dr. g

Joseph L. Grzeskiewicz MD FACS
BOARD CERTIFIED PLASTIC SURGEON
Inspired By Your Natural Beauty

All information submitted in this patient registration form will be treated by Dr. Grzeskiewicz Plastic Surgery as part of your confidential patient record.

For patient safety and as part of our patient identification policy, you will be asked to provide your legal name, sex, date of birth . Also, you will be asked to confirm information at the time of check in and to sign other consent forms.

Please remember on the day of your appointment to bring a signed and dated copy of all attached documents. If you do not have access to a printer, please email your completed document to: registration@drgplasticsurgery.com and we will print a copy for you to sign on the day of your appointment.

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Patient Registration Form

9333 Genesee Ave Suite: 250, San Diego, CA 92121 858-500-7777
72780 Country Club Dr. Suite: 400, Rancho Mirage, CA 92270 858-500-7777

Patient Information

Patient's First Name _____ Patient's Last Name _____ Patient's Middle Name _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Birth Date: _____ E-Mail: _____

Sex: ◯ Male ◯ Female **Marital Status:** ◯ Married ◯ Single ◯ Divorced ◯ Widowed

Patient's Details

Can we leave a message on your home number ☐ Yes ☐ No

Can we leave a message on your cell number ☐ Yes ☐ No

Can we leave a message on your work number ☐ Yes ☐ No

If required can we email you at the address you provided us with? ☐ Yes ☐ No

How did you hear about Dr. Grzeskiewicz. If other please Indicate : _____ _____

Employment Status: _____ _____

Are you in the medical industry? ☐ Yes ☐ No If yes, Area? _____

Method of payment: _____

Emergency Contact

First Name _____ Last Name _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Relationship to patient: _____

Dr. Grzeskiewicz Plastic Surgery

ACKNOWLEDGEMENT OF FINANCIAL POLICY

Please remember that you are responsible for your bill. For surgery, we require a non-refundable deposit to schedule surgery, with the remaining balance to be paid in full two weeks before the surgery date. If surgery is canceled two weeks or less in advance of of date of surgery, 50% of the total surgery fee is forfeited. If revisionary surgery is necessary, there may be charges for surgeons fee, operating room and anaesthesia.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Grzeskiewicz and whatever representatives he may direct to release all information necessary to secure payment of any benefits that I may be due. I further agree that a photocopy of this agreement shall be as valid as the original.

I, _____ understand and agree to the financial policy.

Please Print Name _____ Signature _____ Date _____

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Patient's purpose for visit

Please check the procedures you are interested in:

Facial Procedures

- ☐ Brow lift
- ☐ Eyelid lift
- ☐ Face lift
- ☐ Neck lift
- ☐ Nose surgery
- ☐ Ear surgery
- ☐ Lip surgery
- ☐ Earlobe repair
- ☐ Mole removal
- ☐ Facial augmentation (chin, cheeks, jaw) including fat transfer or implants
- ☐ Other: _____

Breast Procedures

- ☐ Breast augmentation
- ☐ Breast lift
- ☐ Breast reduction
- ☐ Breast asymmetry correction
- ☐ Other: _____

Body Conturing

- ☐ Tummy tuck
- ☐ Liposuction
- ☐ Buttock contouring
- ☐ Mommy Makeover
- ☐ Post-bariatric body conturing
- ☐ Male breast reduction (Gynecomastia)
- ☐ Arm Lift and Thigh lift
- ☐ Other: _____

Non-surgical Procdures

- ☐ Facial fillers
- ☐ Hand augmentation
- ☐ Latisse
- ☐ Skin care
- ☐ Botox/Xeomin/Dysport
- ☐ Other: _____

Dr. Grzeskiewicz provides a 10% discount on any injection service for patients who return after 2 months for follow-up photos. The discount will be applied to any subsequent service. Would you like to sign up for this promotion?

☐ Yes ☐ No

What would you like to accomplish during your consultation today?

Do you have specific goals for your health and appearance? If so, please explain.

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Patient's First Name _____ Patient's Last Name _____ Patient's Middle Name _____ Date _____

Age: _____ D.O.B. _____ Height: _____ Current Weight: _____ lbs

Names and specialties of other health care providers currently caring for you, including providers such as chiropractors and naturopaths:

Name of provider	Date of last exam or treatment

Do you have an Advance Directive? _____ In the event that you are unable to make decisions concerning your medical care, who would you want to make decisions for you?

Name	Relationship

Current and Past Health Problems

Please check any symptoms or health problems you have now or have ever had:

General

☐ Fatigue ☐ Chronic fever ☐ Night sweats ☐ Loss of appetite
☐ Unexpected weight gain/loss

Lungs

☐ Coughing up blood ☐ Shortness of breath ☐ Emphysema ☐ Chronic lung disease
☐ Tuberculosis or positive TB test

Gastrointestinal

☐ Chronic abdominal pain ☐ Chronic bloating ☐ Reflux or ulcer disease ☐ Hepatitis or liver disease
☐ Asthma ☐ Chronic constipation/diarrhea

Breast Health

☐ Discharge ☐ Lumps or breast cancer ☐ Pain
☐ Last mammogram: _____

Nervous System

☐ Dizziness or fainting ☐ Numbness or tingling ☐ Seizures or epilepsy ☐ Tremors or shaking
☐ Stroke ☐ Head injury or concussion ☐ Chronic headaches

Mental

☐ Chronic anxiety ☐ Depression ☐ Addiction or dependence ☐ Body image problems
☐ Eating disorder (e.g. anorexia)

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Current and Past Health Problems Contd...

Heart and Circulation

- ☐ Abnormal EKG
- ☐ Heart failure
- ☐ Heart attack
- ☐ Murmurs
- ☐ Chest Pain
- ☐ Pain in legs with exertion

Musculoskeletal

- ☐ Chronic neck pain
- ☐ Arthritis
- ☐ Chronic back pain
- ☐ Osteporosis
- ☐ Fracture
- ☐ Swollen, red, or painful joints
- ☐ Chronic muscle aches

Blood and Lymph

- ☐ HIV or AIDS
- ☐ Bleeding problems
- ☐ Blood clots/DVT
- ☐ Anemia
- ☐ Blood transfusion

Skin

- ☐ Easy bleeding or bruising
- ☐ Changes in moles
- ☐ Skin cancer
- ☐ Chronic itch, dryness, or rash
- ☐ Psoriasis or eczema
- ☐ Cold sores or herpes
- ☐ Chicken pox

Urinary

- ☐ Chronic urinary infection
- ☐ Kidney failure
- ☐ Kidney stones
- ☐ Bladder problems
- ☐ Incontinence or difficulty with urination

Endocrine/Metabolic

- ☐ Excessive weight gain or loss
- ☐ Diabetes
- ☐ Thyroid
- ☐ Hormone replacement

Head/Eyes/Ears/Nose/Throat

- ☐ Eye pain
- ☐ Visual problems
- ☐ Dry eyes
- ☐ Excessive tearing
- ☐ Cataracts or glaucoma
- ☐ Chronic sinus problems or nasal discharge
- ☐ Chronic or frequent nosebleeds
- ☐ Difficulty breathing through the nose
- ☐ Sores or irritation in the mouth
- ☐ Cancer of the head or neck
- ☐ Problems with teeth or gums

Reproductive - Female

- ☐ Birth control Type: _____
- ☐ Abnormal periods
- ☐ Age at first period: _____
- ☐ Age at breast development _____
- ☐ Pregnancy How many _____
- ☐ Live birth How many: _____
- ☐ Breast feeding How long _____

Reproductive - Male

- ☐ Prostate problems
- ☐ Scrotal pain or swelling
- ☐ Hormone replacement
- ☐ Breast development

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Current and Past Health Problems Contd...

Other

☐ History of cancer Type: _____ Last treatment: _____

☐ Organ transplant Type: _____ Last treatment: _____

☐ Surgical implants Type: _____ Last treatment: _____

☐ Other medical problem not listed. Explain:

Surgical History: Please list any surgical procedures you have ever had: ☐ N/A

Name of procedure	Date

Medications and drugs: Please list all drugs, medications, or supplements that you currently take: ☐ N/A

Allergies: Please list any allergic reactions to drugs or medications that you have ever had: ☐ N/A

Family History: Please list any diseases or disorders that run in your family:

Family member	Medical problem

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Lifestyle and Habits

Lifestyle and Habits: Please answer the following questions:

What is your current occupation? _____

In what country were you born? _____

How many times a week do you exercise? _____ Type: _____

Do you use tobacco products? ☐ Yes ☐ No If so, what type: _____ How much? _____

How long? _____

Do you use recreational drugs? ☐ Yes ☐ No If so, what type: _____ How much? _____

How long? _____

Do you have values or beliefs that we should consider when planning your care? (e.g. cultural or religious) ☐ Yes ☐ No

If yes, please explain:

Additional Comments

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform Dr. Grzeskiewicz's office of any changes in medical status.

Signature (Patient or Authorized Person) _____ Date _____ Relationship, if not patient _____

Appointment Policy

If it is necessary to cancel a reserved appointment time, we request that you give the office at least 48 hours notice so that your time can be made available to another patient. Patients who consistently miss or are late for their appointments will need to make appropriate arrangements for future visits. Communication is very important to us. Please let us know if you have any questions.

Late Cancellations and "No Shows"

A cancellation is considered late when a patient fails to cancel her or his scheduled appointment with a 24 hour advanced notice. A "No Show" occurs when a patient misses an appointment altogether without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in the patient's records as a "No Show" and the consultation fee will not be refunded. This includes arriving 30 minutes or later after a scheduled appointment time. In the case of such late arrivals, a patient may or may not be able to be accommodated at that time depending upon workflow in the office, and rescheduling may be necessary.

At the first occurrence of a "No Show," late cancellation, or late arrival there will be no charge to the patient, however, Dr. Grzeskiewicz's office send a courtesy reminder for the patient to review our attendance policy. The second occurrence will result in a missed appointment fee of $50 billed to the patient's account.

I acknowledge that I have read and understand the Appointment Policy

Patient Name _____ Signature _____ Date _____

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Information Release

I give permission to Dr. Grzeskiewicz and his representatives to discuss my case with the following persons:

Patient Name	Signature	Date

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Authorization for Medical Media

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This is a consent document that has been prepared to help inform you about permission to take photographs, slides, videotapes and/or digital videos and the use of these media for purposes as defined within this document.

It is important that you read this information carefully and completely. After reviewing the document, please sign the consent in the appropriate place.

INTRODUCTION

Medical photographs, slides, videotapes and digital videos may be taken before, during, or after a procedure or treatment. Consent is required to obtain such media. The taking of such images is an important part of a patient's medical care and records. The primary purpose of such images is the documentation of the appearance of a specific body part being treated at a particular point in time. Additionally, such media may be obtained to document the conduct of a particular procedure being performed. As plastic surgery is a very visual specialty, it is vital, and also a community standard of practice, that such documentation is obtained and recorded by a surgeon.

Additionally, you may consent to release these medical photographs, slides, videotapes and/or digital videos for the below stated purposes.

Please Check One:

☐ I authorize Joseph L. Grzeskiewicz, MD, FACS and such assistants as he may assign to take pre-operative, intra-operative, and post-operative photographs, slides, videotapes and/or digital videos. I additionally consent to the use of these media for the purposes of medical education, patient education, and public education in lectures, presentations, publications, commercial television, and electronic digital networks to medical or lay groups. I understand that I will not be entitled to any monetary payment or other consideration in exchange for the use of these media.

Patient Name _____ Signature _____ Date _____

☐ I acknowledge that medical images are an integral part of my medical record, and I authorize Joseph L. Grzeskiewicz, MD, FACS and such assistants as he may assign to take pre-operative, intra-operative, and post-operative photographs, slides, videotapes and/or digital videos for inclusion in my medical record only.

Patient Name _____ Signature _____ Date _____

Eva Tutic, Privacy Officer
9333 Genesee Ave Suite: 250, San Diego, CA 92121
Phone: 858-500-7777

Effective Date: September 22, 2014

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

We understand the importance of privacy and 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 providers to provide 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 medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How this Medical Practice May Use Or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not otherwise use or disclose your medical information for marketing purposes without your written authorization.

8. Required By Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect, domestic violence, to respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public Health. We may, and are sometimes required by law to disclose your health information to public authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health Oversight Activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

11. Judicial and Administrative Proceedings. We may, and are sometimes required by law to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

B. When This Medical Practice May Not Use or Disclose Your Health Information.

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information either mailed to a specific location or you or someone you have authorized in writing may pick up the information in person.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California and federal law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1(treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise

permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously received one.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice available in our reception area, and will offer you a copy.

E. Complaints

If you believe your privacy rights have been violated, you have the right to file a complaint with us by contacting the Privacy Officer identified below and/or to the Secretary of the Department of Health and Human Services http://www.hhs.gov/ocr/privacyhowtofile.com or 800.368.1019 To file a complaint with our office, please contact our Privacy Officer, Eva Tutic at 858-500-7777 or send a letter to the Privacy Officer's attention: 9333 Genesee Ave Suite: 250, San Diego, CA 92121. You will not be penalized for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this medical practice Notice of Privacy Practices. I acknowledge that a copy of the policy will be posted in the reception area and I will be offered a copy of any amended notices at each appointment

Please Print Name _____ Signature _____ Date _____

Print Save Email