SKYPE CONSULTATION DISCLOSURE & CONSENT

Patient Name: **Date of Consultation**:

Skype consultations are offered as a convenience for out of town patients. All paperwork must be completed, signed and returned to our office a minimum of 24 hours prior to your appointment, along with clear photos showing the area of concern (minimum 3 views), a valid photo id and insurance card (if applicable).

Email: lourdes@roxburysurgery.com *E-Fax: (310) 861-1529*

During my consultation, I understand that the doctor will evaluate my concerns based upon the information provided in my intake paperwork and the images seen through Skype. I understand that the will be providing general information about possible procedures and that an in-person consultation will be necessary prior to making final determinations for surgery. Any price quote provided will be an estimate. I understand that the procedure or procedures discussed may vary once I have been evaluated in-person and that applicable fees may vary based upon specifications of the procedure including but not limited to length of procedure and/or required aftercare.

A Skype consultation is not a substitute for a medical exam. If you have any urgent concerns, please seek medical attention immediately. No prescriptions can be provided to patients without an in-person office evaluation.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Andrew P. Ordon, M.D., F.A.C.S.
Ritu R. Chopra, M.D.
Frederick N. Eko, M.D.

465 N. Roxbury Drive, Suite 1001, Beverly Hills, CA 90210
Tel: (310) 248-6250 ◂ ▸ Fax: (310) 861-1529

71-949 Highway 111, Suite 300, Rancho Mirage, CA 92270
Tel: (760) 568-2211 ◂ ▸ Fax: (760) 568-3318

Notice of Privacy Practices

To our patients –

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy -

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances –

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement officer.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To a federal official for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information –

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychological notes. You must submit your request in writing to the Surgery Center.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to The Surgery Center. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Roxbury Clinic and Surgery Center (310-248-6250) or The Plastic Surgery Institute (760-568-2211). All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for used and disclosures that are not identified by this notice or permitted by applicable law.

Notice of Privacy Practices

I hereby acknowledge that I have been presented with a copy of Notice of Privacy Practices by Andrew P. Ordon, M.D., Ritu R. Chopra, M.D., Frederick N. Eko, M.D.

_____

Name of Patient (Please Print)

_____

Signature of Patient

_____

Date

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Date: _____

Name: _____ Age: _____ DOB: _____/_____/_____

Address: _____ Home Tel: (_____)_____

City _____Zip_____ Wk Tel: (_____)_____

Email: _____ Cell: (_____)_____

Referring Physician: _____ SS# _____

How did you hear about our Doctor?_____

Have you been to our website?_____ Was our website helpful? ☐No ☐Yes If No, pls. list reason:

_____

What is the reason for your visit today? (Circle all applicable procedures below)

Nose & Face	Breast & Body	MediSpa
Primary Rhinoplasty	Breast Augmentation	Botox®
Revision Rhinoplasty	Breast Augmentation with Breast Lift	Restylane®
Brow Lift	Breast Reduction	Perlane®
Facelift	Capsulectomy	Juvéderm®
Neck Lift	Mommy Makeover	Radiesse®
Eyelid Surgery	Abdominoplasty	Enzyme Peel
Facial Implants	Post-Bariatric Body Lift	Laser Hair Removal
Chin Augmentation	Brachioplasty (Arm Tuck)	Skin Tightening Laser
Lip Augmentation	Liposuction	Photo Facial
Lip Suspension	Other_____	Pixel Treatment
Other_____	Other_____	Cellulite Treatment
Other_____	Other_____	Vein Treatment
Other_____	Other_____	Other_____

Please describe why you are interested in having the procedure(s) listed above:_____

_____

_____

Have you consulted with other physicians about procedure(s) indicated above: ☐No ☐Yes

If Yes, please describe your understanding of the procedure(s)_____

Is this procedure a revision from a previous surgery ☐No ☐Yes If yes, how many previous surgeries?_____

What is your "ideal time frame" for procedure(s) completion _____

Age _____ Weight _____ Height _____ B/P _____ (taken in office)

Employer _____ Address _____

Occupation: _____ Marital Status: _____

Primary Insurance Co. _____ Policy # _____

Group # _____ Name of person insured _____ SS# _____

Eligibility Phone # _____ Copay _____

Secondary Insurance Co. _____ Policy # _____

Group # _____ Name of person insured _____ SS# _____

Eligibility Phone # _____ Copay _____

HEALTH INFORMATON

Personal Past History:
Do you have any chronic medical problems? (Circle all that apply)

High Blood Pressure	Diabetes	Cancer
Heart Disease	Kidney Disease	HIV or AIDS
Heart Failure	Psychiatric Diagnosis	Stroke
Seizures	Bleeding Problems	Hepatitis
Heart Attack	Liver Disease	Emphysema
Chest Pain	Gastric Reflux	Stomach Problems
	Asthma	Other _____

Is there a personal or family history of anesthetic complications? ☐No ☐Yes

If yes, please explain_____

Family History:
Do you have a family history of any medical problems? (Circle all that apply) Please indicate family member.

