Elizabeth Slass Lee, M.D., APC
Plastic & Reconstructive Surgery
3800 Mt Diablo Blvd. Suite 102
Lafayette, CA 94549
925-299-1985

Registration Form - Pink

Date & Time of Appointment: _____(Date Appt. Given):_____

Please take a moment to read, complete and sign this form. If you have any questions, please bring them to our attention.

Patient_____ Gender: M F Birth Date_____

Address_____ City_____ State_____Zip_____

Phone (Home) _____ Phone (Cell) _____ Phone (Work) _____Ext_____

Email Address _____
(please provide PRIVATE email where you would be comfortable in communicating personal health information)
Would you like to receive our newsletter telling you of our new procedures or special promotions? ☐ Yes ☐ No

Marital Status _____ Spouse or Domestic Partner's Name_____

Employer/Address_____ Occupation_____

Emergency Contact_____ Relationship_____

Phone (Home) _____ Phone (Cell) _____ Phone (Work) _____

Primary Care Physician_____ Location/Phone_____

Referring Physician_____ Location/Phone_____

Reason for Visit_____

How did you hear about us? _____

I consent to the performance of medical treatment and procedures deemed necessary by Dr. Elizabeth Lee. I further agree to release all pertinent information relative for facilitating good patient care. I authorize any holder of medical information pertaining to me to release to Dr. Elizabeth Lee and her agents any and all information. **I understand that I may be responsible for payment for any appointment I fail to keep without appropriate and timely notification.** I have read and shall abide by the above financial obligations. Should my account be referred for collection, I agree to pay any incurred fees and court costs.

A photostat of this form shall be as valid as the original.

Patient's Signature_____ Date_____

Elizabeth Slass Lee, M.D. **Plastic & Reconstructive Surgery**

Initial Patient Visit Questionnaire
Please complete the information requested below. Thank you.

Name: _____ **Date:** _____

1) Have you ever been told you have any of the medical conditions below?

☐ Intestinal Problems	☐ Psychiatric Disorders	☐ Thyroid Disease	☐ Heart Attack
☐ Ulcers	☐ Cancer	☐ High Blood Pressure	☐ Diabetes
☐ Broken Bones	☐ Stroke	☐ Bleeding Problems	
☐ Asthma	☐ Kidney Disease	☐ Other (describe)	

2) Are you currently taking any medications? ☐ Yes ☐ No
If you answered yes, please give the names of the medications.

If you are currently taking *any* herbal remedies or vitamins? (ginkgo, ginsing, Vitamin E, etc.), please list them.

3) Are you allergic to any medications? ☐ Yes ☐ No
If you answered yes, please give the names and your reactions to them.

4) Do you have allergies to any of the following:
☐ Latex ☐ Food ☐ Nuts ☐ Plants ☐ Anesthesia ☐ Other: _____

5) Have you ever had surgery? ☐ Yes ☐ No
If you have answered yes, please describe the surgery you had and when it was performed.

6) Have you ever been hospitalized for anything other than surgery? ☐ Yes ☐ No
If you have answered yes, please describe the condition(s) for which you were hospitalized and when.

7) Are you having any symptoms of the below?

☐ Chest Pain	☐ Difficulty Breathing	☐ Abdominal Pain	☐ Nausea
☐ Headache	☐ Sore Throat	☐ Cough	☐ Dizziness
☐ Body Aches	☐ Fever	☐ Bladder Problems	

8) Does your family history include any of the following? If so, which relative is affected?

☐ Heart Disease	☐ Cancer	☐ Pulmonary Disease	☐ High Blood Pressure
☐ Thyroid Disease	☐ Gastrointestinal Disease	☐ Abdominal Disorders	
☐ Diabetes	☐ Kidney Disease	☐ Other (describe)	

9) Are you? ☐ Single ☐ Married ☐ Domestic Partnership ☐ Widowed ☐ Divorced

Do you have children? ☐ Yes ☐ No If yes, how many children, their ages and sexes? _____

10) Do you *now* smoke? ☐ Yes ☐ No
If no, have you *ever* smoked? ☐ Yes ☐ No
When did you quit? _____
If yes, do you smoke cigarettes, cigars or a pipe? _____
How many years have you smoked? _____
If you smoke cigarettes, how many cigarettes do you smoke in one day?_____

Do you drink alcohol? ☐ Yes ☐ No
If yes, how much alcohol do you consume? _____

Do you wear contact lenses? ☐ Yes ☐ No

Do you have any history with Cold Sores ☐ Yes ☐ No

11) Are you currently pregnant, breastfeeding, or trying to get pregnant? ☐ Yes ☐ No

12) What is your current HEIGHT? _____ WEIGHT? _____

13) Have you ever been diagnosed with a neurologic disorder? ☐ Yes ☐ No
If you answered yes, please describe the condition with which you where diagnosed and give the approximate date of diagnosis.

