TRAN PLASTIC SURGERY LLC

DIPLOMATE AMERICAN BOARD OF PLASTIC SURGERY
MEMBER AMERICAN SOCIETY OF PLASTIC SURGEONS

PATIENT INFORMATION

LAST NAME: _____

FIRST NAME: _____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP CODE: _____

CELL PHONE: _____

EMAIL: _____

D.O.B: _____ SEX: _____

HEIGHT:_____ WEIGHT: _____

MARITAL STATUS: _____

REASON FOR CONSULTATION:_____

_____

EMPLOYER: _____

OCCUPATION: _____

EMERGENCY CONTACT: _____

PHONE: _____

RELATIONSHIP TO PATIENT: _____

WHO REFERRED YOU TO OUR OFFICE:_____

Please check if you have had or have any of the following:

- ☐ Asthma or breathing problems
- ☐ Sleep Apnea
- ☐ Steroids taken within last 3 months
- ☐ Bleeding disorder/anemia
- ☐ Clotting disorder/history of blood clot/Pulmonary embolism
- ☐ History of cancer (e.g breast, colon, etc)
- ☐ Scarring problems/keloids
- ☐ Cold sores
- ☐ High Blood Pressure
- ☐ Heart condition/Pacemaker/ICD
- ☐ Stroke
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Kidney problem
- ☐ Depression/Anxiety/Mental illness
- ☐ Family history of blood clot/DVT/Pulmonary embolism
- ☐ Liver problem - Jaundice/Hepatitis
- ☐ Autoimmune disorders/Lupus/Crohn's/RA
- ☐ Nerve disorder/neuropathy
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Hiatal hernia/GERD (reflux)
- ☐ Physical disability
- ☐ Chronic headache/Migraines
- ☐ Metal plates or pins implants
- ☐ Seizure
- ☐ Back Pain
- ☐ Stiffness or pain in neck/jaw
- ☐ Dentures, caps, bridge

PLEASE ANSWER THE FOLLOWING QUESTIONS. WRITE "NONE" IF THAT IS SO, OR "DON'T KNOW" ON THE LINE PROVIDED IF YOU ARE UNSURE

Please list any medications you are taking, including vitamins/supplements: _____

_____

Please list any allergies to any medication, foods, or latex: _____

_____

Do you **smoke or vape or use any nicotine product?** YES ___ NO ___ If yes, how often?

_____

Do you consume **alcoholic beverages?** YES ___ NO ___ if so, how often? _____

Do you **use marijuana**? YES ___ NO ___ if so, how often? _____

Do you **use any other recreational drugs**? YES ___ NO ___ if yes, please list _____

_____

Please list any birth control pills or birth control implant/device:

_____

Number of pregnancy _____ C-section_____ Live Birth_____

Please list any previous surgery & the month & year of the surgery?_____

_____

Please list any previous PLASTIC SURGERY & the month & year of the surgery? _____

_____

Do you have a family history of cancer or any disorder ? YES ___ NO ___ **if so, please list**

_____

Would you accept blood in an emergency? YES ___ NO ___

Do you have any disease, condition or illness not listed? YES ___ NO ____ **if so, please list**

_____

I have seen the Notice of Privacy Practice and Patient's Bill of Rights posted in the lobby & was offered copies.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient's Name:_____

Signature: _____

Date: _____

NOTICE TO ALL PATIENTS

Your health plan has specific regulations you must follow in order for you to avoid liability from full payment on services rendered by our physician.

PAYMENT METHODS: We accept cash, money order, ACH payment, Zelle transfer, major credit cards, CareCredit, and PatientFi.

APPOINTMENT CANCELLATION POLICY: Please be courteous and call us if you cannot make your scheduled appointment 48 hours in advance. This allows us to see other patients who may be in need of our services. **You will forfeit your consultation booking fee of $50 if you fail to show up to your appointment and do not cancel your appointment at least 24 hours in advance.**

FORMS: There is a charge of $25 to complete any forms including FMLA, work, disability, jury duty or school.

MEDICAL RECORD: For any medical record request, there will be a fee of $1.00 per page for the first 25 pages, and $0.25 per page for each additional page, and postage cost.

BILLING FEE: Co-payments, co-insurance, and deductibles are payable at the time services are rendered. All Cosmetic Consultations have a booking fee of $50 due PRIOR to the time of service.

TEST RESULTS: The surgeon may require a follow-up visit to review and discuss any diagnostic testing or pathology results.

Please familiarize yourself with every rule of the health insurance plan you are enrolled in. Your insurance company will mail a summary of charges, payments, denials or requests for further information. Please review all insurance correspondence.

I have read and understood the above information.

Patient's Name:_____

Signature: _____

Date: _____

Notice of Privacy Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient's Name:_____

Signature: _____

Date: _____

HIPAA AUTHORIZATION FORM

I acknowledge that due to HIPAA laws, my doctor is required to obtain a written consent to disclose any Private Health Information in the presence of anyone other than myself. **Please check the corresponding line:**

- _____**I ALLOW** Tran Plastic Surgery LLC to discuss details of my medical records/financial records with _____. (Please print the name of an authorized family member).
  - Relationship of authorized person to patient
    _____
- _____**I DO NOT ALLOW** Tran Plastic Surgery LLC to discuss details of my medical records/financial records with anyone else but me.

