Rozbeh Torabi, MD • Tim Matatov, MD • Oren Tessler, MD, MBA, FACS • Joseph Zakhary, MD
10910 N. Tatum Blvd, Suite 100
Phoenix, AZ 85028
Tel: (480) 291-6895 • Fax: (480) 948-3750

PATIENT INFORMATION

PATIENTS NAME:______________________________ DATE:______________

DATE OF BIRTH:______________ S.S.#:______________________________

HOME ADDRESS:______________________________ CITY:______________

STATE:__________ ZIP:__________ EMAIL:______________________

HOME PHONE:______________________ CELL PHONE:______________________

OCCUPATION:______________________ EMPLOYER:______________________

BUSINESS ADDRESS:______________________ BUSINESS PHONE:______________________

SPOUSES NAME:______________________ SPOUSES OCCUPATION:______________________

SPOUSE'S: EMPLOYER:______________________ BUSINESS PHONE:______________________

IF CHILD, PARENTS NAME:____

EMERGENCY CONTACT:______________________ PHONE:______________________

REFERRED BY:____

INSURANCE INFORMATION

NAME OF INSURANCE CARRIER:____

POLICY TYPE:__________ GROUP:__________INDUSTRIAL:__________ OTHER:__________

POLICYHOLDER NAME:______________________S.S.#:______________ DOB:__________

ID:______________________ GROUP#:______________________

INSURANCE ADDRESS:______________________________PHONE#:______________

OTHER HEALTH COVERAGE? YES______ NO______ SPECIFY:______________________

POLICY NAME:______________________ID#:______________ GROUP#:______________

DOB:______________ ADDRESS:______________________________________

I hereby assign all major medical and/ or surgical insurance benefits to which I am entitled, including private insurance, Medicare, and any other health plan or insurance benefits, to Dr. Rozbeh Torabi, Dr. Tim Matatov, Dr. Oren Tessler or Dr. Joseph Zakhary. I understand that I am financially responsible for all charges whether or not paid by said Insurance, unless assignee has executed an agreement with my insurance provider or plan. I understand that if such an agreement has been executed, I am responsible to pay the collection agency's cost and or reasonable attorney's fees.

A photocopy of this assignment/authorization is to be considered as valid as the original.

____ ______________________

PATIENT'S SIGNATURE/ GUARDIAN OF PATIENT TODAY'S DATE

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PATIENT MEDICAL QUESTIONNAIRE

NAME: ______________________________ DATE: ______________

MARITAL STATUS: S M W D AGE: __________ OCCUPATION: ______________

DO YOU NOW HAVE ANY SYMPTOMS OR PROBLEMS WITH ANY OF THE FOLLOWING:

EYES: __________ MUSCULOSKELETAL: ______________

HEART: __________ SKIN: __________ GENITOURINARY: __________

LUNGS: __________ ENDOCRINE: __________ BLOOD: __________

GASTROINTESTINAL: __________ EARS, NOSE, MOUTH, THROAT: __________

PSYCHIATRIC: ______________________________

CHECK IF YOU HAVE EVER HAD:

