Jon M. Grazer,M.D.,MPH,FACS

400 Newport Center Drive, Suite 302, Newport Beach, CA 92660
949-644-1240

PATIENT AND FINANCIAL RESPONSIBILITY INFORMATION

Patient Name: ____Date of Birth: ___________

Home Address: ____

City: ______________________________State: ____________Zip Code: ___________________

Email Address: ____

Home Number: (____) ________________Cell Number: (____)________________Age:________

Social Security Number: _____-_____-______ Driver license Number:______________________

Employer: _____________________________________Occupation:_______________________

How did you hear about us? ____

RESPONSIBLE FOR BILLING:

Name: ____________________________Relationship to Patient:__________________________

Mailing Address:____

City: ______________________________State: ___________Zip Code: ____________________

Home Number: (____) ________________Cell Number: (____)____________________________

INSURANCE INFORMATION: **Please present your card to the receptionist to copy**

Name of Insurance Co.:___________________________Phone Number: (____) ______________

Mailing Address: ____

City: ______________________________State: ___________Zip Code: ____________________

ID Info: (policy, group, etc.)____

Secondary Insurance: ____

I understand that I am responsible for all my medical bills incurred, not my insurance company or other third party. I hereby authorize Jon M. Grazer,MD,MPH,FACS to furnish information to the insurance carrier or other third party concerning this illness. I hereby irrecoverably assign to Jon M.Grazer,MD,MPH,FACS All payments for the medical services rendered, I certify that the above information is complete and correct to the best of my knowledge.

____ ______________________

Signature of financially responsible person Date

Name of person to contact in case of emergency:_____________________________________

Relationship to Patient: ___________________________Phone Number: (____)________________

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Patients Name:_______________________________________ Date:____________ Date of Birth:____________

(Doctor Use Only)

Diagnosis:

Location:

Duration:

History of present illness:
- Onset:
- Location initially, sites of recurrence:
- Symptoms, preceding and associated:
- Course and influencing factors:
- Anyone else:
- Previous therapy:
  - Lab test:
  - Biopsy or surgery:
  - UV or X-RAY:
  - Pills or liquid P.O.:
  - Injections:
  - Soaps, Compresses & Baths or creams:

Allergy history: Patient and Family: BA HF HVS ATD

Drugs: PCN, Novocain, Sulfasm, Codeine

Occupations ocntactants:

Present medications:

Review of systems:

Past history:

S.I.:Diabetes M., Peptic Ulcer, TBC, HTCVD, Vision: Reneal or Hepatic

O.I.: AID, IMM.: OB, G&D:

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Health History

(Confidential)

Name ____Today's date_____________
Age ________Birthdate __________Date of last physical exam______________________
Reason for your visit?____

Please circle symptoms you currently have or have had in the past year:

General:
Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of sleep
Loss of weight
Nervousness
Numbness sweats

Muscle/Joint/Bone:
Pain, weakness, numbness in:
Arms, hips, back, legs, feet
Neck, hands, shoulders

Genito-Urinary:
Blood in urine
Frequent urination
Lack of bladder control
Painful urination

Gastrointestinal:
Poor appetite
Bloating
Bowel changes
Constipation
Diarrhea-Gas
Excessive hunger
Excessive thirst
Hemorrhoids
Indigestion
Vomiting
Rectal bleeding
Nausea
Vomiting
Vomiting blood

Cardiovascular:
Chest pain
High/Low blood pressure
Irregular/Rapid heart beat
Poor circulation
Swollen ankles/Varicose veins

Eye, Ear, Nose, Throat:
Bleeding gums
Blurred vision/Double vision
Crossed eyes
Difficulty swallowing
Earache/Ear discharge
Hay fever/Nosebleeds
Hearing loss/Ringing in ears
Persistant cough
Sinus problems
Vision flashes/Vision halos

Skin:
Bruise easily/Hives
Itching/Mole changes
Rash/Scars
Sore that won't heal

Please circle CONDITIONS you have or have had in the past:

AIDS / Alcoholism / Anemia / Anorexia / Appendicitis / Arthritis / Asthma / Bleeding Disorders / Breast Lump / Bronchitis / Bulimia / Cancer / Cataracts / Chemical Dependency / Chicken Pox / Diabetes / Emphysema / Epilepsy / Glaucoma / Goiter / Gonorrhea / Gout / Heart Disease / Hepatitis / Hernia / Herpes / High Cholesterol / HIV Positive / Kidney Disease / Measles / Migraine Headaches / Miscarriage / Mononucleosis / Multiple Sclerosis / Mumps / Pacemaker / Pneumonia / Polio / Prostate Problem / Psychiatric Care / Rheumatic Fever / Stroke / Suicide Attempt / Thyroid Problems / Tonsillitis / Tuberculosis / Typhoid Fever / Ulcers / Vaginal Infections / Venereal Disease

List ALL MEDICATIONS you are currently taking: **Medication/substance ALLERGIES:**

____ ____________________________
____ ____________________________

Have you ever taken Fen-Phen? Yes / No

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Health History (cont)

