EDWARD BERZIN, M.D.
Aesthetic & Reconstructive Surgery
6560 Fannin Street, Suite 1804
Houston, TX 77030

Patient Name: _____ Date: _____
Last First MI

Permanent Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Preferred Method of Contact: _____ Preferred Language: _____

Social Security Number: _____ - _____ - _____ DOB: _____

Marital Status: Single _____ Married _____ Divorced _____ Other _____

Spouse's Name: _____ Spouse's Occupation: _____

Employer: _____ Occupation: _____

Address: _____ Suite Number: _____

City: _____ State: _____ Zip: _____ Phone: _____

Emergency Contact: _____

Relationship to Patient: _____ Phone: _____

Primary Insurance: _____

Policy ID Number: _____ **Group Number:** _____

Claim Filing Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Name of Insured/ Card Holder: _____

Insured's relationship to patient: _____

Insured's date of birth: _____ **Insured's SSN:** _____

Insured's address: _____

City: _____ State: _____ Zip: _____ Phone: _____

PHYSICIAN INFORMATION:

Referring Physician (if applicable): _____ Phone: _____

Primary Care Physician (if applicable): _____ Phone: _____

Date of last exam by your Primary Care Physician or Internist: _____

FINANCIAL DISCLOSURE:

I understand that I am financially responsible for all medical expenses associated with my treatment, or the treatment of my dependent. I understand that such treatment may or may not be covered by my insurance policy or Medicare. I authorized ***Dr. Edward Berzin*** to release my medical records to my insurance company and to file with my insurance carrier to obtain payment. I assign all payments to ***Dr. Edward Berzin*** for any covered expenses.

I understand that any insurance deductible and insurance co-payment must be paid prior to the performance of elective surgery. I understand that pre-certification or pre-authorization of any procedure is not a guarantee of payment and that I am ultimately responsible for all expenses not covered by insurance.

I understand that all returned checks are subject to a **$45.00** returned check fee.

I understand all of my financial responsibilities as explained above.

_____
Signature of Patient

MEDICARE PATIENTS:

I request that payment of authorized Medicare benefits be paid to ***Dr. Edward Berzin.***

_____
Signature of Patient

PHOTO CONSENT:

I authorize ***Dr. Edward Berzin*** to take pre-operative, intra-operative and post-operative photographs which may be used for patient education and may be published on his internet site at ***www.drberzin.com***.

_____
Signature of Patient

CONSENT FOR MINOR PROCEDURE/TREATMENT:

I give consent to ***Dr. Edward Berzin*** to perform minor office procedures or treatment such as simple excisions, injections or other suggested minor forms of treatment.

_____
Signature of Patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT)

I, _____, HAVE VIEWED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

ON BEHALF OF A MINOR CHILD, PARENT, OR SPOUSE, _____, AS THEIR
(PATIENT'S NAME)

PARENT, LEGAL GUARDIAN, OR EXECUTIER.

I HAVE LISTED BELOW FOUR PEOPLE (IF APPLICABLE) WHO MIGHT BE INVOLVED IH HIS/HER MEDICAL UPDATES AND/OR TRANSPORTATION.

	NAME	PHONE NUMBER	RELATIONSHIP
1.			
2.			
3.			
4.			

_____

PLEASE PRINT NAME

_____

SIGNATURE OF PATIENT OR GUARDIAN

* A COPY OF OUR HIPPA POLICY IS AVALIABLE UPON REQUEST.