Elizabeth Slass Lee, M.D., APC
Plastic & Reconstructive Surgery
3800 Mt Diablo Blvd. Suite 102
Lafayette, CA 94549
925-299-1985

Statement of Financial Obligation

Please take a moment to read this statement before signing. If there are any questions, please bring them to the attention of the office staff.

Patient Name: Birthdate:

Address:

I am solely responsible for all payments for services rendered and billed by Dr. Elizabeth Slass Lee.

I am responsible for the entire payment of the consultation fee (when applicable) at the time service is rendered.

Before any surgery or procedure is performed, I am responsible for payment in full for the surgery.

Should my account be referred for collection, I agree to pay any and all incurred fees and court costs.

I have read and shall abide by the above financial obligations.

A copy of this form shall be as valid as the original.

Signature_____Date_____
(Patient, Parent or Guardian)

Elizabeth Slass Lee, M.D.
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.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/2003, and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created and/or received before we made the changes. Before we make a significant change in our privacy practices, we will amend this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Typical Uses and Disclosures of Health Information

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you. Our office will use and disclose you protected health information for purposes of treatment, meaning the provision, coordination and management of your health care and related services. For example, we will use and disclose your health information to a surgery center that provides services to you, or for consultation between our office and other health care professionals if required for your care.

Payment: We may use and disclose your health information to obtain payment and/or pre-authorization of payment for services we provide to you. For example, we will use and disclose you health information in order to coordinate benefits with a third-party payer, to obtain prior approval for treatment and to collect unpaid balances.

Healthcare Operations: We may use and disclose your health information in connection with the business activities of our practice. For example, we will use and disclose you health information for business activities include, but not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Appointment Reminders: We may use and disclose your health information to provide you with appointment reminders, including but not limited to, voicemail messages, postcards, or letters.

Other Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in

effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare. Please be advised that both parents of minors are entitled to disclosure of that minor's health information.

Emergencies: We may use and disclose your health information to notify, or assist in the notification of a family member, your personal representative or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, you may advise us that you object to such uses or disclosures. Under emergency circumstances or in the event of your incapacity, we will use our professional judgment to disclose only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing someone to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Workers' Compensation: We may use and disclose your health information to the extent authorized by and necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use and disclose your health information when we are required to do so by law. (Court of administrative orders, subpoena, discovery request or other lawful process).

Abuse, Neglect, Safety: We may use and disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We may use and disclose you health information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. We may disclose your health information to authorized federal officials if the information is required for lawful intelligence, counterintelligence, or other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Coroners, Medical Examiners and Funeral Directors: We may use and disclose your health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining the cause of death or another matter authorized by law, or to funeral directors to carry out their duties with respect to the deceased individuals.

Your Privacy Rights As Our Patient

Access : Upon written request, you have the right to inspect or get copies of your health information (and that of an individual for whom you are a legal guardian), with limited exceptions. If you wish to examine your health information, you will need to submit your request in writing to the address at the end of this Notice. Once approved, an appointment can be made to review your records. If you request copies of your health information, we will charge you a base fee of $30 for photocopies. If you want the copies mailed you, postage will also be charged. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment : You have the right to request that we amend your health information, if you feel it is inaccurate or incomplete. Your request must be in writing, and it must explain why the information should be amended. Under certain circumstances, your request may be denied.

Non-Routine Disclosures : You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes *other than* treatment, payment, healthcare operations and certain other activities. (these are considered routine disclosures, therefore records are not available). You can request in writing non-routine disclosures going back 6 years or the period time you have been under our care, whichever is less, but not before April 14, 2003. If you request this information more than once in a 12-month period, we may charge you a reasonable fee for responding to these additional requests.

Restriction : You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Questions And Complaints

Please contact us if you have questions regarding this Notice. If you believe your privacy rights have been violated, or if you disagree with a decision we made regarding your access to your health information, you may file a complaint with us using the contact information listed at the end of this Notice or with the U.S. Department of Health and Human Service. All complaints must be made in writing. We support your right to the privacy of your health information, and we will ensure that the care you receive at our office will in no way be impacted if you file a complaint.

