Patient Information

CONFIDENTIAL--For Office Use Only

Please answer all the questions as accurately as possible.

GENERAL INFORMATION:

Patient Name:
Last_____**First**_____**MI**_____
Age: _____**Birthdate: (mm/dd/yy)** _____/_____/_____ **Social Security #:**_____--_____---_____
Address: _____
City:_____**State:**_____**Zip:**_____
Home Phone: _____**Cell Phone:**_____**Email:**_____

EMPLOYMENT:

Occupation:_____**Employer:**_____
Address:_____**City:**_____**State:**_____**Zip:**_____
Business Phone: _____ **Driver's License #:**_____ **State:**_____**Exp:**_____/_____/_____

INSURANCE INFORMATION:

Primary Policy Holder: Last _____**First**_____**MI**_____
Relation:_____**Birthdate:**_____/_____/_____**Social Security #:**_____-_____-_____
Insurance Company:_____**Phone:**_____
Policy #_____**Account #**_____**Group #**_____
EMERGENCY CONTACT:
Name:_____**Relation:**_____**Phone:**_____

HOW WERE YOU REFERRED TO OUR OFFICE?

Circle:	Physician	Name:_____
	Friend/Relative	Name:_____
	Website	Search terms used:_____
	Print Ad	Publication:_____
	Other	Source:_____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

I certify that the above information is true and accurate to the best of my knowledge. I authorize treatment of the person named above and agree to pay for all charges for such treatment. I understand that Dr. Truong does not belong to any insurance plans and that the practice is not responsible for collecting payment from my insurance company. Therefore, I am responsible for payment in full for all services rendered at the time of service and that there is no guarantee that any services will be covered by my insurance plan. I understand that there is a 24 hour cancelation policy fee of $100 for missed appointments or appointments canceled within 24 hours of appointment time. I understand that there is a $500 non--refundable deposit required for any surgeries scheduled and that payment in full is required before my surgery date. If it becomes necessary to refer my account to an attorney or collection agency for collection, I am responsible for all reasonable collection agency and/or attorney fees and court costs.

Signature:_____Date:_____

DR. ANH-TUAN TRUONG
BREAST & BODY SPECIALIST | M.D. | F.A.C.S. | F.A.A.C.S.

1 East Erie St. Suite 242 Chicago IL 60611 T: 312.846.1529 F: 312.846.1743
ChicagoBreastAndBody.com

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PATIENT HEALTH HISTORY

Please answer all the questions as accurately as possible.

GENERAL INFORMATION:

Reason for Visit:

_____

HEALTH HISTORY:

Height:_____ft_____in. Weight:_____lbs

Ethnicity: _____

Conditions/Illnesses:_____
_____
_____

Previous Surgeries:
_____Date:_____
_____Date:_____
_____Date:_____
_____Date:_____

Pregnancy History: Number:_____Dates:_____
C--Sections: Y/N_____

Current Medications:
_____
_____

Allergies:
_____

Social History: Smoking: (circle) YES NO QUIT Packs per Day:_____ Years Smoked:_____
Alcohol: (circle) YES NO QUIT #Drinks per Week: _____
Drugs: (circle) YES NO QUIT IV Drugs? Y/N _____
Exercise: (circle) YES NO Activities:_____ Times per Week: _____

I certify that the above information is true and accurate to the best of my knowledge.

Signature:_____ Date:_____

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Photography Release and Consent

I, _____ , (Participant) irrevocably grant to Chicago Breast & Body Aestheics, (Licensor) its subsidiaries, affiliates, nominees licenses, their successors and assigns, and those acting with its authority, with respect to the photographs film or tape taken of me by or on behalf of the Licensor (the "Pictures"), the unrestricted absolute, perpetual, worldwide right to:

1. (a) reproduce, copy, modify, edit, create derivates in whole or in part, or otherwise use the pictures or any part thereof in combination with or as a composite of other matter, including, but not limited to, text, data, images, photographs, illustrations, animations and graphics, video or audio segments of any nature in any media or embodiment, now known or hereafter to become known, including, but not limited to, all formats of computer readable electronic magnetic, digital laser or optical--based media (the "Works") for any purpose whatsoever, including without limitation to electronic and web content, and
2. (b) use and permit to be used my name, whether in original or modified form, in connection with the Works as Licensor may choose,
3. (c) and display, perform, exhibit, distribute, license, sell transmit or broadcast the Works by any means now known or hereafter to become known.

WE WILL NEVER USE YOUR PHOTOGRAPHS WITHOUT YOUR CONSENT.

I hereby waive all rights and release and discharge the Licensor from, and shall neither sue nor bring any proceeding against any such parties for, any claim, demand or cause of action whether now known or unknown, for defamation, invasion of right to privacy, publicity or personality or any similar matter, or based upon or relating to the use and exploitation of the Pictures.

I agree that there shall be no obligation to utilize the authorization granted by me hereunder. The terms of this authorization shall commence on the date hereof and be without limitation. I warrant and represent that I am "over" the age of 18 years and that I am free to enter into this agreement.

_____ _____

Participant Signature Date

_____ _____

Licensor Date

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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

The Health Insurance Portability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, or paper, or orally, are properly confidential. The Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more providers.

- Payment means such activities as obtaining reimbursements for services, confirming coverage, billing and collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- Health care operations include business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also release confidential medical information to your insurance carriers, to review and assess your insurance, reimbursement, and coverage for office visits and related procedures. We may release confidential medical information to your insurance carriers and their employees that we contact on your behalf, for this purpose. Such information may include your name, age, sex, medical diagnosis, insurance identifiers, employers, or medical providers you identify.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.
We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made with only your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization
You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

• The right to request restrictions on uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

• The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

• The right to inspect and copy your protected health information

• The right to receive an accounting of disclosures of protected health information. • The right to obtain a paper copy of this notice from us upon request.

I acknowledge that I have read and agree to be bound by the terms and office policies stated above in areas of Notice of Privacy Practices. The duration of this authorization is indefinite or until it is revoked in writing.

_____ _____

Patient Signature Date

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