Taylor Theunissen, MD
Aesthetic Plastic Surgery

5233 Dijon Drive
Baton Rouge, LA 70808
Office: 225.218.6108
FAX: 225.223.6010
www.drtplasticsurgery.com

Patient Information

Please Print Clearly

Date: _____

Patient's Full Name: _____
Male: _____ Female: _____ Date of Birth: _____ SS#: _____
Address: _____ City: _____ State: _____
Zip Code: _____ E-mail: _____
Home Phone: _____ Cell Phone: _____
Single: _____ Married: _____ Other: _____ Occupation: _____

Any restrictions for contacting you? No: _____ Yes: _____
Please list restrictions: _____

Reason for visit: _____

How did you hear about Dr.Theunissen? Friend: _____ Relative: _____ Doctor: _____
Other: _____
If you were referred by a specific person, may we thank them? Yes: _____ No: _____

Emergency Contact: _____ Phone Number: _____
Relationship to Patient: _____ Phone Number: _____

Do you have an Advanced Directive? No: _____ Yes: _____

Cosmetic procedures are **NOT** covered by insurance. When scheduling your procedure a deposit will be required. Any remaining balance will be due at your pre-op visit approximately three weeks in advance of your surgery date. If cosmetic fees are not paid in full at that time, your surgery will be canceled. Dr. Theunissen spends a considerable amount of time in describing the elective nature of these procedures. Because you are fully informed of all limitations and risks of the procedure, we do not provide refunds for services already provided.

_____ Date: _____

Signature of Patient or Personal Representative

Confidential Record

Information contained here will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your doctor in decisions regarding your care.

Male: _____ Female: _____ Age: _____ Height: _____ ft. _____ in. Weight: _____

Date of last physical exam: _____ Physician's Name: _____

Primary Care or Referring Physician: _____

Address: _____ Phone: _____

DO YOU HAVE OR HAVE YOU HAD: (CIRCLE)

Please do not leave anything unanswered.

Stroke	YES	NO	Asthma	YES	NO
Cancer	YES	NO	Heart Attack	YES	NO
Tuberculosis	YES	NO	Stomach Ulcers	YES	NO
Leukemia	YES	NO	Kidney Disease	YES	NO
Bronchitis	YES	NO	Keloids/Thick Scars	YES	NO
Epilepsy	YES	NO	Rheumatic Heart Disease	YES	NO
Pneumonia	YES	NO	Bleeding Tendency	YES	NO
Diabetes	YES	NO	High Blood Pressure	YES	NO
Hepatitis/Jaundice	YES	NO	Congenital Heart Disease	YES	NO
Migraine	YES	NO	Nervous Breakdown	YES	NO
Hay Fever	YES	NO	HIV/AIDS	YES	NO
Thyroid Disorder	YES	NO	Sickle Cell Disease	YES	NO
Colitis	YES	NO	Deep Vein Thrombosis	YES	NO
Mitral Valve Prolapse	YES	NO	Sleep Apnea with or without CPAP	YES	NO

Other Medical Conditions not previously listed: _____

_____

Do you wear dentures? YES NO

Do you smoke? YES NO If YES, How much? _____ How many years? _____

Do you drink beer or other alcohol products regularly? YES NO If YES, How much? _____

Confidential Record

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ARE YOU PRESENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS? (CIRCLE)

Please do not leave anything unanswered.

Antibiotics	YES	NO
Seizure Medication	YES	NO
Birth Control Pills	YES	NO
Diabetic medicine	YES	NO
Blood thinner	YES	NO
Thyroid medicine	YES	NO
Diet Pills	YES	NO

List all medications, as well as over the counter medications or supplements: _____

_____

_____

_____

Please list names and dates of your surgeries: _____

_____

_____

List any food or drugs to which you are allergic: _____

_____

Do you have any eye problems? ("dry eye syndrome", glaucoma, detached retina, allergic reactions, etc.)	YES	NO
Do you wear contact lenses or glasses?	YES	NO
Do you bleed excessively from lacerations?	YES	NO
Do you have nose bleeds?	YES	NO
How often? _____		
Do you take aspirin regularly?	YES	NO
How often? _____		

WOMEN ONLY

Are you having regular menstrual cycles?	YES	NO
Date of last menstrual cycle?	YES	NO
Could you be pregnant now?	YES	NO
Do you have a family history of breast cancer?	YES	NO

Date of last **Mammogram:** _____

NOTE: We recommend regular breast and pelvic exams by your personal physician for all adult women.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my physician and/or administrative and clinical staff of Dr. Taylor Theunissen, to disclose general medical information and other protected health information to the following person/persons and/or entities listed below. If no one is listed below, protected health care information will **NOT** be disclosed except in those situations described in the Notice of Privacy Practices for Dr. Taylor Theunissen.

