UTAH EYELID AND FACIAL PLASTIC SURGERY

John D. McCann, MD, PhD - Matheson A. Harris, MD
4400 S 700 E, SUITE 130, SLC, UT 84107 (801)997-9999, (801)264-4420

PLEASE COMPLETE AND SIGN ENTIRE FORM

Name _____ Preferred Name _____

Date of Birth _____ Age _____ M/F _____ Soc Security # _____ Address

_____ City/State/Zip _____

Phone: Cell# _____ Hm# _____ Wk# _____

Preferred method of contact: Cell___ Home___ Work___ Email address _____

Occupation _____ Employer _____

Marital Status: Single ___ Married ___ Domestic Partnership ____ Widowed ____ Divorced _____

Spouses Name _____ Cell # _____

Whom shall we notify in case of emergency? _____ Relationship _____

Address _____Cell# _____ Hm# _____ Wk# _____

Preferred Pharmacy:_____Pharmacy Location:_____

COMPLETE IF PATIENT IS UNDER 18 YEARS OLD

Father _____ Date of Birth _____ Employer

_____ Cell# _____ Wk# _____

Mother _____ Date of Birth _____ Employer

_____ Cell# _____ Wk# _____

REFERRAL SOURCE (PLEASE COMPLETE ALL THAT APPLY)

Friend/Relative/Doctor Name _____ Doctor Location _____

Website ____ Insurance ____ Aesthetician/Hair Stylist Name _____

INSURANCE INFORMATION

Primary Medical Insurance _____ Member ID# _____

Secondary Medical Insurance _____ Member ID# _____

Workers Compensation Case/Claim# _____Adjustor/Claim Handler _____

Ph# _____ Address _____

Would you like more information on cosmetic services, aesthetician services, or how you can look younger? _____

SIGNED _____ DATE _____

Thank you for choosing our office for your healthcare needs. Please complete the medical questionnaire in full to assist us with your medical evaluation.

PATIENT MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME **DATE OF BIRTH**

NAME OF REFERRING PHYSICIAN AND REASON FOR CONSULTATION

LIST ALL TREATING PHYSICIANS (PLEASE INCLUDE PHONE NUMBERS)

	First and Last Name	Phone Number
1		
2		
3		
4		
5		

LIST ALLERGIES TO MEDICATIONS AND REACTIONS

	MEDICATION NAME	REACTION
1		
2		

REVIEW OF SYSTEMS:

Do you currently have any problems in the following areas?

		Yes	No		Yes	No
Allergic/Immunologic				**Ears, Nose, Mouth, Throat**		
	Hay fever symptoms			Chronic cough		
	Head allergy symptoms			Dry throat/mouth		
	Seasonal allergies			Pain with chewing		
Cardiovascular (Heart/Blood Vessels)				Post-nasal drip		
	High blood pressure			Runny nose		
	Pace Maker			Sinus congestion		
	Other			**Endocrine**		
Constitutional Symptoms				Diabetes		
	Fever			Thyroid disorders		
	Muscle Pain			Other		
	Weight Loss			**Gastrointestinal (Stomach/Intestines)**		
Eyes				**Genitourinary**		
	Blurred Vision			Genitals/kidney/bladder		
	Burning			**Hematologic/lymphatic**		
	Chronic infection of eye or lid			Blood		
	Distorted vision (halos)			Lymph nodes		
	Double vision			Swelling		
	Dryness			**Integumentary (Skin or Breast)**		
	Excess tearing/watering			**Neurological**		
	Occasional tearing			**Psychiatric**		
	Eye pain or soreness			Depression		
	Flashing lights			Other		
	Fluctuating visual acuity			**Respiratory**		
	Glare/Light sensitivity			Asthma (childhood/adult)		
	Loss of side vision			Chronic Bronchitis		
	Loss of vision			**Skeletal**		
	Mucous discharge			Back Pain		
	Redness			Joint Pain		
	Tired eyes			Muscle Pain		
	Cataracts					
	Prominent eyes					
	Drooping eyelids					
	Lazy eye					
	Crossed eye					
	Glaucoma					
	Macular degeneration					
	Keratoconus					
	Floaters					
	Foreign body sensation					
	Itching					
	Sties/Chalazion					

PAST HISTORY

List all medications and vitamins you currently take

Medication Name	Dose	Frequency

List all eye medications and/or ointments you currently take or use

Medication Name	Dose	Frequency

List all illnesses (list specific disease)

List any surgeries you have had including cosmetic and eye procedures

Thank you for choosing our office for your healthcare needs. Please complete the medical questionnaire in full to assist us with your medical evaluation.

PATIENT MEDICAL HISTORY QUESTIONNAIRE

FAMILY HISTORY includes Mother, Father, Sister, Brother, Grandparents, Aunt, Uncle

	Yes	No	Relationship to patient	Maternal	Paternal
DISEASE					
Allergies					
Asthma					
Blindness					
Cataract					
Eczema					
Glaucoma					
Macular Degeneration					
Retinal Detachment					
Retinoblastoma					
Arthritis					
Cancer					
Diabetes					
Heart Attacks					
High blood pressure					
Keratoconus					
Kidney Disease					
Lupus					
Sjogren's Syndrome					
Stroke					
Thyroid Disease					
Tuberculosis					
Other					

SOCIAL HISTORY

Current Occupation			

	Yes	No	Comments
Do you drink alcohol?			
If YES, how many glasses per day?			
Do you smoke?			
If YES, how many packs per day?			
Transmissible blood bourne diseases (HIV, Hepatitis, Herpes)?			

I have completed the medical questionnaire and to the best of my knowledge confirm the accuracy of the answers.

