

Ganchi Plastic Surgery

PATIENT INFORMATION

We would like to welcome you to our Center. We are delighted that you have chosen our facility and will try our best to make this a pleasant and comfortable experience for you.

We would like for you to take a few minutes to complete the registration form and return it to our receptionist. We ask that you read and sign our Patient Information statement so that you fully understand our financial policies.

Our policy is to require payment at the time of service. There is no charge for your initial cosmetic consultation. However, if you would like a second consultation, there will be a charge of \$150. This fee will be deducted from the cost of your cosmetic surgery. There is no charge for cosmetic postoperative visits.

For non-cosmetic visits, the deposit for the first office visit is \$150-\$300 and the deposits for follow-up visits are \$75-\$175. Please be aware that we do not participate with any insurance plan. We do not accept insurance as payment in full. You are responsible for any charges incurred and will be billed for any balance including co-payments, non-covered charges, deductibles, and any balance beyond that covered by your insurance.

A 10% non-refundable deposit is required to hold a date for a cosmetic procedure. The balance is due 3 weeks prior to the procedure date and is non-refundable at that time.

If laboratory tests and/or medical clearance are required, the charges are not determined by the Center and will be billed to you by the independent provider of these services.

We strive to provide excellent care to each of our patients and hold ourselves to the nationally recognized standards of the Joint Commission on Accreditation for Healthcare Organizations. As such, we are always looking for ways to improve. We would welcome any suggestions or ideas that you feel would enhance your experience with us. Feel free to contact Leyla Sarram, our office manager, or any of our staff to make a suggestion or to get further information on our complaint resolution policy. You may also contact Joint Commission on Accreditation for Healthcare Organizations at 800.994.6610.

We look forward to meeting you and being of service to you. Please do not hesitate to ask any of our staff for assistance or if you have any questions regarding this form. We appreciate your trust and promise to bring you the latest in medical techniques with a personal touch.

I have read the above information and agree to the terms outlined. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private and/or auto insurance, and any other health plans to Ganchi Plastic Surgery. A photocopy of this assignment is to be considered as valid as an original. I authorize the use of my signature on all insurance submissions. 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. This assignment will remain in effect until revoked by me in writing. I am ultimately responsible for all professional fees.

Print Name

Date of Birth

Signature of patient or guardian

Date

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Name _____

Birth Date _____

Age _____

Height _____

Weight _____

Reason for Visit (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Arm Lift | <input type="checkbox"/> Hand Rejuvenation |
| <input type="checkbox"/> Body Lift | <input type="checkbox"/> Inverted Nipple Correction |
| <input type="checkbox"/> Botox / Dysport | <input type="checkbox"/> Labiaplasty |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Latisse for Eyelashes |
| <input type="checkbox"/> Breast Lift | <input type="checkbox"/> Lip Enhancement |
| <input type="checkbox"/> Breast Reduction (Women, Men) | <input type="checkbox"/> Lipoinjection (Face, Body, Hands) |
| <input type="checkbox"/> Buttock Enhancement | <input type="checkbox"/> Liposuction |
| <input type="checkbox"/> Calf Implants | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> Ear Surgery (Otoplasty) | <input type="checkbox"/> Neck Lift / Shaping |
| <input type="checkbox"/> Eyelid Surgery (Blepharoplasty) | <input type="checkbox"/> "Non-Invasive" Facial Rejuvenation |
| <input type="checkbox"/> Face Lift | <input type="checkbox"/> Rhinoplasty (Nose Surgery) |
| <input type="checkbox"/> Facial Implants (Chin, Cheek, etc.) | <input type="checkbox"/> Scar Treatment / Correction |
| <input type="checkbox"/> Fat Transfer (Face, Body, Hands) | <input type="checkbox"/> Skin Cancer / Mole Removal |
| <input type="checkbox"/> Fillers (Restylane, Juvederm, Artefill, etc.) | <input type="checkbox"/> Skin Care / Peels / Photofacial |
| <input type="checkbox"/> Forehead / Brow Lift | <input type="checkbox"/> Spider Vein Removal |
| <input type="checkbox"/> Ganchi Skin Care Products | <input type="checkbox"/> Surgery after Pregnancy |
| <input type="checkbox"/> Gynecomastia (Male Breast Reduction) | <input type="checkbox"/> Surgery after Weight Loss |
| <input type="checkbox"/> Hair Removal (IPL) | <input type="checkbox"/> Tummy Tuck (Abdominoplasty) |