Name and relationship of the person you wish to allow access – for example, your spouse, significant other, parent, child, sibling, neighbor, caretaker, clergy or close friend.

Name of Person or Entity **Relationship**

_____

_____

_____

_____

This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me.

I understand that information used or disclosed pursuant to this authorization may be disclosed by Dr. Taylor Theunissen, and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information to obtain payment from my health insurance company.

_____ _____

Signature of Patient or Personal Representative Print Name of Patient or Personal Representative

_____ _____

Description of Personal Representative's Authority Date

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Signed: _____ Date: _____

Print Name: _____ Phone: _____

If not signed by the patient, please indicate relationship and describe Authority to act:

[ ] parent or guardian of minor patient
[ ] guardian or conservator of an incompetent patient
[ ] beneficiary or personal representative of deceased patient

Patient Name: _____

For Office Use Only:
Signed form received by: _____
Acknowledgement refused: _____

Good Faith efforts to obtain Acknowledgement:

Reasons acknowledgement was **NOT** obtained: _____
_____
_____

ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/LIMITED SPECIAL POWER OF ATTORNEY

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to Taylor Theunissen, MD, LLC and Alireza Sadeghi, MD (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of one or more of the Providers, or their attorney (or other representative) to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against and person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account.

In the event the insurance carrier responsible for making medical payments to Taylor Theunissen, MD, LLC and Alireza Sadeghi, MD for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider and attorney fees and costs. To this end, Provider has exclusive settlement authority.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers or any other person or business that provides healthcare activity services as a "business associate' (including Howard Healthcare Group) under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.
2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.
3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.
4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.
5. The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third-party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name:_____ Date:_____

Patient Signature: _____

Taylor Theunissen, M.D.
5233 Dijon Drive
Baton Rouge, LA 70808

Effective Date of this Notice: July 1, 2013

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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

About This Notice

Information that we create or receive that identifies you or could be used to identify you and describe your physical or mental health, health care, or payment for health care.

We are required by law to maintain the privacy of your Protected Health Information (PHI) and provide you with this Notice. It will tell you about the ways in which we may use and disclose your Protected Health Information. Beginning April 4, 2004, we are legally required to follow the terms of this Notice (or any other Notice in effect) whenever we use or disclose your Protected Health Information. If you have questions about any part of this notice or if you want more information about our privacy practices, please contact the Privacy Office at:

Privacy Officer
5233 Dijon Drive
Baton Rouge, LA 70808
225-218-6108

How Your Surgeon May Use or Disclose Your Health Information

Your surgeon collects health information from you and stores it in a chart and/or a computer. This is your medical record. The medical record is the property of your surgeon, but the information in the medical record belongs to you. Your surgeon protects the privacy of your health information. The law permits your surgeon to use or disclose your health information for the following purposes:

Treatment

If you are being treated by another health provider, we may discuss your case in order to coordinate care between us. The kinds of health care information we may disclose could include your diagnosis, laboratory reports, etc.

Payment

If you are covered by health insurance we may disclose diagnostic and treatment details to your insurance provider in order to obtain payment for services rendered.

Regular Health Care Operations

Your medical records may be randomly inspected by people who conduct quality assurance reviews to ensure that high standards of care are being maintained.

Information provided to you

Notification and communication with family

We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgement in communication with your family and others.

Required by Law

As required by law, we may use and disclose your health information.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: prevention or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and drug Administration problems with products and reactions to medications and reporting disease or infection exposure.

Health Oversight Activities

We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure, and other proceedings.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons Information

We may disclose your health information to coroners, medical examiners and funeral directors.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board of your surgeon's privacy board.

Public Safety

We may disclose your health information to appropriate persons in order to prevent or lessen a serious or imminent threat to the health and/or safety of a particular person or the general public.

Specialized Government Functions

We may disclose your health information for military, national security, prisoner and government benefits, only to authorized federal officials.

Worker's Compensation

We may disclose your health information as necessary to comply with worker's compensation laws.

Marketing

We may contact you to provide appointment reminders or to give you information about other treatments or health-related benefits and services that may be of interest to you.

