REYNOLDS PLASTIC SURGERY
5550 Painted Mirage Road Ste. 217
Las Vegas, NV 89149
phone: (702)410-9800
fax: (702)924-1520
breynolds@reynoldsreconstruction.com

Patient Name:	Age:
Date:	SS Number:
Phone Number:	Email:
Address:	
City/State/Zip:	
Date of Birth:	

Medical History:

Y	N		Y	N		Y	N	
_	_	Diabetes	_	_	Depression	_	_	Lung Disorder
_	_	High Blood Pressure	_	_	Psychiatric disorder	_	_	HIV/AIDS
_	_	Heart Attack	_	_	High Cholesterol	_	_	Stroke
_	_	Hypothyroidism	_	_	Bleeding tendency	_	_	Hepatitis
_	_	Kidney Stone	_	_	GI disorder	_	_	Cancer
_	_	Heart disease	_	_	History motion sickness	_	_	Asthma
_	_	Rheumatic fever	_	_	Pulmonary Embolism	_	_	DVT
_	_	History of anesthesia Problems	_	_	Other_____			

If yes, please explain: _____
_____

Past Surgical History:

Y	N		Year	Y	N		Year
_	_	Appendectomy	____	_	_	Hernia Repair	____
_	_	Hysterectomy	____	_	_	Oophorectomy	____
_	_	Tonsillectomy	____	_	_	Heart Bypass	____
_	_	Cosmetic:_____	____	_	_	Gallbladder Removal	____
_	_	Other:_____					

please list any surgical history not listed here
_____

Do you or have you ever used tobacco? (Circle one) Yes No
If yes, what form? (Cigarette, Chewing Tobacco, Cigar, Pipe, Vapor Pen) _____
I have smoked ____ pack(s) per day for _____ years. I quit smoking: _____ (date)
Do you use alcohol? (Circle one) Yes No
Drinks per week:_____
Do you use any recreational drugs? (Circle one) Yes No
If yes, please explain_____
Are your immunizations current? **(**Circle one) Yes No
Do you have an Advanced Directive? (Circle one) Yes No
If yes, please provide a copy for our office.
Occupation:

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Patient Name: _____
Date:_____

Family Health History:

Y	N			Circle	
_	_	High blood pressure		Paternal	Maternal
_	_	Heart Disease		Paternal	Maternal
_	_	Stroke		Paternal	Maternal
_	_	Skin cancer	Type_____	Paternal	Maternal
_	_	Breast cancer		Paternal	Maternal
_	_	Ovarian cancer		Paternal	Maternal
_	_	Other cancer	Type_____	Paternal	Maternal
_	_	Other illness	Type_____	Paternal	Maternal

Review of Symptoms

Please check yes or no to any of the following symptoms that you have had within the last **2 weeks:**

Y	N		Y	N		Y	N	
_	_	Abdomen swelling	_	_	Eye Pain	_	_	Pain-testicles
_	_	Ankle Swelling	_	_	Fainting	_	_	Heart palpitations
_	_	Anxious	_	_	Fever	_	_	Rash
_	_	Back Pain	_	_	Gland Swelling	_	_	Scabbing Wound
_	_	Blood in Stool	_	_	Growing Lesion	_	_	Seizures
_	_	Breast Pain	_	_	Hallucination	_	_	Skin Lesion irregular
_	_	Bruising	_	_	Headaches	_	_	Sore Throat
_	_	Chest Pain	_	_	Heat Intolerance	_	_	Sputum
_	_	Chills	_	_	Itching	_	_	Suicidal thoughts
_	_	Cold Intolerance	_	_	Irregular breathing	_	_	Swelling
_	_	Constipation	_	_	Joint Pain	_	_	Thirst-excessive
_	_	Cough	_	_	Labored breathing	_	_	Tired
_	_	Cysts	_	_	Nasal Congestion	_	_	Urination-excessive
_	_	Depressed	_	_	Nausea	_	_	Vomiting
_	_	Diarrhea	_	_	Neck Pain	_	_	Weakness
_	_	Dizziness	_	_	Nipple Discharge	_	_	Weight Loss
_	_	Ear Pain	_	_	Numbness	_	_	Wheezing
_	_	Eye Discharge	_	_	Pain in flank	_	_	Wound-non-healing

Last mammogram date:_____ Location: _____
Have you ever had an abnormal mammogram or breast biopsy? _____
How often do you perform self-breast exams? _____
Number of Children:_____ Have you successfully breast fed? _____
What size of bra do you wear currently?_____

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Patient Name:_____
Date:_____

Do you take:

