Patient Registration

PLEASE PRINT AND ANSWER ALL QUESTIONS. Thank you. **Today's Date** _____

Patient's Name _____
Last First Middle

Address _____
Street, Apartment number City State Zip Code

Home Phone _____ Cell Phone _____ Cell Phone Carrier _____

Email Address _____ Marital Status □Single □Married □Divorced □Separated □Widowed

Are there any restrictions for contacting you? □yes □ no Contact Restrictions _____

Date of Birth _____ Age _____ Social Security Number _____-_____-_____

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Cell Phone _____ Work Phone _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext _____ May we call you at work? □yes □no

Address _____
Street, Suite # City State Zip Code

Primary Health Insurance Company Name _____ Group # _____

Policy # _____ Carrier Phone # _____ Copay? □yes □no $ _____

Insured Name _____ Birthdate _____ Employer _____

Secondary Health Insurance Company Name _____ Group # _____

Policy # _____ Carrier Phone # _____ Copay? □yes □no $ _____

Insured Name _____ Birthdate _____ Employer _____

Primary Care Physician _____ Phone # _____

Who referred you? (How did you hear about Dr. Parva/Parva Plastic Surgery?) _____

We request payment to be made at the time services are rendered. Any unpaid balances are due within 30 days of treatment date, unless other arrangements have been made. I agree to be responsible for costs and attorney fees associated with the collection of fees. Payment is accepted in the form of cash, check, money order or credit card. Please note that returned checks are subject to a $35.00 charge.

I understand that I am responsible for my insurance policy and its terms. I hereby authorize Parva Plastic Surgery to release to my insurance company any medical information necessary to process my claims.

I hereby authorize and direct my insurance carrier to pay directly to Parva Plastic Surgery, benefits due to me under my insurance plan. I agree to pay any balance not paid under this plan. Any payment I receive directly from my insurance company will be forwarded to Parva Plastic Surgery.

Signature_____ **Date** _____

Parva Plastic Surgery ● Behzad Parva, MD, FACS
224-D Cornwall Street, NW, Suite 300 ● Leesburg, VA 20176 ● 703.777.7477 ● 703.777.2050 FAX

Medical History Questionnaire

PLEASE PRINT AND ANSWER ALL QUESTIONS. Thank you. Today's Date _____

Patient's Name _____ Birth Date _____ Age _____
Last, First, Middle

Specific Reason for Visit _____ Referred by _____

MEDICAL HISTORY Have you ever had any of the following? **Please select yes or no.**

High Blood Pressure	☐ yes ☐ no	HIV/AIDS	☐ yes ☐ no	Shortness of Breath	☐ yes ☐ no
Heart Attack	☐ yes ☐ no	Hepatitis	☐ yes ☐ no	Lupus Erythematosis	☐ yes ☐ no
Irregular Heartbeat	☐ yes ☐ no	Diabetes	☐ yes ☐ no	Pulmonary Embolism	☐ yes ☐ no
Heart Failure	☐ yes ☐ no	Skin Disease	☐ yes ☐ no	Deep Vein Thrombosis (DVT)	☐ yes ☐ no
Heart Disease	☐ yes ☐ no	Thyroid Disease	☐ yes ☐ no	Emphysema/COPD	☐ yes ☐ no
Stroke	☐ yes ☐ no	Bleeding Disorder	☐ yes ☐ no	Drug Abuse	☐ yes ☐ no
Epilepsy/seizures	☐ yes ☐ no	Kidney Disease	☐ yes ☐ no	Alcohol Abuse	☐ yes ☐ no
Abnormal Bleeding	☐ yes ☐ no	Liver Disease	☐ yes ☐ no	Are you currently pregnant?	☐ yes ☐ no
Psychiatric Illness	☐ yes ☐ no	Tuberculosis	☐ yes ☐ no	Are you currently nursing?	☐ yes ☐ no
Depression	☐ yes ☐ no	Anemia	☐ yes ☐ no	Rheumatoid Arthritis	☐ yes ☐ no
Scleroderma	☐ yes ☐ no	Fibromyalgia	☐ yes ☐ no	Radiation Treatment	☐ yes ☐ no
Anesthetic Reaction	☐ yes ☐ no	Lung Disease	☐ yes ☐ no	Skin Sensitivities	☐ yes ☐ no
				Cancer	☐ yes ☐ no

Please indicate type of cancer. _____

Please list any other medical history the doctor should be aware of. _____

Please list any prior hospitalization (i.e.: accidents, etc.). _____

SURGICAL HISTORY Please list all previous surgeries/operations, including cosmetic procedures.