Change of Ownership

In the event that your surgeons practice is sold or merges with another organization, your health information/record will become the property of the new owner.

Business Associates

Business associates contracted with your surgeon may use/disclose your health information for the practice management, coding and billing services.

Other Uses and Disclosures Require Your Authorization

Uses and disclosures of your Protected Health Information (PHI) that are not described above will be made only with your written authorization. If you provide us with such authorization, you may revoke it at any time in writing, and this revocation will be effective for future uses and disclosures of Protected Health Information. However, the revocation will not be effective for information that we already have used or disclosed in reliance on the authorization.

Your Rights

You have the following rights with respect to your PHI.

Right to Request a Restriction

You have the right to request a restriction on our use and disclosure of your PHI (1) for payment or health care operations; of (2) to individuals such as a family member, other relative, close personal friend, or any other person identified by you, involved with your health care or the payment of your health care. **Although we will consider all restriction requests carefully, we are not required to agree to any requested restriction.** If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you. Requests for restriction must be made in writing to the Privacy Office at the address listed on the first page of this Notice and specify the PHI you want to restrict and how you want to restrict our use and/or disclosure, including to whom you want the restrictions to apply, for example disclosures to your spouse.

Right to Request Confidential Communications

If our disclosure on all or part of your PHI could endanger you, you have the right to request that we communicate with you about your PHI in a different way or at a different location. For example, you may ask that we only contact you at your work address.

These requests must be made in writing to the Privacy Officer at the address indicated on the front page of this Notice and specify: (1) that you want us to communicate your PHI with you in a different way or at different location; (2) the new way or location that you want us to use in our communications; and (3) that the disclosure of all or part of your PHI is the current way and/or at the current location could put you in danger.

We will accommodate all reasonable requests that comply with these requirements.

Right to Inspect and Copy

You have the right to inspect and copy your PHI that we use to make decisions about your treatment and care. However this does not apply to psychotherapy notes or certain other information.

To inspect and copy such PHI, submit your request in writing to the Privacy Office at the address indicated on the front page of this Notice. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed.

Right to Amend

If you believe that your PHI is incorrect and incomplete, you have the right to request that we amend it. To request an amendment, submit your request in writing to the Privacy Office at the address indicated on the front page of this Notice, specifying the requested amendment and the reason(s) that you believe the amendment is necessary.

We may deny your request if it is not in writing or does not include a reason to support your request. We may also deny your request if you ask us to amend information that:

Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

Is not part of the information that you would be permitted to inspect and copy; or is accurate and complete.

If we deny your request you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement or an accurate summary thereof.

Right to an Accounting of Disclosures

You have a right to request an accounting (list) of our disclosures of your PHI other than:

For treatment, payment, or health care operations;

To you about your PHI

Incident to an otherwise permitted use or disclosure;

Pursuant to an authorization by you or your authorized representative.

You should know that most of our disclosures of your PHI fit into one of the above categories and will not be subject to an accounting. There are also, limited exceptions to this right.

To request an accounting, submit your request in writing to the Privacy Office at the address indicated on the front page of this Notice, specifying the time period for which you want us to account, which may not be longer than the prior six years, and may not include dates before April 14, 2003.

An accounting will list the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure. The first accounting you request within a twelve month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

Changes to This Notice

We reserve the right to change this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all PHI that we maintain, including information that was created or received prior to the date of the charge.

If we change this Notice, we will provide you with a copy of the revised Notice in the same manner that you received this Notice. The effective date of this Notice is displayed on the front page of the Notice.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with your surgeon, or with the Office of Civil Rights, U.S. Department of Health and Human Services (OCR). To file a complaint with your surgeon submit it in writing to the privacy Office at the address indicated on the front page of the Notice. Complaints to the OCR must (1) be filed in writing, either on paper or electronically; (2) name your surgeon and describe the acts or omissions believed to be in violation of the HIPAA privacy standards; and (3) be filed within 180 days after when you knew or should have known that the act or omission complained of occurred (OCR may extend this time limit for "good cause"). Any alleged violation must have occurred on or after April 14, 2003 in order for OCR to have authority to investigate. You may, but are not required to, use OCR's Health Information Privacy Complaint Form. To obtain a copy of this form, or for more information about Privacy Standards or how to file a complaint with OCR, contact any OCR office or go to **www.hhs.gov.ocr.hipaa**. You will not be penalized or retaliated against for filing a complaint made in good faith.