Patient Signature: Date:

Guardian of Patient: Date:

Physician Signature: Date:

Utah Eyelid and Facial Plastic Surgery Photo/Video Release

Patient Name (print)_____ DOB_____

I irrevocably consent to publication and/or distribution of photographs/videos taken of me by Dr. John McCann, Dr. Matheson Harris, Utah Eyelid and Facial Plastic Surgery, and/or its affiliates or associates. Without further approval, the photographs/videos may be released for publication in medical journals or text books, they be shown to other patients in the practice, they may be displayed on the company website, displayed on non-company websites, and/or they may be distributed electronically via any social media including YouTube, Facebook, Instagram and/or Twitter. I understand that in most circumstances the photographs/videos will portray features, which may make my identity recognizable.

I release and discharge the Utah Eyelid and Facial Plastic Surgery, Dr. John D. McCann, Dr. Matheson A. Harris and Dr. Harris and Dr. McCann's affiliates and associates from all rights that I may have in the photographs/videos 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/videos.

***** I voluntarily grant this request and certify that I have read the above authorization to allow my photos/videos to be published and/or distributed.**

Patient Signature_____ Date_____

(Please sign on only one of the two lines on this page)

***** I do not want my photos/videos used for anything except my medical care. I understand that choosing this option is my right and will in no way affect my medical treatment.**

Patient Signature_____ Date_____

Utah Eyelid and Facial Plastic Surgery

COSMETIC AND RECONSTRUCTIVE SURGERY OF THE EYELIDS AND FACE

PAYMENT AND BILLING POLICY

We are committed to providing you with the best service possible. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to do this, we need your assistance and your understanding of our payment policy. **It is the patient's responsibility to ensure we are in network on their insurance plan.** There are hundreds of plans and they frequently change. You can call the number on the back of your insurance card to verify this.

Payment for medical care is due at the time the services are rendered unless payment arrangements have been approved in advance by our staff.

INSURANCE BILLING

Co-payments are due at the time of the office visit.

We will be happy to submit claims to your insurance if you have provided us with the necessary insurance information. We require a copy of your insurance card that lists the name of the insurance company, address, telephone number, and policy/group numbers. It is your responsibility to bring a current referral from your primary care physician or a completed claim form for each visit if this is required by your insurance.

While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility. Regardless of what your insurance pays, your account is due in full within 90 days. Balances over 60 days are subject to a 1 ½ % per month finance charge.

MEDICAID INSURANCE

It is important that you bring your current Medicaid card to every office visit. It is also your responsibility to bring your current referral form from your primary care physician if required.

NON-INSURED OR SELF-PAY

Payment is due in full at the time of the office visit.

Non-emergency procedures require a 60% down payment prior to surgery.

Cosmetic surgeries are required to be paid in full prior to surgery. A $150 cosmetic consult fee is due at the time of the initial office visit and will be applied to future cosmetic surgery if performed within 1 year.

If you do not have insurance or if your insurance does not cover the proposed surgery, our billing manager will meet with you to set up a payment plan that works for you. You will need to sign a payment agreement before any surgery can be scheduled. We realize that temporary financial problems may affect timely payment on your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Signature_____Date_____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

In accordance with the Federal Truth-in-Lending Act which requires all doctors to give their patients complete information in connection with extensions of credit, please be advised of the following credit policies which apply in this office. You may have the option either to:

1. Have an open 30 day account in which statements will be sent out monthly and payment in full will be due within 25 days and prior to the succeeding monthly statement. (Not applicable to cosmetic surgeries—payment required to be paid in full prior to surgery.)

2. Discharge the account in a period of 90 days by paying ¼ down and ¼ per statement over a period of 3 months. No interest charges will be made unless the account is not discharged as per agreement; in which case a monthly charge of 1 ½ % per month (annual percentage rate of 18%) may be made on the unpaid balance with a minimum charge of 50 cents per month. (Not applicable to cosmetic surgeries—payment required to be paid in full prior to surgery.)

I/we acknowledge receipt of a copy of this agreement and agree to pay costs and/or a reasonable attorney's fee if any delinquent balance is placed with an agency for collection or suit.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize my physicians to release any information related to the course of my examination of treatment to my medical insurance carrier for preauthorization requirements and payment of claims.

AUTHORIZATION TO PAY BENEFITS: I hereby authorize payment directly to the supplier of medical service.

Signature_____Date_____

HIPPA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to you past, present or future physical or mental health condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclosure your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of an appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues, as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroner, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates Required Uses and Disclosures; Under the law , we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights to your protected health information.

You have the right to inspect and copy your protected health information.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information.

This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protect health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternative, i.e.; electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any such changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main office number.

The signature below is only acknowledgement that you have received this Notice of Our Privacy Practices:

Signature _____ Print Name _____ Date _____

COSMETIC INTEREST QUESTIONNAIRE

If any of these cosmetic issues are of interest to you please fill out this form so that we may assist you further (please check all that apply):

[ ]	Botox® Cosmetic	[ ]	Skin Care Advice
[ ]	AHA and Glycolic Peels	[ ]	Skin Care Products
[ ]	Collagen Therapy	[ ]	Liver Spots/ Age Spots
[ ]	Skin Rejuvenation	[ ]	Sunscreen Advice
[ ]	Micro-Dermabrasion	[ ]	Facials and Eye Treatments
[ ]	Acne	[ ]	Removing Facial Veins
[ ]	Chemical Peels	[ ]	Other, please specify:

_____

Please answer the following questions on a scale of 1 to 5 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 appearances of my wrinkles.

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

How did you hear about us?

[ ]	My physician (full name)_____
[ ]	My insurance company provider_____
[ ]	The yellow pages (specify advertisement)_____
[ ]	A friend or family member (name)_____
[ ]	Another person not listed above (name)_____
[ ]	Other_____