

ASSIGNMENT OF BENEFITS AND SIGNATURE ON FILE

I request that payment of Medicare, commercial insurance, or any other health insurance be made either to me or on my behalf directly to Dr. Malhotra of Malhotra Center for Plastic Surgery, PC for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare, or private health insurance carrier and its agents any information needed to determine these benefits or the benefits payable for relates services.

Signed _____ Date _____

Printed Name: _____

If you think your bill is wrong or if you need more information write us on a separate sheet at 900 E. Michigan Ave, Jackson, MI 49201. We must hear from within 60 days of sending you your first bill on which the error appeared. You can telephone us, but doing so will not preserve your rights.

In your letter, give us the following information:

- Your name and account number.
- The dollar amount of the suspected error.

You do not have to pay any amount in question while we are investigating, but you are still obligated to pay the parts of your bill that are not in question. While we investigate your question, we cannot report you as delinquent or take any action to collect the amount you question.

STATEMENT OF FINANCIAL RESPONSIBILITY

We render services on the assumption that your charges may not be paid by your insurance company. Patients who carry any form of medical insurance should know that they are responsible for payment of all services rendered. We suggest that you receive advance confirmation from your insurance company.

DISCLOSURES required by the federal Truth and Lending Act: The patient (or responsible party) is here advised and agrees: A) That the full amount of fees, costs and expenses for COSMETIC SURGERY are due and payable 3 weeks before surgery, and that patients' will incur additional costs for revision or touch up surgery. Patients who cancel surgery for non-medical reasons less than 48 hours before their surgery will lose their fees. Patients who undergo cosmetic surgery understand that their procedures will not be billed to their insurance company B) That the full amount of (their) fees, costs and expenses for NONCOSMETIC SURGERY are due and payable within sixty days of date of service, and if not paid, there shall be imposed thereafter a FINANCE CHARGE of 1% per month on the unpaid balance outstanding on the last business day of the month. Returned checks will be assessed a \$50.00 NSF fee in addition to your own bank fees.

No Shows: Patients must cancel their appointments in advance if they cannot attend, otherwise their account will be billed a \$50.00 “no show” charge.

I, the undersigned, realize that all medical and surgical charges incurred by me or my dependents for services rendered are my financial responsibility. Any fees necessary to collect this account are payable by me.

Signed _____

Date _____

Malhotra Center for Plastic Surgery, PC

MEDICAL HISTORY:

Age: _____ Height: _____ Weight: _____

Reason For Visit: _____

Have you ever had any of the following:

Abnormal Bleeding: Yes No	Asthma: Yes No	Hypertension: Yes No
Abnormal Clotting: Yes No	Diabetes: Yes No	Sleep Apnea: Yes No
Acid Regurgitation: Yes No	Fainting Spell: Yes No	Snoring: Yes No
Anemia: Yes No	Heart Problem: Yes No	Ibuprofen use Yes No
Angina: Yes No <input type="checkbox"/>	Hepatitis: Yes No	Tested + for HIV: Yes No

Please list your medical problems: _____

Previous Surgery: _____

List your medications: _____

Drug Allergy: Yes No	List drug(s) and reaction: _____
Latex Allergy: Yes No	Tape Allergy: Yes No
Regular Aspirin Use: Yes No	NSA (Advil, Motrin, Ibuprofen): Yes No

FAMILY HISTORY:

Abnormal Bleeding: Yes No	Coronary Surgery: Yes No	Kidney Disease: Yes No
Abnormal Clotting: Yes No	Diabetes: Yes No	Tuberculosis: Yes No
Anesthetic Problems: Yes No	Heart Attack: Yes No	Other Serious Illness: Yes No
Cancer: Yes No	Hypertension: Yes No	

Please describe questions with a "Yes" answer: _____

SOCIAL:

Smoke: Yes No Amount: _____ Alcohol: _____ per week
Married: Yes No Your Occupation: _____ Employer: _____

REVIEW OF SYSTEMS:

Cold Sores or recent fever	Yes No	Irregular Heart Beat:	Yes No
Double vision	Yes No	Vomiting:	Yes No
Apnea:	Yes No	Difficult Voiding:	Yes No
Shortness of Breath:	Yes No	Seizure:	Yes No
Depression or Psychiatric treatment:	Yes No	Current Pregnancy:	Yes No
Blood Clots:	Yes No	Breast cancer:	Yes No
Walking/balance problems:	Yes No	Immune system problems:	Yes No