Y	N		Y	N		Y	N	
_	_	Blood Thinner	_	_	High blood pressure meds	_	_	Diet Pills
_	_	Heart Medication	_	_	Diuretics (Water Pills)	_	_	Aspirin

Do you (or have you ever) taken:

Y	N		Y	N		Y	N	
_	_	Steroids (cortisone)	_	_	Immunosuppressant	_	_	Vitamin E
_	_	Herbal supplements	_	_	Chemotherapy			

Are you allergic to:

Y	N		Y	N		Y	N	
_	_	Penicillin	_	_	Novocain	_	_	Latex
_	_	Other drugs_____						
_	_	Other allergies_____						

List medications **Strength/Dose**

_____
_____
_____
_____
_____
_____
_____

Reason for today's visit:

_____
_____
_____

Primary Physician's Name and Phone Number:

_____

Last PCP Appointment:_____ **Last EKG:_____** **Last Blood Draw:_____**

How did you hear about us? (Word of Mouth, Internet Search, Facebook, Doctor Referral, Other)

_____

Nurse use only:

Temp_____ BP_____ HR_____ RR_____ Height_____ Weight_____

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Photo Consent Form

AUTHORIZATION FOR RELEASE OF INFORMATION AND/OR PUBLIC USE OF IMAGE (PHOTOGRAPH OR TAPE) TO REYNOLDS PLASTIC SURGERY.

I consent to the taking of photographs by Dr. Brandon Reynolds or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed.

I hereby give my consent to participate in a promotional story, advertisement and/or image (photograph and/or videotape) made for REYNOLDS PLASTIC SURGERY (or the person named below, for whom I am giving consent). I have been told that this story, advertisement and/or image (photograph or videotape) may appear in the public media, including print, internet and/or broadcast media. I have been told that this story, advertisement and/or image (photograph and/or videotape) may be used more than once for promotional purposes by Reynolds Plastic Surgery.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Reynolds.

I have been informed that once information is disclosed it may no longer be protected by federal privacy regulations. I have been informed that this authorization is voluntary and that I may revoke this authorization at any time by notifying Reynolds Plastic Surgery by mail at 5550 Painted Mirage Rd Ste 217, Las Vegas Nevada 89149. The revocation will not affect any actions taken before the receipt of this written notification

Subject Name (Please Print) Date

Address: City, State, Zip

Home Phone, Work Phone, E-Mail

Signature of Subject (or legal guardian) / (if legal guardian)-Printed Name

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FINANCIAL POLICY

Thank you for choosing Reynolds Plastic Surgery for your care. We are providing you with the following information to help you to understand our financial policies.

We accept cash, checks, Visa, MasterCard and American Express as payment. We also accept Care Credit Financing. **You will be charged a $35 fee if a personal check is returned unpaid from your bank.**

Patient Initials_____

INSURANCE

You are responsible to confirm with your insurance company that Reynolds Plastic Surgery is an in-network provider prior to your appointment. If you are covered by an insurance plan that we do not participate with, we will request payment at the time of service for all office visits.

Referrals are sometimes needed for certain insurance carriers. **It is the patient's responsibility to obtain this from their Primary Care Physician before their visit.** If a referral is not obtained, the patient will be responsible for payment of services.

Your insurance policy is a contract between you and your insurance company. We will submit claims to your insurance carrier, for care you have received, if you have given us all of the required information needed to do so. **Please be aware that some and perhaps all of the services provided may be "non-covered" services according to your insurance policy. However, you are still responsible for payment for these services.**

We accept assigned payments for most major insurance companies. However, **you will be responsible for payment of deductibles, co-pays, coinsurance, or non-covered services at the time of services. Any non-covered services will be approved by patient prior to services rendered.**

Unfortunately, timely payments from insurance companies can be a major problem for medical practices. Therefore, our office follows the billing procedures listed below:

- We file an insurance claim within ten business days of your date of service.
- If we do not receive a response from your insurance carrier within 30 days, we will submit a second claim. If we do not receive a response from your insurance carrier within 45 days, you will receive a statement and will need to contact your insurance carrier regarding payment.
- **After 60 days the balance due for medical services rendered will be your financial responsibility. You may pay us directly and receive reimbursement from your insurance company directly.**
- A billing statement covering medical services rendered will be mailed to you on a monthly basis, and **payment of your account is due within 30 days.** If you are unable to pay, you must contact our office within those 30 days to establish a payment plan or other option.

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- **After 90 days from the first billing statement date, we place unpaid patient accounts in collections. Patients are then responsible for any collection costs that are incurred, which will include an additional fee of $25.00.** Refusal to pay will adversely affect your credit and your tax liabilities.
- Should patient accounts be open longer than 180 days, Reynolds Plastic Surgery will be forced to move open accounts forward to court.

