RAYMOND S. DOUGLAS, M.D., PH.D.

150 N. Robertson Blvd. Suite 314 - Beverly Hills, CA 90211
(310) 657-4354- FAX (310) 657-4322

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____ Phone Number _____

City _____ State _____ Zip: _____ CELL: _____ EMAIL: _____

Sex ☐ M ☐ F Age _____ Birth date _____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Patient Employed by: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Phone: _____

Please tell us how you learned about us: _____

Whom may we thank for referring you: _____

In case of an emergency who should be notified: _____ Phone: _____

Personal Physician: _____ Physician's Phone: _____

Physician Fax: _____ Pharmacy of Preference (Phone): _____

RESPONSIBLE PARTY INFORMATION

Relationship to Patient: _____ Phone: _____

Address: _____

PRIMARY INSURANCE

Subscriber Name: _____ Relationship to Patient: _____ Birth Date: _____

Address (if different from patient's): _____ City: _____ State: _____ Zip: _____

Phone: _____

Subscriber Employed by: _____ Business Phone: _____

Insurance Company: _____ Soc. Sec. #: _____

Policy # _____ Group # _____ Subscriber # _____

SECONDARY INSURANCE

Subscriber Name: _____ Relationship to Patient: _____ Birth Date: _____

Address (if different from patient's): _____ City: _____ State: _____ Zip: _____

Phone: _____

Subscriber Employed by: _____ Business Phone: _____

Insurance Company: _____ Soc. Sec. #: _____

Policy # _____ Group # _____ Subscriber # _____

ASSIGNMENT AND RELEASE – ***REGARDING INSURANCE ***

I authorize treatment of the individual named as Patient. I understand that Raymond S. Douglas, M.D., Ph.D. OR any affiliated offices will file with my primary insurance for any services rendered which are covered by insurance and I authorize payment of medical insurance benefits to be made to my treating physician. I also understand that I am financially responsible for any services rendered that are not covered, co-payments, deductibles, share of costs, etc. under the terms of my policy. I authorize Raymond S. Douglas, M.D., Ph.D. OR any affiliated offices to release or obtain any medical information related to its treatment of Patient. A photocopy of this authorization shall be considered as effective and valid as the original.

I further understand that elective, cosmetic surgery is not covered by insurance in any way, and that I am solely responsible to cover all costs involved – including, but not limited to lab work, medical clearance, surgeon's fees, operating room time and anesthesia, as applicable.

I fully understand and comply with this policy:

_____ _____
Signature of Patient or Responsible Party Date

HAVE YOU EVER HAD:	YES	NO
Eye disease, including glaucoma and "dry eye"?	☐	☐
Kidney disorder?	☐	☐
Diabetes?	☐	☐
Bleeding Disorder?	☐	☐
Lung or respiratory disease?	☐	☐
Arthritis or joint disease?	☐	☐
Depression or anxiety?	☐	☐
Hepatitis?	☐	☐
Thyroid disease?	☐	☐
AIDS or AIDS related complex?	☐	☐
A reaction to anesthetic?	☐	☐
Cancer, including skin cancer?	☐	☐
Stomach trouble, ulcers?		
Do you smoke?	☐	☐
How much? _____		
Do you drink alcohol?	☐	☐
How much?_____		
Do you have difficulty breathing through your nose?	☐	☐
Do you have frequent nosebleeds or bruise easily?	☐	☐
Do you scar easily or excessively?	☐	☐
Do you have any skin disease, i.e. cold sores, herpes, eczema psoriasis, acne, fever blisters, dermatitis?	☐	☐
Are you allergic to adhesive tape, iodine or any cosmetics?	☐	☐
Are you allergic to any medications?	☐	☐
Please List:_____		
_____		

