Aesthetic Arts Institute
OF PLASTIC SURGERY

FIRM MEDIA

New Patient Form

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Introducing myTouchMD.com
myTouchMD.com is a secure website that allows you to review your TouchMD content and share that information with others. Log in using your home computer to:

- Learn more about the doctor, their staff and facilities.
- Explore topic videos about your procedure or medical condition.
- View or print any images saved by your doctor during your office visit and share this experience with your loved ones.
- Review pre and post operative instructions provided by your doctor.
- Inform your doctor of your interest in other services and/or products offered by their practice.

What is TouchMD?
TouchMD is a state-of-the-art system that enhances doctor-patient relationships. Learn more about your upcoming procedure or medical condition using an easy-to-navigate touch-screen computer in the doctor's office.

How to Log In
To log in, enter **https://patient.touchmd.com/** into your web browser. You will then be directed to enter an email and password. For your convenience, you can enter it below and we will give you this back for your reference so you can view it at your home.

Registration Code: Kaweski8415

Email:

Password:

Personal Information

Aesthetic Arts Institute
OF PLASTIC SURGERY

Full Name

Sex
☐ Male ☐ Female

Preferred Pronouns

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widow

Date of Birth

Social Security Number

Contact Information

Email Address

Cell Phone Number

Home Phone Number

Work Phone Number

Do We Have Permission To Contact You Through Email or Text Message & Send You Promotions?
☐ Yes ☐ No

Full Address

Employer Name

Employer Phone Number

Spouse Name

Spouse Phone Number

Spouse Employer

Spouse Employer Phone

Emergency Contact

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Name Of Person NOT Living With You

Relationship

Emergency Contact Address

Cell Phone

Home Phone

Patient's Referral Information

Friend's Name

May we thank them?

☐ Yes ☐ No

Source

☐ Yellow ☐ Website ☐ Magazine ☐ Internet AD ☐ My doctor

Doctor Referral

Doctor Referral Phone Number

Primary Care Doctor

Primary Care Doctor Phone Number

Insurance Information

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Name of Insured

Primary Insurance

Primary Insurance Address

Group #

Insured SSN#

Do you have a Secondary Insurance?

☐ Yes ☐ No

Secondary Insurance

Secondary Insurance Addres

Secondary Insurance Group #

Secondary Insured SSN#

Primary Insurance ID Number

Insurance Phone

Insured DOB

Secondary Insurance ID Number

Secondary Insurance Phone

Secondary Insured DOB

Medical History Information

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Patient Name

Age

Height

☐

Weight (lbs)

Past Medical History

Heart Attack
☐ Yes ☐ No

Congestive Heart Failure
☐ Yes ☐ No

Autoimmune Disorder
☐ Yes ☐ No

Drug Dependency
☐ Yes ☐ No

Asthma
☐ Yes ☐ No

Lung Disease
☐ Yes ☐ No

Serious Accident
☐ Yes ☐ No

Blood Clotting Disorders
☐ Yes ☐ No

Latex Allergies
☐ Yes ☐ No

Hepatitis
☐ Yes ☐ No

Blood Disorder
☐ Yes ☐ No

Bulimia or Anorexia
☐ Yes ☐ No

Anxiety Disorder
☐ Yes ☐ No

Sleep Apnea
☐ Yes ☐ No

Depression
☐ Yes ☐ No

Acid Reflux
☐ Yes ☐ No

Stroke
☐ Yes ☐ No

Chronic Illness
☐ Yes ☐ No

Bipolar Disorder
☐ Yes ☐ No

Anemia
☐ Yes ☐ No

High Blood Pressure
☐ Yes ☐ No

Cancer
☐ Yes ☐ No

Diabetes
☐ Yes ☐ No

CPAP Machine
☐ Yes ☐ No

Environmental Allergies
☐ Yes ☐ No

Birth Control
☐ Yes ☐ No

HIV
☐ Yes ☐ No

Pacemaker
☐ Yes ☐ No

Past Medical History (Continued)

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Medical Allergies

List All Medications And Herbal Supplements (please include dosage and daily use):

Childbirth (if Female)

Is there any chance that you are or could be pregnant now?

☐ Yes ☐ No

List Number of Pregnancies and Number of Children

Lifestyle

Do you Smoke/Vape

☐ Yes ☐ No

Packs Per Day

Number of Years

When did you quit?

How many drinks containing alcohol do you drink in a week?

Do you take Aspirin or Ibuprofen on a regular basis?

☐ Yes ☐ No

Are you on a diet pill or diet program?

☐ Yes ☐ No

Have you been in the past 3 years?

☐ Yes ☐ No

Do you exercise?

☐ Yes ☐ No

What types of activities?

Patient Questionnaire

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Name **Date**

What Procedure(s) Are You Interested In?

☐

How Long Have You Been Thinking About This?

Has Anything Happened Recently To Stimulate Your Interest In Having This Done At This Time?What Do You Expect This Surgery/Procedure To Do For You?

Do You Have Concerns About Having This Surgery/Procedure?

When Are You Thinking Of Having This Procedure Done?

Have You Discussed This With Your Spouse, Family, And/Or Friends?

☐ Yes (please select below) ☐ No

Choose Option(s)

☐ Spouse ☐ Family ☐ Friends

What Was Their Opinion?

☐ Very Supportive ☐ Supportive ☐ Uncommitted ☐ Against It ☐ Very Much Against It

Other Family/Friends Comments:

Patient Questionnaire

Aesthetic Arts Institute
OF PLASTIC SURGERY

Have You Visited Our Website?

☐ Yes ☐ No

Did Our Website Influence Your Decision To See Us?

