Christopher A. Park, MD
Ryan E. Rebowe, MD
The Park Clinic for Cosmetic and Reconstructive Plastic Surgery
3153 Dauphin Street
Mobile, AL 36606
Phone: (251) 445-8888
Fax: (251) 479-7164
info@mprsd.com
www.mprsd.com

Today's Date:

PATIENT INFORMATION

Last Name **First Name** **Middle Initial** **Nickname**

Date of Birth **Social Security Number** **Gender**

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Cell Phone** **Email Address**

Employer **Occupation**

Pharmacy Name/Location **Pharmacy Phone Number**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician **Referring Physician**

Referral Source
___ TV - Station: **____ Established Patient – Name:**
___ Magazine – Name: **____ Internet – Site:** **___ Radio – Station:**
____ Physician – Name: **___ Newspaper:**

EMERGENCY CONTACT INFORMATION

Name **Relationship to Patient** **Phone Number**

Please list all whom we can discuss medical care with

Marital Status **Name of Spouse**

HOW MAY WE CONTACT YOU

May we contact you by email (i.e. appointment reminder)?	**Y**	**N**
May we contact you by text (i.e. appointment reminder)?	**Y**	**N**
May we add you to our email list for specials and promotions?	**Y**	**N**

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient **___ Self (if self, skip this section)** **___ Spouse** **___ Parent** **___ Other**

Last Name **First Name** **Middle Initial**

Date of Birth **Social Security Number**

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Cell Phone** **Email Address**

Employer **Occupation**

Primary Insurance **Policy Number** **Group Number**

Secondary Insurance **Policy Number** **Group Number**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION & ASSIGNMENT OF BENEFITS

I authorize **The Park Clinic for Cosmetic and Reconstructive Plastic Surgery** to furnish my insurance company(s) and/*or* other physician all information, which I may be requested concerning my health. I also assign the claim payments to be made payable to **The Park Clinic for Cosmetic and Reconstructive Plastic Surgery** and/or **Christopher Park, MD or Ryan Rebowe, MD.** Insurance co-payments are due at the time of service. Giving fraudulent insurance information could be considered theft of services. I understand that this account is my responsibility. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay reasonable attorney fees and collection expense. All delinquent accounts bear interest at the legal rate. I agree, in order for the practice to service my account or to collect monies I may owe, **The Park Clinic for Cosmetic and Reconstructive Plastic Surgery**, and or agents may contact me by telephone at any telephone number associated to my account, including wireless telephone numbers, which could result in charges to me. You may also contact be my test messages and by email using the email address I provided.
I understand methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, if applicable.

I/we have read this disclosure and agree that the practice's employees and/or agents, may contact me/us as described above.

Signature of Patient/Responsible Party Date

The Park Clinic for Cosmetic and Reconstructive Plastic Surgery at MPRSD
Christopher A. Park, MD | Ryan E. Rebowe, MD

Patient Name: **Today's Date:**

MEDICAL HISTORY

Specific Reason for Visit

Your Own Personal Medical History (Please circle yes or no for each)

Abnormal Bleeding	**Y**	**N**	**Clotting Disorder**	**Y**	**N**
Acid Reflux/Heartburn	**Y**	**N**	**Cancer**	**Y**	**N**
High Blood Pressure	**Y**	**N**	**Diabetes**	**Y**	**N**
Mitral Valve Prolapse	**Y**	**N**	**Transfusions**	**Y**	**N**
Heart Attack/Disease	**Y**	**N**	**Seizures**	**Y**	**N**
Heart Surgery/Stents	**Y**	**N**	**Sleep Apnea**	**Y**	**N**
Hepatitis/Liver Trouble	**Y**	**N**	**TB**	**Y**	**N**
Stroke	**Y**	**N**	**Epilepsy**	**Y**	**N**
Bleeding Disorder	**Y**	**N**	**Glaucoma**	**Y**	**N**
Anemia	**Y**	**N**	**Ulcer/Hiatal Hernia**	**Y**	**N**
Asthma	**Y**	**N**	**Blood Clots**	**Y**	**N**
HIV/AIDS	**Y**	**N**	**Kidney Problems**	**Y**	**N**
Sickle Cell Disease/Trait	**Y**	**N**	**Current Infections**	**Y**	**N**

Any Other Illness Not Listed?

