

Please complete entire form

Patient Name: (Last) _____ (First) _____ (M) _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ Age: _____ Sex: M F Social Security #: _____

(If Using Insurance this is required)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Marital Status: _____ if married spouses name & number: _____

Patient Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

How did you hear about us? _____ Email: _____

How would you like to receive appointment reminders? *(Circle one)* **Text Message** **Email** **Phone Call**

If we are billing your insurance company, please complete the following:

Primary Insurance Co: _____ Insurance Phone: _____

Policy/ID#: _____ Group: _____ Employer: _____

Policy Holder: _____ DOB: _____ SSN: _____

Secondary Insurance Co: _____ Insurance Phone: _____

Policy/ID#: _____ Group: _____ Employer: _____

Policy Holder: _____ DOB: _____ SSN: _____

STATEMENT OF FINANCIAL RESPONSIBILITY

Alpine will bill my insurance. I hereby authorize Alpine to bill my insurance company or other third parties responsible for my medical charges. I also authorize Alpine to release any medical information that may be requested by my insurance company to help with the process of my claims. I authorize and request that payment be made directly to Alpine Plastic & Reconstructive Surgery or Alpine Surgical Center, LLC for all medical and surgical services. I understand that I am responsible for any balance not covered by my insurance company.

Signature of Patient/Responsible Party/Legal Guardian Relationship to Patient Date



Medical/Surgical History

Patient Name: _____ Today's Date: _____

Age: _____ Height: _____ Weight: _____ Last Physical Exam: _____ Primary Care Dr: _____

Have you had the following?

- | | | | | | | | | |
|------------------------------|-----------------------------|------------------------|------------------------------|-----------------------------|-----------------------|------------------------------|-----------------------------|--------------------|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Diabetes | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Stroke | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Stomach Problems |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Hypoglycemia | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Seizures | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Bowel Problems |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Thyroid Disorder | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Neurological Problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Back Trouble |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Heart Disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Headaches | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Arthritis |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Chest Pain | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Shortness of Breath | <input type="checkbox"/> YES | <input type="checkbox"/> NO | TMJ |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Heart Murmur | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Asthma | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Cancer |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Palpitations | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Sleep Apnea | <input type="checkbox"/> YES | <input type="checkbox"/> NO | MRSA |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Rheumatic Fever | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Liver Problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Glaucoma |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Blood Clots (factor 5) | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Kidney Problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Tuberculosis |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Anemia | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Hepatitis | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Depression/Anxiety |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | High Blood Pressure | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Bladder/Prostate | <input type="checkbox"/> YES | <input type="checkbox"/> NO | History of falls |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Cold/Cough/Fever | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Other _____ | | | |

List all medications that you are currently or have taken in the last 6 months (*prescription and non-prescription*):

Medication(s) (ESPECIALLY ASPRIN):	Amount:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all drug allergies: _____

Do you take herbal supplements (*especially Gingko, Ginger, Garlic, St. John's Wort*)?: _____

Do you take vitamins (*especially C, E, Fish Oils*)?: _____

Do you smoke/E-Cig/Vape? **YES NO** If **YES**, how much: _____ How long? _____ Quit how long ago? _____

How much caffeine do you drink? _____ Alcohol? _____

Do you exercise? **YES NO** If **YES**, how often? _____

Do you have (*circle all that apply*): **LOOSE, FALSE, CHIPPED TEETH / CONTACT LENSES / BODY PIERCINGS**

List all surgeries that you have had (*Include Plastic Surgery*):

Is there any possibility that you may be pregnant? **YES NO** How many Pregnancies: _____ Births: _____

Did you breast-feed in the past? **YES NO** How long? _____

Have you or anyone in your family ever had unusual reactions to anesthesia? **YES NO**

Do you have an advanced directive? **YES NO** would you like info about advanced directives? **YES NO**

If the patient is a child was he/she (*circle all that apply*): **PREMATURE / BREATHING PROBLEMS / IMMUNIZATION PROBLEMS**

NOTE: Please stop aspirin products and other blood thinners 2 weeks prior to surgery or discuss with the doctor.

