



Patient Introduction

Dear Patient,

I would like to welcome you to my Plastic and Reconstructive Surgery Practice. Office hours are Monday through Friday from 9am to 4pm. My top priority is to give you the best care possible. I believe in high quality care through personalized treatment plans and patient education. To assist me in this, it is important that you are an active participant in your healthcare and are aware of the following office policies:

- ❖ My practice is limited to plastic and reconstructive surgery. I do no primary care. Please continue to see your Primary Care Physician for your non-plastic/reconstructive medical needs.
- ❖ Out of respect for you and our other patients, we work very hard to stay on schedule. To ensure I have adequate time to spend with you at your appointment, it is very important that you arrive on time. The later you arrive, the less time I will have with you. If there is not enough time, you may be asked to reschedule your appointment. If you are running late, please call our office to let us know.
- ❖ We understand that occasionally appointments are forgotten, so as a courtesy, an appointment reminder call will be made 1-2 days before your scheduled visit. Our office requests 24-hour notice to cancel or reschedule an appointment. If you do not call to cancel or reschedule your appointment, a fee of \$50 may be charged. Reason being, a missed appointment not only delays your evaluation, but it also takes up an appointment time when another patient could have been seen.
- ❖ Your insurance provider (such as Blue Care Network, HMO plans, etc) may require that you get a referral from your Primary Care Physician. If so, it is *your* responsibility to obtain the referral. If we do not receive your referral by your appointment time, your appointment will have to be rescheduled.
- ❖ As a courtesy, when dealing with insurance related care, we contact your insurance company and verify your benefits. Keep in mind, however, there is a possibility your insurance plan could require a portion due by you. We try to ensure that all details and arrangements are addressed, but ultimately, it is *your* responsibility to know the terms of your insurance policy. Please understand that co-payments are due at the time of service. We accept cash, check, and debit/credit Visa, Mastercard, or Discover.
- ❖ In case of an urgent problem, I can be reached after hours by calling the office phone number. This service is provided for *established patients only* for urgent matters during non-office hours. Please refrain from using this service for anything other than an actual urgency. In the event of a life-threatening emergency, please go to your local hospital's emergency room. Please also note that I do not call in prescription refills over the weekend.
- ❖ Lastly, because of the increasing requirement for paperwork from employers, insurance companies, lenders, etc. we charge a \$15 processing fee for any disability or leave-of-absence documents needed within the first 3 months of your initial visit. Your paperwork will be promptly completed within 5-7 business days upon receipt of payment.

I hope that this information will serve as the basis for a dedicated and trusting relationship. I look forward to meeting you at your future appointment.

Sincerely,

M. Azhar Ali, M.D., F.A.C.S.



Patient Demographic Information

Name (Last, First, M.I.) _____ Birth Date _____

Address _____

City _____ State _____ Zip _____

Primary Phone # _____ Alternate Phone # _____

E-mail _____ SS# _____

Sex: Male Female Occupation _____

Circle One: Single Married Separated Divorced Widowed Minor

Pharmacy _____ Pharmacy Phone # _____

Pharmacy Crossroads & City _____

Insurance Information

Insurance Company _____

Insurance ID # _____

Group # _____

Subscriber's Name _____

Subscriber's Date of Birth _____

Subscriber's Employer _____

Subscriber's Relation to Patient _____

Secondary Insurance _____

Emergency Contact

Name _____

Phone # _____

Relation to Patient _____

Responsible Party For Patients Under Age 18

Name _____

Phone # _____

Relation to Patient _____

Patient/Legal Guardian Signature

Date



Patient Demographic Information

How did you hear about Dr. Ali?

Physician Referral

▪Please tell us the referring physician's name, phone number and city

Former/Current Patient

▪Please tell us the patient's name _____

Internet

▪Which internet search engine did you use?

Google Yahoo Bing Vitals.com Healthgrades.com Other _____

Other Source

▪Please be specific _____

Who may we discuss and/or release your medical information to?

Name _____ Phone _____

Relation to you _____

Name _____ Phone _____

Relation to you _____

Patient/Legal Guardian Signature

Date



Reviewed by Dr. Ali _____

Patient Health History

(please fill out completely - if more room is needed, continue on back of paper)

Patient Name _____

Age _____ Height _____ Weight _____

Please explain the reason for your visit today _____

Please note: *Gathering race, ethnicity, and language information is now a federal requirement mandated by CMS for Medicare and Medicaid services*

Race (check all that apply):

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Middle-Eastern
- Native Hawaiian or Other Pacific Islander
- White
- Other: _____

Ethnic Background: _____

Languages Spoken: _____

Allergies (please include reaction)

Drug Allergies:

Non-Drug Allergies (such as latex, dyes, food, seasonal):

Medications (include dosage and frequency)

Please list all prescribed, over-the-counter, and supplements you are currently taking:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

