WESTFIELD PLASTIC SURGERY - PATIENT REGISTRATION FORM

DATE _____

PATIENT INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____
First Middle Initial Last
SS# _____ AGE _____ SEX _____ **PRIMARY CARE PHYSICIAN** _____

HOME ADDRESS _____
Street Address City State Zip
HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____

EMERGENCY CONTACT _____
Name Phone # Relationship

EMPLOYER _____
Name Street Address City State Zip Phone #

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Self Employed

IS YOUR VISIT TODAY THE RESULT OF AN ACCIDENT? ☐ Yes ☐ No IF YES, WHAT WAS THE DATE OF YOUR INJURY?_____

(POLICY HOLDER) PRIMARY INSURANCE INFORMATION

INSURED'S NAME _____ DATE OF BIRTH _____ SS# _____

INSURANCE COMPANY NAME _____ (____ **DOES YOUR INSURANCE CARD HAVE "REFERRALS REQUIRED" printed on the Front?)**

WCOMP CASE MANAGER NAME: _____ PHONE NUMBER: _____

A. **Notice of Privacy Practices**. The policies and procedures of Westfield Plastic Surgery are designed to comply with the Health Insurance Portability and Accountability Act of 1996. I agree that the Privacy Notice of Westfield Plastic Surgery has been made available to me.

B. **Authorization to Treat**. I authorize and direct the medical practitioners of Westfield Plastic Surgery and his/her designee to provide medical services and diagnostic services for me as they deem necessary and appropriate. I understand that I have the right to receive information, to request treatment, and to seek a second opinion. Patients 18 years and younger must be accompanied by guardian.

C. **Assignment of Insurance Benefits.** I hereby assign all medical insurance benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to Westfield Plastic Surgery. I understand that I am financially responsible for co-payments, co-insurance, deductibles, and any other balance not paid for by my insurance plan.

The undersigned patient or patient's guardian hereby acknowledges to have read, understood and agreed to conditions set forth in the Notice of Privacy Practices, Authorization to Treat, Assignment of Insurance Benefits, and, if applicable, Medicare Patient's Information.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed name of Patient

ETHNICITY (☐ Black or African American) (☐ Hispanic) (☐ White) (☐ American Indian or Alaskan Native) (☐ Asian) (☐ Other)

Your PHARMACY_____ LOCATION_____

HOW DID YOU HEAR ABOUT US ?? (☐ Doctor If Doctor Referral (Name)_____)

(☐ Family) (☐ Friend) (☐ Radio) (☐ Magazine) (☐ Patient) (☐ Insurance Co. Representative Provider List)

(**Online**- ☐ Google ☐ Westfieldpsc.com ☐ Real Self ☐ Build My Bod ☐ Other) (___ Other_____)

PERSONAL HISTORY

Clinic Name	For Internal Use Only Medical Record #

Full Name	Preferred Name/Nickname	Birth Date	Today's Date

Personal Medical History (Check if you presently have or have had any of the following)

- ☐ Headache
- ☐ High blood pressure
- ☐ Stroke
- ☐ Phlebitis (blood clots)
- ☐ Heart attack
- ☐ Congestive heart failure
- ☐ Chest pain
- ☐ Heart palpitations (irregular heart beat)
- ☐ Heart murmur
- ☐ High cholesterol
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Diabetes
- ☐ Anemia
- ☐ Allergies/hay fever/ chronic sinusitis
- ☐ Cancer
- ☐ Ulcer
- ☐ Chronic diarrhea
- ☐ Constipation
- ☐ Nervous stomach
- ☐ Hepatitis
- ☐ Gallbladder disease
- ☐ Low back pain
- ☐ Arthritis
- ☐ Gout
- ☐ Thyroid disease
- ☐ Dizziness/fainting
- ☐ Seizures/convulsions
- ☐ Alcoholism
- ☐ Depression
- ☐ Nervousness/anxiety
- ☐ Psychiatric disorder
- ☐ Osteoporosis
- ☐ Menstrual disorder
- ☐ Incontinence
- ☐ Prostate disease
- ☐ Sexually transmitted disease
- ☐ Frequent infections
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ Chronic rashes
- ☐ Glaucoma
- ☐ Other – Describe:
- ☐ Other – Describe:

Current Medications: **(Include vitamins/ supplements)** (continued on back)

Drug Allergies **(continued on back)**

Environmental Allergies (such as latex, pollen, foods) (continued on back)

Do you have a living will? ☐ **Yes** ☐ **No**

WOMEN ONLY:

Pregnant ☐ Yes ☐ No

Planning Pregnancy ☐ Yes ☐ No

Using Birth Control ☐ Yes ☐ No

Method: _____

Number of Pregnancies/Births /

Hospitalizations and Major Surgeries (continued on back)

Reason	Year/Age	Reason	Year/Age

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Other	Describe
Heart Disease	☐	☐	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	☐	☐	
Migraine Headache	☐	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	☐	

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Other	Describe
Mental Illness	☐	☐	☐	☐	☐	☐	
Kidney Disease	☐	☐	☐	☐	☐	☐	
Bleeding Disorder	☐	☐	☐	☐	☐	☐	
Osteoporosis	☐	☐	☐	☐	☐	☐	
Epilepsy/ Seizures	☐	☐	☐	☐	☐	☐	
Other: Describe:	☐	☐	☐	☐	☐	☐	
Other: Describe:	☐	☐	☐	☐	☐	☐	
Other: Describe:	☐	☐	☐	☐	☐	☐	

Habits

	How much/How Long			Describe
☐ Tobacco		☐ Caffeine		☐ Sleep problems
☐ Alcohol		☐ Street drugs		

Please list year of last:

Chest X-ray	Mammogram	EKG
Pap smear	Tetanus shot	Cholesterol

Current Medications: (Include vitamins/ Supplements)	

Drug Allergies

Environmental Allergies (such as latex, pollen, foods)

Hospitalizations and Major Surgeries			
Reason	**Year/Age**	**Reason**	**Year/Age**

Westfield Plastic Surgery Center

Name of Patient: _____

Patient Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices: Initial___

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices.

_____ _____
Signature of Patient/Patient Representative Date

_____
Relationship to Patient

Acknowledgement of Receipt of Financial Policy: Initial___

I acknowledge that I have received a copy of Westfield Plastic Surgery Center's financial policy.

_____ _____
Signature of Patient/Patient Representative Date

_____
Relationship to Patient

Documentation of Good Faith Efforts
To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/hospital on _____ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign.
- ☐ Patient was unable to sign or initial because:

_____

Signature of Employee Completing Form: _____

Date Signed: _____

WESTFIELD PLASTIC SURGERY CENTER
9900 NICHOLAS STREET, SUITE 300
OMAHA, NE 68114

CONTACT AUTHORIZATION

Name	Patient Account Number	Date

Westfield Plastic Surgery Center is committed to protecting our patient's privacy. Without authorization, messages left on answering machines, voicemail, or with other individuals will be limited to the caller's name, that they are calling for Westfield Plastic Surgery Center and the phone number to call. If you prefer that more complete information be provided, please fill out the form below. This authorization will remain valid for one year unless revised by you.

Please contact me as follows:

Home/Cell Phone ( )_____ *Leave message-appointment date and time* *Leave message-provide name/phone number* *Leave message-lab/test results, meds, changes* *Do not leave message of any kind* *Email Address_____*	If you have authorized us to leave a message, please indicate specifics below: *Voicemail/answering machine only* *Whoever answers the phone* *Only the following individuals:* _____ _____
Work Phone ( )_____ *Leave message- appointment date and time* *Leave message-provider name/phone number* *Leave message-lab/test results, meds, changes* *Do not leave message of any kind*	Any written communication will go to the address on file. Please verify that we have the correct address listed. Any changes please contact us at 402.829.6384.

Please sign below to authorize or verify the above contact information. Changes to this form will require a new form to be completed.

Date	Patient Authorization Signature (or parent or legal guardian) OR Staff Verification

WESTFIELD PLASTIC SURGERY CENTER
DR. NAGI T. AYOUB M.D., FACS
9900 NICHOLAS ST. SUITE 300
OMAHA, NE 68114

CONSENT TO OUTPATIENT SERVICES

Authorization for Medical Treatment: I authorize the physician(s), therapist(s), their assistants and/or designees in charge of my medical care to administer any treatment as may be necessary or advisable in my diagnosis and treatment. This authorization includes, but is not limited to, routine diagnostic procedures, rehabilitation therapy, laboratory tests, x-rays, and transfusions of blood or blood products. I also authorize copies of the medical records to be released to other physicians and healthcare facilities as deemed necessary by any physician(s) or therapist(s) whose care I am under. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to results of examination and treatment received at this Facility(s). I acknowledge that my care is under the direction of my treating physicians(s) and the Facility(s) will follow the instructions of my physician(s) in the provision of said care.