High Blood Pressure	Diabetes	Cancer
Heart Disease	Kidney Disease	HIV or AIDS
Heart Failure	Psychiatric Diagnosis	Stroke
Seizures	Bleeding Problems	Hepatitis
Heart Attack	Liver Disease	Emphysema
Chest Pain	Gastric Reflux	Stomach Problems
	Asthma	Other _____

Please list all prior operations:	Date	List any complications
1._____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

4. _____ _____ _____

5. _____ _____ _____

6. _____ _____ _____

Please list all prior Hospitalizations:	Date	List any complications
1._____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Please list **ALL** medications and/or dietary supplements including:
(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil and St. John's Wort)

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

Please list **ALL** allergies and describe reactions: (i.e. Shellfish, Latex, Penicillin, etc).

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Social History:

Have you ever used tobacco products? ☐No ☐Yes If yes, how long?_____ how much?_____
Which tobacco product(s) have you used?_____
If you are a former smoker, state the year you stopped: _____

Past or current use of Nicotine Gum, Patch, or any other type of stop-smoking aid: ☐No ☐Yes
If yes, please list: _____

Alcohol Consumption: _____Never (Do not consume alcohol) _____ Rare (1-2 drinks a week)

_____ Moderate (7-10 drinks a week) _____ Heavy (daily or more than 10 drinks a wk)

Did you ever drink heavily in the past? ☐No ☐Yes Are you feeling hopeless about the present/future? ☐No ☐Yes Do you currently have thoughts of harming yourself? ☐No ☐Yes

Review of Systems:

Please answer the following Yes or No questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

CARDIOVASCULAR

High Blood Pressure	Y ___ N ____	Heart Failure	Y ___ N ____
Heart Attack	Y ___ N ____	Irregular Heartbeat	Y ___ N ____
Angina/chest pain	Y ___ N ____	Heart Murmur	Y ___ N ____
Heart bypass surgery	Y ___ N ____	Do you exercise?	Y ___ N ____
Pacemaker	Y ___ N ____	Comments: _____	

NEUROLOGICAL

Stroke	Y ___ N ____
Seizures	Y ___ N ____
Fainting	Y ___ N ____
Dizziness	Y ___ N ____
Headache	Y ___ N ____
Double Vision	Y ___ N ____

PSYCHIATIC

Depression	Y ___ N ____
Anxiety	Y ___ N ____
Psychiatric Care	Y ___ N ____
Obsessive Compulsive Disorder	Y ___ N ____

ENDOCRINE

Diabetes	Y ___ N ____
Thyroid Disease	Y ___ N ____
Taken Steroids	Y ___ N ____

HEMATOLOGIC/ONCOLOGIC/

Bleeding Tendency	Y ___ N ____
Easy Bruising	Y ___ N ____
Anemia	Y ___ N ____
Sickle Cell Disease	Y ___ N ____
Blood clots in legs	Y ___ N ____
Blood clots in lungs	Y ___ N ____
Radiation Therapy	Y ___ N ____

URINARY/REPRODUCTIVE

Kidney Disease	Y ___ N ____
Urinary Disease	Y ___ N ____
Dialysis	Y ___ N ____
If female, could you be preg?	Y ___ N ____

Number of live births_____

Number of pregnancies _____

Date of last mammogram _____

Date of date of menses (period)_____

RESPIRATORY

Abnormal Chest X-ray	Y ___ N ____
Asthma	Y ___ N ____
Bronchitis	Y ___ N ____
Emphysema	Y ___ N ____
Recent Chest Infection	Y ___ N ____
Shortness of Breath	Y ___ N ____
Shortness of Breath at night	Y ___ N ____
Shortness of Breath on exertion	Y ___ N ____
Cough	Y ___ N ____
Cough with Sputum	Y ___ N ____
Sleep Apnea	Y ___ N ____
-Use a C-PAP Machine	Y ___ N ____

MUSCULOSKELETAL

Sciatica	Y ___ N ____
Herniated disc	Y ___ N ____
Arthritis	Y ___ N ____
Rheumatoid	Y ___ N ____
Neck, Back, Arm,Leg Prob	Y ___ N ____

INFECTIOUS GASTROINTESTINAL

Jaundice	Y ___ N ____
Hepatitis	Y ___ N ____
Ulcers	Y ___ N ____
Hiatal Hernia	Y ___ N ____
Heartburn	Y ___ N ____

SKIN

Basal cell skin cancer	Y ___ N ____
Melanoma	Y ___ N ____
Staph Infection	Y ___ N ____

EYES

Cataracts	Y ___ N ____
Glaucoma	Y ___ N ____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Andrew P. Ordon, M.D., Ritu R. Chopra, M.D. , Dr. Frederick N. Eko, M.D. a Professional Corporation, all Medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. If the nature of the disability be such that it is not covered by insurance, I will be responsible to the doctor for payment of the entire bill. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured/Guardian Date

_____ _____

Patient's Signature Date