Female PATIENTS ONLY: Last menstrual period _____ Did you breast feed? Yes No Birth control: Yes No

Malhotra Center for Plastic Surgery, PC

Patient Photography Consent

Patient Name _____

I consent to the taking of photographs by Dr. Pramit S. Malhotra or his designee of me in connection with the procedure(s) to be performed. I further authorize Dr. [Pramit S. Malhotra](#) to release to the American Society of Plastic Surgeons® (“ASPS®”) such photographs. I hereby also grant permission for the use of my medical records including illustrations, photographs, or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by the The American Board of Plastic Surgery, Inc.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of Dr. [Pramit S. Malhotra](#) and may be retained or released by Dr. [Pramit S. Malhotra](#) for the purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals, textbooks, Web sites, patient demonstration purposes for the purpose of informing the medical profession, the general public, and prospective patients about plastic surgery procedures. I understand the photographs may portray features that will make my identity recognizable.

I understand I may refuse to authorize the release of any health information, but will not affect the health care services I receive.. I understand I may inspect and copy the information that I have authorized to be disclosed and to revoke this authorization in writing at any time. I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). I further understand that, because Dr. [Pramit S. Malhotra](#) is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA.

I release and discharge Dr. [Pramit S. Malhotra](#) , ASPS, and all parties acting under their license and authority from all rights and claims that I may have in the photographs and relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.. We do not release photos to patients. We recommend taking your own photos if you wish to follow your results.

I understand that the doctor-patient relationship is a bond of trust and mutual respect that ethically and legally precludes Dr. Malhotra from disclosing information about me without my permission. Therefore, I too, agree not to disclose any information regarding the care I received from him without his permission. If a Patient does prepare commentary for publication about the Doctor, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Doctor for any written, pictorial, and/or electronic commentary. Patient and Doctor acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, Patient and Doctor agree to the right of equitable relief (including but not limited to injunctive relief). The Malhotra Center for Plastic Surgery collects email addresses for marketing purposes. We may use your email to extend special offers by us or third parties.

I certify I have read the above Authorization and Release and internet posting policy and understand its terms.

Signature _____ Date _____

Exceptions (i.e. medical records only) _____

I have read the above consent. I am the **parent, guardian, or conservator** of _____, a minor. I am authorized to sign this authorization on his/her behalf and give this authorization.

Signature: _____ Date: _____

**Malhotra Center for Plastic Surgery, PC
Demographics**

Last Name: _____ First Name _____ Sex: M F

Date of Birth: _____ Social Security #: _____

Address: _____ City/Zip Code: _____

Phone numbers: Home _____ Work _____ Mobile _____

E-mail address: _____ Marital status: _____

How did you hear about us? _____

Insurance Information of Policy Holder:

Primary Insurance: _____ ID# _____

Name (Policy Holder) _____ SS# _____

Secondary Insurance: _____ ID# _____

DOB of Policy Holder: _____ Copay _____

Please circle your areas of Interest:

- | | | |
|----------------------|-----------------------|-----------------|
| Botox | Liposuction | Tummy Tuck |
| Breast Augmentation- | Breast Lift | Eyelid Surgery |
| Facelifts | Forehead Lifts | Chin Surgery |
| Nose surgery | Male breast reduction | Skin Care/Peels |
| CoolSculpting | | |

Other: _____

Emergency Contact Information:

Name: _____ Phone# _____

Malhotra Center for Plastic Surgery, PC
Confidential Communication Request

Acknowledgement of Receipt of Notice of Privacy Practice

As required by Health Information Portability and Accountability Act of 1996 you have the right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some methods of contact must be provided, and as appropriate, information as to how payment will be handled.

I, _____ (***print name***) hereby request the use of the following confidential channels for the communication of information related to my personal health or treatment. This request supercedes any prior request for confidential communications I have made.

What telephone number(s) may we use to contact you?

What email address may we use for correspondence? _____

May we discuss pertinent information with anyone else? YES NO

If yes, please state name and relationship to you:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

By signing below, I hereby authorize my health information, as more specifically described as a medical record or protected health information, to be used or disclosed at my request to the above named, Dr. Malhotra's staff, and my primary or referring physician.

I hereby acknowledge that I have been presented with a copy of Malhotra Center for Plastic Surgery Notice of Privacy Practices.

Patient Name: (please print) _____

Signature: _____ **Date:** _____

(If minor or disabled, Legal Guardian signature)