



PLASTIC SURGERY ASSOCIATES, P.C.

CSABA L. MAGASSY, MD, FACS
1300 Chain Bridge Road McLean VA, 22101
703-790-5454

Welcome to Plastic Surgery Associates, P.C. Thank you for choosing us for your reconstructive and plastic surgery needs. We kindly ask that you fill out our patient information and medical history-sheet to help us better serve you and maintain our records.

Please inform the front desk if you need assistance in tilling out these forms.

Reason for consultation: _____ **Today's Date:** _____

Patient's Full Name:			
Patient's Address:			City/State/Zip
Patient's SSN:	Date of Birth:	Marital Status:	Gender:
Home Phone:	Work Phone:	Cell Phone:	Pager:
Email Address:		May we send you correspondence via email: Yes No	
Employer:	Employer Address:		
Occupation:	Employment Status: Full Time / Part Time / Student / Retired / Other		
Emergency Contact Name:		Emergency Contact Relationship:	Emergency Contact Phone
If the Patient is a child. Who may authorize Treatment:			Relationship to Child:
Person Financially responsible:		Relationship to the Patient:	Phone Number:
Address of the Person who is accepting Financial Responsibility:			
Please list the names of everyone you authorize the release of your private health information to:			

To help keep you looking beautiful for life, we would like to ensure you are informed of the latest cosmetic treatments and procedures. May we mail correspondence to your home address?
YES NO



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Whom can we thank for referring you to our practice? If there is no referral source, please specify your primary care physician's name. (Please select one)

Physician's Name:	Previous Patient: (Name)
Seminar: (Where)	Website:
Magazine:	Yellow/White Pages:
Mailer:	Other

INSURANCE INFORMATION

Primary Insurance		Policy Number	Group Number
Policy Holder's Name	Policy Holder's Date of Birth	Policy Holder's SSN	Relationship to the Patient
Secondary Insurance		Policy Number	Group Number
Policy Holder's Name	Policy Holders Date of Birth	Policy Holder's SSN	Relationship to the Patient



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HEALTH HISTORY

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____ SEX: _____ M _____

1. Are you allergic to any medications or have you had any reactions to medications? If yes, please list.
2. Are you taking any medications? ___ Yes ___ No If Yes, please list, and include over the counter preparations such as Aspirin, Antihistamines, Motrin, Anti-Inflammatory or Diuretics.
3. Are you taking any vitamins or dietary supplements? If yes, please list.

Do YOU have a history of any of the following?	Yes	No	If you answered yes to any or the following please give a brief description....
Anemia			
Arthritis			
Asthma			
Bleeding Problems			
Bronchitis/Pneumonia			
Cancer			
Diabetes			
Emphysema			
Fainting Spells			
Glaucoma			
Hay Fever			
Heart Murmur			
Heart Problems/Angina/Irregularities			
Hiatal Hernia			
High Blood Pressure			
Kidney Problems			
Liver Problems			
Rheumatic Fever			
Seizures			
Sleep Apnea			
Thyroid Problems			
Ulcers			
Other			



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4. Do you smoke? Yes No - If yes, how many packs per day? _____
5. Do you drink alcohol? Yes No-If yes, how much? _____
6. Do you now or have you ever used recreational drugs? Yes No If yes, when was the last time? _____

7. When was your last chest x-ray? _____
8. Have you ever had any surgery? If yes, please explain? _____

9. Have you or any member of your immediate family had any problems with anesthesia? If so, please explain? _____

10. Is there a chance you might be pregnant? Explain _____ LMP _____
11. Are you under the care of a physician? If so, please list name and address: _____

12. How could you describe your present health? Excellent Good Fair Poor
13. Have you ever had a blood transfusion? Yes No If so, when? _____
14. Do you have any dentures, partial plates, or capped teeth? Yes No
15. Are you bothered by motion sickness? Yes No
16. Have you had any recent weight gain/loss? Yes No - If so, how much? _____
17. Do you have any visual impairment? Contacts Glasses Eyelid Obstruction of Vision
18. In case of an emergency, please contact: _____ Tel. No. _____
Relationship to patient _____

- All information on this form is strictly confidential

Please complete the next form...



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NOTICE OF PRIVACY PRACTICES (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 READ IT CAREFULLY. THIS NOTICE IS FROM PLASTIC SURGERY ASSOCIATES, P.C., A LIMITED LIABILITY COMPANY.

Plastic Surgery Associates provides plastic surgery, cosmetic dermatology, out-patient surgery and related medical aesthetic services. Plastic Surgery Associates is committed to maintaining the privacy of health information and providing patients with a notice of its legal duties and privacy practices. Plastic Surgery Associates will not use or disclose private health information except as described in this notice. "Private Health Information" is information about you which was created or received by Plastic Surgery Associates and that relates to the past, present, or future, physical or mental health or condition, or provision, or payment for health care and which could be used to identify the patient.

Examples of disclosures for treatment, payment, and health operations are described in the following categories, stating how Plastic Surgery Associates may use or disclose private health information without written authorization.

Treatment: Plastic Surgery Associates will use health information in the provision and coordination of health care. We may disclose all or any portion of private health information, such as medical reports, to attending physicians and other health care providers who have an emergent need for such information in the care and continued treatment of the patient. Plastic Surgery Associates also may disclose health information to other people, such as family members, clergy, and others who may be directly involved in the patient's care.

