MICHAEL BYUN, M.D. SC

PLASTIC AND COSMETIC SURGERY
www.chicagocosmeticsurgery.com

1775 Walters Avenue, Suite 100
Northbrook, IL 60062
Tel: (847) 513-6899
Fax: (847) 513-6898

1 East Erie Street, Suite 530
Chicago, IL 60611
Tel: (312) 397-9600
Fax: (847) 513-6898

Patient Information

(Please Print)

Date: _____

Name: _____
Last Name **First Name** **Initial**

How would you like to be addressed: ☐ Mr. ☐ Mrs. ☐ Dr. ☐ Last Name ☐ First Name ☐ Other _____

S.S#: ___-___-_____ Birth date: ___/___/___ Age: _____ Sex: ☐ M ☐ F Marital Status: ☐ Married ☐ Single

Address: _____

City: _____ State: _____ Zip: _____

Home Phone :( ) _____ Cellular Phone: ( ) _____

Preferred Number to Call :( )_____ **Can we leave a message?** ☐ Y ☐ N

May we send you mail to above address? ☐ Y ☐ N Other address _____

Email: _____ **May we email you information?** ☐ Y ☐ N

Patient Employed by: _____ Occupation: _____

If retired, previous occupation: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Business Phone: ( ) _____ Fax: ( ) _____

Emergency Contact:

Name: _____ Relationship: _____

Contact #: ( ) _____

Referred By

How did you hear about Dr. Michael Byun? (*Please check all that apply.)*

☐ Internet
What keywords did you use when searching: _____ Site Name: _____
(ex: breast augmentation, American board certified, facelift, etc.)

☐ Chicago Magazine
☐ TCW- Today's Chicago Woman Magazine
☐ Chicago Health and Beauty Magazine
☐ Postcard
☐ Dr. Byun's Newsletter
☐ Newspaper: _____
☐ Directory: _____
☐ Dr. Michael Byun's Book- Non Surgical Face Lift
☐ Dr. Michael Byun's Articles (*Please specify the name of source.*) _____
☐ Dr. Michael Byun's Patient(s): Name _____
☐ Hospital, Healthcare, or Other Physicians: Name _____
☐ Other kinds of referral (*Please specify*) _____

updated May 2014

MICHAEL BYUN, M.D., S.C.

History & Physical Form

(Please Print)

DATE: _____ **Patients Name:** _____

Last name *First name* *Middle initial*

Reason for Visit: □ Face □Body □ Skin □ Trauma □ Other: _____

Medical History: Check (√) diagnosis you currently have or had in the past. Check all that applies.

□ AIDS	□ Blood Clots	□ Hernia	□ Keloid Scarring	□ Stroke	□ Other_____
□ Anemia	□ Bulimia	□ Herpes	□ Liver Screening	□ Suicide Attempt	_____
□ Anorexia	□ Cancer	□ High Cholesterol	□ Migraine Headache	□ Thyroid Problems	_____
□ Arthritis	□ Diabetes	□ HIV Positive	□ Pacemaker	□ Tuberculosis	_____
□ Asthma	□ Heart Attack	□ Hypertension	□ Pregnancy	□ Ulcers	_____
□ Bleeding Disorders	□ Heart Disease	□ Kidney Disease	□ Psychiatric Care		

Surgical History: Check (√) surgeries you have had recently or in the past. Check all that applies.

□ Abdominal Surgery □ Thyroid Surgery □ Heart Surgery

□ Previous Surgery: Type: _____ Date: _____
□ Previous Cosmetic Surgery: Type: _____ Date: _____
□ Other Type: _____ Date: _____
Type: _____ Date: _____

Family History: Check (√) all that applies.

□ Diabetes □ Cancer □ Blood Pressure Problems □ Other: _____

Social History: Check (√) all that apply.

□ Alcohol How often: □ Daily □ Weekly □ Monthly □ Occasionally
□ Tobacco How often: □ Daily □ Weekly □ Monthly □ Occasionally How many packs a day? _____ How many years? _____
□ Cocaine How often: □ Daily □ Weekly □ Monthly □ Occasionally
□ Marijuana How often: □ Daily □ Weekly □ Monthly □ Occasionally
□ E How often: □ Daily □ Weekly □ Monthly □ Occasionally
□ Other: _____ □ Heavily □ Socially

Medication: Check (√) all that apply.

□ Anxiety Pills _____ _____
□ Sleeping Pills _____ _____
□ Diet Pills _____ _____
□ Multivitamins _____ _____
□ Motrin /Ibuprofen _____ _____
□ Aspirin _____ _____
□ Herbal Pills _____ _____

Allergies: List all allergies and symptoms.