Procedure	Surgeon	Hospital	Date of Surgery

Please list any complications or problems you experienced during and/or following any of the above procedures. _____

ALLERGIES and/or SENSITIVITIES Please indicate which, if any, are present. ☐ **I Have No Known Allergies or Sensitivities**

Penicillin	☐ yes ☐ no	Latex	☐ yes ☐ no					
Sulfa	☐ yes ☐ no	Adhesive tape	☐ yes ☐ no					
Codeine	☐ yes ☐ no	Vaccines	☐ yes ☐ no	Please list	_____			
Eggs	☐ yes ☐ no	Antibiotics	☐ yes ☐ no	Please list	_____			

Please list any other allergies that you have. _____

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MEDICATIONS Please list medications and dosage you currently take, including appetite suppressants, vitamins, herbal supplements, or any homeopathic medication.

Do you take any blood thinners (i.e.: Coumadin, Warfarin, Plavix), Aspirin or any Aspirin-containing compound, Motrin, Advil or Ibuprofen?

☐ yes ☐ no If "yes", please list and indicate reason. _____

Do you take Vitamin E? ☐ yes ☐ no If "yes," please indicate how much and how often. _____

Have you ever taken Accutane? ☐ yes ☐ no If "yes," please indicate when. _____

FAMILY MEDICAL HISTORY Please list history of disease i.e.; heart, lung, cancer, etc and indicate relationship of relative.

SOCIAL HISTORY Occupation _____ Marital Status □Single □Married □Divorced □Separated □Widowed

Height _____ Weight _____ Pregnant? ☐ yes ☐ no # of Pregnancies _____ # of Live Births _____

Cigarette Smoking ☐ yes ☐ no If "yes," how many packs per day? _____ How long have you been smoking? _____

Chew tobacco or snuff ☐ yes ☐ no If "yes," how much per day? _____ Length of time using smokeless tobacco? _____

Alcohol Use ☐ yes ☐ no If "yes," how often? Occasional / Moderate / Heavy

Caffeine ☐ yes ☐ no If "yes," how often? _____ How Much? _____

Street and Illicit Drugs ☐ yes ☐ no If "yes," please list drug, and frequency _____

REVIEW OF SYSTEMS Do you have any of the following symptoms? Please select yes or no.

GENERAL			**NEUROLOGICAL**			**SKIN**		
Weight change	☐ yes	☐ no	Headaches/migraines	☐ yes	☐ no	Keloids	☐ yes	☐ no
Fatigue/energy loss	☐ yes	☐ no	Dizziness	☐ yes	☐ no	Rash	☐ yes	☐ no
Fevers	☐ yes	☐ no	Fainting	☐ yes	☐ no	Itching	☐ yes	☐ no
Heat/cold intolerance	☐ yes	☐ no	Muscle weakness	☐ yes	☐ no	Flushing	☐ yes	☐ no
Night sweats	☐ yes	☐ no	Numbness	☐ yes	☐ no	Scar easily	☐ yes	☐ no
Changes in nails	☐ yes	☐ no	Tingling	☐ yes	☐ no	Hair loss	☐ yes	☐ no
CARDIOVASCULAR			**EAR/NOSE/THROAT**			Skin sensitivities	☐ yes	☐ no
Heart murmur	☐ yes	☐ no	Sore throat	☐ yes	☐ no	**EYES**		
Chest pain	☐ yes	☐ no	Changes in voice	☐ yes	☐ no	Blurry vision	☐ yes	☐ no
Irregular heartbeat	☐ yes	☐ no	Trouble swallowing	☐ yes	☐ no	Blindness	☐ yes	☐ no
Swelling in feet	☐ yes	☐ no	Frequent runny nose	☐ yes	☐ no	Dry eyes	☐ yes	☐ no
GASTROINTESTINAL			Hearing loss	☐ yes	☐ no	Light sensitivity	☐ yes	☐ no
Abdominal pain	☐ yes	☐ no	**MUSCULOSKELETAL**			Wear glasses	☐ yes	☐ no
Heartburn/ulcers	☐ yes	☐ no	Muscle pain	☐ yes	☐ no	History of glaucoma	☐ yes	☐ no
Loss of appetite	☐ yes	☐ no	Arthritis/joint pain	☐ yes	☐ no	**PSYCHIATRIC**		
Nausea/vomiting	☐ yes	☐ no	Back/neck pain	☐ yes	☐ no	Panic disorder	☐ yes	☐ no
Constipation	☐ yes	☐ no	**GENITOURINARY**			Mood changes	☐ yes	☐ no
Diarrhea	☐ yes	☐ no	Loss of bladder control	☐ yes	☐ no	Depression	☐ yes	☐ no
Blood in stools	☐ yes	☐ no	Frequent urination	☐ yes	☐ no	Anxiety/nervousness	☐ yes	☐ no
RESPIRATORY			Painful urination	☐ yes	☐ no	Anorexia/bulimia	☐ yes	☐ no
Shortness of breath	☐ yes	☐ no	Blood in urine	☐ yes	☐ no	**HEMATOLOGICAL**		
Wheezing	☐ yes	☐ no	Menstrual problems	☐ yes	☐ no	Anemia	☐ yes	☐ no
Cough	☐ yes	☐ no	**IMMUNE**			Bleed/bruise easily	☐ yes	☐ no
			Frequent infections	☐ yes	☐ no	Blood clots	☐ yes	☐ no
			Swollen glands	☐ yes	☐ no	Blood transfusion	☐ yes	☐ no