FOR OFFICE USE ONLY

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES HOWEVER ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE:

_____ INDIVIDUAL REFUSED TO SIGN

_____ COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT

_____ EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT

_____ OTHER (PLEASE SPECIFY)

_____

_____

DATE: _____ AGE: _____

PATIENT: _____ SEX: M F

HEIGHT: _____ WEIGHT: _____

HISTORY OF PRESENT ILLNESS:

Reason for your visit today and when did the condition first begin? _____

_____

_____

_____

Allergies (include reaction): _____

_____

Current Medications (please include aspirin, ibuprofen, birth control pills, etc. and dosage):

_____

_____

Medical Illnesses: _____

_____

Previous Surgeries: _____

_____

FAMILY & SOCIAL HISTORY:

Ethnicity: _____ Race: _____ No. of Children: _____

History of Family Illnesses: _____

_____

_____

Alcohol Use (Describe type & amount): _____

Never Occasionally Daily Weekly

Tobacco Use (Describe type & amount): _____

Never Occasionally Daily Weekly

Special Diet (Describe type & amount): _____

Never Occasionally Daily Weekly

REVIEW OF SYSTEMS:

Please indicate any history of problems with the following:

	Yes/No		Yes/No		Yes/No
Weight Loss/Gain	☐ ☐	Heartburn	☐ ☐	Fainting/Dizziness	☐ ☐
Fever/Chills	☐ ☐	Reflux	☐ ☐	Stroke	☐ ☐
Thyroid	☐ ☐	Indigestion	☐ ☐	Seizures	☐ ☐
Cough	☐ ☐	Nausea/Vomiting	☐ ☐	Depression/Anxiety	☐ ☐
Shortness of Breath	☐ ☐	Hernia	☐ ☐	Hepatitis	☐ ☐
Palpitations	☐ ☐	Jaundice	☐ ☐	Implants	☐ ☐
Chest Pain	☐ ☐	Urinary Symptoms	☐ ☐	Skin or Breast Mass	☐ ☐
High Blood Pressure	☐ ☐	Change in Bowel Habit	☐ ☐	Abnormal Mouth	☐ ☐
Arthritis	☐ ☐	Hemorrhoids	☐ ☐	Ear, Nose,	☐ ☐
Abdominal Pain	☐ ☐	Anemia	☐ ☐	Diabetes	☐ ☐
Ulcer	☐ ☐	Bleeding	☐ ☐	Cancer	☐ ☐

If answered yes to any of the above, please describe in detail:

_____

_____

_____

_____

PHYSICIAN COMMENTS:

_____

_____

_____

Patient Signature: _____

Attending Physician: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you (or minor child) may be used and disclosed and how you can get access to this information. Please review carefully.

Overview

Our office uses health information about you for treatment, to obtain payment for treatment, administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of our practice.

The law requires us to maintain the privacy of your protected health information (PHI) in accordance with this Notice of Privacy Practices (Notice), as long as this Notice remains in effect. We are also required to provide you with a copy of this Notice, which contains our privacy practices, our legal duties, and your rights concerning your PHI.

From time to time, we may revise our privacy practices and the terms of our Notice at any time, as permitted or required by applicable law. We reserve the right to apply a change in our policies to previously received PHI. We will promptly revise and distribute our Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in the Notice. We will mail a copy of the revised Notice to the address of record if requested.

Our Privacy Practices

Use and Disclosure. We may use or disclose your PHI for treatment, payment or healthcare operation. For your convenience, we have provided the following examples of such potential uses or disclosures:

Treatment. Your PHI may be used to provide you with medical treatment for services. For example, information obtained by a healthcare provider, such as a physician, nurse or other persons providing healthcare services to you, will record information in your record that is related to your treatment. This information is necessary for healthcare providers to determine what treatment you should receive.

Payment. Your PHI may be used or disclosed in order to collect payment for the medical services provided to you. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course or treatment.

Healthcare Operation. Your PHI may be used or disclosed as part of our internal health care operations. Such healthcare operations my include, among other things, quality of car, audits of our staff and affiliates, conducting training programs, accreditation, certification, licensing or credentialing activities.

Authorizations. We will not use or disclose your medical information for any reason except those described in this Notice, unless you provide us with a written authorization to do otherwise. We may request such an authorization to use or disclose your PHI for any purpose but you are not required to give us such authorization as a condition of your treatment. Any written authorization from you may be revoked by you in writing at any time but such revocation will not affect any prior authorized uses or disclosures.