☐ Yes ☐ No

Have You Ever Had Any Surgery or Procedure(s) Before?

☐ Yes ☐ No

List All Previous Surgeries, Procedure(s), Doctor Name, and Date(s):

Name of Doctor **Procedure Date**

What qualities do you consider most important in your choice of the doctor, staff, and facility to do your surgery/procedure?

☐ Quality ☐ Trust ☐ Confidence ☐ Superior Facilities ☐ Safety ☐ Experience

☐ Reputation ☐ Results ☐ Financing ☐ Convenience ☐ Guidance ☐ Price

☐ Board Certification

Financial and Payment Policy

Aesthetic Arts Institute
OF PLASTIC SURGERY

Thank you for choosing Aesthetic Arts Institute of Plastic Surgery. We are committed to providing you with quality and affordable health care. Because some of our patients have questions regarding patient and insurance responsibility for services rendered, we developed this financial/payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. INSURANCE

We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility; please contact your insurance company with any questions you may have regarding your coverage.

- **Proof Of Insurance:** All patients must present a current valid insurance card before seeing the doctor. If you fail to provide us with your correct insurance information in a timely manner, you may be responsible for the balance of a bill. When your insurance changes, please notify us before your next visit so we can make the appropriate changes and help you receive your maximum benefits.
- **Claims Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly; it is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.
- **Non-Covered Services:** Please be aware that some and perhaps all-of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurance plans. You must pay for these services in full at the time of your visit or as soon as we notify you that the services will not be covered by your insurance plan.

2. CO-PAYS

All co-pays must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-pays from patients can be considered fraud. Please help us in upholding the law by paying your co-pays at each visit. A billing fee may be added to the amount due if a statement must be sent to you for an unpaid co-pay. If you have two insurances, your primary insurance co-pay is applicable; co-pays are not billable to any secondary/supplemental insurance plans.

3. NON-PAYMENT OF ACCOUNT

Please be aware that if a balance remains unpaid over 90 days, we may place your account in pre-collection status or refer your account to a collection agency. These actions can possibly jeopardize any future appointments or result in discharge from this practice.

4. MISSED APPOINTMENTS

Our policy is to charge $75.00 for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointments.

Thank you for understanding our financial/payment policy. Please let us know if you have any questions or concerns.

I have read and understand the financial/payment policy and agree to abide by its guidelines:

Your Signature **Date**

Notice Of Privacy Practices And Assignment Of Benefits

Aesthetic Arts Institute
OF PLASTIC SURGERY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this "notice", sign, and return this form along with your paperwork to our office.

We collect, use, and disclose information provided by and about you for healthcare payment and operation, or when we are otherwise permitted or required by law to do so. We must have your written consent to use and disclose health information for the following purposes:

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff, or other personnel who are involved in taking care of you and your health. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling procedures, and ordering X-rays. Other healthcare providers may be part of your medical care outside of this office and may require information about you that we have.

For Payment: We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party.

For Health Care Operations: We may use and disclose health information about you in order to run this office and make sure that you and our other patients receive quality care.

Appointment Reminders: We may contact you or your representative as a reminder that you have an appointment for treatment or medical care at this office.

As Permitted Or Required By Law: Information about you may be used or disclosed to regulatory agencies, such as during audits, licensure, or other proceedings; for administrative or judicial proceedings; to public health authorities; or to law enforcement officials, such as to comply with court orders or subpoena.

Public Health Risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury, or disability or report suspected abuse or neglect, non-accidental physical injuries, reactions to medications, or problems with products.

Family/Friends: We may disclose health information about you to your family or friends if we obtain your verbal or written agreement to do so. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family or friends is in your best interest. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person or persons to act on your behalf in scheduling office appointments, procedures, or other necessary services to coordinate your care.

Other Uses and Disclosures Of Health Information: Other uses and disclosures of protected health information will be made only with your written permission unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing. We will then stop using your information for that purpose. However, if we have already used your information based on your authorization, you cannot take back your agreement for those past situations.

Right to Inspect and Copy: You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request in order to inspect and/or copy your health information. Our office will provide copies of your records for a reasonable fee.

Right to Amend: If you believe the health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, complete and submit a Medical Record Amendment/Corrections Form to this office. We may deny your request for an amendment that is not in writing or does not include a reason to support the request.

Right to an Account of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and healthcare operations. You must submit your request in writing to this office. It must state a time period, which may not be longer than six years.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. To request restrictions, you may complete and submit the Request for Restrictions on Use/Disclosure of Medical Information to this office.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must submit the Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communications to this office.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services.

ASSIGNMENT OF BENEFITS-FINANCIAL AGREEMENT
I hereby give authorization for insurance benefits to be made directly to Susan Kaweski, M.D., FACS for services rendered. I understand that I am financially responsible for all charges whether

Your Signature **Date**

Acknowledgement of Broken Appointment Notice And No Show Policy

Aesthetic Arts Institute
OF PLASTIC SURGERY

As of July 1, 2012

I acknowledge and agree that I have to give at least a 24-hour notice to cancel and reschedule an appointment. Unless it is an emergency you may leave a message on our voicemail in regards to your cancellation. All messages are checked every morning, with the exception of the weekend. If you fail to do so, there will be a $50.00 fee. I also acknowledge and agree that no further appointment will be made until the balance is paid in full.

We will bill the patient for this, not the insurance.

After 20 years of practice, I am truly sorry that these regulations must be instituted at this time. However, I find it unfair to the vast majority of responsible patients who suffer because of the irresponsibility of a few.

Susan Kaweski, M.D.

Your Signature **Date**