Patient's Name:_____

Signature: _____

Date: _____

IF FOR ANY REASON, I AM NOT COMPLETELY SATISFIED WITH THE RESULTS OF MY SURGERY OR ANY CARE RECEIVED BY DR. BAOTRAM TRAN, OR ANY MEMBER OF HER STAFF, OR SURGERY CENTER'S STAFF, I WILL DISCUSS THIS MATTER WITH DR. BAOTRAM TRAN PERSONALLY. I WILL NOT POST NEGATIVE OR DEROGATORY COMMENTS ON ANY BLOG OR PUBLIC WEBSITE. IF I DO SO, I RESCIND MY HIPPA RIGHTS AND ALLOW DR. BAOTRAM TRAN AND HER STAFF TO RESPOND TO THE POSTING.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT COMPLETELY.

PLEASE ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING.

Patient's name (or Guardian) :_____

Signature:_____

DATE: _____

CONSENT FOR PHOTOGRAPHY

I, _____ , acknowledge that the surgeon will photograph me for medical purposes and the pictures will be a part of my medical record.

- _____**I ALLOW** Tran Plastic Surgery LLC, Dr. Baotram Tran, and its affiliates to use my photographs to appear in filming, photographs, videotaping and/or interviews for public relations and advertising. I consent to unlimited use without compensation to me or my family member(s) in publications and/or websites, social media, news media reports, newspapers, magazine, television or radio, billboard or any type of advertising.

- _____**I DO NOT ALLOW** Tran Plastic Surgery LLC to use my photographs to appear in filming, photographs, videotaping and/or interviews for public relations and advertising

Patient's Name:_____

Signature: _____

Date: _____

Patient Consent for Use of Credit Cards, Debit Card, and Financing and 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 at our practice paid with any payment forms including cash, zelle, 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 TRAN PLASTIC SURGERY LLC and Dr. Baotram Tran to use and disclose my protected health information to the Credit Card Entity, Bank, or Financing Company if they request such information to process a revoked payment or to process an account and assist with payment.

- I will not challenge such cash, credit, debit, or financing card payments.
- I agree that this non credit card challenge agreement is irrevocable.

Patient's Name:_____

Signature: _____

Date: _____

EMAIL, TEXT MESSAGING, & SOCIAL MEDIA MESSAGING AND COMMUNICATION CONSENT FORM

Tran Plastic Surgery LLC and its staff members shall be referred to throughout this consent form as "Provider".

RISK OF USING EMAIL, TEXT MESSAGING, & SOCIAL MEDIA PLATFORM MESSAGING AND COMMUNICATION TO COMMUNICATE WITH YOUR PROVIDER:

Provider offers patients the opportunity to communicate by EMAIL, TEXT MESSAGING, & SOCIAL MEDIA PLATFORM MESSAGING AND COMMUNICATION. Transmitting patient information via this method(s) has a number of risks that patients should consider before using. These include, but not limited to, the following risks:

- Messages can be circulated, forward, and stored in numerous paper and electronic files.
- Messages can be immediately broadcast worldwide and be received by unintended recipients.
- Message senders can easily type in the wrong email address.
- Email is easier to falsify than handwritten or signed documents.
- Backup copies of messages may exist even after the sender or recipient has deleted his or her copy.
- Employers and online services have a right to archive and inspect messages transmitted through their system.
- Messages can be intercepted, altered, forward, or used without authorization or detection.
- Messages can be used to introduce viruses into the computer system.
- Messages can be used as evidence in court.
- There will be an unknown delay in response time to these types of messaging, and there are platforms where a preformed auto-response is used. DO NOT USE THESE METHODS OF COMMUNICATION IF YOU HAVE A MEDICAL EMERGENCY. IF YOU HAVE A MEDICAL EMERGENCY, CALL 911 OR IF YOU ARE ABLE, THEN SEEK MEDICAL HELP IN THE EMERGENCY ROOM

CONDITIONS FOR THE USE OF EMAIL, TEXT MESSAGING, & SOCIAL MEDIA MESSAGING AND COMMUNICATION:

Because of the risks outlined above, Provider cannot guarantee the security and confidentiality of EMAIL, TEXT MESSAGING, & SOCIAL MEDIA MESSAGING AND COMMUNICATION, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of EMAIL, TEXT MESSAGING, & SOCIAL MEDIA MESSAGING AND COMMUNICATION for patient information. Consent to the use of these methods of communication includes agreement with the following conditions.

- All messages to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the

medical record, other individuals authorized to access the medical record will have access to those messages.

- Provider may forward messages internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward messages to independent third parties without the patient's prior written consent, except as authorized or required by law.
- The patient is responsible for protecting his/her password or other means of access to message communication of any method. Provider is not liable for breaches of confidentiality caused by the patient or any third party.

- Provider shall not engage in messaging communication that is unlawful

- It is the patient's responsibility to follow-up and/or schedule an appointment.

- Do not use any communication method that you feel is unsafe.