Health Care Operations: Plastic Surgery Associates may use and disclose private health information during routine healthcare operations including, without limitation, utilization review, evaluation of our staff, assessing the quality of care and outcomes in the patient's case and similar cases, internal auditing, accreditation, certification, and the modalities used and may include a copy of the medical report.

Scheduling and Appointment Reminders: Plastic Surgery Associates may use or disclose private health information obtained when scheduling medical or other health care services and when it contacts the patient as a reminder of an appointment for services. Plastic Surgery Associates may also use and disclose private health information to tell the patient or others of information about treatment alternatives or other health related benefits and services of possible interest to the patient.

Business Associates: Plastic Surgery Associates may use or disclose certain private health information about the patient to business associates. A business associate is an individual or entity under contract with Plastic Surgery Associates to perform with or assist Plastic Surgery Associates in a function or activity that would necessitate access to, or the use or disclosure of, private health information. Examples of business associates include but are not limited to, a copy service used by Plastic Surgery Associates to copy private health records, consultants, accountants, lawyers, practice management organizations, private health transcriptionists, case managers, marketing, customer service personnel, and third party billing companies. Plastic Surgery Associates will attempt to require the business associate to protect the confidentiality of private health information.

Regulatory Agencies: Plastic Surgery Associates may disclose private health information to a health oversight agency for activities authorized by law, including, but not limited to licensure, certification, audits, investigations, and inspections.

Law Enforcement / Litigation: Plastic Surgery Associates may disclose private health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

Public Health: Plastic Surgery Associates may disclose private health information to public health or legal authorities charged with preventing or controlling disease. For Example: Plastic Surgery Associates may be required to report the existence of communicable disease to the department of health to protect the health and well being of the general public.

I acknowledge that I have read, understand and agree to the above notice of privacy practices. I further understand that at my request I may obtain a signed copy of this notice for my records.

Signature of Patient/Parent/Responsible Party	Date
Printed name of Patient/Parent/Responsible Party	Reserved for Local Use (staff only)



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FINANCIAL AND PAYMENT POLICY

Cosmetic Patients:

The fees quoted for cosmetic surgery are inclusive of the following: Your pre-operative examination, surgical fees, facility fees, anesthesia, most supplies, and your post operative visits. The fees for in-office treatments such as, microdermabrasion, botox, collagen or other filler material, chemical peels, vascular lasers, or other similar procedures are priced either on a per treatment basis or as a package option. Office treatments are payable in full at the time of your appointment.

If you elect surgery, you may schedule as soon as you would like. This will improve your chances of getting the date that works best for you. A \$500.00 deposit is required to reserve your surgery date, which will be applied to your total balance due. Plastic-Surgery Associates requires that all surgical, anesthesia, and facility fees be paid two weeks prior to surgery. Once surgery is scheduled, operating room time has been reserved and nursing staff has been scheduled for your surgery; therefore, please be aware that the fees are non-refundable if you should cancel within seven days of your surgery date. The fees quoted will be honored for 90 days from the date of your consultation.

Returned Check Fees:

Plastic Surgery Associates charges a \$40.00 fee for any returned checks. After a check is returned for non-sufficient funds, you must then pay by credit card, cashier's check, or cash.

Medical Records Release:

I hereby authorize Plastic Surgery Associates to release my medical records to, and to discuss with, my treating physicians and all other health care providers. I further authorize all of my treating physicians and other health care providers to release my medical records to Plastic Surgery Associates. I am aware that Plastic Surgery Associates does not keep records that exceed six years.

Non-Payment:

If your account is turned over to a collection agency or attorney for non-payment, you will also be responsible for any and all additional fees permitted by law and a 33% collection fee will be added to your account.

Signature of Patient/Parent/Responsible Party	Date
Printed name of Patient/Parent/Responsible Party	Reserved for Local Use (staff only)



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Patient Photographic Authorization and Release

I consent to the taking of photographs or video tapes of me or parts of my body, by Dr. Csaba Magassy of Plastic Surgery Associates or designee, in connection with any care or procedures provided by Dr. Csaba Magassy of Plastic Surgery Associates or designee in the past or future. I understand that any such media will become the property of Dr. Csaba Magassy of Plastic Surgery Associates or designee.

These procedures will be performed by Dr. Csaba Magassy of Plastic Surgery Associates or designee. I further consent to the release by Dr. Csaba Magassy of Plastic Surgery Associates or designee to the America Board of Aesthetic Plastic Surgery (ASAPS) of such photographs, video tapes or case histories. I also hereby grant permission for the use of any of my medical records including illustrations, photographs, or other images created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery.

I understand that such photographs, videotapes or case histories may be published by Dr. Csaba Magassy of Plastic Surgery Associates or designee and/or ASAPS and/or any party acting under their license and authority in any print, visual, or electronic media including, but not limited to, medical journals and text books, scientific presentations and teaching courses, and internet websites, for the purpose of informing the medical profession or the general public about plastic surgery methods.

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

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on actions taken prior to my revocations. If I do not revoke this authorization it will expire 20 years from the date written below.

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 further understand that because ASAPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected my HIPAA and may be re-disclosed.

I release and discharge Dr. Csaba Magassy of Plastic Surgery Associates or designee, ASAPS, and all parties acting under their license and authority from all rights that I may have in the photographs, videotapes, or case histories 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 these materials in any medium.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above authorization and release and fully understand its terms.

Signature of Patient/Parent/Guardian	Date
Printed Name of Patient/Parent/Guardian	Reserved for Local Use (Staff Initials)