories to the appropriate insurance companies for surgical pre-authorization and/or claim review.

I fully and specifically grant my permission for the use of photographs, videotapes or case information for the following additional purposes as indicated by my initials below. As a result of this use, I understand that these photographs, videotapes, or case information may appear in other related, updated, or reprinted formats at any concurrent or future occasion. Neither I, nor any member of my family, will be identified by name in any publication. I understand that such consent is strictly on a volunteer basis. I understand that I may refuse to sign this additional authorization and such refusal will have no effect on the medical treatment I receive from Dr. Jeffrey Williams. I understand a copy of this consent may be supplied with images to any third party wherein they may be published or presented. l understand that some photographs may, by their representation make me identifiable in appearance to others. I authorize Dr. Jeffrey Williams to use my photographs, videotapes, and case information in the following educational or scientific settings **that I have initialed:**

_______ Medical journals and textbooks, scientific presentations and teaching courses in any prior, visual or electronic media, for the purpose of informing the medical profession about plastic surgery methods.

_______ My surgeon’s office patient education materials, including pre- and postoperative photographs available only to prospective patients for viewing in the office.

_______ My surgeon’s personal web site or web page.

_______ Lectures and multimedia presentations given by my surgeon for the general public.

_______ Television programs in which my surgeon participates/

_______ Newspaper or magazine articles in which my surgeon participates.

_______ Case studies presented on professional, society web sites.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) 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 (" HIPAA"').

I release and discharge Dr. Jeffrey Williams, and all parties acting under their license and authority from all rights that I may have in the photographs, videotapes or cast histories 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 these materials in any medium.

I grant this consent as a voluntary action and certify that I have read the above Authorization and Release and fully understand its terms.

_______________________________________ _______________

Patient Name | Date

_______________________________________ _______________

Patient Signature | Date
(Parent/Guardian Signature if patient under the age of 18 years)

_______________________________________ _______________

Witness | Date

General Records Release

JEFFREY S. WILLIAMS D.O., P.C.
Plastic & Reconstructive Surgery
Cosmetic Surgery
Hand & Micro Surgery
Pediatric Plastic Surgery

To: ________________________

I herby authorize you to release to: **Dr. Jeffrey S. Williams, 575 Rivergate Ln. Ste. 205, Durango Co. 81301; Phone 970-259-5990 Fax 970-259-5934**; any information including the diagnosis and records of any treatment or examination rendered to me during the period from ____________ to _______________.

This records release is good until ______ _______ ________.
Month Day Year

____
Date

____
Patient Signature

____
Print Name

____
Witness

____
Date of Birth

Medical History

Patient's Name ____
First Middle Initial Last

Birthdate: Age: Weight: Height: Reason for Visit: ____________________

Parent(s)/Guardians:______________________________Referring Doctor:______________________________

Primary Care Provider______________________________Cardiologist/Oncologist______________________________

How did you learn about our practice? ☐ **Referring Provider** ☐ **Friend/family** ☐ **Internet/social media** ☐ **Phone book**
☐ **Promotional event (Which one?)** ____________ ☐ **Radio** ☐ **Other: Please list**____________

ALLERGIES: ☐ Environmental Allergies ☐ Latex Allergies ☐ Tape Allergies ☐ No Known Drug Allergies

List all DRUG ALLERGIES And Type of REACTION:

____

____

MEDICATIONS, VITAMINS, & SUPPLEMENTS: Attach list if more than five prescription medications

Rx:	Dose:	Reason:
Rx:	Dose:	Reason:
Rx:	Dose:	Reason:
Rx:	Dose:	Reason:
Rx:	Dose:	Reason:

Do you use any of the following? Mark all that apply: ☐ Insulin ☐ Coumadin ☐ Home Oxygen ☐ Aspirin or Ibuprofen ☐ Steroids

PREFERRED PHARMACY______________________________**ADDRESS**______________________________

PERSONAL PAST MEDICAL HISTORY: Have you ever had any of the following?

