PATIENT REGISTRATION

First name _____ Last name _____ M.I. _____ ○ M ○ F

Street Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Social Security Number _____ Date of Birth _____/_____/_____ Age _____

PRIMARY INSURANCE (complete ONLY for non-cosmetic procedures)

Policy Holder Name _____ Social Security Number _____

Date of Birth _____/_____/_____ Relationship to Patient _____ Home Phone (if different from Pt.) _____

SECONDARY INSURANCE

Policy Holder Name _____ Social Security Number _____

Date of Birth _____/_____/_____ Relationship to Patient _____ Home Phone (if different from Pt.) _____

Please tell us how you heard about our office: _____

Would you like to be contacted regarding special promotions by : ☐ mail ☐ Email

May we leave messages at your home regarding your care: ☐ yes ☐ no

It is the practice of Nicholas R. Husni, M.D., Inc., to collect cosmetic consultation fees at the time of service or to bill your insurance company with regards to any procedure that is considered to be medically necessary, however in the event that said insurance company should deny the claim it becomes the responsibility of the patient to make payment or payment arrangements within 90 days of the insurance companies denial. I authorize the release of any medical information necessary to process my insurance claim. I subsequently authorize payment of medical benefits directly to Nicholas R. Husni, M.D., Inc. By signing this agreement I acknowledge the financial responsibility of Nicholas R. Husni, M.D., Inc. and myself.

Signature of Responsible Party _____ Date _____/_____/_____

PATIENT MEDICAL HISTORY

Patient Name: _____

In Case of Emergency Contact: _____

Relationship: _____ Phone Number: _____

PRESENT MEDICAL CONDITION

Medication Allergies: _____

Current Illnesses Being Treated for: _____

Current Medications (including vitamins):

Do you smoke? ☐ yes ☐ no If yes how much? _____

Do you drink or use illegal drugs? ☐ yes ☐ no If yes how often? _____

Are you or do you think you might be pregnant? ☐ yes ☐ no

Date of last mammogram: _____ /_____ /_____

List all previous operations:

In the event of an emergency do you object to receiving a "screened" blood transfusion? _____

Have you ever had any of the following conditions or diseases?

- ☐ Heart Disease
- ☐ Prolapsed Mitral Valve
- ☐ Emphysema or Asthma
- ☐ Chronic Bronchitis
- ☐ Kidney Disease
- ☐ Bowel Disease
- ☐ Circulation Problems
- ☐ Diabetes
- ☐ Glaucoma
- ☐ HIV or AIDS
- ☐ Emotional Problems
- ☐ Abnormal Scarring
- ☐ History of Cold Sores
- ☐ Rheumatic Fever
- ☐ High Blood Pressure
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Ulcer
- ☐ Bleeding Disorder
  Anemia
- ☐ Epilepsy or Seizures
- ☐ Thyroid Disorder
- ☐ Cancers or Tumors
- ☐ Chronic Infection
- ☐ Radiation Treatments

I have completed this medical information form to the best of my knowledge and acknowledge that all the information is true.

_____ _____ /_____ /_____

Signature Date

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.

If you have any questions about this Notice please contact our privacy representative:

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry our treatment, payment or health care operations and for the other purposes that 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 that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked to sign a consent form. Your information may be used by the physician, the office staff and others outside of the office that are involved in your care and treatment for the purpose of providing healthcare services to you. Your protected health information may be used and disclosed to pay your health care bills and to support the operation of the physicians practice.

Following are examples of the types of uses and disclosures of your protected health information that the physician's office is permitted to make.

- **Treatment**
- **Payment**
- **Healthcare Operations**

Other permitted and required uses and disclosures that my be made with your consent, authorization or opportunity to object:

Other permitted and required uses and disclosures that may be made with your consent, authorization or opportunity to object:

- **Others involved in your Healthcare** (ie; family members, relative, others identified by you; if you are unable to agree or object, we must disclose such information as necessary; use in assistance with disaster relief efforts).
- **Emergencies**
- **Communication barriers**

Other permitted and required uses and disclosures that may be made without your consent, authorization or opportunity to object:

- **Required By Law**
- **Public Health**
- **Communicable Diseases**
- **Health Oversight**
- **Abuse or Neglect**
- **Food and Drug Administration**
- **Legal Proceedings**
- **Law Inforcement**

- **Coroners, Funeral Directors and Organ Donation**
- **Research**
- **Criminal Activity**
- **Military Activity and National Security**
- **Worker's Compensation**
- **Inmates**
- **Required Uses and Disclosures**

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights:

- **You have the right to inspect and copy your protected health information**
- **You have the right to request a restriction of your protected health information**
- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location**
- **You may have the right to have your physician amend your protected health information**
- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information**
- **You have the right to obtain a paper copy of this notice from us**

COMPLAINTS

- You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our private contact of your complaint.
- You may contact our office at (216) 264-7800 or 29001 Cedar Road, Suite 300, Lyndhurst, Ohio 44124 for further information about the complaint process.

This notice was published and becomes effective May 3, 2017

_____ _____ /_____ /_____

Signed Acknowledgement of Receipt

Nicholas R. Husni

29001 Cedar Road, Suite 300
Lyndhurst, Ohio 44124

PATIENT PHOTOGRAPHIC CONSENT

I, being of lawful and legal age, do hereby authorize my physician and/or his assistants to take photographs of me; these photographs will be included as part of my medical record and related to my medical care. I certify that I have received lawful and due consideration therefore. I understand that these photographs will be kept confidential, and will remain in my patient chart forever.

I hereby grant permission for the use of any of my medical records including illusions, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

_____ _____ /_____ /_____

Patient Signature Date

_____

Witness Signature

I am legal parent or guardian of _____ who is a minor, and do grant authorization, subject to all conditions stated above.

Nicholas R. Husni

29001 Cedar Road, Suite 300
Lyndhurst, Ohio 44124

PATIENT CONSENT FOR USE OF CREDIT CARDS, DEBIT CARD, AND FINANCING DISCLOSURE OF PROTECTED HEALTH INFORMATION

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.

Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Nicholas R. Husni, M.D. to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment.

_____ I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.

_____ I agree that this non credit card challenge agreement is irrevocable.

_____

Signature of Patient or Legal Guardian

_____ _____ /_____ /_____

Print Patient's Name Date

Nicholas R. Husni

29001 Cedar Road, Suite 300

Lyndhurst, Ohio 44124