Randy Tate, M.D.
CENTRE FOR FACIAL PLASTIC SURGERY

Please fill out all information as completely as possible. This information will help us in processing your office visit and make your visit a smoother, quicker and more efficient process. Please have all insurance cards and information needed at the time of your visit.

Thank you!

PATIENT INFORMATION

Name:_______________________ **Date of Birth:**_______________________

Address:_______________________ **Sex:**_________ **Age:**_________ **Marital Status:**_____________

City:_______________________ **State:**______ **Zip:**_________ **Social Security #:**_______________________

Home Phone: _______________________**Work Phone:**_______________________ **Cell Phone:**_______________________

Employer Name:_______________________ **Occupation:**_______________________

Spouse Name:_______________________ **Social Security #:**__________________ **Date of Birth:**_______

ADDITIONAL INFORMATION

What is the chief complaint that brought you to the doctor's office:
____

Pharmacy Name: _______________________ **Pharmacy Location:** _______________________

Referring Source:_______________________

Your e-mail address:_______________________ **Receive our cosmetic newsletters'/e-mail's? Y N (CIRCLE ONE)**

Do you see an Esthetician? Y N (CIRCLE ONE) If so, who: _______________________
Are you interested in a Complimentary Skin Care Consultation? Y N (CIRCLE ONE)

Are you currently using skincare? Y N (CIRCLE ONE) If so, what line: _______________________

Are you currently using Latisse? Y N (CIRCLE ONE) If not, are you interested? Y N (CIRCLE ONE)

INSURANCE INFORMATION

*** Please give cards to receptionist ***

***Primary* Insurance:**_______________________ **I.D. #:**_______________________
Subscriber (Who Carries Insurance):_______________________

***Secondary* Insurance:**_______________________ **I.D. #:**_______________________
Subscriber (Who Carries Insurance):_______________________

EMERGENCY CONTACT

Person to notify (in case of emergency):_______________________

Relationship:_______________________

Phone #:_______________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Centre for Facial Plastic Surgery to release any information required to process my claims.

_______________________ _______________________
Patient Name **Date**

Randy Tate, M.D.
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Medical History/Information

Medication Allergies and Reactions: ____
____
____

Current Medical Problems (i.e. Diabetes, Heart Disease): ______________________________
____
____

Medications

Name	Dosage	Name	Dosage

Do you take aspirin/ibuprofen/Motrin? Y N

Surgery/Hospitalizations

Procedure	Date

Social History

Do you currently smoke? Y N

Number if packs per day? ______ **How many years?** _______

If no, have you smoked in the past? Y N **Date you quit?** ____/_____/______

Do you currently drink alcohol? Y N **How many per day?** _____

Do you use Recreational Drugs? Y N

Occupation?__________________________ **Are you retired?** Y N

Family History

Are there diseases that run in your family? Y N

Relationship	Disease

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PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD:

RESPIRATORY:	Yes	No	Don't Know
Daily chronic cough	☐	☐	☐
Sputum, phlegm or mucus production	☐	☐	☐
Asthma, wheezing	☐	☐	☐
Bronchitis, Emphysema, COPD	☐	☐	☐
Tuberculosis (TB)	☐	☐	☐
Can you walk 2 flights of stairs with out stopping to catch your breath?	☐	☐	☐

CARDIOVASCULAR:	Yes	No	Don't Know
Chest pain, angina, heart attack	☐	☐	☐
Leg swelling, CHF	☐	☐	☐
Shortness of Breath	☐	☐	☐
High Blood Pressure, Hypertension	☐	☐	☐
Heart Murmur, rheumatic fever	☐	☐	☐
Cramping in legs when walking	☐	☐	☐
Phlebitis (blood clots)	☐	☐	☐
Do you sleep on more then 2 pillows?	☐	☐	☐
Do you wake up short of breath?	☐	☐	☐

ENDOCRINE:	Yes	No	Don't Know
Diabetes, high/low blood sugar	☐	☐	☐
Thyroid problems, heat or cold tolerance	☐	☐	☐

HEMATOLOGIC:	Yes	No	Don't Know
Bleeding Problems	☐	☐	☐
Anemia	☐	☐	☐

DERMATOLOGIC:	Yes	No	Don't Know
Skin Cancer	☐	☐	☐

GASTROINTESTINAL:	Yes	No	Don't Know
Hiatal hernia, heartburn	☐	☐	☐
Ulcers, vomiting blood	☐	☐	☐
Hepatitis, jaundice	☐	☐	☐
Liver disease, cirrhosis	☐	☐	☐

GENITOURINARY:	Yes	No	Don't Know
Could you be pregnant?	☐	☐	☐
Difficulty passing urine	☐	☐	☐
At risk for AIDS or VD	☐	☐	☐

MUSCULOSKELETAL:	Yes	No	Don't Know
Physical limitations or prosthesis	☐	☐	☐
Arthritis	☐	☐	☐

NEUROLOGICAL/PSYCHIATRIC:	Yes	No	Don't Know
Depression	☐	☐	☐
Seizures, convulsions, fainting, epilepsy	☐	☐	☐
Stroke, fleeting blindness, weakness	☐	☐	☐
Paralysis	☐	☐	☐
Psychiatric Treatment	☐	☐	☐

GENERAL:	Yes	No	Don't Know
Headaches, unexplained weight loss or fatigue	☐	☐	☐

Other ________________________________

Randy Tate, M.D.

