Patient Registration - Please Complete Entire Form

Patient Name: (First) ______________________________ (M) _______________ (Last) ________________________________

Address: ____City: _____________________ State: __________ Zip: _____________

DOB: _____/______/_____ Age: ________ Social Security #: _______-_______-_______ **(If using insurance this is required)**

Cell/Home Phone: ___________________ Work Phone: _________________ Email: ___________________________________

Sex: M F Race: __________________________ Ethnicity: ________________________ Decline: ___________

Marital Status: ______________ if married, Name: ______________________________ Phone: __________________________

Emergency Contact: ____________________________ **Relationship:** ________________ **Phone:** ____________________

Patient Employed: Yes No Patient Employer: _____________________________ Occupation: _____________________

Employer Address: _________________________________ City: _____________________ State: ___________ Zip: __________

How did you hear about us? __________________ If patient or friend referral (name): ___________________________________

If using insurance, please complete the following:

Primary Insurance Co: _____________________________ Policy/ID#: ______________________Group#: _________________

Policy Holder: ______________________________ DOB: ______/_____/______Policy Holder SSN: ________-_____-_________

Policy Holder Employer: _________________________________ Employer Phone Number: ____________________________

Secondary Insurance Co: ___________________________ Policy/ID#: ______________________Group#: _________________

Policy Holder: ______________________________ DOB: ______/_____/______Policy Holder SSN: ________-_____-_________

Policy Holder Employer: _________________________________ Employer Phone Number: ____________________________

Statement of Understanding

By Signing below, I certify all the information above is true and correct to the best of my knowledge.

____ ______________________________ ____________________

Signature of Patient/Responsible Party/Legal Guardian Relationship to Patient Date

____ ______________________________ ____________________

Printed Name of Patient/Responsible Party/Legal Guardian Relationship to Patient Date

Alpine Staff Initials: _______________

Patient Name: ____ **Age:** _______ **Height:** _______ **Weight:** _______

Date of Last Physical Exam: _______________ **Primary Care Physician/Clinic:** ______________________________

Do you CURRENTLY have any of the following? (If YES please check appropriate box): ☐ **N/A**

☐ Fatigue
☐ Fever
☐ Shortness of Breath
☐ Brain Fog/Memory Loss
☐ Dizziness/Vertigo
☐ Vision Chang
☐ Bulging Eyes
☐ Severe Headaches/Migraines
☐ Trouble Concentrating
☐ Heart Palpitations
☐ Heart Murmur
☐ High Blood Pressure
☐ Ear Ringing
☐ Chronic Earaches
☐ Hearing Loss
☐ Bleeding Disorder/Bruising
☐ Blood Clots/Factor 5
☐ Anemia

☐ Low Blood Sugar
☐ Muscle Aches/Pain
☐ Muscle Weakness
☐ Muscle Fatigue
☐ Joint Pain/Soreness
☐ Leg Swelling/Pain
☐ Cold/Heat Intolerance
☐ Cold Hands/Feet
☐ Hair Loss
☐ Insomnia
☐ Night Sweats
☐ Low Libido
☐ Sore Throat
☐ Acid Reflux
☐ Difficulty Swallowing
☐ Skin Rash
☐ Skin Pigment Changes
☐ Chronic Inflammation
☐ Numbness/Tingling

☐ Hormone Imbalance
☐ Sun Sensitivity
☐ Dry Skin/Mouth/Eyes
☐ Chest Pain
☐ Neck Pain
☐ Back Pain
☐ Frequent/Painful Urination
☐ Dehydration
☐ Chronic UTI's
☐ Chronic Yeast Infections
☐ Breast Mass/Nodules
☐ Breast Pain
☐ Swollen Lymph Nodes
☐ Nail Changes
☐ Kidney Dysfunction
☐ Liver Dysfunction
☐ Abdominal Pain
☐ Nausea
☐ Irregular Menstrual Cycle

☐ Constipation
☐ Diarrhea
☐ Rectal Bleeding
☐ Leaky Gut
☐ Persistent Cough
☐ Difficulty Breathing
☐ Body Odor
☐ Food Allergies
☐ Sinus Infection
☐ Smell Sensitivity
☐ Depression
☐ Panic Attacks
☐ Anxiety Attacks
☐ Mood Swings
☐ Suicidal Thoughts
☐ Weight Gain/Loss

☐ Other: ____

Have you ever been diagnosed from a physician with any of the following? ☐ **N/A**

☐ Fibromyalgia
☐ Lyme Disease
☐ Sleep Apnea
☐ Crohns Disease
☐ Ulcerative Colitis
☐ Hyper/Hypo Thyroid
☐ Hashimotos Disease
☐ Addison Disease
☐ Celiac Disease
☐ Myasthenia Gravis
☐ Mononucleosis
☐BIA-ALCL Lymphoma

