Jandali Plastic Surgery

PATIENT INFORMATION FORM - Tattooing

Name: First_____Middle_____Last_____

Address:_____

City_____ State _____ Zip Code _____

Home Phone #(____)_____-_____ Work #(____)_____-_____ Cell #(____)_____-_____

Emergency # (____)_____-_____ Emergency Contact Name _____ Relationship _____

Social Security Number_____-_____-_____ Date of Birth_____/_____/_____ Age: _____ □ Male □ Female

E-mail Address _____@_____

Who is your primary care physician? _____ Phone: (____) _____-_____
(If you go to a group please specify the name of the physician you see most often.)

Your privacy is of the utmost importance to us. Please indicate below if there are any restrictions in contacting you:
_____

PHARMACY INFORMATION

As of January 1, 2018 the State of Connecticut is going to an e-prescribe system for all prescriptions.

Preferred Pharmacy Name: _____ Address: _____ Phone: _____

POLICY HOLDER INFORMATION (If Other Than Patient)

Name: _____Relationship to Patient _____ Date of Birth: ____/____/_____

Social Security Number: _____-_____-_____ Address: (if different from patient)_____

Employer Name, Address, & Phone _____(____) _____-_____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

____A Physician	Name: _____ Phone: _____
____Family Member/Friend	Name:_____
____Newspaper/Television	Which publication/program_____
____Seminar	Date & Topic? _____
____Internet	Website:_____
____Other	Please explain_____

Authorization to Release Information: I authorize Dr. Shareef Jandali and Jandali Plastic Surgery to release any information necessary, acquired in the course of my treatment, to process insurance claims.
Authorization to Pay Benefits Directly: I authorize my insurance company to pay Dr. Shareef Jandali and Jandali Plastic Surgery directly for medical service rendered. I understand that I will be responsible for non-covered charges, balances after insurance company benefits, deductibles and copayments.
Insurance: I understand that Dr. Shareef Jandali participates with Medicare, Medicaid, Anthem, and Connecticare. For all other private insurances, Dr. Jandali does not participate and is an out-of-network provider. I affirm that I elect to receive services from Dr. Jandali.

_____ _____
Signature Date

Name_____

PATIENT HISTORY FORM

Do you have any medical problems:_____
_____
_____

Circle if you have any of the following:
Thyroid disease Bleeding disorder Pacemaker or defibrillator Pigmentation disorder

Photo allergies Skin cancer Diabetes Polycystic ovarian disease

What surgeries have you had and when:_____
_____
_____

Medications: (please list dosage and # of times taken daily; include over the counter and herbals remedies)
_____
_____
_____
_____

Are you currently taking any Antibiotics?_____

Allergies: (which medications and what happens)_____
_____

Personal Social History: (please circle or fill in)
Do you smoke? Yes No How much and for how long?_____

If you used to smoke but quit, how much, for how long, and when did you quit?_____

Do you drink alcohol? Yes No How much and how often?_____

Do you take aspirin, Advil, or fish oil daily? Yes No

WOMEN: Are you Pregnant, Trying to get Pregnant, or Lactating (nursing)? _____

Are you currently using or have you ever used Retin-A? Yes No
If yes, when started? _____ Stopped when? _____

Are you currently using or have you ever used Accutane? Yes No
If yes, when started? _____ Stopped when? _____

Do you have any skin disorders? Yes No
If yes, please explain: _____

Do you have or have you ever had vitiligo (loss of skin pigment)? Yes No

Have you had any chemical peel or skin resurfacing procedure in the last month? Yes No

Are you a keloid former (thick scars)? Yes No

Are you required to take antibiotics before dental or medical procedures? Yes No

Have you taken any mood-altering medication in the last 12 hours? Yes No

Do you have any mental impairment that may affect your judgment? Yes No

Do you have any permanent makeup or tattoos? Yes No

Are you currently under the care of a physician? Yes No
If so, why?_____ Physician's name:_____

Have you **ever** had a cold sore or herpes skin infection? Yes No
If yes, you must tell Dr. Jandali so that he can prescribe ZOVIRAX or VALTREX to prevent a cold sore outbreak.