□ No Allergies
□ Yes, allergies. If you answer "yes" please list them below:

Allergy: _____ Symptoms/Reaction: _____
Allergy: _____ Symptoms/Reaction: _____
Latex Allergies: _____ YES _____ NO

□ **Not applicable**

Patient Signature _____ **Witness:** _____

TESTING NEEDED: Hemogram (within 30 days) EKG (patients 50 years and older, within 6 months)

PE: BP: _____ P: _____ Height: _____ Weight: _____
HEENT: _____
CV: _____
Lung: _____
Abd/Back: _____
Neuro: _____

MEDICAL CLEARENCE: **Indicated:** _____ **Not Indicated:** _____

Signature MD: _____ **Date:** _____

updated January 2014

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Insurance Information

(Please Print)

Doctor's Fee

Dr.Byun is **not** a network provider. If you decide to utilize your insurance you will be responsible for paying the Out of Network percentage that is not covered before surgery. Any unpaid balance from insurance is also your responsibility.

Insurance Holders Name: _____
Last Name **First Name** **Initial**

Home Phone: (*If different from patient*)-( ) _____

Birth date: _____ Soc. Sec. #: _____

Address: (If *different from patient*) _____

City: _____ State: _____ Zip: _____

Employed by: _____ Occupation: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Business Phone: ( ) _____ Fax: ( ) _____

Relationship to Patient (*Please check one*):

☐ Self ☐ Mother ☐ Father ☐ Spouse

Insurance Company (*Please check one or fill in name*):

☐ Blue Cross Blue Shield of Illinois
☐ United Healthcare
☐ Cigna
☐ Humana One
☐ Aetna
☐ Other: _____

Claims Address: _____

City: _____ State: _____ Zip: _____ Phone: ( ) _____

ID #: _____ Group#: _____ Subscriber: _____

Assignment and Release of Insurance benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and or/dependents and that I will be bound by this signature as though the undersigned had personally signed the claim.

I _____ hereby authorize _____
Name of Insured **Name of Insurance Company**

to pay and hereby assign directly to **DR. MICHAEL BYUN, M.D.** all insurance payments. I understand that I am financially responsible for all charges that are not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits.

_____ _____ _____
Responsible Party Signature **Relationship** **Date**

MICHAEL BYUN M.D., S.C.
CHICAGO COSMETIC SURGERY
NOTICE OF PRIVACY PRACTICES

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

I have received the attached Chicago Cosmetic Surgery Notice of Privacy Practices.

Signature of Patient	Signature Date
Print Name	Date of Birth of the Patient
Signature of Parent/Legal Guardian/Legal Representative	Relationship to Patient
Witness	Date (if indicated)

THIS NOTICE BECAME EFFECTIVE ON APRIL 14, 2003.

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

UNDERSTANDING YOUR HEALTH INFORMATION AND MEDICAL RECORD

Each time you visit a hospital, physician, or other healthcare provider, they document information about you and your visit. Typically, this record is referred to as your medical record and contains your name, symptoms, health history and exam, test results, diagnoses, treatment given and a plan for future care or treatment ("Health Information"). This medical record is used to plan your care and treatment and be a source of your health information as described below.

YOUR HEALTH INFORMATION RIGHTS

Your medical record is the physical property of the Chicago Cosmetic Surgery site, however the information within your medical record belongs to you. Federal and Illinois Laws provide you with the following rights regarding your health information that is contained in the medical record that Chicago Cosmetic Surgery keeps about you.

- Right to obtain a copy of this Notice of Privacy Practices.
- Right to request certain restrictions on the uses and disclosures of your health information.
- Right to inspect or receive a copy of your health record.
- Right to request an amendment to your health record if you believe it contains an error.
- Right to obtain a list of all the people and companies to which Chicago Cosmetic Surgery has released your health information (an "accounting" of disclosures).
- Right to request that we communicate with you about your health care at a confidential phone number or address.
- Right to revoke your written consent/authorization to use or disclose your health information except when the use or disclosure has already happened.

Federal and Illinois laws also provide you with the right to be informed about and give your written authorization before any health information, including Highly Confidential Information, is disclosed, unless such disclosure is allowed or required by law. Examples of Highly Confidential Information are mental health treatment information, substance abuse prevention, treatment or referral; developmental disability services; HIV/AIDS testing and treatment, venereal disease treatment, sexual assault treatment, and testing and treatment for genetic disorders.

CHICAGO COSMETIC SURGERY'S RESPONSIBILITIES ARE TO

• Maintain the privacy of your health information as required by law.
• Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
• Do what is required by this Notice or a Notice that is in effect at the time Chicago Cosmetic Surgery uses or discloses your health information.
• Notify you if we are unable to agree to your requested restriction on disclosure of your health information.
• Agree to reasonable requests to communicate your health information by an alternative method or at an alternative location.

We reserve the right to change our privacy practices and to use a new Notice of Privacy Practices for all health information we maintain about you and other patients. If Chicago Cosmetic Surgery changes its practices, a new Notice of Privacy Practices will be available upon your request, by mail or in person at this site.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Chicago Cosmetic Surgery will use and disclose your health information contained within the Chicago Cosmetic Surgery medical record to give you treatment, obtain payment for your treatment and operate our healthcare businesses.

MICHAEL BYUN M.D., S.C.
CHICAGO COSMETIC SURGERY
NOTICE OF PRIVACY PRACTICES

EXAMPLES OF HOW YOUR HEALTH INFORMATION WILL BE USED OR DISCLOSED FOR TREATMENT, PAYMENT AND OPERATIONS.