☐ Pernicious Anemia
☐ Diabetes (type: _______)
☐ Irritable Bowel Syndrome
☐ Meniere's Disease (Inner Ear)
☐ Seizures
☐ Cancer (area: ________)
☐ Asthma
☐ Rheumatoid Arthritis
☐ Lupus
☐ Sjogren's Syndrome
☐ Raynaud's Syndrome

☐ Graves Disease
☐ Scleroderma
☐ Multiple Sclerosis
☐ Epstein-Barr Virus
☐ ADHD
☐ HIV
☐ Menopause:
(age at onset: ________)
☐ MRSA
☐ Glaucoma
☐ Bi-Polar Disorder
☐ Guillain-Barre Syndrome

☐ Psoriasis
☐ Vasculitis
☐ Kidney Stones
☐ Gall Stones
☐ Hepatitis (type: ______)
☐ Seizures
☐ TMJ
☐ Tuberculosis
☐ Malignant Hyperthermia (you or family hx)
☐ Other: ____________________

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Patient Name: ______________________________________

List ALL medications you are currently taking (Prescription Medications, Non-Prescription (OTC) including Aspirin, Herbal Medications, Vitamins):

Medication(s)	Dose	Frequency

☐ **Patient takes no medication(s)**

****If you take Aspirin, Ibuprofen or other blood thinners you must stop taking these 1 week prior to any surgery.**

Drug Allergies: ☐ **No Allergies**

____

All Surgical History (Including Cosmetic Surgery):

____

____

Social History	YES	NO
Do you **Smoke/Vape/Chew**? **If you are planning on surgery, you will be asked to quit.	☐ If yes, how much daily? _______ How many years? ______________	☐
Do you exercise?	☐ Weekly, how often? _________	☐
Do you drink caffeine?	☐ How much daily? ___________	☐
Do you drink alcohol?	☐ How often? _______________	☐
Do you have body piercings?	☐ If yes, location: ______________	☐
Do you have an unusual reaction to Anesthesia?	☐ If yes, what: ________________	☐
Do you have an advanced directive? (living will)	☐ If No, Would you like information about it? __________	☐
Any Recreational Drugs?	☐ Please List__________________	☐

Female Patients Only	Y	N
Are you pregnant?	☐	☐
Are you planning on becoming pregnant?	☐	☐
Did you breast feed in the past? how long? _______________ ___________________	☐	☐
How many births? _________		
Hysterectomy? YR_____		

Patient Initials: _______________________

Office Staff Initials: ___________________

HIPAA Acknowledgement & Privacy Consent

Alpine Plastic Surgery understands the importance of privacy and we are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care provider's quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this practice properly. By law, we are required to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. Our notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your PHI. If you have any questions about the notice, please contact our privacy officer at 801-689-3500.

By signing this form, you consent to Alpine's use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent in writing. You also have the right to obtain a copy of the privacy notice. Our practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996.

Also, by signing this form, you are also giving Alpine Plastic Surgery and Alpine Surgical Center, LLC permission to discuss your medical information with: (please check one)

□ Alpine Plastic Surgery may discuss pertinent information with **ANY** family or friends about my care.

□ Alpine Plastic Surgery may **ONLY** discuss pertinent information with the person(s) named below:

Person	**Relationship**	**Contact Number**
______________________	______________	______________________
______________________	______________	______________________

Note: If you bring family or friends with you to your appointments, we will assume you have authorized us to tell them information about your case or treatment, unless you advise us ahead of time. We may also decide in our professional judgment such persons may have a need to have information about your care and treatment, such as for driving or post-operative care.

By signing below, I understand that my protected health information may be disclosed for treatment, payment or health care operations. I acknowledge that I have been presented with a copy of Privacy Practices and I understand that I may obtain a copy of the notice at any time. I have the right to restrict the use of my information, but the practice does not have to agree to the restrictions. I understand that I can revoke this consent at any time in writing.

______________________________	____________________	______________
Signature of Patient or Legal Representative	Relationship to patient	Date

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PATIENT CONSENT TO TREATMENT AND FINANCIAL RESPONSIBILITY

The undersigned, as either (a) the Patient receiving care by Alpine Plastic & Reconstructive Surgery, P.C. or its physicians or medical staff (collectively "Alpine") or by Alpine Surgical Center, LLC or its nursing and other personnel (the "Facility") or (b) the legally authorized representative or responsible financial guarantor of the Patient, hereby makes the following consents, understandings, and agreements on my own behalf and on behalf of the Patient, in partial consideration of health care services to be provided to the Patient by Alpine, by or in the Facility, or by their respective medical staffs:

Consent for Services: I hereby give consent to Alpine and the Facility, and their respective medical staff, contractors, physicians, and employees to provide health care services to the Patient and to administer physician orders and related medical care, tests, studies and/or services for the benefit of the Patient for this visit and any subsequent visits. Patient will inform Alpine and its medical staff of all medications being taken and will discontinue use of medications which are not ordered or approved by Alpine or its medical staff as reflected in Alpine's medical records for Patient. I understand that there is a risk of substantial and serious harm involved in such health care services, and I accept such risk in the hope of obtaining beneficial results from such services. No promises or guarantees of any particular outcome or successful result have been made.

