4201 S. Minnesota Ave, Suite 112
Sioux Falls, SD 57105

612 Sioux Point Road, Suite 600
Dakota Dunes, SD 57049

Plastic Surgery Associates
OF SOUTH DAKOTA LTD

Patient Information Form ~ .

Patient Name: _____
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Cell Carrier: _____

DOB & Age: _____ Race: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Sex: _____ SSN: _____ Email Address: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____
Preferred Pharmacy: _____ Location: _____
How did you hear about our clinic? Radio

☐ ☐ Patient Referral: _____
☐ ☐ Friend: _____
☐ Google ☐ Dr. Referral: _____
☐ Other: _____

What is the nature of your visit? _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Insurance

Name: _____ Policy #: _____ Group ID: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance

Name: _____ Policy #: _____ Group ID: _____

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Consent to Communicate

Patient Name: _____

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appt Reminders				
☐ Email Medical Info				
☐ Email Marketing Info				
☐ Send Regular Mail	-	-		-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Page	-	-	-	-
☐ Text Appt Reminders or additional scheduling information, if so, list cell carrier:				
☐ Text Marketing Info – if so, list cell carrier:				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

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HIPAA Information and Consent Form

Patient Name: _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

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I hereby authorize PLASTIC SURGERY ASSOCIATES OF SOUTH DAKOTA, LTD. to release any medical information necessary to process the claim and authorize payment of medical benefits including MEDICARE AND MEDICGAP, directly to Plastic Surgery Assoc. of SD, Ltd.

X: _____

Signature/Date

WORKMAN'S COMPENSATION CLAIMS ONLY: (Complete in full)

Were you hurt on the job? _____	Date of injury _____
Last day worked _____	Employer at time of accident _____
Employer's Address _____	Phone No. _____

FINANCIAL POLICY

(1) All unpaid balanced are due and payable within 30 days of the date in which professional services are rendered. A 1 ½ % per month (18% per annum) finance charge will be imposed upon all balances 60 days past due.

(2) It is the policy of Plastic Surgery Assoc. of S.D., Ltd., and Rivers Edge Aesthetic Surgery that any professional services are rendered for cosmetic purposes only, be paid at least one week in advance of said services.

(3) It is the policy of Plastic Surgery Assoc. of SD., Ltd. and Rivers Edge Aesthetic Surgery that payment in full for insurance copays is due at each appointment.

(4) Plastic Surgery Assoc. of SD., Ltd. and Rivers Edge Aesthetic Surgery expressly reserve the right all methods authorized by South Dakota law to collect on account past due.

I have read the foregoing financial policy and declare that I understand its contents

X: _____

Signature/Date

MUST BE COMPLETED IN FULL PRIOR TO BEING SEEN

Plastic Surgery Associates
OF SOUTH DAKOTA LTD

VHM☐ LPM☐ JAB☐ JMM☐

Date: _____ Last Appt: _____

Name: _____ DOB _____

Reason for today's visit: _____

City you currently reside in: _____

Age _____ Ht _____ Wt _____ BP _____ Married: Y☐ N☐

Allergies: _____

Occupation: _____ Previous Patient: Y☐ N☐

Referring Doctor: _____ Primary Doctor: _____

Accompanied by: _____ Relationship? _____

Current Medications:

Past Surgeries (Including C-Section):

_____ any problems? _____ _____ any problems? _____

_____ any problems? _____ _____ any problems? _____

Medical History:

Smoker/Tobacco: Y☐ N☐ If yes, how much: _____

Drink/Alcohol: Y☐ N☐ If yes, how much: _____

Diabetes: Y☐ N☐ Heart: Y☐ N☐

Lungs: Y☐ N☐ Brain: Y☐ N☐

Liver: Y☐ N☐ Kidney: Y☐ N☐

Psychiatric: Y☐ N☐ Problems with Anesthesia: Y☐ N☐

Bleeding Disorder: Y☐ N☐

Other Concerns:

PLEASE COMPLETE THE APPROPRIATE PORTION OF THE FORM PRIOR TO BEING SEEN

Breast Augmentation Patients:

Current Cup size: _____ Desired Cup size: _____

Recent Mammogram: Y☐ N☐ Date: _____ Results: _____

History of Breast Cancer: Y☐ N☐ Personal / Family Relationship: _____

Fibrocystic Disease: Y☐ N☐

Nipple Drainage: Y☐ N☐

Cysts requiring aspiration: Y☐ N☐

Nursing Staff Complete this portion:

Asymmetry? Y☐ N☐

Recommendations: Subpectoral __ Retromammary __

Silicone _____cc / Saline _____cc

Incision site: Areolar☐ Inframammary☐

Notes:

PLEASE COMPLETE THE APPROPRIATE PORTION OF THE FORM PRIOR TO BEING SEEN

Breast Reduction Patients:

Current Cup size: _____ Desired Cup size: _____
Recent Mammogram: Y☐ N☐ Date: _____ Results: _____
History of Breast Cancer: Y☐ N☐ Personal / Family Relationship: _____
Fibrocystic Disease: Y☐ N☐
Nipple Drainage: Y☐ N☐
Cysts requiring aspiration: Y☐ N☐
Do you have children: Y☐ N☐ Did you breast feed: Y☐ N☐
Do you have pain in any of the following: (check those that apply)
Back ☐ Shoulders ☐ Neck ☐ Breasts ☐ Headaches ☐
Do you take medications for the pain: What _____ Dosage_____
Do you have shoulder grooves: Y☐ N☐
Do you have rashes under your breasts: Y☐ N☐
Have you seen a chiropractor in the past: Y☐ N☐ Who: _____ How long? _____
Have you received physical therapy? Y☐ N☐ Where: _____ How long? _____
Do you have documented back, neck or disk problems? _____
Have you had an MRI or CT? Y☐ N☐
Have you had weight loss: Y☐ N☐ How much: _____ Any change in breast size: Y☐ N☐
Have you tried special bras or bra modifications? Y☐ N☐

Nursing Staff Complete this portion:

Asymmetry? Y☐ N☐ _____
Nipple to notch: Right _____cm Left _____cm
Internipple distance: _____cm Breast Width: _____cm
Ptosis: Y☐ N☐ Grade: I ☐ II ☐ III ☐ IV ☐
Total Grams: Right _____ Left _____
Total Grams to be removed: Right _____ Left _____

Notes:

PLEASE COMPLETE THE APPROPRIATE PORTION OF THE FORM PRIOR TO BEING SEEN

Facial Rejuvenation:

What is your concern: _____

What is your current skin care routine: _____

_____

What skin care products do you use: _____

_____

How often do you wear sunscreen: _____

Nursing staff complete this portion:

Recommendations: _____

_____

Skin Care: _____

Notes:

PLEASE COMPLETE THE APPROPRIATE PORTION OF THE FORM PRIOR TO BEING SEEN

Body Rejuvenation:

What is your concern: _____

Have you had any weight loss: Y__ N__ How much: _____ How long ago: _____

Any rashes or open sores from excess skin: Y__ N__ Treatment: _____ How long: _____

Nursing staff complete this portion:

Recommendations: _____

_____

Notes:

Consent to Photograph or Film

I, _____ give consent that Plastic Surgery Associates of South Dakota can photograph or film me but only to the extent necessary and so long as the images are used solely for purposes of (a) identifying me as a patient or for purposes of documenting my health status, diagnosis and treatment while a patient; (b) conducting education and training, quality assurance and performance improvement functions for and on behalf of Plastic Surgery Associates of South Dakota and its professional staff; and (c) publishing the results of my treatment on Plastic Surgery Associates of South Dakota's website which, in this particular case, required me to sign the HIPAA authorization form.

The purpose of this form is to obtain my prior written consent so that Plastic Surgery Associates of South Dakota may photograph or film me for one or more of the following purposes listed below for which I do hereby consent. **(Initial all purposes that apply):**

_____ Use or disclosure of image for marketing or advertising purposes and patient education

_____ Use or disclosure of image for medical specialty board in formulating its examination of applicant physicians

_____ Use or disclosure of image in a professional presentation or journal publication

Unless earlier revoked, this authorization will expire on the end of the treating physician's practice of surgery, except there will be no expiration for the purpose of medical or scientific research or use in specialty board examinations.

I also agree to sign the HIPAA authorization form which permits Plastic Surgery Associates of South Dakota to use or disclosure these images but only to the extent permitted by HIPAA and other applicable laws and regulations.

Computer Imaging Disclaimer
Computer imaging may be used to better educate you about your upcoming surgery. Although an approximation of intended results is to be displayed, I realize that there are differences in graphic artistic ability and surgical technique. I realize that computer imaging does not constitute and should not be construed to be an exact representation of post-surgical results. I understand that it is impossible to guarantee intended results. I understand that the alteration of any images is purely for the purpose of education, illustration and discussion.

_____ _____
Patient (or Patient's Legal Representative) Signature Date

_____ _____
Witness Signature Date