How to Contact Us

Practice Name: Elizabeth Slass Lee, M.D.

Privacy Officer: Maria S. Ling

Address: 3800 Mt Diablo Blvd. Suite 102, Lafayette, CA 94549

Tel: (925) 299-1985

ArtfulSurgery, Elizabeth Slass Lee, MD
Plastic & Reconstructive Surgery
3800 Mt. Diablo Blvd, Suite 102, Lafayette, CA 94549
925-299-1985

Scheduling and Cancellation Policy - ArtfulSurgery

Thank you for choosing ArtfulSurgery, the office of Elizabeth Slass Lee, M.D. We realize that you have a choice in medical providers and are pleased that you have chosen to seek care with us. Our goal is to provide quality medical care in a timely manner. The policy enables us to best utilize available appointments for our patients in need of medical care. Please feel free to contact our office if you have any questions regarding our policies.

OFFICE HOURS

Our office is available Monday-Friday 9:00am to 5:00pm, and may be reached at 925-299-1985. Should you have an emergency after hours, our answering service is available to reach Dr. Lee through our regular number. **Please call us during regular business hours to schedule or modify an appointment.**

APPOINTMENTS

ArtfulSurgery is committed to providing quality care to our patients. To ensure timely continued care, we encourage patients to schedule appointments in advance and to be on time. If this is your first appointment with us, please arrive 10 minutes before your appointment time to do your patient intake paperwork, if you have not done this already online.

We make every effort to be on time, but sometimes a patient may require a bit more care than we anticipated. For this reason, we kindly request your patience and understanding should a delay in your appointment be unavoidable.

A $50 consultation fee is collected when you make your first appointment to reserve your time with Dr. Lee. We respect your time and do not double book appointments; your time is reserved just for you. The $50 guarantee is refundable when changes or cancellations are made at least one business day before your scheduled appointment.

APPOINTMENT CANCELLATION

In order to be respectful of the medical needs of our patients please be courteous and call ArtfulSurgery promptly if you are unable to attend or need to reschedule an appointment. This enables us to better serve our patients who are waiting to be scheduled. We greatly respect your time and appreciate your reciprocating the same.

Should a you fail to keep, or cancel an appointment closer than the schedule below, we reserve the right to charge for that missed appointment. This courtesy payment is due before we can reschedule you in the office.

CANCELLATION SCHEDULE AND FEES

Appointment type	Cancellation window minimum	Cancellation Fee
Consultation	24 hours/1 business day	$50
Office visit or service with Dr. Lee	24 hours/1 business day	$50
Laser	72 hours/3 business days	$75
Coolsculpting	7 days	$175 per hour scheduled

ACKNOWLEDGMENT FORM-SCHEDULING AND CANCELLATION POLICY

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with policies and procedures explained in **Scheduling and Cancellation Policy-ArtfulSurgery**.

_____
Printed name

_____ _____
Signed Name Date

Thank you!
ArtfulSurgery, Elizabeth Slass Lee M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices under the privacy regulations of the federal Health Insurance Portability and Accountability Act (HIPAA), which states how we may use and/or disclose your health information.

Please sign and date this form to acknowledge receipt of the Notice.

I acknowledge that I have been provided a copy of Notice of Privacy Practice from the office of Elizabeth S. Lee, M.D.

Print Name

Patient Signature

Date

Text/Email Consent

ArtfulSurgery uses text/email as a convenient way to communicate Patient appointment reminders. Our system will send out appointment reminders and allows Patients to confirm appointments. We may also send text messages/emails if we need to make any changes to your appointment. The text/email system is unable to accept cancellations, so Patients must still call the office to cancel or reschedule. Text/email may also contain information about appointment cancellation timelines and pre-procedure instructions. Yearly Birthday discounts and seasonal promotions may also be sent.

I understand texts and emails are not a secure mode of communication for transmitting personal health information (PHI) such as medical test results, medical management questions and my photo images. I understand that I must call the office to cancel or reschedule my appointments.

I authorize ArtfulSurgery to send me information via text and/or email.

Please use my mobile # _____
And/ or my private email address _____
for all the purposes outlined above.

_____
Print Name

_____
Patient Signature

_____
Date