	YES	NO		YES	NO		YES	NO
Abnormal Bleeding			Asthma			Attention Deficit		
Blood Clots			Fainting Spells			Atrial Fibrillation		
Heart Attack			Sleep Apnea			Cancer		
Coronary Stents			Thyroid Disease			Epilepsy/Seizure		
Heart Murmur			Tuberculosis			Anxiety/Depression		
Heart Disease			Hepatitis			Melanoma		
Anemia			Diabetes			Cystic Fibrosis		
High Blood Pressure			Kidney Disease			Melasma		
Stroke			HIV/AIDS			Lupus, Vitiligo, Porphyria		
Pacemaker			Cold Sores			Other		

Type of Cancer:______________________________ Other: ____________________ ☐ No major illness or hospitalizations

Have you been hospitalized in the past 6 months? ☐ No ☐ Yes: ______________________________

Are your immunizations current? ☐ Yes ☐ No ☐ Unsure

Do you wear any of the following? (Mark all that apply) ☐ Contact lenses ☐ Eye glasses ☐ Hearing aids ☐ Dentures

PAST SURGERIES: ☐ No Past Surgeries

Date: Type: Hospital: Surgeon:

____

____

____

Have you ever had a transfusion? ☐ No ☐ Yes

When? ______________________________

Have you had any complications or bad reactions to anesthesia? Describe:______________________________

Medical History

Are you currently pregnant? ☐Yes☐No ☐Maybe
Number of Pregnancies: __________ Number of natural children: __________ Do you breastfeed? ☐Yes☐No
Date of last mammogram: ____________ Have you had your tubes tied? ☐Yes☐No Have you had a hysterectomy? ☐Yes☐No

FAMILY HISTORY: Have any blood relatives ever had any of the following?

	YES	NO		YES	NO		YES	NO
Breast Cancer			Tuberculosis			Thyroid disease		
Heart Disease			Stroke			AIDS/HIV		
Diabetes			Epilepsy			Cystic Fibrosis		
Abnormal Bleeding			Kidney Disease			Melanoma		
			Blood Clots			High Blood Pressure		

List any other serious illness not listed above: ______________________________
☐ Adopted or family history unknown

SOCIAL HISTORY: ***Adult Patients Only***

Gender: ________ Occupation: ____________ Marital Status:____________ Name of significant other: __________________
Is a responsible adult available to assist during surgery recovery period? ☐ Yes ☐ No

Do you smoke? ☐ No ☐ Yes – What: ☐ Cigarettes ☐ Cigars How much? _____ packs/day or packs/week_____
Have you ever smoked? ☐ No ☐ Yes – Number of years smoked? ____________________________________ Date quit: ______
Are you aware that smoking increases the risk for surgical complications? ☐ Yes ☐ No
Do you drink alcohol? ☐ No ☐ Yes – How much? ______ drinks ☐ Daily ☐ 2-3 x per week ☐ Weekly ☐ Occasionally
Do you have a history of drinking to excess? ☐ No ☐ Yes – Date quit: ________________________ -
Do you use any recreational drugs? ☐ No ☐ Yes – List: ____ -

COSMETIC PATIENTS ONLY:

<u>SKIN CARE</u>

What products and regimen do you use on your face at home?

AM: ____
PM: ____

Is your skin: ☐ NORMAL ☐ OILY ☐ DRY ☐ COMBINATION

Do you wear sunscreen? ☐ YES ☐ NO

<u>PREVIOUS INJECTIONS & LASER TREATMENTS</u>

Have you had any of the following?

Botox / Xeomin / Dysport ☐ YES ☐ NO **Treatment Date & Area:** ______________________________
Dermal Filler ☐ YES ☐ NO **Treatment Date & Area:** ______________________________
Laser Treatments ☐ YES ☐ NO **Treatment Date & Area:** ______________________________
Vein Treatments ☐ YES ☐ NO **Treatment Date & Area:** ______________________________
OTHER ____