I have read the above information regarding cold sores and ZOVIRAX or VALTREX, and understand its use is mandatory if I desire lip line or full lip color tattooing procedures.

_____ _____
Signature Date

*****Do YOU want to learn how to take care of your skin?*** YES NO

AUTHORIZATION FOR AND RELEASE OF
MEDICAL PHOTOGRAPHS AND/OR VIDEO FOOTAGE

Name _____

I consent to the taking of photos or video footage by Dr. Shareef Jandali or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Shareef Jandali or his designee.

I provide this authorization as a voluntary contribution for the limited purpose of including them in any print, visual, or electronic media, specifically including, but not limited to, websites, social media, magazines, newspapers, media reports, medical journals, and textbooks, for the purpose of advertising or informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the images may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Shareef Jandali.

I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any affect on any actions taken prior to my revocation and I do hereby release Dr. Shareef Jandali, his agents and employees from all liability in connection with said actions.

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 release and discharge Dr. Shareef Jandali and all parties acting under his license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____
Signature Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of _____ _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

_____ _____
Signature Date

Jandali Plastic Surgery

CONSENT FOR COMMUNICATION via E-MAIL or TEXT

I hereby consent to have Dr. Shareef Jandali communicate, where appropriate, with me or members of his staff, other physicians, nurse practitioners, physician assistants, billing services, and insurance carriers, via e-mailing or text messaging regarding aspects of my medical care and treatment. I understand that e-mail and text are not a completely confidential method of communication. I further understand that there is a risk that e-mail or text communications between my physician and others (listed above) regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. Our practice will take utmost care in protecting personal health information, but this form of communication is often necessary to maintain close patient care. I understand that in an urgent or emergent situation, I should call my provider or go to the Emergency Room and not rely on email and/or text messaging.

Patient Name: _____

Patient's Signature_____ Date_____

AUTHORIZATION FORM FOR PATIENT RECORDS RELEASE

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that my patient information may be subject to re-disclosure by the authorized recipients of the information listed below and that my information may no longer be protected by federal privacy regulations once it is disclosed.

Patient Name: _____

Patient's Signature_____ Date_____

Persons/entities authorized to receive my patient information:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

Specific description of the information to be used or disclosed (including date(s) if applicable):

_____

_____

_____

Jandali Plastic Surgery

ASSIGNMENT OF BENEFITS & LIMITED POWER OF ATTORNEY

I, _____, irrevocably assign to you, Dr. Shareef Jandali, as my surgeon, co-surgeon, assistant surgeon, rendering physician and ancillary medical provider, all of my rights and benefits under my insurance contract and/or any employee welfare benefit plan for payment for services rendered to me, including but not limited to all of my rights and benefits under the **Employee Retirement Income Security Act** ("ERISA") applicable to the medical services at issue. I irrevocably authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier/employee welfare benefit plan for any and all rights and benefits under ERISA or applicable statute/law, including but not limited to the claim for penalties and fees under ERISA for failure to provide Plan documents and other equitable relief. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills and/or to file insurance claims on my behalf for services rendered to me. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage and I specifically authorize you to pursue any administrative appeals conducted pursuant to ERISA.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this **limited/special power of attorney** and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney-in-fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. **I authorize you and or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.**

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

If you, my medical provider, initiates a collection proceeding against me, whether through litigation, arbitration or otherwise, in connection with any and all claims unreimbursed and/or under-reimbursed by my insurance carrier, I agree to pay any and all of my medical provider's attorneys' fees and court fees in connection with that proceeding.

Signature: _____

Date: _____

Jandali Plastic Surgery

Late Cancellation & No-Show Policy
AUTHORIZATION FORM FOR CREDIT CARD CHARGE

At Jandali Plastic Surgery, we desire to offer the best service at all times and we value each patient's time in our office. When we make your appointment, we are reserving a room and staff for your particular needs. We understand that plans change. For this reason, we keep a wait list of patients who would like to be seen in the event of a cancellation.

