EAST BAY HAND & PLASTIC SURGERY CENTER
PRASAD G. KILARU, M.D., M.B.A.
PLASTIC, RECONSTRUCTIVE, COSMETIC AND HAND SURGERY

CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY

39141 Civic Center Drive. Suite 110, Fremont CA 94538
Phone: (510) 791-9700 Fax: (510) 791-9703

RECONSTRUCTIVE PATIENT FORM

Date: _____

Name: _____ Phone :_____(H)

Address: _____ Phone: _____(C)

City: _____ State: _____ Zip: _____ Phone: _____ (W)

Email: _____ S. S. # _____

Date of Birth: _____/_____/_____ Height_____ Weight_____

Sex: M F Status: [ ]S [ ]M [ ]D [ ]W

Employer: _____

Who referred you to this office: _____

In case of emergency: _____Relation:_____ Phone:_____

Primary Care Physician: _____ Referring Physician: _____

Pharmacy Name: _____Location:_____ Phone:_____

Insurance Information

Please have your insurance cards and your co-pay ready for the receptionist.

Do we have permission to:

Leave a message on your answering machine at home?	YES	NO
Leave a message at your place of employment?	YES	NO
Discuss your medical condition with any member of your household?	YES	NO

Signature of patient or legal guardian_____Date: _____

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What are we seeing you for today? _____

How long have you had this condition? _____

Do you have or have you had any of the following? (Circle yes or no)

AIDS or HIV Positive	Yes	No	Hepatitis	Yes	No
Anemia	Yes	No	High Blood Pressure	Yes	No
Arthritis	Yes	No	Kidney Problems	Yes	No
Asthma	Yes	No	Migraine Headaches	Yes	No
Back problems	Yes	No	Nervous Breakdown	Yes	No
Blood clots	Yes	No	Nose/ Throat problems	Yes	No
Blood disorders	Yes	No	Pneumonia	Yes	No
Bleeding Problems	Yes	No	Psychiatric condition	Yes	No
Breathing Problems	Yes	No	Rheumatic Fever	Yes	No
Cancer	Yes	No	Seizures	Yes	No
Chest Pains	Yes	No	Shortness of breath	Yes	No
Colitis	Yes	No	Skin cancer	Yes	No
Diabetes	Yes	No	Stomach problems	Yes	No
Epilepsy	Yes	No	Stroke	Yes	No
Heart Problems	Yes	No	Thyroid problems	Yes	No
Heart Murmur	Yes	No	Tuberculosis	Yes	No
Heart palpitations	Yes	No	Transfusion	Yes	No

Family and Social History:

Current medical condition: _____

List any hospitalizations and/or surgeries and dates: _____

_____

Are you allergic to any medications? _____

Have you had any allergic or bad reactions to local or general anesthesia? _____

Do you currently smoke	Yes	No	How may packs per day_____ how many years_____
Have you ever smoked	Yes	No	How many packs per day ____ When quit_____
Do you drink alcohol	Yes	No	If yes, how much _____ How often_____

Do you have relatives who have had breast cancer? Yes No Who_____

Have you ever had a mammogram Yes No When was the last one_____

Do you have excessive scarring or keloid _____

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Contact Authorization

According to federal law our office must obtain authorization from you to send to you via email or regular mail information regarding our practice such as products we sell or any of the services the practice offers such as promotions, events or special discounts. Our office **Does Not** sell or share our patient's information.

I understand that my health care will not be affected if I do not sign this form. I have the right to receive a copy of this authorization. I also understand I may revoke or modify this authorization at any time by notifying East bay Hand and Plastic Surgery in writing. I must sign and date my written request and send it to:

East Bay Hand and Plastic Surgery
39141 Civic Center Dr. Suite 101
Fremont, CA 94538

I DO_____ I DO NOT_____

Authorize East Bay Hand and Plastic Surgery to use and disclose my Protected Health Information to mail me any information regarding services, products, and/or promotions the practice offers.

Patient Signature_____ Date:_____

Email Address _____

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California, 800-633-2322, www.mbc.ca.gov

Notice of Privacy Practices Acknowledgement

I understand that, under the health Insurance Portability & Accountability Act of 1996 ("HIPAA"). I have certain rights to privacy regarding my protected health information. I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Patient Name: _____Relationship to Patient_____

Signature: _____ Date: _____

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Policies

CANCELLATION POLICY:
Effective January 1, 2012 we will be charging a $25.00 fee for all appointments not cancelled within a 24 hour period or a no show. The fee will need to be paid at the next scheduled visit. If you have any questions regarding this policy please direct them to the office manager, Delilah Pomarejos.