Please Explain All That You Answered "YES" To

Medications – Please list all medications including Regular Vitamins and Herbal Supplements. Please mark through any medications you are no longer taking.

Medication Name / Dosage / Frequency	**Medication Name / Dosage / Frequency**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Regular Aspirin/NSAID use	**Y**	**N**	**If YES, Why? _____**
Are you allergic to Food Dyes or Tape?	**Y**	**N**	**If YES, What? _____**
Are you allergic to Latex?	**Y**	**N**	
Are you allergic to any medication(s)?	**Y**	**N**	

If YES, What Medication(s) and What Reaction(s) do you have?

Gynecology History (If Applicable)

Number of Pregnancies **Number of Births** **Number of Miscarriages**

LMP **Date of Last Mammogram** **Result**

Did you Breastfeed? **Y** **N**

Any plans for additional pregnancies? **Y** **N**

Previous Surgeries **Date**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Habits

Tobacco	**Y**	**N**	**Amount: _____**	**How Long: _____**
Alcohol	**Y**	**N**	**Amount: _____**	**How Long: _____**
Drugs	**Y**	**N**	**Amount: _____**	**How Long: _____**
Exercise	**Y**	**N**	**Amount: _____**	

Family Medical History

Kidney Disease	**Y**	**N**	**Heart Attack/Disease**	**Y**	**N**
Diabetes	**Y**	**N**	**Tuberculosis**	**Y**	**N**
Cancer	**Y**	**N**	**Abnormal Bleeding**	**Y**	**N**
High Blood Pressure	**Y**	**N**	**Deep Vein Thrombosis**	**Y**	**N**
Anesthesia Issue	**Y**	**N**	**Other Not Listed**	**Y**	**N**

Please Explain All That You Answered "YES" To

Review of Systems

General:	**Weight Gain or Loss**	**Y**	**N**	**Recent Illness**	**Y**	**N**	**Fever/Chills**	**Y**	**N**
Neuro:	**Weakness/clumsiness**	**Y**	**N**	**Tingling/Numb**	**Y**	**N**	**Seizures**	**Y**	**N**
Cardiac:	**Chest Pain**	**Y**	**N**	**Irregular Beat**	**Y**	**N**	**Short of Breath**	**Y**	**N**
Lungs:	**Wheezing**	**Y**	**N**	**Cough**	**Y**	**N**	**Bloody Sputum**	**Y**	**N**
GI:	**Heartburn**	**Y**	**N**	**Nausea/Vomit**	**Y**	**N**	**Diarrhea**	**Y**	**N**
Kidney:	**Dehydration**	**Y**	**N**	**Painful Urine**	**Y**	**N**	**Bloody Urine**	**Y**	**N**
Endocrine:	**Diabetes**	**Y**	**N**	**Hair Loss/Gain**	**Y**	**N**	**Feel Hot/Cold**	**Y**	**N**
Extremities:	**Pain**	**Y**	**N**	**Stiff**	**Y**	**N**	**Disuse**	**Y**	**N**
Skin:	**Rash**	**Y**	**N**	**Lesions**	**Y**	**N**	**Dry/Wet**	**Y**	**N**
Other:	**_____**	**Y**	**N**	**_____**	**Y**	**N**	**_____**	**Y**	**N**

Please Explain All That You Answered "YES" To

Height: _____ **Weight: _____**

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AUTHORIZATION FOR BEFORE & AFTER PHOTOGRAPHS

See below for explanations.

MEDICAL RECORD (required)	IN OFFICE	WEBSITE	PUBLICATIONS
_____	_____	_____	_____
Initial	**Initial**	**Initial**	**Initial**

_____
Date

Medical Record: The use of photographs is essential to the planning and evaluation of surgery. These photographs are a required and permanent part of your medical record and will never be shown to anyone without your consent. These photographs are useful in reviewing your own outcome.

In Office: Dr. Park and Dr. Rebowe are often asked to show before and after photos of patients considering the same surgery. This is voluntary. Names will never be used and identifying features will be avoided whenever possible.

Publications: Dr. Park and Dr. Rebowe as physicians give lectures and write articles/chapters to educate others and photos are used in these. Names will never be used and identifying features will be avoided whenever possible.

