Star medical group, p.c.
plastic surgery

"It's ALL About You" Assessment

Why are you considering cosmetic surgery?
(please check all that may apply)

- ❑ To improve my appearance
- ❑ To look younger
- ❑ For career advancement
- ❑ To improve my social life
- ❑ To have my clothes fit better
- ❑ So I can look the best I can
- ❑ To improve my self-confidence
- ❑ Other: ____________________________________

2. How long have you been thinking about having cosmetic surgery?
   ❒ 6 months ❒ 1 year ❒ 2 years or more

3. What type of surgical results would you like to achieve with your cosmetic procedure?
   ❒ Average ❒ Above Average ❒ Good ❒ Best

Thank you for sharing this information to help us help you feel your Best!

________________________ ____________________ ________
STAR Plastic Surgery Specialist *Patient Initials* *Date*

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Medical History Screening (Patient to complete)

Name ______________________ Date ______________________

Age ______________________ Date of birth ______________________

List all medications that you take including supplements and herbs

List all medication allergies

Do you have any of the following medical problems?

	yes	no	Comments
High blood pressure			
Heart problems			
Lung problems (ie asthma, emphysema)			
Diabetes or blood sugar problems.			
Anemia or low blood count			
Kidney problems			
Blood clots or bleeding problems			
Liver problems			
Stomach problems			
Chest pain			
Seizures			
Cancer			
Depression or anxiety			
Have you ever had a problem with anesthesia?			
Do you smoke?			
Do you drink alcohol?			
Do you use street drugs?			
Family history of breast cancer			

List all previous surgeries you have had.

Please list your medical doctors name and phone number.

Who will assist with your care after surgery? Name, relationship and phone number.

Patient Signature ______________________

WE DO NOT ACCEPT INSURANCE FOR SURGERY

Name: ____

Address: ______________________________ City: ______________

State: ______________________________ Zip: ______________

Home Phone:____________________ Work Phone: ____________________

Cell Phone:________________ Email: ________________________

May we contact you at home? ❑ **Yes** ❑ **No** *May we contact you via Email?* ❑ **Yes** ❑ **No**

Date of Birth:____________________Height:__________Weight:__________

Have you ever had cosmetic surgery? ❑ **Yes** ❑ **No** *If Yes, please complete the following:*

Type of Surgery:____________________ Date of Surgery: _____/_____/_____

Physician name:____

How long have you been thinking of having cosmetic surgery?

❑ 6 months ❑ 1 year ❑ 2 or more years

Do you have a history of, or do you suffer from, any of the following:

❑ Heart Disease ❑ Diabetes ❑ High Blood Pressure

❑ Allergies ❑ Smoking ❑ Depression

Are you in good health? ❑ **Yes** ❑ **No** *If No , please explain:* ____________________

____

Do you know of any reason that would disqualify you from having cosmetic surgery?

❑ **Yes** ❑ **No** *If Yes, please explain:* ______________________________

____

Were you referred to us by your physician? ❑ **Yes** ❑ **No**

Name of referring physician: ______________________________

❑ Referred by friend / relative Name of referring friend / relative:____________________

❑ Television ❑ Radio ❑ Newspaper ❑ Magazine ❑ Internet

Other: ____

WHAT TYPE OF COSMETIC SURGERY ARE YOU CONSIDERING?

❑ Breast Augmentation ❑ Breast Lift ❑ Breast Reduction

Tummy Tuck: ❑ Mini ❑ Full

Liposuction: ❑ Abdomen ❑ Thighs ❑ Hips ❑ Arms ❑ Chin
❑ Other Areas ____________________

Eyelids: ❑ Upper ❑ Lower

❑ **Nose Reshaping**

Face Lift: ❑ European Mini ❑ Full Face ❑ Neck ❑ Forehead

❑ **Hollywood Booty**

Body Lift: ❑ mini ❑ Full

Other: ____________________

____

When do you plan to have your surgery? Month_______ Year_______

Are you employed? ❑ **Yes** ❑ **No**

Employer:____________________ City ____________________

What type of work do you do? ____________________

Have you made arrangements for time off from your job or profession for your surgery and recovery? ❑ **Yes** ❑ **No**

I plan to pay for my surgery by: ❑ **Cash** ❑ **Credit Card** ❑ **Financing***
❑ **Other** ____________________

*Please complete the attached financing application.

COST OF COSMETIC SURGERY

Each patient fee is based upon you, individually. No two patients are alike-even twins. The same rule applies to plastic surgeons. The education, skill and ability of your surgeon should be of utmost importance to you when considering cosmetic surgery.

Please list any questions that you have in the space below:

____

____

____

____

Signature ____________________ Date:____________________

HIPAA Notice of Privacy Practices

Star Medical Group, P.C.
42450 West Twelve Mile Road, First Floor
Novi MI 48377
248-735-3800 Fax 248-7342434

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.

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

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight:
Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement; Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation:
Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You **have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made. if any. of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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 privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14.**2003. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: ____

Signature: ____ Date____________________