	YES	NO
Do you require treatment for hay fever or other allergies?	☐	☐
High Blood pressure?	☐	☐
Have you ever had an injury to your head, face, or neck?	☐	☐
Do you plan to gain or lose more than 10 pounds?	☐	☐
Current Wt:_____ Wt. one year ago:_____		
Do you exercise regularly?	☐	☐
Have you ever received local anesthesia from a doctor or dentist?	☐	☐
How long have you been thinking about having plastic surgery?_____		
Have you had plastic surgery before?	☐	☐
If yes, what was done and when?_____		
_____		
Were you happy with the results?	☐	☐
Have you ever had any other surgery to your head, face, or neck?	☐	☐
How do you think plastic surgery will benefit you? _____		
Do you think plastic surgery will significantly change your life?	☐	☐
Which of the following features/problems are you interested in changing/improving?		
☐ Nose ☐ Hair		
☐ Breathing ☐ Appearance ☐ Scars		
☐ Chin ☐ Acne ☐ Other		
☐ Eyelids ☐ Ears		
☐ Forehead ☐ Wrinkles		
☐ Face (facelift) ☐ Facial blemishes (moles, etc)		
☐ Other: _____		
WOMEN:		
Do you suspect you might be pregnant?	☐	☐
Last menstrual period:_____		

Please explain any "yes" answers: _____

_____

_____

_____

Please list your current medications, including dose, if possible. (Remember to include aspirin, Advil, birth control pills and hormones, steroids, heart and asthma medications, vitamins, and blood thinners.)

_____

_____

_____

_____

I, _____, a patient at Raymond S. Douglas, M.D., Ph.D.'s Office, do hereby voluntarily give consent to the taking of photographs of me for my medical records under the following conditions:

1. An assistant or photographer approved or designated by my physician may take the photographs only with the consent of my physician, or
2. The photographs shall be taken by my physician or by an assistant photographer approved or designated by my physician.
3. The photographs or other visual materials may be released to other physicians or insurance companies when necessary.
4. The photographs will be used for medical records.

_____ _____

Signature (Patient, Parent, or Guardian) Date

_____ _____

Witness Date

PHOTOGRAPHIC RELEASE AND CONSENT

Raymond S. Douglas, M.D., Ph.D.

I understand and accept that I may be recognized from my likeness or case history. Nevertheless, I authorize my surgeon to use my photographs, videotapes and case information in educational and scientific settings including, but not limited to, lectures and multi-media presentations for an audience of medical professionals, at which members of the press may be present, and medical, surgical and scientific journal articles.

Neither I, nor any member of my family will be identified by name in publication. I understand that in some circumstances the photographs may portray features, which shall make my identity recognizable.

I authorize the use of my photographs, videotapes and case information in the following specific commercial/educational settings, but not limited to: my surgeon's office patient education materials, my surgeon's file of pre- and postoperative patient photographs available to prospective patients for viewing in the office; newspapers and magazine articles in which my surgeon participates; television programs in which my surgeon participates; my surgeon's personal web site, web page or social media; and lectures and multi-media presentations given by my surgeon for the general public.

I release and discharge Raymond S. Douglas, M.D., Ph.D. and all parties acting under their license and authority from all rights that I mage have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above authorization and release and fully understand its terms.

_____

Patient Signature Date

_____

Printed Name

_____

Witness Signature Date

_____

Printed Name

RAYMOND DOUGLAS, MD PHD
AESTHETIC ORBITAL AND OCULOPLASTIC SURGEON

PATIENT PRIVACY RIGHTS (PATIENT CONSENT)

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or discloser of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Full Name:

Signature:_____ Date:_____

OFFICE COPY

RAYMOND DOUGLAS, MD PHD
AESTHETIC ORBITAL AND OCULOPLASTIC SURGEON

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper discloser of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

PATIENT COPY

Patient: PLEASE KEEP THIS SHEET

RAYMOND DOUGLAS, MD PHD
AESTHETIC ORBITAL AND OCULOPLASTIC SURGEON

Text Message and E-mail As a Form of Communication

I am aware that text messaging and e-mailing is not a Health Insurance Portability and Accountability ACT (HIPAA) compliant means of communication with Dr. Raymond Douglas regarding my care. I understand this means my privacy cannot be fully protected or guaranteed with this means of communication. Understanding this, should I choose to communicate with Dr. Douglas by text message or e-mailing before, during, or after his care for me as a patient, I give Dr. Raymond Douglas permission to respond with a text message or e-mail in return.

_____
Signature

_____
Date