Patient Access. We will provide you with access to your PHI as described below in the Individual Rights section of the Notice. With your permission, or in some emergencies, we may disclose your PHI to your family members, friends or other people to aid in your treatment or in the collection of payment. A disclosure of your PHI may also be made if we determine it is reasonably necessary or in your best interest for such purposes as allowing a person acting on your behalf to receive filled prescriptions, medical supplies, x-rays, etc.

Locating Responsible Parties. Your PHI may be disclosed in order to locate, identify or notify a family member, your personal representative or other persons responsible for your care. If we determine in our professional judgment that you are capable of doing so, you will be given the opportunity to consent to or to prohibit or restrict the extent or recipients of such disclosure. If we determine that you are unable to provide such consent, we will limit the PHI disclosed to the necessary minimum.

Appointments. We may contact you to provide appointment reminders (such as voicemail messages, postcards or letters) or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Deceased Persons. After your death, we may disclose your PHI to a coroner, medical examiner, funeral director, or organ procurement organization in limited circumstances.

Disasters. We may use or disclose your PHI to any public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Military and National Security. We may disclose to military authorities the medical information of armed Forces personnel under certain circumstances. When required by law, we may disclose your PHI for intelligence, counterintelligence and other national security activities.

Required by Law. We may use or disclose your medical information when we are required to do so by law. For example, your PHI may be release when required by privacy laws, work-related injuries or illness, public health laws, court or administrative orders, subpoenas, certain discovery request or other laws, regulations or legal processes. Under certain circumstances, we may make limited disclosures of PHI directly to law enforcement officials or correctional institutions regarding an inmate, lawful detainee, suspect, fugitive, material witness, missing person or a victim or suspected victim of abuse, neglect, domestic violence or other crimes. We may disclose your PHI to the extent reasonably necessary to avert a serious threat to your health or safety or the health or safety of others. We may disclose your PHI when necessary to assist law enforcement officials to capture a third party who has admitted to a crime against you or who has escaped from lawful custody.

Your Individual Rights

Access and Copies. In most cases, you have the right to review or to purchase copies of your PHI by requesting access or copies in writing to our Privacy Officer. Please contact our Privacy Officer regarding our copying fees. Our office will provide records within 30 days of a placed request.

Disclosure Accounting. You have the right to receive an accounting of the instances, if any, in which your PHI was disclosed for purposes other than those described in the following sections above: Use and Disclosures, patient Access, and Locating Responsible Parties. For each 12 month period, you have the right to receive one free copy, however, if you request a disclosure accounting more than once in a 12-month period, we will charge you a reasonable cost-based fee for each additional request. Please contact our Privacy Officer regarding these fees.

Additional Restrictions. You have the right to request that we place additional restrictions on our use or disclosure of your PHI, but we are not required to honor such a request. We will be bound by such restrictions only if we agree to do so in writing signed by our Privacy Officer.

Alternate Communications. You have the right to request that we communicate with you about your PHI by alternative means or in alternative locations. We will accommodate any reasonable request if it specifies in writing the alternative means or location and provides a satisfactory explanation of how future payments will be handled.

Amendments to PHI. You have the right to request that we amend your PHI. Any such request must be in writing and contain a detailed explanation for the requested amendment. Under certain circumstances, we may deny your request but will provide you with a written explanation for the denial. You have the right to send us a statement of disagreement to which we may prepare a rebuttal, a copy of which will be provided to you at no cost. Please contact our Privacy Officer with any further question about amending your medical record.

Copy of Notice of Privacy Practices. Should you obtain a copy of this Notice electronically, you may request a paper copy of this Notice. Please contact our Privacy Officer and a copy will be made available to you at no cost.

Our Obligations

We are required to:

- Maintain the privacy of protected health information
- Provide you with this Notice of our legal duties and privacy practices with respect to your health information
- Abide by the terms of this Notice
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed
- Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations
- Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Complaints

If you believe we have violated your privacy rights, you may complain to us or to the secretary of the U.S Department of Health and Human Services. You may file a complaint with us by notifying our Privacy Officer.