By signing below, I attest that all of the questions I have answered and information I have provided are true and accurate.

Patient Signature _____ Name (PLEASE PRINT) _____ Date _____

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Notice of Privacy Practices

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES
AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

I acknowledge I have received a copy of the Parva Plastic Surgery **Notice of Privacy Practices**, describing how my health information may be used or disclosed under state and federal patient privacy laws. Provided that Parva Plastic Surgery continues in its good faith effort to comply with the requirements of the privacy laws, I hereby consent to the use and disclosure of my health information for the purpose and activities permitted under the privacy laws, which are described in the **Notice of Privacy Practices**.

I understand that I should read the **Notice of Privacy Practices** carefully. I am aware that the Notice may be changed at any time. I understand that a copy of the Notice is posted on www.parvaplasticsurgery.com and a copy is posted in the office.

Patient Name _____ Date _____

Signature of Patient _____ Date of Birth _____

If signed by a personal representative:

Name of Personal Representative _____ Relationship to Patient _____ Date _____

Signature _____ Driver's License Number _____ State _____

If you received this form electronically, please sign and date the form and return it to Parva Plastic Surgery at 224-D Cornwall Street, NW, Suite 300, Leesburg, VA 20176 or fax it to 703-777-2050.

For Physician Office use only:

Complete this section if form not signed and dated by the patient or patient's representative.

Patient Name _____ Date of Birth _____ SS# _____

Address _____ Phone Number _____

Reason Signature and Date Not Obtained _____ Date Requested _____

Signature of Employee _____ Date _____

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Notice of Privacy Practices

AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)
EFFECTIVE DATE: APRIL 14, 2003

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR COMMITMENT TO YOUR PRIVACY

At Parva Plastic Surgery Center, P.C., we are committed to protecting the privacy rights of our patients. You have a variety of rights under the federal law known as HIPAA, the Health Insurance Portability and Accountability Act of 1996, and the related Privacy Rule published by the U.S. Department of Health and Human Services. Those federal rights are described in this notice.

PURPOSE OF THIS NOTICE

This Notice describes your legal rights, advises you of our privacy practices, and lets you know how Parva Plastic Surgery is permitted to use and disclose your Protected Health Information.

WHAT IS PROTECTED HEALTH INFORMATION?

Health information includes more than just information about medical procedures. The term includes all information that relates to: (a) the past, present, or future physical or mental health or condition of an individual; (b) the provision of health care to an individual; and (c) the past, present, or future payment for the provision of health care to an individual.

Health information that identifies an individual or which can probably be used to identify the individual is protected by law. The protected health information is known as PHI. When treating you, we need to use all available relevant medical information. However, in other circumstances, we use the minimum PHI necessary for the transaction.

USES AND DISCLOSURES OF PHI

Parva Plastic Surgery may use or disclose your PHI for the purposes of treatment, to obtain payment for treatment, to evaluate the quality of care you receive, and for administrative purposes in most cases without your written authorization or without giving you a chance to object or to agree to the use of the disclosure. Examples of our use of your PHI include:

Treatment: We will use and share your medical record for your care. This includes such things as verbal and written information we obtain about you and use pertaining to your medical condition and treatment.

Payment: This includes activities we must undertake in order to receive reimbursement for services we provide to you, including such things as organizing your PHI and submitting bills to insurance companies, management of billed claims for services rendered, medical necessity determinations and reviews, and collection of outstanding accounts.

Health Care Operations: This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes.

