

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can access this information. PLEASE REVIEW CAREFULLY. **PLEASE KEEP FOR YOUR RECORDS.**

Dr. Kim-Chi Vu knows that the information we collect about you and your health is private. Dr. Vu is required by Federal and State law to protect this information. The information in this notice tells you how we may use or disclose information about you. Not all situations are described. We are required to give you notice of our privacy practices regarding the information we collect and keep about you.

Dr. Vu may use and disclose information without your written authorization under the following circumstances:

- Treatment- We may use or disclose information with health care providers who are involved in your treatment or care. Information may be shared to carry out a plan for your diagnosis and treatment.
- Payment- We may disclose information to receive payment or to pay for health care services you receive. Information may be provided to your health plan for billing purposes.
- Appointments and Test Results- We may send you reminders for your medical care and results of medical testing we may order in the course of your treatment.
- State or Federal Requests- We may use and disclose information when required by federal or state law, or by a court order.
- Abuse- Information required by law to report suspected abuse may be disclosed to appropriate government agencies.
- Government Programs- Information for public benefits under government programs, such as Supplemental Security Income (SSI).
- To Avoid Harm- Information to law enforcement agencies to avoid serious threat to the health and safety of persons or the public.
- Family- We may disclose information to your family or others who are involved in your medical care. **YOU HAVE THE RIGHT TO OBJECT TO THE SHARING OF INFORMATION IN THIS SITUATION.**
- Responsibility – Your healthcare is your own. We encourage you to ask questions and take responsibility for your health and healing.
- Release of Information – If you request we submit Dr. Vu’s notes to a third party other than another a physician’s office we require that you sign a release.
- Request for Restriction on Use and Disclosure – If you have a restriction you wish The Vu Center to be aware of we will provide you with a form to sign. Please see a staff member.

Other uses and disclosures require your written authorization. At your request you will be given a Request for Restriction, Use and Disclosure of Health Information form to complete. You may cancel this authorization at any time in writing.

You will be asked to sign acknowledgement of this disclosure. We thank you for your cooperation in protecting your privacy.

PATIENT INFORMATION

Name _____ MI _____ DOB _____ Age _____

Parent/Guardian if patient is a minor _____

S.S # _____ Male _____ Female _____ Single _____ Married _____

Address _____ City _____ State _____ Zip _____

**May we send correspondence by mail to the above address? (circle) YES / NO*

Home Ph# _____ Cell # _____ Work # _____

**May we leave a message on the above phone numbers? (circle) YES / NO*

Email _____

**Would you like to communicate by email & receive our e-newsletter or promotional emails? (circle) YES / NO*

CARETAKER/EMERGENCY CONTACT INFORMATION

Name _____

Relationship to you: (circle) Spouse / Friend / Parent / Grandparent / Child

Address _____ City _____ State _____ Zip _____

Phone# _____ Cell # _____ Work # _____

**Do you allow The Vu Center to disclose medical information regarding your treatment?(circle) YES / NO initial _____*

Referred By _____ Phone _____
PCP _____ Phone _____

PLEASE READ AND SIGN BELOW:

AUTHORIZATION FOR RELEASE OF INFORMATION:

I hereby authorize The Vu Center for Plastic and Hand Surgery, PC to release any information requested by my caretaker/emergency contact, insurance company (reconstructive procedures), or to release information to any hospital, laboratory or physician I may be referred to by this office. I also acknowledge that I have received a copy of the privacy practices.

I hereby consent and authorize examination and treatment by Dr. Kim-Chi Vu and such assistant or staff as may be assigned by her.

“To the best of my knowledge I have provided above and on the following page, regarding my medications, past medical history, allergies, and smoking history is accurate, complete and honest. I understand that failure to disclose this information may be detrimental to my condition and treatment and accept responsibility for any omissions.”

A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ **Date** _____

Relationship: (circle one) Self Parent Guardian

FOR OFFICE USE ONLY
 NEW PATIENT
 ESTABLISHED PATIENT
 CONSULTATION
 REPORT SENT:

PATIENT INTAKE HISTORY

DATE:

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

GYNECOLOGIC HISTORY

	PHYSICIAN'S NOTES
LAST NORMAL MENSTRUAL PERIOD (FIRST DAY):	
AGE PERIODS BEGAN:	
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING):	
NUMBER OF DAYS BETWEEN PERIODS:	
ANY RECENT CHANGES IN PERIODS?	
ARE YOU CURRENTLY SEXUALLY ACTIVE?	
HAVE YOU EVER HAD SEX?	
NUMBER OF SEXUAL PARTNERS (LIFETIME):	
SEXUAL PARTNERS ARE <input type="checkbox"/> MEN <input type="checkbox"/> WOMEN <input type="checkbox"/> BOTH	
PRESENT METHOD OF BIRTH CONTROL:	
HAVE YOU EVER USED AN INTRAUTERINE DEVICE (IUD) OR BIRTH CONTROL PILLS?	
IF YES, FOR HOW LONG?	
WHEN WAS YOUR LAST PAP TEST?	
WHAT WAS THE RESULT?	
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?	
DO YOU DO REGULAR BREAST SELF-EXAMINATIONS?	