Please fill in information about your **Family history:**

	Age	State of Health	Age at Death / Age of Death	Cause of Death
Father:	____ (Age)	____ (State of Health)	____ (Age at Death)	____ (Cause of Death)
Mother:	____ (Age)	____ (State of Health)	____ (Age of Death)	____ (Cause of Death)
Brothers:	____ (Age)	____ (State of Health)	____ (Age of Death)	____ (Cause of Death)
	____ (Age)	____ (State of Health)	____ (Age of Death)	____ (Cause of Death)
Sisters:	____ (Age)	____ (State of Health)	____ (Age of Death)	____ (Cause of Death)
	____ (Age)	____ (State of Health)	____ (Age of Death)	____ (Cause of Death)

Please circle any of the following diseases your blood relative have or have had:
Arthritis / Gout / Asthma / Hay Fever / Cancer / Chemical Dependency / Diabetes /
Heart Disease / Strokes / High blood Pressure / Kidney disease / Tuberculosis /
other____

Hospitalizations:

Year	Hospital	Reason for Hospitalization and Outcome
______	______________	______________________________
______	______________	______________________________

Have you ever had a blood transfusion? Yes / No

Please list serious injuries or illness with the dates and outcome:

____

____

____

Please list all Pregnancies, including dates and complications if any:

____

____

Circle which substance you use and describe how much:

Caffeine______________________________ Drugs________________________________
Tobacco______________________________ Other________________________________

______________________________ Patient Signature

______________ Date

______________________________ ______________
Reviewed By Date

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Insurance Patients

Please be advised that our office is not contracted with any insurance company. We will accept PPO plans however you will be charged for services up front. The PPO will be billed promptly in the effort to reimburse you only up to the amount you paid us.

I understand the above paragraph:

______________________________ ______________
Patient Signature Date

______________________________ ______________
Witness Date

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Cancellation Policy

In order to provide timely and quality services to all our patients, we request a 24-hour cancellation notice.

A fee of $75 will be charged for cancellations or no shows within the 24 hour time fame of your scheduled appointment.

________________________________ ______________
Patient Signature Date

________________________________ ______________
Witness Date

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Authorization for Disclosure of Information

I authorize Jon M. Grazer M.D. to disclose complete information concerning his medical findings, treatment and any photographs of the undersigned, from the initial office visit until the date of the conclusion of such treatment, to those individuals who, in Jon M. Grazer's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review and credentialing by the American Board of Plastic Surgery.

______________________________ ____________
Patient Signature Date

______________________________ ____________
Witness Date

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Financing Agreement

Please be advised that all quotes given are cash prices. If you choose to finance any portion of your surgery/procedure, there will be a 10% processing fee added to the borrowed amount.

______________________________	______________
Patient Signature	Date
______________________________	______________
Witness	Date

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Injectable/Re-injection Agreement

If you are purchasing an injectable filler and do not use the whole syringe in one appointment, please be advised that there is a re-injection fee of $125 for the doctors time and supplies. When you return for the re-injection, and if you decide that you would like to purchase an additional syringe(s), this fee will be waived.

______________________________ Patient Signature   ____________ Date

______________________________ Witness   ____________ Date

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Policy for Facials, Oxygen Rescue Therapy Series and Microdermabrasion Series.

I understand that all pre-paid series packages are non refundable once they have been purchased.

There is a 24 hour cancellation policy on all treatments and facials. A charge of $75 will be issued for all treatments and facials not cancelled 24 hours prior to the appointment.
If on a series, the treatment will be accounted for and lost without the 24 hour notice.

Thank you for your cooperation on adhering to our policy so that we may provide services that are equal and fair for all of our patients.

__________________________________ Patient Signature

________________ Date

__________________________________ Witness

________________ Date

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HIPAA 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 it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present and future physical, mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

______________________	______________________	__________
Patient Name (print)	Patient Signature	Date

(HIPAA NOTICE OF PRIVACY PRACTICES CONT. ON NEXT PAGE)

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HIPAA NOTICE OF PRIVACY PRACTICES (CONT.)

Your Rights: The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under Federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in civil, criminal, or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively; i.e. electronically

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You'll then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the secretary of Health Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.
We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is acknowledgement that you have received notice of our privacy practices:

Patient Name (print)	Patient Signature	Date

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

ARTICLE 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary, unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California Law, and not by a lawsuit or resort to court process except as California Law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it are giving up their constitutional rights to have any such dispute decided in court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, the physician's partners, associates association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for the loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

ARTICLE 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for neutral arbitrator by each party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator together with other expense incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Each party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joiner in this arbitration of any person or entity which would otherwise be proper additional party in court action, and upon such intervention and joiner any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California Law applicable to health care providers shall apply to disputes with this arbitration agreement, including, but not limited to, Code of Civil procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

ARTICLE 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by applicable California statute of limitations, or (2) the claimant fails to pursuer the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions rating the arbitration.

ARTICLE 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

ARTICLE 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to emergency treatment) patient should initial below.

Effective as of the date of first medical services _______
Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE A GREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHTS TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

BY:____ **BY:**____
Physician's Signature or Representative Date **Patient Signature Date**

Jon M. Grazer, MD, MPH, Inc. **BY:**____
Print Name