# GABRIEL M. KIND, M.D., FACS
# DAVID S. CHANG, M.D., FACS

*Welcome to our office. Please provide the following information:*

Today's date: ____/____/_____

Name: _____ _____ ____
*(Last)* *(First)* *(M.I.)*

( ) Male ( ) Female Date of birth: _____/_____/_____ SSN#: _____

Address: _____
STREET CITY STATE ZIP

Mobile: ( ) _____ Work: ( ) _____

Home: ( ) _____ Email: _____

We send periodic email updates to our patients. Is this OK? [ ] Yes [ ] No

Occupation: _____ Employer: _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Domestic Partner

Emergency contact person: _____ Tel #: ( ) _____

Relationship to you: _____

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Referred By: [ ] Dr._____ [ ] Friend _____ [ ] Internet _____

Primary Care Physician (PCP): _____ PCP Phone #: ( ) _____

Pharmacy Name: _____ Pharmacy #: ( ) _____

## Insurance Information

Insurance company name: _____ Tel #: ( ) _____

[ ] Medi-Care [ ] PPO [ ] HMO [ ] Worker's Compensation [ ] Other _____

Insured Name (If other than yourself): _____

Date of birth: _____/_____/_____ SSN#: _____

[ ] Self [ ] Spouse [ ] Parent [ ] _____

**NOTE: Dr. Kind and Dr. Chang are NOT participating providers for the following health plans: Covered California, Medi-Cal, Aetna, Great West and Individual Blue Cross PPO. For your convenience, our office will send bills directly to your insurance company. Please be advised that if you receive health coverage from one of the above plans, you will be responsible for out-of-pocket expenses.**

## Workers Compensation Information

Company: _____

Claim #: _____ DOI: _____

Adjustor: _____Tel #: _____ Fax #: _____

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# Confidential Health Intake Form

Height: _____
Weight: _____

**What is the reason for your visit?** _____

Please list **current medications** (include supplements, vitamins, herbal medication)

Do you have any medication allergies? Yes ☐ _____ Reaction _____ No ☐

**Past Medical History** (Have you had any of the following?)

| | | |
|---|---|---|
| Anemia | HIV or AIDS | Anxiety |
| Asthma | Bleeding disorder | Arthritis |
| Blood transfusion | Cancer | Blood clots |
| Diabetes | Epilepsy | Cataracts |
| Heart disease | High Blood Pressure | Glaucoma |
| High cholesterol | Hepatitis | Kidney disease |
| Lung disease | Depression | Stroke |
| Arrhythmia | Pacemaker | Thyroid disorder |

Other: _____

**Past Surgical History** (Please list previous operations and year of surgery, including cosmetic procedures.)

_____

_____

Have you had any difficulties with anesthesia? Yes ☐ No ☐

**Do you have any of the below?**

| | | |
|---|---|---|
| Dry eyes | Change in vision | Cold sores |
| Easy bruising | Easy bleeding | Excessive scarring |
| Keloids | Chest pain | Shortness of breath |
| Skin rashes | Numbness or tingling | Significant weight change |
| Leg pain or cramps | | |

Do you smoke cigarettes? ☐ Yes; how many/day? _____ ☐ No; if you used to smoke, when did you quit? _____

How much do you drink? ☐ Never ☐ Occasionally ☐ Daily

Does anyone in your family have cancer? _____

Is there any other information that may be helpful in your care? _____

The above information is true to the best of my knowledge. I will not hold my surgeon or his office responsible for errors or omissions that I may have made in completing this form.

Patient Name: _____ Signature: _____ Date: _____

AMERICAN SOCIETY OF PLASTIC SURGEONS

45 Castro Street, Suite 410 • San Francisco, California 94114
T: 415.565.6884 F: 415.600.6886 • www.kindchangplasticsurgery.com

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# Insurance Authorization

You are responsible for your bill. Statements are sent at the end of each month and payment is expected upon receipt. A late payment will result in a charge of 1.5% per month (annual rate of 18%). We will bill your primary Insurance for you - any other insurance billing will be your responsibility. The under signed certifies that he/she has read the above and is authorized to execute and accept the above terms in the amount of the statement billed.

I request that payment of Medicare Benefits be made either to me or on my behalf to Dr. Gabriel M. Kind/Dr. David S. Chang for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

I authorize my insurance company to make payment directly to Dr. Gabriel M. Kind /Dr. David S. Chang.

**Patient Name** (*please print*): _____

**Signature: _____ Date: _____**

AGREEMENT TO ARBITRATION: By signing this contract, you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial.

**Signature: _____ Date: _____**

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# Photograph Consent

I consent to the taking of photographs and/or videos by Kind Chang Plastic Surgery for diagnostic and treatment purposes. I also give my permission to release the photographs in scientific and medical presentations and/or in scientific and medical writings.

**Signature:** _____ **Date:** _____

I also understand and give my consent that my photographs may be posted on our practice website and other websites that promote our practice, in a manner that my physician deems proper. In this case, I understand that my name or any identifying information will not be used.

**Signature:** _____ **Date:** _____

# Electronic Correspondence

I, _____**,** give permission to Dr. Kind/Dr. Chang and staff to email and/or text me information pertaining to my care. Information that may be sent can include appointment dates and times, documents related to surgery scheduling and answers to simple questions. More complex questions may require a phone call by the doctor. I understand that these messages will be sent through unsecured servers and therefore at risk of security breach.

**Signature:** _____ **Date:** _____

**Witness:** _____ **Date:** _____

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# Summary of Notice of Privacy Practices

## Gabriel M. Kind, M.D., FACS
## David S. Chang, M.D., FACS

## Susana Saenz, Privacy Officer (415)565-6884

**Name of Patient: _____**

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices; I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

**Signed: _____** **Date: _____**

*If not signed by the patient, please indicate your relationship to the patient: _____*

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**For Office Use only**:

- □ Signed form received by: _____
- □ Acknowledgement refused:

  Efforts to obtain:

  _____

  _____

  Reasons for refusal:

  _____

  _____

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# Summary of Notice of Privacy Practices

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## David S. Chang, M.D., FACS

## Susana Saenz, Privacy Officer (415)565-6884

**The following is a brief summary of your rights and our responsibilities as detailed in the attached Notice of Privacy Practices (the "Notice"). This Summary is for your convenience and is not a substitute for reading the entire Notice and does not modify the terms of the Notice.**

1. **Uses and Disclosures of Your Health Information.** We may use the information we develop and collect for treatment by our practice or disclose the information to others to whom we refer you for treatment, for payment for these services and for certain health care "operations" such as improving the competence and quality of our staff and business associates planning and management . We may disclose your information to our business associates such as medical transcriptionists, billing services and others who assist in the operations of our practice. We may call you to remind you of appointments and may leave a message on your answering machine if you have one. We may also disclose information to your family about your location, general condition or death. If you are available and able, we will ask your consent first. We may also use your information to recommend products or services related to your care but will not use or disclose your medical information for marketing purposes without your written authorization. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, judicial and administrative proceedings, subject to the limits imposed by state and federal law, and certain other purposes.
2. **Other Uses and Disclosures.** Except as described in the Notice, we will not use or disclose your medical information without your authorization. You can revoke an authorization at any time, except to the extent that we have already taken in reliance on the authorization.
3. **Your Health Information Rights.** You have a number of rights under state and/or federal law which are subject to the terms and conditions specified in the Notice:
    a) You may request restrictions on certain uses and disclosures of your information
    b) You may request that you receive your information from us in a certain way
    c) You may inspect and copy your medical records
    d) You may request an amendment to any record you believe is inaccurate
    e) You may request an accounting of disclosures made of your records
4. **Changes to the Notice.** We reserve the right to change the Notice. If we do so, we will post it in our office, and provide copy upon request.
5. **Complaints.** You may file a complaint to our Privacy Official whose name is above or with the federal government as detailed in the Notice. You will not be penalized for filing any complaint.

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