PATIENT HISTORY

Patient Name: _____ **Date of Birth:** _____
Date of Visit: _____ **Reason for Visit:** _____

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Diabetes	___	___	High Blood Pressure	___	___
Thyroid Disease	___	___	Heart Disease	___	___
Jaundice	___	___	Kidney Disease	___	___
Mental Disease	___	___	Lung Disease	___	___
Breast Cancer	___	___	Depression	___	___
Any other medical Condition: _____					
If female: date of LMP _____ Any possibility of pregnancy _____					

HAVE YOU HAD ANY SURGERY IN THE PAST?

PLEASE LIST SURGERY TYPE AND DATE

1. _____
2. _____
3. _____
4. _____

ARE YOU TAKING ANY MEDICATION?

PLEASE LIST MEDICATION NAMES AND DOSAGE

1. _____
2. _____
3. _____
4. _____

ARE YOU ALLERGIC TO ANY MEDICATION?

PLEASE LIST: _____

SOCIAL HISTORY:

Children? _____ Married or Single? _____
Hobbies? _____ Type of work you do? _____
Smoke? How Much? _____ Alcohol? How much? _____
Intravenous Drug Use? _____

DOES ANY OF YOUR FAMILY MEMBERS HAVE ANY OF THE FOLLOWING?

PLEASE INDICATE WHICH FAMILY MEMBER

1. Diabetes _____
2. High Blood Pressure _____
3. Kidney Disease _____
4. Heart Disease _____
5. Bleeding Disorder _____
6. Breast Cancer _____

Any other medical condition – Please Explain

DO YOU HAVE ANY RECENT SIGNS OF SYMPTOMS OF THE FOLLOWING?

1. Headache
2. Dizziness
3. Respiratory Infection
4. Chest Pain
5. Heart Burn
6. Reflux
7. Gastrointestinal Bleeding
8. Genitourinary Difficulty
9. Bleeding Disorder
10. Musculoskeletal: Comprising the skeleton and the muscles.

Any other medical condition: Please explain

PAYMENT POLICY COSMETIC SURGERY

Thank you for allowing us to provide the services you desire in cosmetic and reconstructive surgery. As part of cosmetic surgery, our policy is that payment in full is due prior to commencement of surgery. The following guidelines have been set to allow you to fully understand our policy. We are committed to you to assist you in anyway to make your surgery as comfortable as possible. Please read the following outlines and initial each statement to acknowledge that you have read our guidelines. Please do not hesitate to ask us if you have any questions, as we hope to make your surgery as favorable as possible so that we may continue to provide the services that you may desire. Thank you.

- *All cosmetic consultations are \$51.00, nonrefundable. We require a credit card to hold all consultations. If you need to cancel your consultation you must do so 24 hours prior to your appointment. If you cancel without giving the office 24 hour notice your card will be charge a nonrefundable fee of \$75. If you do not arrive to your consultation and you do not call your card will be charged a \$75 nonrefundable fee.* Initial: _____
- *You will be provided with a written estimate of fees at your consultation. The quote will include surgeon's fee, operating room fee, and anesthesia fee. This estimate is subject to change, since we do not have control over the fees for operating room and anesthesia. Once you have decided to proceed with surgery confirmation of fees from the facility and anesthesiologist will be confirmed. Fees for additional items which may include but not limited to hospital stay, implants, garments, cosmetic insurances, pain pump are not included in the fee quote and may be billed separately. Pre/post lab work, surgical recovery and autologous blood, if needed, are not included in this quote.* Initial: _____
- *After scheduling your surgery date, you will be scheduled for a preoperative visit prior to surgery. At that time, we ask that you pay the remaining balance on your account. **We accept all major credit cards except AMEX.** We also accept CareCredit, Cash, Check and Money Order.* Initial: _____
- *If an EKG, lab work or pathology report is found to be medically necessary before or after your surgery it will be billed separately by the hospital or laboratory. Pre/Post lab work, surgical recovery - autologous blood, if needed, are not included in the fee quote.* Initial: _____
- *We are not responsible for the operating room fee, facility fee, and anesthesia fee, but it is included in the estimated quote. It is your responsibility to set up payment arrangements with them or we will be more than willing to disburse the funds on your behalf, whichever you prefer.* Initial: _____
- *Prescription medications vary from patient to patient; they are a separate expense and are not included in the quote. Your health insurance will typically pick up these expenses with your routine co-pay.* Initial: _____
- *If reversionary procedures are deemed necessary, a surgeon's fee may apply depending on each individual case; however the cost of the operating room, facility, supplies and anesthesia would be your responsibility.* Initial: _____
- *We offer interest free payment plan options to all of our patients. You have a choice of a 3 or 6 month payment plan. **Your surgery must be paid off before you may have it performed.** There will be a \$500 nonrefundable scheduling fee due upon the time you schedule and enter into a payment plan agreement.* Initial: _____
- *Within this payment plan agreement, if you need to reschedule there will be an additional nonrefundable fee of \$250.00. You have (10) business days from the day you enter into a payment plan agreement to cancel and you will be refunded all money minus the original \$500 deposit. This deposit will be held for you for one year at which time you may use only towards another surgery. If you cancel your surgery after this period you will be charged 15% of the amount collected up until that point, not including the \$500 deposit.* Initial: _____
- ***CANCELATION POLICY:** All of our patients who cancel appointments or surgeries do so for legitimate, honest reasons such as a death in the family, illness of a child, loss of job, etc. Nonetheless, Dr. Vu's time is valuable thus we must uphold our policy evenly and across-the-board without judging whether one patient's reason for cancellation is more valid than another's.* Initial: _____