- If you do not want the public to see your comments or specific questions, do not post on social media. Communicate directly with the provider's office.

- There will be an unknown delay in response time to these types of messaging, and there are platforms where a preformed auto-response is used. DO NOT USE THESE METHODS OF COMMUNICATION IF YOU HAVE A MEDICAL EMERGENCY. IF YOU HAVE A MEDICAL EMERGENCY, CALL 911 OR IF YOU ARE ABLE, THEN SEEK MEDICAL HELP IN THE EMERGENCY ROOM

PATIENT RESPONSIBILITIES AND INSTRUCTIONS:

To communicate by EMAIL, TEXT MESSAGING, & SOCIAL MEDIA MESSAGING AND COMMUNICATION, the patient shall:

- Limit or avoid using his/her employer's computer.
- Inform Provider of changes in his/her email address
- Confirm that he/she has received and read the email from the Provider.
- Put the patient's name in the body of the message
- Include the category of the communication in the message subject line where applicable, for routing purposes.
- Take precautions to preserve the confidentiality of messages, such as using screen savers and safeguarding his/her computer password.
- Withdraw consent only by written communication to the Provider.
- Do not use any communication method that you feel is unsafe.
- If you do not want the public to see your comments or specific questions, do not post on social media. Communicate directly with the provider's office.
- There will be an unknown delay in response time to these types of messaging, and there are platforms where a preformed auto-response is used. DO NOT USE THESE METHODS OF COMMUNICATION IF YOU HAVE A MEDICAL EMERGENCY. IF YOU HAVE A MEDICAL EMERGENCY, CALL 911 OR IF YOU ARE ABLE, THEN SEEK MEDICAL HELP IN THE EMERGENCY ROOM

TERMINATION OF THE EMAIL, TEXT MESSAGING, & SOCIAL MEDIA MESSAGING AND COMMUNICATION RELATIONSHIP

The Provider shall have the right to immediately terminate the messaging relationship with you, if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with Dr. Baotram Tran or his/her staff and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email, text messaging, social media messaging and communication between Tran Plastic Surgery LLC, Dr. Baotram Tran, her staff and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by the various methods listed. Any questions I may have had were answered.

I have read and understood the above information.

Patient's Name:_____

Signature: _____

Date: _____

PHYSICIAN'S RELEASE AND ASSIGNMENTS

** IF YOUR INSURANCE REQUIRES A REFERRAL FOR YOU TO SEE DR. BAOTRAM TRAN, IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH THE REFERRAL. IF YOUR INSURANCE COMPANY DENIES PAYMENT – DUE TO NO REFERRAL – YOU THE PATIENT AGREE TO PAY TRAN PLASTIC SURGERY LLC AND DR. BAOTRAM TRAN IN FULL FOR ANY CHARGES INCURRED DURING YOUR VISIT. **

I understand that I am financially responsible for all charges incurred by me, and I agree that in the event that this account is referred to collections, to pay all collection expenses.

Patient's Name:_____

Signature: _____

Date: _____

INSURANCE RELEASE INFORMATION

I HEREBY AUTHORIZE THE OFFICE TO RELEASE TO MY INSURANCE COMPANY ANY NECESSARY INFORMATION NEEDED TO FILE AND EXPEDITE PAYMENT ON MY CLAIM. I FURTHER ASSIGN ANY BENEFITS PAYABLE ON MY BEHALF TO DR. BAOTRAM TRAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER.

Patient's Name:_____

Signature: _____

Date: _____

HOLD HARMLESS

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider, and any breach by me of these restrictions and conditions.

Patient's Name:_____

Signature: _____

Date: _____

CONSENT TO MANDATORY AND EXCLUSIVE JURISDICTION IN BROWARD COUNTY, FLORIDA

I understand that my doctors will do everything possible to provide quality medical care at all times. If I am not satisfied with the care received, however. Legal grounds exist to pursue a claim for damages; I expressly agree to submit to the jurisdiction of the courts located in Broward County, Florida, for any possible claim against my doctor or its staff or professional association and that Broward County, Florida shall be the exclusive jurisdiction for all claims of personal injury, negligence, or medical malpractice to the exclusion of any other courts or jurisdiction(s). I expressly agree that any disputes which arise between myself and my doctors, staff, or its professional association shall be governed in all respects by the laws of the state of Florida.

Patient Name: _____

Date of Birth: _____

Practice, doctor and/or supporting staff attending to the patient: Tran Plastic Surgery LLC, Dr. Baotram Tran, and staff/affiliates.

I have read, understand and agree with the above statement:

Date _____

Patient Signature:_____

"Under Florida Laws physicians are generally required to carry medical malpractice Insurance or otherwise demonstrate financial responsibility to cover potential claims for
Medical malpractice"

YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.

This is permitted under Florida Laws subject to certain conditions. Florida Laws imposes Penalties against no insurance physicians who fail to satisfy adverse judgments arising From claims of medical malpractice.
This notice is provided pursuant to Florida Laws.
Florida Statute 458.320(5)(g)(1)

THE UNDERSIGNED HAS BEEN FULLY INFORMED ABOUT THIS MATTER

Name: _____

Signature:_____

Date: _____