PATIENT CONSENT TO TREATMENT AND FINANCIAL RESPONSIBILITY

The undersigned, as either (a) the Patient receiving care by Alpine Plastic & Reconstructive Surgery, P.C. or its physicians or medical staff (collectively "Alpine") or by Alpine Surgical Center, LLC or its nursing and other personnel (the "Facility") or (b) the legally authorized representative or responsible financial guarantor of the Patient, hereby makes the following consents, understandings, and agreements on my own behalf and on behalf of the Patient, in partial consideration of health care services to be provided to the Patient by Alpine, by or in the Facility, or by their respective medical staffs:

Consent for Services: I hereby give consent to Alpine and the Facility, and their respective medical staff, contractors, physicians, and employees to provide health care services to the Patient and to administer physician orders and related medical care, tests, studies and/or services for the benefit of the Patient for this visit and any subsequent visits. Patient will inform Alpine and its medical staff of all medications being taken and will discontinue use of medications which are not ordered or approved by Alpine or its medical staff as reflected in Alpine's medical records for Patient. I understand that there is a risk of substantial and serious harm involved in such health care services, and I accept such risk in the hope of obtaining beneficial results from such services. No promises or guarantees of any particular outcome or successful result have been made.

Cosmetic Surgery: I understand that certain medical services and procedures, including but not limited to elective cosmetic surgery procedures, are generally not covered or otherwise entitled to benefits under individual or group welfare benefit plans, including insurance plans or products, that I may have or be entitled to benefits under "Uninsured Procedures".

Fees: Due to the wide variety of patient medical conditions and the nature of the cosmetic, surgical and reconstructive services Alpine physicians treat, Alpine and Facility are generally unable to estimate in advance the fees or charges which might be incurred for your treatment. The fees of Alpine and Facility are based upon its reasonable and customary fee schedule. I understand and agree that, if and to the extent Alpine has quoted any fee reduction or other discount for multiple surgical procedures or other health care services, any such fee reduction or discount is intended to, and shall, apply solely to uninsured procedures. Solely, with respect to uninsured procedures, the fee quoted by Alpine includes (i) the physician fees of Alpine (including usual and customary post-operative visits), (ii) the fee payable by patient to the Facility and (iii) the fee payable by patient to Anesthesia. In all other cases, Patient is directly responsible for payment of the Facility fee to Facility and the Anesthesia fee to Anesthesia. Fees do not include, and Patient is solely responsible for, fees or charges of any other health care providers or facilities which provide items or services to patient (for instance, if patient is transferred in emergent circumstances).

Payment and Scheduling Policies: All co-payments, deductibles, co-insurance, and/or charges for non-covered services are due and payable on or before the time of service. I understand that it is my responsibility to know the provisions of my insurance policies, what services are covered and which providers, facilities or locations are preferred or within network. A list of insurances accepted by Alpine and the Facility is available upon request.

Medical Non-Insured Patients: A \$250.00 payment is due at the first appointment for non-surgical consultations. Surgical consultations will be required to make a \$1000.00 payment at the first appointment. Patient and the undersigned, if other than the patient, remain responsible for any remaining balance for items or services rendered in addition to consultation.

All patients: When scheduling a surgery date you are required to set up a pre-operative appointment. Your pre-operative appointment should be scheduled at least two weeks prior to your surgery date. If you do not show up for your pre-operative appointment you will be taken off of the surgery schedule.

- Payment in full or insurance company pre-authorization is required at the time of your pre-operative appointment to secure your surgery date and time. Methods of payment accepted: Cash, Money Order, Cashier's Check, Travelers Check, Visa, or Master Card. No personal checks will be accepted. Once you have secured a surgery date and time, a \$500.00 cancellation fee will be applied. This fee is non-refundable. If you are scheduled for a no charge procedure or touch up procedure and cancel the procedure within one week of your surgery date a \$500.00 rescheduling fee will be charged.

Relationship of Providers: I understand that (a) Alpine provides professional medical services (including but not limited to plastic and reconstructive surgery services) of physicians licensed under the Utah Medical Practice Act, (b) the Facility provides outpatient surgery center facility services (e.g., nursing services, services of technical personnel and other services related to the surgical procedure, drugs, biological, surgical dressings and administrative, recordkeeping and housekeeping items and services), and (c) anesthesia services are provided by an independent anesthesiologist and/or certified registered nurse anesthetists under the supervision of the independent anesthesiologist (collectively, "Anesthesia"). Alpine, the Facility and Anesthesia are legally separate and independent providers.

Release of Information: Alpine and the Facility are each required by law to make and keep records of the Patient's medical treatment. Both Alpine and the Facility safeguard those records and use and disclose such records and the information they contain only in accordance with applicable state and federal privacy laws. Such uses and disclosures are described in detail in Alpine's and the Facility's respective Notice of Privacy Practices, which may be amended from time to time. I understand that either the Patient or I may ask to see a copy of the current notice at any time.