10. _____ 11. _____ 12. _____



Reviewed by Dr. Ali _____

Patient Health History

Medical Problems (please check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Acid Reflux/Heartburn | <input type="checkbox"/> Depression | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Anesthesia Reaction | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Anxiety/Nervousness | <input type="checkbox"/> Epilepsy/Seizers | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> New or Changing Skin Lesion |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bi-Polar Disorder | ▪ _____ | <input type="checkbox"/> Previous Head Injury |
| <input type="checkbox"/> Bleeding Disorder: | <input type="checkbox"/> Hepatitis Type ____ | <input type="checkbox"/> Skin Disease |
| ▪ _____ | <input type="checkbox"/> Hernia | ▪ _____ |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Herpes Simplex/Fever Blisters | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Breathing Difficulties | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer: | <input type="checkbox"/> HIV/AIDS | ▪ _____ |
| ▪ _____ | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Vision Problems |
| | | ▪ _____ |

Previous Surgeries (please include year of surgery)

Social History

Tobacco Use? ____ If yes, how much/often? _____

Consume Alcohol? ____ If yes, how much/often? _____

Illegal Drug Use? ____ If yes, how much/often? _____

Exercise? ____ If yes, how many times a week? _____

Special Diet? ____ Please explain _____

For Women Only

Date of most recent mammogram _____

Results _____

of pregnancies _____

of children _____

Patient/Legal Guardian Signature

Date



HIPAA Consent

(Notice of Patient Privacy Practices Effective April 1, 2003)

I consent to the use and/or disclosure of my "protected health information" by M. Azhar Ali, MD FACS, for the purpose of providing treatment to me and obtaining payment for health care operations.

I understand that I have the right to request a restriction as to how my protected health information is disclosed to carry out treatment, payment, or health care operations of the practice. Dr. Ali is not required to agree to the restrictions that I may request. However, if Dr. Ali agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent in writing at any time, except to the extent that Dr. Ali has taken action in reliance on this consent.


My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, from another health care provider, and my employer or a health care clearing house. This protected health information relates to my present or future physical or mental health or condition and identifies me, or there is a reasonable chance the information may identify me.

I understand I have a right to review Dr. Ali's Notice of Privacy practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in healthcare operations of Dr. Ali's practice. The full Notice of Privacy Practices can be obtained by requesting a copy at the front desk.

The Privacy Practices also describes my rights and Dr. Ali's responsibility to protect my Personal Health Information. Dr. Ali reserves the right to revise or amend the Notice of Privacy Practices. Any revision or amendment will be effective for all records, past, present, and future. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy or by asking for one at the time of my next appointment.

Patient/Legal Guardian Signature

Date



amae Patient Consent & Authorization

The undersigned hereby makes the following Acknowledgements and Agreements regarding medical treatment, insurance benefits, financial responsibility and release of information to be provided by M. Azhar Ali, M.D. F.A.C.S., or associates or assistants to the patient whose name appears below.

CONSENT FOR EXAMINATION: I understand that medical treatment may be necessary for the patient by M. Azhar Ali, M.D. F.A.C.S., or associates or assistants.

I understand the examination procedures will be explained to me and I shall consent to the rapid, partial or complete medical examination of the parts of my body I show to the examiner. I understand that the examination results will be provided to me with recommendations. The responsibility for any follow-up examinations to check abnormalities found and treated, lies with me and not with the physician. I hereby release my examiner from all responsibility in connection with this examination.

CONSENT FOR TREATMENT: I understand that medical treatment is necessary for the patient by M. Azhar Ali, M.D. F.A.C.S., or associates or assistants. I hereby authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in judgment of the physician. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments.

INSURANCE BENEFITS: As a courtesy to patients of M. Azhar Ali, M.D. F.A.C.S., acceptable insurance claims will be processed. I hereby authorize my insurance benefits to be paid directly to M. Azhar Ali, M.D. F.A.C.S. I am financially responsible for all office visit charges which are payable at the time of service, all deductibles, coinsurance (co-pay), and non-covered and/or disallowed services by Medicare, Blue Cross Blue Shield, Medicaid, Private Insurance or collection costs, court costs and reasonable attorney fees. This also applies to co-pays or deductibles towards surgery or pathology costs.

NO INSURANCE BENEFITS: For patients with NO insurance, I acknowledge I am responsible for all charges for services and payment is expected at the time of service unless arrangements are made in advance for a payment plan. Patients are encouraged to discuss fees with the finance department of the practice prior to any office visit, major medical or surgical procedure.

INSURANCE CHANGES: Please be advised that it is the patient's responsibility to inform our office of any insurance or address changes promptly. In the event that the wrong insurance is billed it will be the patient's responsibility for payment.

BLUE CARE NETWORK AND ALL HMO PLANS: Please be advised that it is the patient's responsibility to obtain a written referral prior to all scheduled office visits.

RELEASE OF INFORMATION: I hereby authorize M. Azhar Ali, M.D. F.A.C.S., to release any information in the course of my examination or treatment as may be needed to process my insurance claims and to inform my private physician as to my course of treatment.

I have read the above Acknowledgements and Agreements and fully understand the same.

Patient/Legal Guardian Signature

Date