Aesthetica Clinique LLC
Louis Potyondy MD
801 Pacific Ave. Tacoma, WA 98402
253.627.1001

Patient Registration

Last Name	**First Name**	**Middle Name**
Date of Birth / **Gender**	**Social Security Number**	**Marital Status**
(Area code) Home Phone Number	**(Area code) Work Number**	**Cellular Phone Number**
Home Address	**City** / **State**	**Zip Code**

Guarantor Information

Last Name	**First Name**	**Middle Name**
Date of Birth / **Gender**	**Social Security Number**	**Marital Status**
(Area code) Home Phone Number	**(Area code) Work Number**	**Cellular Phone Number**
Home Address	**City** / **State**	**Zip Code**

Guarantor Relation to Patient _____

Referring Physician/ Telephone number	**Primary Physician/ Telephone number**

Employment Information

Patient / Parent / Guardian
Circle one

Name of Employer

Address of Employer

Phone #	**Supervisor/Contact Person - Name**

Insurance Information

Please provide receptionist with your MOST CURRENT **PRIMARY and any applicable SECONDARY INSURANCE CARDS** so that a photocopy may be obtained.

Emergency Contact *(please provide 2 contacts)*

_____	_____	_____
Name	**Relationship (to patient)**	**Phone Number**
_____	_____	_____
Name	**Relationship (to patient)**	**Phone Number**

Additional Information

Is patient's condition related to:

a.) Employment (current or previous)? _____ Yes _____ No

b.) Auto Accident? _____ Yes (if so, State _____) _____ No

c.) Other Accident? _____ Yes _____ No

Payment of Benefits

I request that payment of authorized benefits be made to Aesthetica Clinique LLC. I authorize any holder of my medical information to release to my insurance carriers, including the Center for Medicare and Medicaid Services (CMS) and its agents, any information needed to determine the benefits or the benefits payable for related services.

I hereby authorize the release of any confidential medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS, necessary to process insurance claims or any other medical information that is required for any health care related utilization review or quality assurance activities or to any healthcare professional requiring this information in order to treat me.

I hereby assign and authorize payment to Aesthetica Clinique LLC for all medical and/or surgical benefits including major medical policies, to which I am entitled under any insurance policy or policies, any self-insurance program or any other type of benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf. I understand that if overpayment results in a credit balance to this practice, that the credit will first be applied to any outstanding balance on my account before being refunded to me.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

_____ _____

Signature of Patient/Guardian **Date**

AESTHETICA CLINIQUE, LLC
801 Pacific Avenue Tacoma, WA 98402 - (253) 627-1001

NOTICE OF PRIVACY PRACTICES & PATIENT'S RIGHTS

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

As a patient, you have the right to:

- Considerate, respectful and confidential treatment
- Continuity and completion of treatment
- Be protected from abuse and neglect and have access to protective services
- Have confidentiality, privacy, security, spiritual care and not be restricted from communication with others (and if communication restrictions are necessary for patient care/safety, we will document/explain restriction to patient/family)
- Access to complete and current information about your condition and to be informed of any unanticipated outcomes
- Advance knowledge of the cost of treatment
- Informed consent
- Explanation of recommended treatment, alternate treatment, the option to refuse treatment and the risk of no treatment.
- Be involved in all aspects of care (including refusing care) and resolving problems with care decisions as wells as to have family input in care decisions
- Emergency, incremental and total patient care
- Treatment that meets the standard of care in the profession
- Access to a patient advocate
- Voice complaint about care/treatment without fear of retribution or denial of care and have timely complaint resolution (see below for complaint process)

Additionally, as a patient you have the following rights to information:
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff timeContact us using the information listed at the end of this Notice for a full explanation of our fee structure.)
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

PATIENT'S RESPONSIBILITIES
In acknowledging the personal worth and dignity of each individual, we also recognize that you, as the patient, have certain responsibilities that support the health care we provide. In order to ensure your proper care with the best outcome it is your duty to comply with our office protocols, which have been designed to promote optimum safety.