Cosmetic Surgery: I understand that certain medical services and procedures, including but not limited to elective cosmetic surgery procedures, are generally not covered or otherwise entitled to benefits under individual or group welfare benefit plans, including insurance plans or products, that I may have or be entitled to benefits under "Uninsured Procedures".

Fees: Due to the wide variety of patient medical conditions and the nature of the cosmetic, surgical and reconstructive services Alpine physicians treat, Alpine and Facility are generally unable to estimate in advance the fees or charges which might be incurred for your treatment. The fees of Alpine and Facility are based upon its reasonable and customary fee schedule. I understand and agree that, if and to the extent Alpine has quoted any fee reduction or other discount for multiple surgical procedures or other health care services, any such fee reduction or discount is intended to, and shall, apply solely to uninsured procedures. Solely, with respect to uninsured procedures, the fee quoted by Alpine includes (i) the physician fees of Alpine (including usual and customary post-operative visits), (ii) the fee payable by patient to the Facility and (iii) the fee payable by patient to Anesthesia. In all other cases, Patient is directly responsible for payment of the Facility fee to Facility and the Anesthesia fee to Anesthesia. Fees do not include, and Patient is solely responsible for, fees or charges of any other health care providers or facilities which provide items or services to patient (for instance, if patient is transferred in emergent circumstances).

Payment and Scheduling Policies: All co-payments, deductibles, co-insurance, and/or charges for non-covered services are due and payable on or before the time of service. I understand that it is my responsibility to know the provisions of my insurance policies, what services are covered, and which providers, facilities or locations are preferred or within network. A list of insurances accepted by Alpine and the Facility is available upon request.

Medical Non-Insured Patients: A $250.00 payment is due at the first appointment for non-surgical consultations. Surgical consultations will be required to make a $1000.00 payment at the first appointment. Patient and the undersigned, if other than the patient, remain responsible for any remaining balance for items or services rendered in addition to consultation.

All patients: When scheduling a surgery date, you are required to set up a pre-operative appointment. Your pre-operative appointment should be scheduled at least two weeks prior to your surgery date. If you do not show up for your pre-operative appointment you will be taken off of the surgery schedule.

- Payment in full or insurance company pre-authorization is required at the time of your pre-operative appointment to secure your surgery date and time. Methods of payment accepted: Cash, Money Order, Cashier's Check, Travelers Check, Visa, or Master Card. No personal checks will be accepted. Once you have secured a surgery date and time, a $500.00 cancellation fee will be applied. This fee is non-refundable. If you are scheduled for a no charge procedure or touch up procedure and cancel the procedure within one week of your surgery date a $500.00 rescheduling fee will be charged.

Relationship of Providers: I understand that (a) Alpine provides professional medical services (including but not limited to plastic and reconstructive surgery services) of physicians licensed under the Utah Medical Practice Act, (b) the Facility provides outpatient surgery center facility services (e.g., nursing services, services of technical personnel and other services related to the surgical procedure, drugs, biological, surgical dressings and administrative, recordkeeping and housekeeping items and services), and (c) anesthesia services are provided by an independent anesthesiologist and/or certified registered nurse anesthetists under the supervision of the independent anesthesiologist (collectively, "Anesthesia"). Alpine, the Facility and Anesthesia are legally separate and independent providers.

Release of Information: Alpine and the Facility are each required by law to make and keep records of the Patient's medical treatment. Both Alpine and the Facility safeguard those records and use and disclose such records and the information they contain only in accordance with applicable state and federal privacy laws. Such uses and disclosures are described in detail in Alpine's and the Facility's respective Notice of Privacy Practices, which may be amended from time to time. I understand that either the Patient or I may ask to see a copy of the current notice at any time.

Insurance/Assignment of Benefits: Any and all benefits from insurance companies and other third party payors that are payable to the Patient, or on behalf of the Patient for health care services and related payments for services rendered or provided to the Patient are hereby transferred and assigned to Alpine and/or the Facility, as the case may be, for the exclusive purpose of paying for charges associated with the health care services provided to the patient by Alpine or the Facility. I understand and intend that all insurance companies and other third party payors will pay benefits directly to Alpine and/or the Facility in payment of their charges and the charges of any other health care providers for whom either Alpine or the Facility is authorized to bill in connection with health care services provided to the patient.