CENTRE FOR FACIAL PLASTIC SURGERY

ACKNOWLEDGMENTS

- I AGREE TO THE FINANCIAL POLICY FOR DR. RANDY TATE OF THE CENTRE OF FACIAL PLASTIC SURGERY.

- ***I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE "NOTICE OF PRIVACY PRACTICES" (HIPPA) FROM DR. RANDY TATE'S OFFICE***

- ***I UNDERSTAND DR. RANDY TATE IS LICENSED BY THE MEDICAL BOARD OF CALIFORNIA.***

Patient Signature: ________________________________

Date: _________________________

PATIENT COPY

Financial Policy

TO OUR VALUED PATIENTS:

Thank you for choosing The Centre for Facial Plastic Surgery, Dr. Randy Tate. We are committed to providing you with the best medical care possible. Please review a brief explanation of our policies & procedures below. If you have any questions, please ask the front desk coordinator to assist you with an explanation. After you have read the document in its entirety, please sign below. Your signature constitutes an agreement to the procedures and policies of our practice.

Thank You,

The Centre for Facial Plastic Surgery
Dr. Randy Tate

OFFICE HOURS

We are open Monday-Friday 9:00 AM-5:00 PM

DEFINITIONS:

In-Network-We refer to "IN NETWORK" as the insurance companies that we have a contractual agreement with. If we are in network, we have agreed upon a pay scale with the insurance company. In other words, we have agreed to a discounted rate for members of the insurance carrier with whom we are contracted.

Out of Network/Non-Participating Insurance-If we are not in network with your insurance carrier, we will bill your carrier as a courtesy. If payment is not received within 60 days, the balance may become your responsibility. You, the patient, will have to contact your insurance company to determine why payment has not been made. Please be aware you may incur more out of pocket expenses for seeing a doctor out of network. It is your responsibility to check with your insurance company for benefits.

Accept Assignment Definition-Accept assignment means that we agree to accept check payment from the insurance company for services rendered.

Payment at Time of Service

As a courtesy, we will bill your insurance for all office visits. However, we ask that you pay any portion not covered by your insurance due to deductibles or co-payments that you are aware of on the day of service.

Submission of Claims

We will submit your insurance claims. However, it is important to remember that your insurance contact is between YOU & YOUR insurer. Although we file insurance claims as a courtesy to you, you are still responsible for payment of services regardless of the amount your insurance pays.

Balances Due after Insurance Pays

If there is a remaining balance due after your insurance carrier pays, you have 30 days to make payment on the invoice. You will be sent a patient statement within the 30 day time frame on at least 2 occasions as a reminder. Payment arrangements can be made for special circumstances by contacting the office manager within 30 days of receipt of the most current invoice. It is your responsibility to make contact with our office to make special arrangements.

Outstanding Balances

We urge you to keep your account current to avoid any misunderstandings with our office. All account balances past due over 90 days may be sent to an outside collection agency for collections. At that point, the account may be out of our hands. If you need to make special arrangements, it is your responsibility to contact the office manager at our office before your account is sent to the outside collection agency.

Payment Options

Our office accepts Cash, Checks, VISA, MASTERCARD & Bank Debit Cards.

Medicare Patients

If you have Medicare as your primary insurance carrier & you do not have a secondary insurance, you are responsible for the 20% coinsurance.

Motor Vehicle Accident

It is your responsibility to furnish our office with all necessary automobile insurance & policy numbers at time of visit. We do not accept liens.

Cash Payment

If you pay cash, please ask for a receipt so that you will have a record of your payment.

Billing Procedure

Your 1st statement with your remainder balance due will be mailed to you once we receive a reply/explanation of benefits from your insurance company.

Return Check Policy

We charge $10 per check returned to us unpaid.

Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, coinsurance or other balances.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to attorney's fees and cost of collection.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Dr. Tate.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

PATIENT COPY

HIPPA NOTICE OF PRIVACY PRACTICES
(Health Insurance Privacy & Portability Act)
Effective Date: 07/06/09

THIS NOTCE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Health Information Coordinator.

WHO WILL FOLLOW THIS NOTICE

This notice describes our office's practices and that of:

- Any health care professional authorized to enter information into your chart.
- All departments and units of this office.
- Any member of a volunteer group we allow to help you while you are in the office.
- All employees, staff and other office personnel.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by office personnel or your personal doctor.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **FOR TREATMENT** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in your treatment. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange appropriate meals. Different departments also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights reading medical information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but may not include some mental health information.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to James R. Tate, M.D. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for this office.

  To request an amendment, your request must be made in writing and submitted to James R. Tate, M.D. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for this office;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosure." This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment and health care options, as those functions are described above.

  To request this list or accounting of disclosures, you must submit your request in writing to James R. Tate, M.D. Your request must state a time period which may not be longer that six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically).

  The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about your for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care like a family member or friend. For example, you could ask
  that we do not use or disclose information about a surgery you had.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

  To request restrictions, you must make your request in writing to James R. Tate, M.D. In your request, you must tell us (1) what information you want to limit ;(2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you must make your request in writing to James R. Tate, M. D. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy for this notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or change notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office waiting room. The notice will contain on the first page, in the top right-hand corner, the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Health Information Coordinator. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.