It is every patient's responsibility to:
• Keep scheduled appointments (or to tell the office when you are unable to keep an appointment) and cooperate with the planned treatment program prescribed by the provider (or to explain why cooperation is not possible).
• Take an active role in your medical care.
• Request additional information or clarification when any detail of your medical care is not understood.
• Be honest and accurate in all health care information that you provide to us.
• Update your personal information as necessary to ensure the accuracy of our records.
• Show consideration for other patients and for your health care providers in this office with respectful conduct.
• Be patient when an appointment is delayed; keep in mind that an emergency may be taking place.
• Maintain the same level of confidentiality and privacy for others that you would expect to receive.
• Inform office personnel of any unsafe conditions.
• Be prompt in fulfilling financial obligations to this office.

Our goal is to keep you, our patient, in the best health possible. If you feel that you are being treated unfairly or improperly, please bring it to the attention of your physician or the office manager.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer:
Jaime Potyondy
Telephone: (253) 627-1001 Fax: (253) 272-1040
Address: 801 Pacific Ave. Tacoma, WA 98402

If you have a complaint that you feel has not been adequately addressed by Aesthetica Clinique, you have the right to contact the **Washington State Department of Health** at: 1(800)633-6828 or (360)236-4700

HSQA Complaint Intake
PO Box 47857-7857
Olympia, WA 98504-7857
Email: HSQAComplaintIntake@doh.wa.gov
Fax: (360)236-2626

Office of the Medicare Ombudsman
www.medicare.gov/ombudsman/resources.asp

Medicare Help and Support: 1(800)-MEDICARE

_____ _____
Patient Signature (or Guardian) Date

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FINANCIAL POLICY

1. It is your responsibility to check with your insurance plan prior to your visit to make sure we are participating providers. Failure to do so could result in reduced payments by your insurance company.

2. You and your insurance company are responsible for your bill. We realize that insurance requirements are confusing, but knowing your benefits is your responsibility. Any questions concerning your coverage should be directed to your insurance company. We will file secondary insurance but if the secondary insurance denies payment, you are responsible for the balance.

3. **If your primary insurance company requires a co-payment, you must make that co-payment at the time services are rendered**. Please remember that we are contractually obligated by your insurance company to collect all co-pays, deductibles and any other patient responsibilities (per your insurance policy) at the time of service. The balance of your charges will be billed to your insurance company. After payment by your insurance company, any remaining balance will become the patient responsibility which is due upon receipt of your statement.

4. **Proof of current, valid insurance must be provided at time of service**. If you do not provide this information or if insurance is not applicable due to type of service (e.g. cosmetic procedures), you will be considered a self pay patient. Self pay patients are required to pay their office visit and/or procedure charges in full at the time of service.

5. **Failure to receive your statement does not relieve you of your financial obligation**. It is your responsibility to notify us of any changes in your billing information.

6. **We accept cash, checks, money orders, and major credit cards**.

7. **Returned checks are subject to a $30 insufficient funds/return check fee**

8. **Past due accounts are subject to our collections process and your relationship with our office may be terminated.**

_____ _____

Signature of Patient/Guardian **Date**

AESTHETICA CLINIQUE
Louis Potyondy MD
Board Certified, American Board of Plastic Surgery
801 Pacific Ave.
Tacoma, WA 98402
(253) 627-1001

Patient Questionnaire

Reason for visit_____
How long have you had this problem? _____
Has it become worse? _____
Any related problems? _____
What medical problems do you currently have? _____
_____
What medical problems have you had in the past? _____
_____
What surgeries have you had in the past? _____
_____
What medications do you take?_____
_____
Do you have any allergies to medications? _____
If so what kind of reaction did you experience?_____
What is your occupation/school? _____
Who do you live with? _____
How many children do you have? _____
Do you smoke? _____If so, how many cigarettes per day do you smoke and for how many years? _____
Do you drink alcohol? _____ If so, how much alcohol do you consume daily?
_____
Do you use any illicit drugs? _____
What medical problems run in your family? _____
Who has these problems (please specify whether on mother or fathers side of family)?
_____
How much do you weigh? _____ What is your height? _____
Have you lost or gained any weight? _____
How much over how many months? _____

How did you hear about us? _____
Can we mail information to your home? ☐ Yes ☐ No
Can we leave a message for you at home? ☐ Yes ☐ No
Can we leave a message for you at work? ☐ Yes ☐ No