ADDITIONAL USES AND DISCLOSURE OF PHI WITHOUT YOUR AUTHORIZATION

Parva Plastic Surgery is also permitted to use or disclose your PHI without your written authorization, or opportunity to object in certain situations, including:

- For Parva Plastic Surgery's use in treating you or in obtaining payment for services provided to you or in other health care operations;
- For the treatment activities of another health care provider;
- To another health care provider or entity for the payment activities of the provider or entity that receives the information (such as your hospital, facility, or insurance company);
- To another health care provider for the health care operation activities of the covered entity that receives the information as long as the covered entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;
- For health care fraud and abuse detection or for activities related to compliance with the law;
- To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. In situations where you are not capable of objecting (because you are not present or due to incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to your family member, relative, or friend is in your best interest. In that situation, we will disclose only health information relevant to that person's involvement in your care.
- To a public health authority in certain situations (such as reporting a birth, death or disease as required by law, as part of a public health investigation, to report child or adult abuse or neglect or domestic violence, to report adverse events such as product defects, or to notify a person about exposure to a possible communicable disease as required by law);
- For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
- For judicial and administrative proceedings as required by a court or administrative order, or in response to a subpoena or other legal process; except as may be further limited by applicable state law regarding health records privacy;
- For law enforcement activities in limited situations;
- For military, national defense and security and other special government functions;
- To avert a serious threat to the health and safety of a person or the public at large;
- For workers' compensation purposes, and in compliance with workers' compensation laws;
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;

- If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation;
- To remind you of appointments;
- For research projects, but this will be subject to strict oversight and approvals and health information will be released only when there is minimal risk to your privacy and adequate safeguards are in place in accordance with the law.

Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization, (the authorization must specifically identify the information we seek to use or disclose, as well as when and how we seek to use or disclose it). You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information based upon that authorization.

We will make reasonable efforts to limit PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request.

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

PATIENT RIGHTS

As a patient, you have certain rights regarding your PHI. We cannot require you to waive those rights under the Privacy Rule. Those rights include:

Right to Inspect and Copy your PHI: You have the right to inspect and/or request a copy of most of the medical information about you that our practice maintains. We will normally provide you with access to this information within 15 days of your request. We will also charge you a fee to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials.

We have forms available for you to request access to your PHI. We will provide a written response if we deny you access and let you know your appeal rights. If you wish to inspect and/or receive a copy of your medical information, please contact the privacy official listed at the end of this Notice.

Right to Amend your PHI: You have the right to ask us to amend written medical information that we may have about you. If errors are found, we will generally amend your information within 30 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information, but only in certain circumstances. If you wish to request that we amend the medical information we have about you, you should contact in writing the privacy official listed at the end of this Notice.

Right to an Accounting of Disclosures: You may request an accounting from us of certain disclosures of your medical information that we have made in the last six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations.

We are also not required to give you an accounting of our uses of your PHI for which you have already given us written authorization. If you wish to request an accounting of the medical information about you that we have used or disclosed that is not exempt from the accounting requirement, contact the privacy official listed at the end of this Notice.

Right to Request Restrictions: You have the right to request that we restrict how we use and disclose the medical information we have about you for payment, treatment or health care operations or to restrict the information that is provided to family, friends and other individuals involved in your health care. We are not required to agree to your request. If we agree, we will follow your request unless the information restricted is needed to provide you with emergency treatment. You must inform us (in writing) of the type of restriction you want and to whom it applies.

Right to Request Confidential Communications: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. In order to request a type of confidential communication, you must make a written request to the privacy official listed at the end of this Notice. Our practice will accommodate reasonable requests.

Right to Paper Copy of this Notice: We have prominently posted a copy of this Notice on our web site at www.parvaplasticsurgery.com and the Notice is available electronically through the web site. You may also request a paper copy of the Notice by contacting the privacy official listed below.

Revisions to the Notice: We reserve the right, when we change a privacy practice, to change the terms of our notice and to make the new notice provisions effective for all PHI that we maintain. If we change those material terms of our notice, we will promptly provide them in our office and on our website (www.parvaplasticsurgery.com). You may receive a paper copy of the Notice by contacting the privacy official listed below.

Your Legal Rights and Complaints: You also have the right to complain to us, or to the Office of Civil Rights of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or the government. Should you have any questions, comments or complaints, you may direct all inquires to the privacy official listed below. All complaints must be submitted in writing.

Behzad Parva, MD, FACS
Parva Plastic Surgery Privacy Official
224-D Cornwall Street NW, Suite 300
Leesburg, VA 20176
703.777.7477
703.777.2050 FAX

You may also file a written complaint with the
Office for Civil Rights, DHHS
150 S Independence Mall West, Suite 372
Philadelphia, PA 19106-3499
215.861.4441; 215.861.4440 (TDD)
215.861.4431 FAX
ocrmail@hhs.gov