MEASLES: ____ RHEUMATIC FEVER: ____ KIDNEY PROBLEMS: ____ MUMPS: ____

HERPES SIMPLEX(COLD SORES): ____ HERPES ZOSTER(SHINGLES): ____ CHICKEN POX: ____

VALLEY FEVER: ____ BLEEDING PROBLEMS: ____ HERPES GENITALS: ____ MRSA: ____

PNEUMONIA	HOSPITALIZED? ______	
ASTHMA	LAST ATTACK? ______	MEDICATIONS? ______
DIABETES	MEDICATIONS? ______	
THYROID PROBLEMS	SURGERY? ______	MEDICATIONS? ______
HEART PROBLEMS	SURGERY? ______	MEDICATIONS? ______
AUTOIMMUNE DISEASE	WHAT? ______	MEDICATIONS? ______
HIGH BLOOD PRESSURE	MEDICATIONS? ______	
BLOOD TRANSFUSIONS	WHEN? ______	
HEPATITIS	WHEN? ______	TYPE? ______
SERIOUS INJURIES	HOSPTIALIZED? ______	SURGERY? ______
FRACTURES	WHAT BONES? ______	TREATMENT: ______
CANCER	WHERE? ______	TREATMENT: ______
TEST FOR HIV	WHEN? ______	NEG OR POS TREATMENT: ______
WEAR GLASSES	NEARSIGHTED? ______ FARSIGHTED? ______	ASTIGMATISM? ______
GLAUCOMA	SURGERY? ______	MEDICATIONS? ______

SURGICAL PROCEDURES YOU HAVE HAD:

	AGE	DOCTOR		AGE	DOCTOR
TONSILLECTOMY:			THYROID:		
APPENDECTOMY:			D&C:		
HERNIA REPAIR:			OVARIES:		
HEART:			TUBAL LIGATION:		

SURGICAL PROCEDURES YOU HAVE HAD: (CONTINUED)

	AGE	DOCTOR		AGE	DOCTOR
GALL BLADDER REMOVAL			HYSTERECTOMY		
STOMACH(GI)			TYPE		
INTESTINAL:			NEUROSURGICAL:		
KIDNEY:			CATARACT:		
BLADDER:			GLAUCOMA:		
VASECTOMY:			RK:		
ORTHOPEDIC:			OTHER:		

PLASTIC SURGICAL PROCEDURES YOU HAVE HAD:

	AGE	DOCTOR		AGE	DOCTOR
BREAST ENLARGEMENT			RHINOPLASTY		
BREAST REDUCTION			LIPOSUCTION		
BREAST LIFT			AREAS?		
BREAST RECONSTRUCTION			ABDOMINOPLASTY		
EYELIDS (BLEPHAROPLASTY)			DERMABRASION		

FOREHEAD LIFT ______ BROW LIFT ______ CHEMICAL PEEL ______

FACELIFT ______ LASER RESURFACING ______

DO YOU SMOKE?______ **DRINK COFFEE?**______ **DRINK ALCOHOL?**______

ALLERGIES: FOODS:______ POLLENS:______ DRUGS:______

MEDICATIONS:

NAME OF MEDICATION	DOSE & FREQUENCY

HEIGHT:______ **WEIGHT:**______ **LAST MAMMOGRAM:**______ **BRA SIZE:**______

FAMILY MEDICAL HISTORY:

MOTHER ______

FATHER ______

BROTHER(S) ______

SISTER(S) ______

SPOUSE ______

CHILDREN ______

WOMEN ONLY:

FIRST DAY OF LAST MENSTRUAL PERIOD?______ FREQUENCY OF PERIOD- EVERY _____ DAYS FOR _____ DAYS

PREGNANCIES ______ C-SECTIONS:______

______

PATIENT'S SIGNATURE

______

DATE

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PATIENT CONSENT OF USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT'S NAME: ________________________ DATE OF BIRTH: ________________

SSN: ______________ PREVIOUS NAME: ________________________

I understand that my/the patient's health information is private and confidential. I understand that Dr. Torabi/ Dr. Matatov/Dr. Tessler/Dr. Zakhary works hard to protect my/the patient's privacy and preserve the confidentiality of my/the patient's health information.

I understand that Dr. Torabi/Dr. Matatov/Dr. Tessler/Dr. Zakhary may use and disclose my/the patient's health information to provide treatment to my/the patient, to handle billing and payment, and to take care of other healthcare operations. In general, there will be no other uses and disclosures of this information without my permission. These situations are very unsusal.

Dr. Torabi/Dr. Matatov/Dr. Tessler/Dr. Zakhary has a detailed document called the "Notice of Privacy Practices." It contains more detailed information that is used or disclosed to carry out treatment, payment, or healthcare operations. I understand that Dr. Torabi/Dr. Matatov/Dr. Tessler/Dr. Zakhary, does not have to agree to my/the patient's request. If Dr. Torabi/Dr. Matatov/Dr. Tessler/Dr. Zakhary, does agree to my/the patient's request, I understand that Dr. Torabi/ Dr. Matatov/Dr. Tessler/Dr. Zakhary, will follow the agreed limits.