Other: _____

Have you seen other plastic surgeons? Yes No

If yes, who have you seen? _____

Are you in good health? Yes No Explain: _____

Primary Physician: _____ Phone: _____

Your Pharmacy: _____ Phone: _____

When was your last physical examination? _____ Was everything OK? Yes No

List all drug allergies and your reaction: _____

List other allergies (latex, tape, food, seasonal): _____

Family History – Have any of your blood **relatives** had the following problems:

- | Yes | No | Yes | No |
|--------------------------|--|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> | <input type="checkbox"/> Abnormal Clotting / Phlebitis | <input type="checkbox"/> | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> | <input type="checkbox"/> Anesthesia Problems | <input type="checkbox"/> | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> | <input type="checkbox"/> Cancer | <input type="checkbox"/> | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> Suicide |

If yes to any of the above, please give details: _____

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Have **you** ever had or do **you** now have:

Yes No Eyes

- Wear Glasses / Contacts
- Cornea Problems / Cataracts
- Poor Vision / Loss of Vision
- Eye or Eyelid Surgery (list below)
- Blurred Vision
- Dry Eyes
- Crossed or Lazy Eyes
- Glaucoma

Nose

- Injury to Nose
- Nasal Allergies
- Nose or Sinus Surgery (list below)
- Difficulty Breathing through Nose
- Nose Bleeds

Heart

- Chest Pain / Angina
- Heart Attack
- Irregular Heart Beat
- Heart Murmurs
- Pacemaker / Defibrillator
- Mitral Valve Prolapse
- High Blood Pressure
- Low Blood Pressure
- Poor Circulation
- Heart Disease

Chest

- Bronchitis / Chronic Cough (circle)
- Sleep Apnea / Snoring (circle)
- Shortness of Breath
- Asthma / Wheezing
- Emphysema

Breast

- Nipple Discharge
- Breast Lump / Biopsy (Result _____)
- Breast Pain
- Mammogram (Result _____ Date _____)
- Did You Breastfeed?

Psychiatric

- Psychiatric Care (Diagnosis _____)
- Drug Dependency
- Alcoholism
- Depression / Anxiety
- Suicide Attempt
- Body Dysmorphic Disorder
- Anorexia / Bulimia

Yes No Face

- Facial Cosmetic Surgery (list below)
- Facial Paralysis / Weakness / Bells Palsy
- Use Retin-A / Accutane (circle)
- Chemical Peels, Dermabrasion (circle)
- Laser Resurfacing
- Cold Sores / Fever Blisters

Other

- Bad Scarring / Keloids
- Use Birth Control (Type _____)
- Abnormal Bleeding
- Bruise Easily
- Abnormal Clotting / Phlebitis
- Anemia / Low Blood Count
- Blood Disease
- Slow or Poor Healing
- Varicose Veins
- Swelling of Ankles
- Blood Transfusion (When _____)
- Acid Reflux / Heartburn
- Stomach Ulcers
- Digestive Problems
- Diabetes (Taking Insulin? Yes No)
- Neck / Back / Spine Problems
- Muscle / Joint / Bone Pain
- Arthritis (Where _____)
- HIV / AIDS
- Steroid / Cortisone Use (When _____)
- Thyroid Problems
- Autoimmune Disease (Which _____)
- Dentures
- Hepatitis
- Neurological Disorder (Which _____)
- Migraines / Headaches (circle)
- Stroke / TIA
- Epilepsy / Convulsions
- Fainting / Dizziness
- Numbness (Where _____)
- Kidney Disease
- Staph Infection
- Frequent Skin Infections / Boils
- Tuberculosis
- Yeast Infections
- Weight Change (How Much _____)
- Herpes (Genital or Shingles)
- Painful Intercourse
- Cancer (Of _____)
- Skin Cancer
- Hernia (Where _____)
- Go Tanning Outside / Use Tanning Beds (circle)

If yes to any of the above, please give details: _____

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Name Birth Date Age Date

List all medications you are taking (including birth control, water pills, sleep pills, aspirin products, blood thinners, over-the-counter pills, steroids, cortisone, heart or blood pressure pills, hormones, pain medication, supplements, and herbal medication): _____

List all other past and current medical conditions and illnesses: _____

List all operations (including cosmetic) with dates and name of surgeon: _____

Have you ever had a bad surgical result? _____

Have you ever had a bad reaction to anesthesia? _____

List all hospitalizations, injuries, and accidents with dates: _____

Have you ever consulted a professional for emotional problems? Explain: _____

Do you smoke or have you ever smoked? Yes No I Quit If so, how much? _____

Are you exposed to second hand cigarette, cigar or pipe smoke? Yes No Explain: _____

Do you use nicotine replacement products? Yes No If so, what do you use? _____

Do you drink alcohol? Yes No I Quit If so, how many drinks per week? _____

Do you use or have you ever used drugs? Yes No I Quit Explain: _____

Are you pregnant or planning a pregnancy? Yes No You last menstrual period: _____

Before you undergo surgery, list any other facts (medical or other) that we should know about you: _____

List below people with whom we are authorized to discuss your medical information:

Name Relationship DOB Name Relationship DOB

Name Relationship DOB Name Relationship DOB

- I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the above have been answered to my satisfaction. I will not hold my surgeon, or any of his/her staff responsible for any errors or omissions that I have made in completing the above questionnaire.

- I am responsible for and will pay all charges and fees of Ganchi Plastic Surgery for services rendered to me and/or my child. I understand that although I may have insurance to cover the cost of treatment, I remain responsible for payment. All payments are due at the time services are rendered.

- I was offered/received the Ganchi Plastic Surgery Notice of Privacy Practices.

Signature _____ Guardian/Parent Date _____

Ganchi Plastic Surgery, PA and Leyla Plastic Surgery Center are operated by Parham A. Ganchi, PhD, MD

I have reviewed the above information with the patient:

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PATIENTS' RIGHTS AND RESPONSIBILITIES

YOU HAVE CERTAIN RIGHTS

1. You have the right to be treated with respect, consideration and dignity.
2. You have the right to high- quality medical care delivered in a safe, timely, efficient and cost-effective manner and the right to be assured that the expected results can be reasonably anticipated.
3. You have the right to privacy to the extent possible.
4. You have the right to have your disclosures and records treated confidentially and, except when required by law, those disclosures and records will not be released without your approval.
5. You have the right to be provided, to the degree known, complete information concerning your diagnosis, evaluation, treatment and prognosis.
6. You have the right to copies of your medical records at a nominal cost and, if you request it, those records will be transferred to another practitioner in a timely manner.
7. You have the right to be informed of all reasonable options or alternatives for care and/or treatment and of the potential advantages and disadvantages of each including the advantages or disadvantages and the alternatives to having the procedure performed in an office or other out-patient facility.
8. You have the right to participate in decisions regarding all aspects of care.
9. No procedure or treatment will be undertaken without your informed consent after the alternatives mentioned in #7, above have been discussed with you.
10. You have the right to refuse any diagnostic procedure or treatment and to be advised of the likely medical consequences of such refusal.
11. You have the right to know all of your rights as outlined above.
12. You have the right to know the conduct expected of you in the facility and the consequences of failure to comply with these expectations.
13. You have the right to know the services available at the facility.
14. You have the right to know the provisions for after-hours and emergency care.
15. You have the right to know if any of the planned procedures or treatments is part of a research study and the right to refuse to participate in that study.
16. You have the right to know whether or not your providers are insured.
17. You have the right to know how to go about expressing suggestions to the facility and the policies regarding grievance procedures and external appeals in the event that you are dissatisfied with your treatment.
18. You have the right to know the name of your provider.
19. You have the right to know what fees are expected and what the payment policies are.
20. You have the right to know what your providers credentials are.
21. You have the right to change providers.

YOU ALSO HAVE CERTAIN RESPONSIBILITIES

1. You have the responsibility to accurately and completely provide all clinical personnel with the health information they need including any medications you are taking. All forms should be filled out completely and accurately.
2. You have the responsibility to follow directions of the staff or physician with regard to diet and/or medication.
3. You have the responsibility to abstain from using any drugs that have not been prescribed for you and that you have not revealed to your staff or physician. Abstain from the use of alcohol as directed by your physician.
4. You have the responsibility to follow all instructions given to you after any procedure(s) and to prioritize and be on time for all follow-up appointments.
5. You have the responsibility to inform the staff or physician if you do not understand any directions or you do not understand the course of treatment planned for you.
6. You have the responsibility to inform the staff or physician if you are unable to comply with your post-procedure instructions BEFORE you have the procedure.
7. You have the responsibility to timely pay all medical bills which are not in dispute and to forward to us any monies you receive from any insurance company for our services.

Print Name

Date

Signature

Date of Birth