Insurance/Assignment of Benefits: Any and all benefits from insurance companies and other third party payors that are payable to the Patient, or on behalf of the Patient for health care services and related payments for services rendered or provided to the Patient are hereby transferred and assigned to Alpine and/or the Facility, as the case may be, for the exclusive purpose of paying for charges associated with the health care services provided to the patient by Alpine or the Facility. I understand and intend that all insurance companies and other third party payors will pay benefits directly to Alpine and/or the Facility in payment of their charges and the charges of any other health care providers for whom either Alpine or the Facility is authorized to bill in connection with health care services provided to the patient.

- I understand that I am responsible for complying with the pre-authorization and other requirements of any insurance policies which provide, or may provide, coverage for services rendered or provided by Alpine and/or the Facility, and that I am responsible for any balances remaining after third party payments, if any, are received. Alpine and/or the Facility will file insurance claims with insurance companies and other third party payors for any procedures which are likely to be covered under patient's insurance, so long as I furnish proof of coverage and related insurance benefits information at or prior to my pre-operative appointment.

Financial Responsibility: Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay for all health care services rendered or supplies provided to the Patient by Alpine and/or the Facility including but not limited to any amounts not paid by any insurance company or other third party payor (excluding any contract discounts agreed upon in writing by Alpine and/or the Facility with the applicable third party payor). Patient and the undersigned, if other than the patient, remain responsible for all co-payments, deductibles, co-insurance, and/or non-covered services regardless of amount paid by insurance or third party payor. Should collection become necessary, the responsible party agrees to pay an additional 25% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court cost. A service charge may be collected in connection with any check or other instrument tendered by the Patient or the undersigned but returned unpaid.

Patient's Certification: I authorize any holder of medical or other information about me to release to the Social Security Administration, other intermediaries or carriers, the State, or any insurance company or other payor any information needed to process a claim for this or any related service. I request that payment of authorized charges be made on my behalf directly to Alpine and/or the Facility for its charges and for any charges of physicians or other providers for whom Alpine and/or the Facility is authorized to bill in connection with its service.

Certain Financial Relationships: Dr. Barnett is the owner of the Facility and therefore has a "financial relationship" with the Facility for purposes of Utah Code § 58-67-801. Alpine patients may choose any surgery facility for the purpose of having the medical services and procedures performed. Alpine physicians are only able to perform surgical procedures in hospitals or other health care facilities in which they have medical staff privileges and which are otherwise medically appropriate for the services or procedures.

Entire Agreement: Patient and the undersigned, if other than the Patient, each jointly and severally agree that, except for the most recent written fee or price quote by Alpine to Patient for uninsured cosmetic surgery procedures (which price quote is incorporated herein by specific reference), this Agreement is a final and complete expression of the agreement between the parties and no other terms or conditions, regardless of whether written or verbal, are or shall be a part of this Agreement.

The undersigned signs this document either as the Patient, or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient, or responsible financial guarantor of the patient (and as an accommodation to patient and for other legally adequate consideration), I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I indicate my understanding by signing below. I understand that I am entitled to request and obtain a copy of this document.

Completed by (print name): _____ Relationship to patient: _____
 Signature: _____ Date: ____/____/____
 Witness: _____ Title: _____
 (Alpine employee)

HIPAA & Privacy Consent

Alpine Plastic Surgery understands the importance of privacy and we are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care provider's quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this practice properly. By law, we are required to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. Our notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your PHI. If you have any questions about the notice, please contact our privacy officer at 801-689-3500.

By signing this form, you consent to Alpine's use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent in writing. You also have the right to obtain a copy of the privacy notice. Our practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996.

Also by signing this form, you are also giving Alpine Plastic Surgery and Alpine Surgical Center, LLC permission to discuss your medical information with: (please check one)

- Alpine Plastic Surgery may discuss pertinent information with **ANY** family or friends about my care.
- Alpine Plastic Surgery may **ONLY** discuss pertinent information with the person(s) named below:

Person

Relationship

Note: If you bring family or friends with you to your appointments, we will assume you have authorized us to tell them information about your case or treatment, unless you advise us ahead of time. We may also decide in our professional judgment such persons may have a need to have information about your care and treatment, such as for driving or post operative care.

By signing below, I understand that my protected health information may be disclosed for treatment, payment or health care operations. I acknowledge that I have been presented with a copy of Privacy Practices and I understand that I may obtain a copy of the notice at any time. I have the right to restrict the use of my information but the practice does not have to agree to the restrictions. I understand that I can revoke this consent at any time in writing.

Signature of Patient/Responsible Party/Legal Guardian

Relationship to patient

Date