I understand that every attempt will be made to represent me and the physician accurately and with integrity and dignity in all representations. I understand that these consents have no bearing on medical care. These releases will remain in effect for 15 years unless revoked in writing.

ACKNOWLEDGMENT OF RECEIPT OF PRIVARY NOTICE

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

_____ _____
Name Date

_____
Signature

The Park Clinic for Cosmetic and Reconstructive Plastic Surgery at MPRSD
Christopher A. Park, MD | Ryan E. Rebowe, MD

FINANCIAL POLICY

This financial policy contains important information about billing and payment for our professional services. It is intended to help us provide the best possible medical care while also controlling administrative costs. It outlines our responsibilities, and those of our patients, with regard to billing and payment of our services.
There will be a $30 charge for each returned check.

INSURANCE CASES
Our practice participates with many health insurance companies and managed care programs. Our billing office will submit a claim for any services rendered to a patient who is a member of one of these plans. Patients must provide all necessary insurance information and complete any forms before leaving the office.
If a patient is a member of an insurance plan with which we do not participate, our office will also file the claim on the patient's behalf; however, the patient will be responsible for any remaining balance not covered by the carrier.
It is the patient's responsibility to make payment at the time of service for any co-payment or co-insurance due. Any services not covered by a patient's insurance plan are the patient's responsibility and the payment in full is expected at the time of service.
Payment for professional services can be made by cash, check, credit card or debit card.
It is the patient's responsibility to provide us with current insurance information and to present an active insurance card at each visit. If the patient does not have insurance coverage or their coverage will not cover the serves being performed, payment in full is expected at the time of the service.
Our staff is happy to help with insurance questions related to a claim that has been filed, or to provide additional information required by the insurance carrier to process the claim. However, patients should direct questions about coverage for specific procedures to a representative of their insurance company's member services department. The phone number for member services is usually on the insurance card.
Each time a payment is made by your insurance carrier you will receive an EOB (Explanation of Benefits) from your insurance carrier. The EOB explains how the insurance carrier paid the claim, as well as, the patient responsibility portion.
You, the patient, have a contract with your insurance carrier. It is important to note that the physician also has a contract with the carrier. It is part of your contract to pay all co-pays, co-insurances, and deductibles. It is part of the physician's contract that we will diligently collect co-pays, co-insurances, and deductibles. Repeated failure to pay the patient portion of a visit will be reported to your insurance carrier.

SELFPAY
20% scheduling fee required to schedule surgery and hold surgery time. Full payment is due 2 weeks prior to procedure. Cancellations prior to 2 weeks will be refunded less 10%, within two weeks nonrefundable, but can be applied to rescheduled procedure less a $250 rescheduling fee.
Fees for anesthesia, OR, and overnight observation are set by the facilities and are estimates only, may change with timing, location, and other variables. If used, these are to be paid directly to providers. The fees can be fully determined once procedure is scheduled. We are trying to provide you with a reasonable estimate but cannot be held responsible for their fees.
Combining procedures can widely alter these estimates due to discounts provided by the facilities. **They must be paid in advance to the facility/anesthesia or the payment discount is not honored and the cost will increase significantly.**

An adult accompanying a child under 18 and/or the parent or guardian of the child is responsible for payment according to the terms described above. Non-emergency treatment for unaccompanied children may be rescheduled unless charges and/or co-pays are made at the time of service.

I have read the above agreement and have received a copy of it. I fully understand and agree to the contents in full of the above policy.

Patient or Legal Guardian Signature	**Date**
Witness Signature	**Date**

The Park Clinic for Cosmetic and Reconstructive Plastic Surgery at MPRSD
Christopher A. Park, MD | Ryan E. Rebowe, MD

Patient Name: **Date:**

COSMETIC INTEREST QUESTIONNAIRE

Filling this out is patient optional**.**

Areas of concerns and interests that you would like discussed or additional information:
Please circle the number(s) of topics you are interested in.

