

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	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disorder
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric disorder	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol/triglycerides	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stone	<input type="checkbox"/>	<input type="checkbox"/>	GI disorder	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	History of motion sickness	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Embolism	<input type="checkbox"/>	<input type="checkbox"/>	DVT
<input type="checkbox"/>	<input type="checkbox"/>	History of anesthesia Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other _____			

If yes, please explain: _____

Past Surgical History:

Y	N		Year	Y	N		Year
<input type="checkbox"/>	<input type="checkbox"/>	Appendectomy	_____	<input type="checkbox"/>	<input type="checkbox"/>	Hernia Repair	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy	_____	<input type="checkbox"/>	<input type="checkbox"/>	Oophorectomy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy	_____	<input type="checkbox"/>	<input type="checkbox"/>	Heart Bypass	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cosmetic: _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Removal	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	_____	*please list any other surgical proc*			

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 to our office.

Occupation _____

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Patient Name: _____

Date: _____

Family Health History:

Y	N		Type	Circle	
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure		<input type="checkbox"/>	Paternal Maternal
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease		<input type="checkbox"/>	Paternal Maternal
<input type="checkbox"/>	<input type="checkbox"/>	Stroke		<input type="checkbox"/>	Paternal Maternal
<input type="checkbox"/>	<input type="checkbox"/>	Skin cancer	Type _____	<input type="checkbox"/>	Paternal Maternal
<input type="checkbox"/>	<input type="checkbox"/>	Other cancer	Type _____	<input type="checkbox"/>	Paternal Maternal
<input type="checkbox"/>	<input type="checkbox"/>	Other illness	Type _____	<input type="checkbox"/>	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	
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen swelling	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	Pain-testicles
<input type="checkbox"/>	<input type="checkbox"/>	Ankle Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Heart palpitations
<input type="checkbox"/>	<input type="checkbox"/>	Anxious	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Rash
<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Gland Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Scabbing Wound
<input type="checkbox"/>	<input type="checkbox"/>	Blood in Stool	<input type="checkbox"/>	<input type="checkbox"/>	Growing Lesion	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Breast Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hallucination	<input type="checkbox"/>	<input type="checkbox"/>	Skin Lesion irregular
<input type="checkbox"/>	<input type="checkbox"/>	Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Sputum
<input type="checkbox"/>	<input type="checkbox"/>	Chills	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal thoughts
<input type="checkbox"/>	<input type="checkbox"/>	Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Irregular breathing	<input type="checkbox"/>	<input type="checkbox"/>	Swelling
<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Thirst-excessive
<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Labored breathing	<input type="checkbox"/>	<input type="checkbox"/>	Tired
<input type="checkbox"/>	<input type="checkbox"/>	Cysts	<input type="checkbox"/>	<input type="checkbox"/>	Nasal Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Urination-excessive
<input type="checkbox"/>	<input type="checkbox"/>	Depressed	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Nipple Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss
<input type="checkbox"/>	<input type="checkbox"/>	Ear Pain	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	<input type="checkbox"/>	Eye Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Pain in flank	<input type="checkbox"/>	<input type="checkbox"/>	Wound-non-healing

Response to Sun Exposure: (Circle)

- Do not tan and burn easily
- Tan with difficulty and burn easily
- Tan easily and rarely burn

Eye Color: (Circle one)

- Blue
- Green/Hazel
- Brown

Amount of Sun Exposure: (Circle one)

- Little, none intentionally
- Some
- A moderate amount, I try to tan

Have you ever had skin cancer, if so, when? _____

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Patient Name: _____

Date: _____

Do you take:

Y N

— — Blood Thinner

— — Heart Medication

Y N

— — High blood pressure meds

— — Diuretics (Water Pills)

Y N

— — Diet Pills

— — Aspirin

Do you (or have you ever) taken:

Y N

— — Steroids (cortisone)

— — Herbal supplements

Y N

— — Immunosuppressants

— — Chemotherapy

Y N

— — Vitamin E

Are you allergic to:

Y N

— — Penicillin

— — Other drugs _____

— — Other allergies _____

Y N

— — Novocain

Y N

— — Latex

List medications

Strength/Dose

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)

Nursing use only:

Temp _____ BP _____ HR _____ RR _____ Height _____ Weight _____

1 2 3 4 5

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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 _____