- I understand that I am responsible for complying with the pre-authorization and other requirements of any insurance policies which provide, or may provide, coverage for services rendered or provided by Alpine and/or the Facility, and that I am responsible for any balances remaining after third party payments, if any, are received. Alpine and/or the Facility will file insurance claims with insurance companies and other third-party payors for any procedures which are likely to be covered under patient's insurance, so long as I furnish proof of coverage and related insurance benefits information at or prior to my pre-operative appointment.

Financial Responsibility: Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay for all health care services rendered or supplies provided to the Patient by Alpine and/or the Facility including but not limited to any amounts not paid by any insurance company or other third party payor (excluding any contract discounts agreed upon in writing by Alpine and/or the Facility with the applicable third party payor). Patient and the undersigned, if other than the patient, remain responsible for all co-payments, deductibles, co-insurance, and/or non-covered services regardless of amount paid by insurance or third-party payor. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court cost. A service charge may be collected in connection with any check or other instrument tendered by the Patient or the undersigned but returned unpaid.

Patient's Certification: I authorize any holder of medical or other information about me to release to the Social Security Administration, other intermediaries or carriers, the State, or any insurance company or other payor any information needed to process a claim for this or any related service. I request that payment of authorized charges be made on my behalf directly to Alpine and/or the Facility for its charges and for any charges of physicians or other providers for whom Alpine and/or the Facility is authorized to bill in connection with its service.

Certain Financial Relationships: Dr. Barnett is the owner of the Facility and therefore has a "financial relationship" with the Facility for purposes of Utah Code § 58-67-801. Alpine patients may choose any surgery facility for the purpose of having the medical services and procedures performed. Alpine physicians are only able to perform surgical procedures in hospitals or other health care facilities in which they have medical staff privileges, and which are otherwise medically appropriate for the services or procedures.

Entire Agreement: Patient and the undersigned, if other than the Patient, each jointly and severally agree that, except for the most recent written fee or price quote by Alpine to Patient for uninsured cosmetic surgery procedures (which price quote is incorporated herein by specific reference), this Agreement is a final and complete expression of the agreement between the parties and no other terms or conditions, regardless of whether written or verbal, are or shall be a part of this Agreement.

The undersigned signs this document either as the Patient, or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient, or responsible financial guarantor of the patient (and as an accommodation to patient and for other legally adequate consideration), I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I indicate my understanding by signing below. I understand that I am entitled to request and obtain a copy of this document.

Completed by (print name): ____ Relationship to patient: ___________________

Signature: ____ Date: _________________________________

Witness: ____ Title: _________________________________
(Alpine employee)

Revised 12/2/19…cb

Notice of Information Practices / Patient Rights and Responsibilities Acknowledgement of Receipt

I have received/read and understand the Notice of Privacy Practices and the Patient Rights & Responsibilities of Alpine Plastic & Reconstructive Surgery and Alpine Surgical Center, LLC. I understand that by signing this document I am acknowledging that I have received these forms and that I understand that additional copies are available to me per my request. I understand that I may contact the privacy officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Providers business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practices Notice of Privacy Practice Policy.

___________________________________	____________________
Signature of Patient or Legal Representative	Date

___________________________________	____________________
Printed Name of Patient or Legal Representative	Relationship to Patient

Revised 11/20/19 at

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Prescription Pick-up Authorization

There may be times when you need a friend or family member to pick-up a prescription from our office. For us to release a prescription to your family member or friend, we will need their name to keep on file.
Prior to release of the prescription, your designee will need to present valid picture identification and that identification will be copied and entered into your file.

_______ (Pt Initials) Alpine Plastic Surgery **MAY NOT** release any prescriptions to family/friends

_______ (Pt Initials) Alpine Plastic Surgery **MAY** release prescriptions for pick-up on my behalf to the individuals listed:

Person	**Relationship**	**Contact Number**
______________________	______________	______________________
______________________	______________	______________________

If an individual is not listed above Alpine Plastic Surgery will not release any prescriptions for pick-up until the patient has come in and added them to the list of authorized persons.

If a medication or medication refill is prescribed by Dr. Barnett and you would like us to call in that medication for you, please list the pharmacy and phone number of that pharmacy.
Narcotics will not be called in, emailed or faxed to a pharmacy the patient/patient representative will need to physically pick up written prescription at our office.

Pharmacy Name	**Pharmacy Phone Number**	**Pharmacy Address**
________________	________________	______________________

By signing below, I understand that I have given consent to the above. I acknowledge that I have the right to restrict and change this list at any time, but I must do so in person and in writing. I understand that I can revoke this consent at any time in writing.

______________________	________________	____________
Signature of Patient or Legal Representative	Relationship to patient	Date
______________________	________________	
Printed Name of Patient or Legal Representative	Relationship to patient	

Revised 11/20/19 at