We kindly request that you give us at least ***24 hours advance notice*** if you cannot make a scheduled appointment time or date. For a Monday appointment, you must cancel by Friday no later than 2 p.m. If no advance notice is given and an appointment is missed, there will be a **Late Cancellation/No-Show fee of $50**. All cancellations are to be made with the office, not with our answering service. For a late cancellation or no-show, your credit card will be charged ***$50*** on the day of the missed appointment.

PLEASE NOTE: Insurances do not cover No-Show or Late Cancellation Fees so you will be responsible for payment.

Courtesy calls to remind patients of appointments do not substitute for a No-Show or Late Cancellation.

If a Cosmetic Consult is missed or not cancelled 24 hours prior to the appointment, you will forfeit your $150 consultation payment.

Your credit card information will be kept in our secure files and will only be charged if there is a no-show or late cancellation for a scheduled appointment. A receipt will be sent to your address on file. If your credit card is declined, you will not be able to reschedule any future appointments until payment is remitted.

Credit Card (please circle): Visa Mastercard American Express Discover

Credit Card Number:_____ Security Code: _____

Expiration:_____ Zip Code for Billing Address: _____

I understand that the Late Cancellation & No-Show charge can be avoided if I give the office advance notice of at least 24 hours if I am unable to attend my scheduled appointment. I understand that this charge is nonrefundable.

I hereby authorize my credit card to be charged by Jandali Plastic Surgery in the event of a missed appointment or late cancellation.

Patient Name: _____

Patient's Signature_____ Date_____

Jandali Plastic Surgery

COSMETIC PROCEDURE DOWN PAYMENT AND FINANCIAL POLICY

At Jandali Plastic Surgery, the down payment fee to schedule and book the date of any cosmetic procedure, treatment, or surgery, is 10% of the total cost of the procedure.

- If the procedure or surgery is cancelled over 2 weeks before the surgery date, 50% of the down payment will be refunded.
- If the procedure or surgery is cancelled within 2 weeks of surgery, the full **DOWN PAYMENT IS NON-REFUNDABLE**, except in extenuating circumstances (proof may be requested).

Full payment for the procedure/surgery, implant (if applicable), facility fee, and anesthesia fee needs to be received within 2 weeks of scheduled surgery date, or the surgery will be cancelled or delayed, with loss of the down payment.

We also offer a layaway program to help patients who are not approved for financing and wish to make payments at regular intervals ***before*** surgery. This allows weekly or monthly payments with the full payment being paid 2 weeks before surgery.

The cosmetic procedure surgeon's fee quote will be good for six (6) months from the date of the consultation. This does not pertain to the implant cost or facility (operating room) and anesthesia fees, which are set by the hospital or surgery center, are subject to possible change, and are out of the control of Jandali Plastic Surgery.

From time to time, as an executive and discretionary measure, the surgeon's fees may be waived to assist patients in achieving their goals. This in no way indicates an admission of negligence or sub-standard care. This may include revisions/corrections within one year of surgery on a case-to-case basis. This does not include operating room charges, anesthesia charges, or cost of implants. Consideration of waived fees for revisions requires that you keep all postoperative appointments and that you demonstrate that postoperative instructions were followed.

At times, extenuating circumstances arise leading to a change in your reserved procedure or operating room date. In the event that this occurs, the surgical scheduler will notify you and work with you to accommodate the next most convenient date. Rescheduling of your surgery or procedure by our office does not entitle you to any discount of deposit paid or the overall cost of the procedure. If you cannot or desire not to proceed with surgery at another scheduled date, we will honor a full refund of your deposit.

Services that are performed that are paid with credit card, debit card, or with financing, are not eligible for post-care payment challenges. The practice encourages a complete postoperative care and follow-up interaction to address any issues that might arise.

Fees may be paid by cash, money order, Visa, MasterCard, Discover, American Express, CareCredit financing, or Alphaeon financing. Personal checks are NOT accepted.

I understand the Cosmetic Procedure Down Payment and Financial Policy.