1. Skin care products for texture and pore size, tone, spots
2. Facials, Hydrafacial, Phytofacial
3. Injectables for folds and wrinkles
4. Skin resurfacing – Peels/Lasers/Dermbrasion
5. Eyelash length/texture – Latisse
6. Spider Vein treatment
7. Hair Removal
8. Skin lesions, birthmarks
9. Sagging/Loose skin
10. Eye rejuvenation
11. Cellulite – Cellulze
12. Facial Rejuvenation
13. Neck Rejuvenation
14. Brow Lift
15. Lip Augmentation
16. Nose job/Rhinoplasty
17. Breast Augmentation
18. Breast Lift
19. Breast Reduction
20. Tummy Tuck
21. Liposuction/Smart Lipo/Laser Lipo
22. Buttock Augmentation/Lift
23. Thigh Lift
24. Arm Lift
25. Hand Rejuvenation
26. Vaginal Rejuvenation
27. Tattoo Removal
28. Scar Care products
29. Medical Grade Sunblock
30. Spray Tan – safe, nontoxic, no sun damage
31. Other –

When I look at myself in the mirror, I believe I look:

Younger Than		**True Age**	**Older Than My True Age**	
0	**1**	**2**	**3**	**4**

NOTICE OF PRIVACY PRACTICES

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.

Our practice is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. Our practice is required by law to abide by the terms of this Notice.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Our office is required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. To request a revised notice you may call the office and request that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:
We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered and in order to support the business activities of the practice, including, but not limited to, use by administrative personnel reviewing the quality of the care you receive, employee review activities, training of medical students, licensing, contacting, or arranging for other business activities. We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

Appointment Reminders
We may contact you to provide appointment reminders by phone, email, or text message.
Treatment Information
We may contact you with information about treatment alternatives or other health-related benefits and services.
Disclosure to Department of Health and Human Services
We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation of determination of our compliance with relevant laws.
Family and Friends
Unless you object, we may disclose your medical information to family members, other relatives, or close personal friends when the medical information is directly relevant to that person's involvement with your care.
Notification
Unless you object, we may use or disclose your medical information to notify a family member, a personal representative, or another person responsible for your care of your location, general condition, or death.
Disaster Relief
We may disclose your medical information to a public or private entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts.
Health Oversight Activities
We may use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure, or disciplinary actions, administrative and/or legal proceedings.
Abuse or Neglect
We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.
Legal Proceedings
We may disclose your medical information in the course of certain judicial or administrative proceedings.
Law Enforcement
We may disclose your medical information for law enforcement purposes or other specialized governmental functions.

Coroners, Medical Examiners, and Funeral Directors
We may disclose your medical information to a coroner, medical examiner, or a funeral director.
Organ Donation
If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.
Research
We may use or disclose your medical information for certain research purposes if an Institutional Review Board or a privacy board has altered or waived individual authorization, the review is preparatory to research or the research is on only decedent's information.
Public Safety
We may use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or to the public.
Worker's Compensation
We may disclose your medical information as authorized by laws relating to worker's compensation or similar programs.
Business Associates
We may disclose your health information to a business associate with whom we contract to provide services on our behalf. To protect your health information, we require our business associates to appropriately safeguard the health information of our patients.

AUTHORIZATIONS:
We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time. To request a Revocation of Authorization form, you may contact:

Christopher A. Park, MD and Ryan E. Rebowe, MD The Park Clinic for Cosmetic and Reconstructive Plastic Surgery 3153 Dauphin Street Mobile, AL 36606 251-340-6600

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:
You have the following rights with respect to your medical information:
You may ask us to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.
You have the right to receive communications from us in a confidential manner.
Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.
You have the right to receive an accounting of the of the disclosures of your medical information made by our practice during the last six years (or following December 1, 2008) except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.
You may request a paper copy of this Notice of Privacy Practices for Protected Health Information.
You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please contact:

Christopher A. Park, MD | Ryan E. Rebowe, MD
The Park Clinic for Cosmetic and Reconstructive Plastic Surgery 3153 Dauphin Street Mobile, AL 36606 251-340-6600

If you would like further information regarding your rights or regarding the uses and disclosures of your medical information, you may contact:
US Department of Health and Human Services 200 Independence Ave. SW Washington, DC 20201

THIS NOTICE IS EFFECTIVE AS OF April 14, 2003.

REVISION OF NOTICE OF PRIVACY PRACTICES
We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice at our office and will make paper copies of the revised Notice of Privacy Practices available upon request.