Minor patients (Under 18 Years of Age)

The parent/guardian/adult accompanying a minor child is responsible for payment. Any child 18 or over is legally an adult and responsible for his/her bill. We therefore cannot release financial or medical information to a parent/guardian of a patient over the age of 18 without the patient's written permission. Please check your insurance policy to determine which company is primary before the appointment.

Collection Balances

If you had a previous collection balance or are presently in collection, the physician may use his or her discretion as to providing you with further treatment. You may be required to pay your previous balance in full prior to being seen. You will be responsible for payment of the office visits, co-pay, deductible, etc., on the day of the visit.

Reschedule/Cancellation Policy

Please assist us with serving you better by keeping your scheduled clinic appointment. If you are unable to do so, please notify us at least 24 hours in advance. You will be charged a $50 fee if notification to reschedule or cancel your clinic appointment is less than 24 hours in advance.Due to the large block of time needed for surgery, last minute rescheduling or cancellations can cause problems and added expenses for the office. If you are unable to keep your scheduled surgery, please notify us at least 10 days in advance. You will be charged a $75 fee if notification to reschedule or cancel surgery is less than 10 days in advance.

These fees will not be covered by your insurance company. After two rescheduled or cancelled surgeries, Reynolds Plastic Surgery reserves the right to discharge you as a patient.

I understand and agree to this policy.

_____ _____

Signature of Patient or Responsible Party **Date**

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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY NOTICE AND

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgment and Consent

This acknowledgment and consent authorizes Reynolds Plastic Surgery to use and disclose health information about you for treatment, payment, and health care operations purposes.

Notice of Privacy Practices

Reynolds Plastic Surgery has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent.

Amendments

We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our office.

Acknowledgment and Consent

Print or type all information except the signature

I have received the Notice of Privacy Practices for Reynolds Plastic Surgery. Reynolds Plastic Surgery is authorized to use and disclose health information about _____ (patient name) for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ Date_____
Signature of patient or patient's personal representative

Personal representative information (if applicable);

_____
Name of personal representative

_____
Relationship to patient (or other authority)

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In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I agree to be contacted in the following manner (check all that apply):

____Home Telephone (____)-_____-____

____It is okay to leave a message with detailed information

____Leave a message with call-back number only

____Cell Telephone (____)-_____-_____

____ It is okay to leave a message with detailed information

____ Leave a message with call-back number only

____Work Telephone (____)-____-_____

____ It is okay to leave a message with detailed information

____ Leave a message with call-back number only

My health information may be shared with:_____
Name Phone number Relationship

My health information may be shared with:_____
Name Phone number Relationship

_____ _____
Patient Signature Date

_____ _____
Print Name Birth Date

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

This document must be signed by the patient or person authorized by law.

I _____,

authorize (Dr. and/or Name of Institute): _____

Phone: _____ Fax: _____

to release a copy of my complete medical records to the following:

Reynolds Plastic Surgery
5550 Painted Mirage Rd. Ste. 217
Las Vegas, NV 89149
Phone: 702-410-9800
Fax: 702-924-1520

My information will be used on my behalf for the following purpose (s):

_____

_____
Name of Patient

_____ _____
Date of Birth Social Security Number

_____ _____
Signature of Patient or Person Authorized by Law Date

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PATIENT INFORMATION

Patient's Last Name	First	M.I.	Date of Birth Age
Street Address		Apt. #	Social Security #
City	State	Zip Code	Marital Status M S D W Other
Home Phone	Work Phone	Alternate Phone	Gender M F
Patient's Occupation	Employer's Name	Family Physician/Phone	
Person to Notify in Emergency (Name and Phone #)		Referred By	

INSURANCE – Please present your insurance card to the receptionist

Insurance Company Name and Address		
Identification #	Group #	Effective Date
Policy Holders Name and Address	SS#	Date of Birth

SECONDARY INSURANCE- Please present your insurance card to the receptionist

Insurance Company Name and Address		
Identification #	Group #	Effective Date
Policy Holders Name and Address	SS#	Date of Birth

I consent to treatment necessary for the care of the above patient. I authorize the release of all medical records to the referring and/or family physician and insurance company, if applicable. I allow fax transmittal of my medical records, if necessary, I acknowledge full financial responsibility for services rendered by Reynolds Plastic Surgery, whether or not paid by insurance. I agree to pay all reasonable attorney fees and collection cost in the event of default of payment of my charges. I authorize and request that insurance payments be made directly to Reynolds Plastic Surgery. I understand that payment of charges occurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I consent to the use of photography for pre and post-operative analysis, peer review, and educational purposes. I have read and fully understand the above and sign with intent to be legally bound.

Signature_____ Date _____