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:	Date of Birth:
Phone Number:	SS Number:
Address:	Email:
City/State/Zip:	Occupation:
Primary Care Physician:	

Medical History:

Y	N		Y	N		Y	N	
_	_	Diabetes	_	_	DVT	_	_	Lung Disorder
_	_	High Blood Pressure	_	_	Heart disease	_	_	HIV/AIDS
_	_	Hypothyroidism	_	_	Bleeding tendency	_	_	Stroke
_	_	GI Disorder	_	_	Asthma	_	_	Hepatitis
_	_	Pulmonary Embolism	_	_	Skin Cancer	_	_	Pacemaker/defibrillator
_	_	Photoallergic	_	_	Pigmentation Disorder	_	_	Tanning Bed Use
_	_	History of keloids	_	_	Dermatological issues	_	_	History of cold sores
_	_	Accutane within 6 months	_	_	History of motion sickness	_	_	Allergies

Past Surgical History:
Please list any cosmetic or medical procedures:
_____
_____

List medications: **Strength/Dose**
_____
_____
_____

Medication Allergies:
_____
_____

Have you ever had:
Laser Treatments (Resurfacing, Photofacial, Laser Hair Reduction, etc)?_____
Injectibles (Botox, Juvederm, Voluma, etc)?_____
Other MedSpa Procedures?_____

Do you or have you ever used tobacco? (Circle one) No Yes (What form?) _____
I have smoked ____ pack(s) per day for _____ years. I quit smoking: _____ (date)
Do you use alcohol? (Circle one) Yes No
Drinks per week:_____

Reason for today's visit:_____
_____

How did you hear about us?_____

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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

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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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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

FINANCIAL POLICY

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

To reserve a procedure date, the total amount due will be collected at the time of booking, in the form of cash (2% discount), Visa, Discover, MasterCard or American Express. Financing is accepted through Care Credit and United Medical Credit (processing fees apply). Once payment is made in full, procedures will be charged at the individual treatment rate for completed treatments within the package and remaining balance may be refunded.

Patient Initials_____

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.

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. After two rescheduled or cancelled appointments, Reynolds Plastic Surgery reserves the right to discharge you as a patient.

I understand and agree to this policy.

Patient Initials_____

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, if applicable. I allow fax transmittal of my medical records, if necessary, I acknowledge full financial responsibility for services rendered by Reynolds Plastic Surgery. I agree to pay all reasonable attorney fees and collection cost in the event of default of payment of my charges. 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 _____