I understand and agree to pay the fee of $25.00 for a no show appointment or a cancellation outside the 24 hour period.

Signature: _____Date:_____

COPAY POLICY:
Effective January 1, 2012, all copays should be paid at the time of service. If you are unable to pay your copay at the time of service and we have to bill you for it, there will be an additional $15.00 billing fee included.

Signature: _____Date: _____

INSURANCE BILLING:
As a courtesy our office will be billing your insurance for all office visits, surgeries etc. You are responsible for all charges not paid by your insurance company. You will be billed by our office for any unpaid charges.

Signature: _____Date: _____

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Due to Medicare compliance rules we are required to have each of our patients fill out the following information. We appreciate your cooperation in this process.

RACE: _____

ETHNICITY: _____

PRIMARY LANGUAGE: _____

Thank you,
Dr. Kilaru and Staff

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Patient Consent for use of Credit Cards, Debit Card, and Financing-

Disclosure of Protected Health Information

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.

Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am allowing East Bay Hand and Plastic Surgery Center to use and disclose my protected health information to any Credit Card Entity, Bank, or financing Company when they request such information to process an account and assist with payment.

(initial)_____ **I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise.**

_____

Signature of Patient or Legal Guardian

_____

Print Patient's Name **Date**

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Patient Name:_____Date:_____

TO OUR PATIENT OR LEGAL REPRESENTATIVE PLEASE READ AND SIGN:
IF PATIENT IS MINOR: Please fill out the following CONSENT FOR MEDICAL TREATMENT

I,_____(Print name), am the parent/legal guardian of_____ (print name of minor), currently a minor, whose date of birth is ___/___/___. I authorize East Bay Hand and Plastic Surgery Center to provide medical care to my son/daughter, including, but not limited to, diagnostic examinations (including radiological and laboratory testing).

_____
SIGNATURE OF CUSTODIAL PARENT/LEGAL GUARDIAN

PLEASE BE ADVISED THAT WE BILL YOUR INSURANCE ON YOUR BEHALF, HOWEVER, IT IS THE PATIENTS'S RESPONSIBILITY **TO KNOW AND UNDERSTAND POLICIES AND BENEFITS OF THEIR OWN INSURANCE PLAN.**

ASSIGNMENT OF BENEFITS-FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to be made directly to East Bay Hand and Plastic Surgery Center for services rendered. I understand **that I am financially responsible for all charges whether or not they are covered by insurance.** In the event of default, I agree to pay all cost of collection, and reasonable attorney's fee. I hereby authorize this healthcare provider to release all necessary information to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

HIPPA COMPLIANCE

As mandated by federal government and office of Civil Rights, East Bay Hand and Plastic Surgery Center is required to follow the **HIPPA Compliance Act to ensure patient confidentiality.** I understand that as part of my healthcare, East Bay Hand and Plastic Surgery Center maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care treatment.

I understand that this information serves as a 1) basic for planning my care and treatment; 2) means of communication amount the many healthcare professional who contribute to my care; 3) source of information for applying my diagnosis and surgical information to my bill; 4) means by which a third-part can verify that service billed were actually provided; 5) a tool for routine healthcare operations such as assessing care quality and reviewing competence of healthcare professional.

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I understand that I have the right: 1) to object to the use of my health information for directly purpose 2) to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operation-and the organization is not required to agree to the restrictions requested: 3) to revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I REQUEST THE FOLLOWING RESTRICTIONS TO THE USE OR DECLOSURE OF MY HEALTH INFORMATION:

Detailed message regarding test result can be left on my answering machine: **[ ] YES [ ]NO**

MEDICAL INFORMATION CAN BE DISCUSED WITH: **[ ] PATIENT ONLY**

[ ] FAMILY MEMBER OR FRIEND _____ [ ] PHYSICIAN [ ] OTHER_____

[ ] OTHER RESTRICTIONS_____

_____

SIGNATURE of Patient or Legal Representative

If you are a medicare patient, please read and sign.

MEDICARE AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I REQUEST THAT PAYMENT OF AUTHORIZED Medicare benefits be made or on my behalf to East Bay Hand and Plastic Surgery Center for any services rendered by physician/supplier. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim, if item 9 of the HCDA 1500 claim form is complete, my signature authorize releasing information to the insurer of the agency shown. In Medicare assigned cases, the physician/supplier agrees to accept the charge determination of Medicare. The patient is responsible only for the deductible, co-insurance, and non-coverable services. Co-insurance and deductibles are based upon the charge determination made by the Medicare carrier.

_____

Signature of Patient or Legal Representative

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Medication Log

Medication	Dose	Frequency

PATIENT NAME:_____