I may cancel this consent in writing at anytime by doing one of the following:

1) Signing and dating a form that Dr. Torabi/Dr. Matatov/Dr. Tessler/Dr. Zakhary, can give me called "Revocation of Consent for Use and Disclosure of Healthcare Information".

OR

2) Writing, signing and dating a letter to Dr. Torabi/ Dr. Matatov/Dr. Tessler/Dr. Zakhary. If I write a letter, it must say that I want to revoke my/the patient's consent to authorize the use and disclosure of my/the patient's health information for treatment, payment and healthcare operations.

If I revoke this consent, Dr. Torabi/Dr. Matatov/Dr. Tessler/Dr. Zakhary, does not have to provide any further healthcare services to me/the patient.

My signature below indicates that I have been given the chance to review a current copy of Dr. Torabi/Dr. Matatov/ Dr. Tessler/Dr. Zakhary's "Notice of Privacy Practices." My signature means that I agree and consent to allow Dr. Torabi/ Dr. Matatov/Dr. Tessler/Dr. Zakhary, to use the disclose my/the patient's protected health information to carry out treatment, payment, and healthcare operations.

____ ____________________
SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE DATE

____
PRINT NAME OF PATIENT'S REPRESENTATIVE

____
RELATIONSHIP TO THE PATIENT

ELITE PLASTIC SURGERY
AND
RESTORATIVE BREAST CENTER

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AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS/SLIDES/AND OR VIDEO FOOTAGE

NAME: ____ DATE: ___________________________

I consent to the taking of still photographs, slides, or video footage by Dr. Torabi/Dr. Matatov/Dr. Tessler/Dr. Zakhary or his designee(s) of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Torabi/Dr. Matatov/Dr. Tessler/Dr. Zakhary. I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs and videos may be used in any print, visual or electronic media, specifically including, but not limited to, websites, medical journals and textbook, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the images may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Torabi/Dr. Matatov/Dr. Tessler/Dr. Zakhary.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire one year 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 the discharge Dr. Torabi/Dr. Matatov/Dr. Tessler/Dr. Zakhary, videos and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publications, including any claims for payment in correction with the distribution or publication of photographs. I certify that I have read the above authorization and release and fully understand its terms.

____ ______________________________
SIGNATURE DATE

I have read the above authorization and release. I am the parent, legal guardian, or conservator of _____________, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

____ ______________________________
SIGNATURE DATE

ELITE PLASTIC SURGERY
AND
RESTORATIVE BREAST CENTER

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ADDITIONAL FINANCIAL POLICY

Please note our office may be out of network with your health insurance company.

If this is the case the following will apply

1. Partial payment may be required upfront for services provided. Please refer to the attached fee schedule.

2. Your health insurance company may send a payment for the services provided directly to you the patient/ guardian in the form of a check. This check is for payment of services that were provided to you by our medical professional, therefore, we require you to endorse the check over to "Elite Plastic Surgery" and send the check to us when received. Along with the check it is very helpful to our billing company that you provide a copy of the Explanations of Benefits that your health insurance sent in accompaniment with the check. This allows our billing company to correctly apply the amount paid to your account.
    a. Your insurance company may not fully compensate you for the entire amount charged by our office for services, if this is the case, a statement will be sent stating the remaining balance owed by you to our office.

3. If your health insurance company does not pay for the services provided, a reasonable payment option is stated on our attached schedule provided. For further details, please ask the office staff.

By signing this you agree to the above financial policy and are in agreement that payment issued to you by your health insurance company will be reissued to our office by a form of payment mentioned above. Please obtain a copy of this document for your records.

PRINT PATIENT NAME ______________________ DATE ______________

PATIENT/ LEGAL GUARDIAN SIGNATURE ______________________