- There will be a \$500.00 nonrefundable scheduling fee due upon the time you decide to schedule your surgery, which will be applied to Dr. Vu's surgeon fee. If you need to reschedule there will be an additional nonrefundable fee of \$250.00. If you cancel your surgery within ten (10) business days before your surgery you will be charged 25% of the surgeon's fee. If your surgery is cancelled before (10) business days, we will refund your money minus the original \$500 deposit fee. This deposit will be held for you for one year at which time you may use only towards another surgery. Please understand that such changes affect not only your surgeon, the surgical facility, the anesthesiologist, but other patients as well. Initial: _____
- We do have Financing Programs available to assist you with paying for your surgery. If you wish to learn more we will gladly provide you with the proper information. We accept certain plans with Care Credit, Medical Financing and Chase Health Advance. These options of payment are only accepted when paying full price for surgeries. Initial: _____
- We occasionally have specials on our cosmetic surgeries and treatments. If there is a surgery you are interested in that is currently on special you may only pay with credit card, check or cash. We will not accept payments from third party financing companies for surgeries on special. We also do not accept American Express. Initial: _____
- Payment for Botox, injectable fillers, products, Thermage, microdermabrasion, or laser in clinic is paid in full on the day of your procedure. Initial: _____
- There will be a \$50.00 charge for all returned checks. Initial: _____
- Skin care products purchased are nonrefundable, unless there is a legitimate contamination or tampering of the product. Initial: _____
- Procedures purchased as package treatment programs are at a discounted rate, and must be paid in full at the time of your first treatment. Should you decide to cancel your treatments at any time during your treatment package program, then each treatment session performed will be charged at the individual treatments full price and any remaining balance will be refunded back to you. Initial: _____
- You will be directly billed for all services provided. If you do not pay the patient balance within 30 days after receiving the initial statement, we will contact you to establish a payment plan. Initial: _____
- An administration fee may be applied to the surgeon's fee due at your pre operative appointment when paying in any form other than cash or check. The administrative fee is a percentage and will be determined at your consultation. Initial: _____
- After 60 days, if we have not received payment from you or been contacted about payments, your bill will be submitted to a collection agency or small claims court, depending on the amount due. Initial: _____
- All outstanding balances will have a reoccurring administrative fee of \$7.50 per month. You are able to dispute the charges after the entire principal balance is paid in full, but it is on a case by case basis. Please speak to your billing representative for further questions. Initial: _____
- There will also be a \$25.00 collection fee if account gets transferred into collection agency. Initial: _____
- If we feel our patient is not physically or mentally ready or prepared to undergo a surgical procedure we reserve the right to cancel the surgery or refuse to schedule. Initial: _____

The Vu Center for Cosmetic Surgery Questionnaire

Patient Name: _____

Date: _____

<p>I am concerned about: <i>Face</i></p> <ul style="list-style-type: none"><input type="checkbox"/> Perceived that I am scowling<input type="checkbox"/> My nose size or shape<input type="checkbox"/> My teeth are yellow<input type="checkbox"/> The quality of my skin<input type="checkbox"/> The fact that look older than I feel<input type="checkbox"/> My face is red and blotchy<input type="checkbox"/> My face has scars and bumps	<p>I am concerned about: <i>Body</i></p> <ul style="list-style-type: none"><input type="checkbox"/> My breast size or shape<input type="checkbox"/> Hanging skin on my stomach<input type="checkbox"/> My stomach/love handle size<input type="checkbox"/> My buttock/Hip size or shape<input type="checkbox"/> The size of my legs<input type="checkbox"/> The size of my arms	<p>I am concerned about: <i>Vagina</i></p> <ul style="list-style-type: none"><input type="checkbox"/> The fact that I feel undesirable due to the size/shape of my vagina<input type="checkbox"/> Extra skin on my inner lips<input type="checkbox"/> My outer lips are too big/small<input type="checkbox"/> Loss of pleasure during intercourse<input type="checkbox"/> I have very little warning when I have to go to the bathroom
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My actual age is _____ *What age do you feel others perceive you as?* _____

How did you hear about us?

Please mark the option that applies

- Another of Dr. Vu's patients | *Please share who so we may thank them:* _____
- Our website – www.plastic-surgery-portland.com
- Google search
- facebook or Twitter
- Yelp
- Other: _____

COMMENTS: