1441 AVOCADO AVENUE
SUITE 706
NEWPORT BEACH, CA 92660
(855) STOP-SWEAT
STOPSWEATNOW.COM

PATIENT INFORMATION

Date:________________

Patient Full Name:____
First Middle Initial Last

Home Address: ____

City: __________________________________ State: __________ Zip:_________________

Preferred Phone Number: ________________________________

Email Address: ____

Date of Birth: _________________ Social Security #: _____________ Sex: M__ F__

Age: ______ Marital Status ______________

Emergency Contact:______________________Telephone:______________________Relationship:_______________

Referred By: ____

CLINICAL DATA

Height _____ Weight: _____ Latex Allergy: Y N Tape Allergy Y N

Do you Smoke? Y N Quantity: __________________ Alcohol Use: Y N Quantity: ______________

When did you quit smoking? ____________________ When did you quit drinking? _______________

Allergies: Y N Specify: ____

____

Are you pregnant or lactating: Y N

Current Medications, including Vitamins:

____

____

____

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Patient Name: ____ **Date:**_______________

Personal History Of:				Family History of:		Who?
Hepatitis	Yes	No	Type:___________	Yes	No	_______________
High blood pressure	Yes	No	When___________	Yes	No	_______________
Heart disease	Yes	No	When___________	Yes	No	_______________
Heart murmur	Yes	No	When___________	Yes	No	_______________
Heart attack	Yes	No	When___________	Yes	No	_______________
Diabetes	Yes	No	Type:___________	Yes	No	_______________
Bleeding problems	Yes	No	Type:___________	Yes	No	_______________
Cancer	Yes	No	Type:___________	Yes	No	_______________

Other Medical Conditions:

Previous Operations (Including Cosmetic)	Date	Surgeon
____________________________________	______________	__________________________
____________________________________	______________	__________________________
____________________________________	______________	__________________________

Number of Pregnancies:___________________ Number of Children:______________________

Indicate the type(s) of anesthesia received in the past, list any complications / reactions you experienced:

____

____

I have reviewed the previous information & have correctly stated my information.

Patient Signature:____**Date**:____________________

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FINANCIAL POLICY

Thank you for choosing Michael A. Bain, MD as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read prior to any treatment. All patients must complete our patient information forms before seeing the doctor.

With any surgical procedure, including cosmetic surgery, there are no guarantees given. Everyone hopes for the best possible outcome, but each person heals, responds, and scars differently. Results cannot be predicted by anyone prior to surgery, therefore once surgery has been performed, the surgeon's fees are non-refundable. If you would require additional surgery for any reason, you are responsible for the fees involved. We accept Visa, MasterCard, Discover and American Express.

Please note that cosmetic consultations and procedures are not covered by health insurance. If you are seeing Dr. Bain for a covered benefit and you also wish to discuss non-covered issues, he will be required to charge you a separate cosmetic consultation fee, per the laws of California.

I acknowledge that I have read and understand the above stated financial policies of Stop Sweat Now

Patient Signature: ____ Date:_______________

Witness Signature: ____ Date: _______________

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NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

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2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: Michael A. Bain, MD, 1441 Avocado Avenue, Suite 706, Newport Beach, CA 92660.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Michael A. Bain, MD, 400 Newport Center Drive, Suite 609, Newport Beach, CA 92660. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Michael A. Bain, MD, 1441 Avocado Avenue, Suite 706, Newport Beach, CA 92660. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If you have any questions regarding this notice or our health information privacy policies, please contact Stop Sweat Now at (949) 706-2800.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been presented with a copy of HIPPA Notice of Privacy Practices for Stop Sweat Now.

Signature ______________________________ Date: ____________

Print Name ______________________________

Witness Signature: ______________________________ Date: ____________