Patient Name: _____

Patient's Signature_____ Date_____

Jandali Plastic Surgery

Notice of Privacy Practices and HIPAA Compliance

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, please contact our office at (203)374-0310.

Who will follow this notice?

Jandali Plastic Surgery provides health care to our patients in partnership with other professionals and health care organizations. The information privacy practices in this notice will be followed by:

- Any healthcare professional who treats you at our office.
- All departments and units of any of the hospitals or surgery centers to which Dr. Shareef Jandali has staff privileges.
- All employees, trainees, students, physician assistants, or volunteers at our office.
- Third party billing companies that work as independent contractors for billing purposes for Jandali Plastic Surgery

Our pledge to you:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by our office and any of the separate facilities and providers described above. We are required by law to:

- Keep medical information about you private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

How we may use and disclose medical information about you:

We may use and disclose medical information about you without your prior authorization for treatment (such as sending medical information about you to a specialist as part of a referral) (this includes psychiatric or HIV information if needed for purposes of your diagnosis and treatment); to obtain payment for treatment (such as sending billing information to your insurance company); and to support our healthcare operations (such as comparing patient data to improve treatment methods or for professional education purposes) (Note: only limited psychiatric or HIV information may be disclosed for billing purposes **without your authorization**). If you are treated in a specialized substance abuse program, your special authorization will be needed for most disclosures other than emergencies.)

Other examples of such uses and disclosures include contacting you for **appointment reminders** and telling you about or recommending **possible treatment options**, **alternatives**, **health-related benefits or services** that may be of interest to you. We may also contact you to support our **fundraising efforts.**

We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give our medical information about you, without prior authorization **for public health purposes, abuse or neglect reporting, health oversight audits or inspections, medical examiners, funeral arrangements and organ donation, workers' compensation purposes, emergencies, national security and other specialized government functions, and for members of the Armed Forces as required by Military Command authorities.** We also disclose medical information when required by law, such as in response to a request from **law enforcement** in specific circumstances, or in response to valid judicial or administrative orders or other **legal process**.

Under certain circumstances, we may use and disclose health information about you for **research purposes**, subject to a special approval process. We may also allow potential researchers to review information that may help them prepare for research, so long as the health information they review does not leave our facility, and so long as they agree to specific privacy protections.

We may disclose medical information about you to a friend or family member whom you designate or in appropriate circumstances, unless you request a restriction. We may also disclose information to disaster relief authorities so that your family can be notified of your location and condition.

Other uses of Medical Information:

In any other situations not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Right to Access and or Amend Your Records:

In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information is not maintained by us; or if we determine that your record is accurate. You may submit a written statement of disagreement with a decision by us not to amend a record.

Right to an Accounting:
You have the right to request a list of accounting for any disclosures of your health information we have made, except for uses and disclosures of treatment, payment, and healthcare operations, circumstances in which you have specifically authorized such disclosure and certain other exceptions.
To request this list of disclosures, indicate the relevant period which must be after July 1, 2011, but in no event for more than the last six years. You must submit your request in writing to our office as appropriate.

Right to Request Restrictions:
You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request and work to accommodate it when possible, but we are not legally required to accept it. We will inform you of our decision on your request. All written requests should be submitted to our office.

Requests for Confidential Communications:
You have the right to request that medical information about you be communicated to you in a confidential manner such as sending mail to an address other than you home, by notifying us in writing of the specific way or location for us to use to communicate with you.

Right to request a paper copy of this Notice:
You may receive a paper copy of this Notice from us upon request, even if you have agreed to receive this notice electronically.

Changes to this Notice:
We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in waiting areas and on our website at www.jandaliplasticsurgery.com. You can receive a copy of the current notice at any time. Copies of the current notice will be available each time you come to our office for treatment. You will be asked to acknowledge in writing your receipt of this notice.

Complaints:
If you are concerned that your privacy rights may have been violated, or you disagree with a decision made about access to your records, you may contact out office at (203)374-0310.
If you are not satisfied with our response, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our office can provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been offered a copy of this Notice of Privacy Practices.

Patient Name: _____

Patient's Signature_____ Date_____