Patient Rights: I, the undersigned, have received a separate document informing me of my rights and responsibilities as a patient.

Personal Valuables: Facility(s) shall not be liable for my loss of or damage to any personal property.

Assignment of Facility Benefits: I hereby assign all insurance benefits and/or Medicare/Medicaid benefits to Facility(s) and authorize direct payment to the Facility(s). This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. This assignment also includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgement for personal injuries caused by a third party. I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be valid as the original.

Assignment of Professional Benefits: I hereby assign all insurance benefits and/or Medicare/Medicaid benefits to all physician(s), therapist(s) and and/or medical professionals providing services to me and authorize direct payment to physician(s) and therapist(s). This assignment also includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgement for personal injuries caused by a third party. I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.

Authorized Representative: I hereby authorize Facility(s), its agent and representatives to act on my behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for services provided to me by Facility(s).

Statement of Responsibility: I understand that I am financially responsible to the Facility as the patient, parent, guardian, conservator or insured for all out of pocket expenses. Charges may include medical insurance deductibles, coinsurance, or out of pocket expenses. I authorize Facility(s) or physician(s) to access and review my credit report for purposes related to billing or collection of accounts payable to Facility(s) or physician(s).

Authorization to Release Information to Insurance Company/Third Party Payor: I hereby authorize Facility(s), any authorized healthcare provider, including Veteran's Administration or governmental hospital, any insurance company or any other person, institution, or organization to release my medical record to any person, corporation, worker's compensation carrier, governmental agency (or representative thereof) which is, or may be, liable under any contract or governmental program to this Facility(s), the patient, or a family member for all or part of the Facility(s) charge. This Facility(s) will endeavor to protect the confidentiality of my medical records. However, this Facility(s) shall not be liable by reason of its release of said medical records or any part thereof when responding in good faith to an apparently valid release.

Noncovered Medicare/Medicaid Services: The Medicare and Medicaid Programs have certain inpatient, outpatient and observation hospital admissions that are excluded from coverage, including but limited to: cosmetic surgery, non-medically dental surgery, routine diagnostic workups, routine physical exams, and oral drugs. I acknowledge I am financially responsible for all charges incurred if my medical chart indicates my admission is for any of the foregoing treatments.

Please initial: _____ I acknowledge receipt Notice of Privacy Practices.

Please initial: _____I acknowledge that I was provided with information about my patient rights and responsibilities.

The undersigned certifies that he or she has read the foregoing, is the patient, patient's guardian, power of attorney, parent or is duty authorized by or on behalf of the parent to execute the above and accept its terms.

Patient's Signature/Parent if Minor/Power of Attorney/Guardian	Relationship	Date
Responsible Party's Signature (If Not Same as Patient or Parent)	Insured's Signature	
Witness Signature	Patient Unable to Sign Consent Because	

Cosmetic & Reconstructive Plastic Surgery

WESTFIELD
Plastic Surgery Center

Patient Authorization and Release

for Dr. Nagi T. Ayoub MD PC's use of Quotation

I, _____, hereby give Dr. Nagi Ayoub the absolute and irrevocable right, license, and permission to utilize and post on Dr. Nagi Ayoub's patient website or any other marketing materials or media of Dr. Nagi Ayoub, my photograph and/or video in whole or part in connection with cosmetic and/or reconstructive surgery.

I release, discharge, and hold harmless Dr. Nagi Ayoub from any and all claims and demands arising out of or in connection with the use of, photograph, and/or video, including, but not limited to, any and all claims of libel, slander, or invasion of privacy.

This authorization and release shall also inure to the benefit of the legal representatives, licensees, employees, agents, and assigns of Dr. Nagi Ayoub and his staff.

I have read the foregoing and fully understand the contents thereof.

Patient's signature _____ Date _____

Printed name _____ Date _____