We will use your health information for treatment.
For example: Your physician, nurse or other members of your healthcare team will collect and document information about you in your medical record. We may disclose information to a physician or other health care provider who will be assuming your care, for immediate continuity of care. This health information will used to choose the treatment they believe is best for you. Nurses and other members of the team will document in your medical record the actions they took and their observations made of you. Your physician will then know how you are responding to the chosen treatment.

We will use your health information for payment.
For example: We will send a bill that includes some of your health information to you, to the person responsible for the bill and your third party payer (such as your health insurance company or Medicare). In some instances, we may need to send a copy of part or all of your medical record to your third party payer. The type of health information we will send includes your name, other identifying information, diagnosis, treatment, procedures performed and supplies provided during your treatment.

We will use you health information for our routine operations.
For example: Physicians, nurses and quality improvement professionals will use your health information to review the treatment you received and outcomes. They may also compare your treatment and outcomes to those of other patients like you. We compare cases to help us continually improve the quality and effectiveness of our healthcare services.

OTHER USES OR DISCLOSURES OF YOUR HEALTH INFORMATION

Upon receipt of your written authorization to use and/or disclose your health information.
We will use and/or disclose your health information to those persons or companies for which you give us your written authorization or permission to do so. If you authorize us to use or disclose your information, you must complete our Release of Health Information Form. You may revoke your authorization in writing at any time except to the extent that we have already used or disclosed your health information as you previously authorized. If your health information includes Highly Confidential Information, we may only use and disclose such information for treatment, payment and operations as described above. Otherwise, unless a disclosure is allowed or required by federal or Illinois law, you must give us your written authorization to disclose your Highly Confidential Information. A person who can verify your identity must witness and co-sign an Authorization to Release Health Information form about treatment for a mental illness or developmental disability

Chicago Cosmetic Surgery may without your written authorization release your health information for the purposes described below.
Business Associates: We provide some services through other persons or companies that need access to your health information to carry out these services. The law refers to these persons or companies as our Business Associates. Examples of these Business Associates include billing and record copying companies that assist us with billing for our services or copying medical records. Other types of business associates are organizations that collect information about patients who have been treated with similar problems such as cancer or trauma. These organizations list the information in registry directories that help physicians throughout Illinois to improve the quality of care for other patients with these same problems. We may disclose your health information to our Business Associates so that they can do the job we have contracted with them to do. We require that they use appropriate safeguards to ensure the privacy of your health information.

Health Oversight Activities and Specialized Government Functions. We may disclose your health information to an agency that oversees healthcare systems and ensures compliance with the rules of government health programs such as Medicare or Medicaid; under certain circumstances to the U.S. Military or U.S. Department of State.

Law Enforcement Officials, Medical Examiners and Coroners and Court or Administrative Orders. We may disclose your health information to the police, other law enforcement officials, medical examiners and coroners, and to the courts or administrative proceedings as allowed or required by law, or required by a court order or other legal process.

Notification and Other Communications with Your Relatives, Close Friends or Caregivers. You or your legal representative must tell your physician, nurse or other healthcare team members which of your relatives or other persons may receive information about you. After learning who these persons are, we may, in our best judgment, use and disclose your health information, except for your Highly Confidential Information, to notify these person(s) of what they need to know to care for you. In an emergency or other situation where you are not able to identify your chosen person(s) to receive communications about you, we may exercise our professional judgment to determine whether such a disclosure is in your best interest, who is the appropriate person(s) and what health information is relevant to their involvement with your healthcare.

Funeral Directors and Organ, Eye and Tissue Organizations. We may disclose your health information to funeral directors as necessary to carry out their duties and as allowed by law; or to organ, eye and tissue organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

Public Health Activities. We may report your identity and other health information to: public health authorities for the purpose of controlling disease, injury or disability; to the U.S. Food and Drug Administration for regulating certain products or activities; to

governmental authorities about suspected or known child abuse and neglect, elder adult abuse and neglect, or domestic violence; to a person exposed to a contagious disease or has the risk of contracting or spreading a disease; to your employer and governmental agencies as required by federal and state laws regarding work-related illness or injury; to prevent or lessen a serious or imminent threat to a person's or the public's health or safety; or, to a public or private entity that is authorized to assist in disaster relief efforts.

Research. We may use or disclose your health information to identify you as a potential candidate for a research study that has been approved by an Institutional Review Board or for governmental research studies in which your identifiable information will not be released.

Workers Compensation. We may disclose your health information as allowed or required by Illinois law relating to workers' compensation or to other similar programs.

Other Communications with You. We may contact you to remind you of appointments with your physicians or other healthcare team members and to follow up on the services you received. We may leave messages about appointments or other reminders on your telephone or with a person who answers the phone. Unless you notify your nurse or registration coordinator that you object, we may also contact you about other health care services we offer that may benefit you.

USES AND DISCLOSURES THAT YOU MAY OBJECT TO OR REQUEST

Directory (Hospitals Only): We may disclose your name and general condition to a member of the media who asks for you by name. We may disclose your name and location in the hospital to a member of the general public who asks for you by name.

If you are receiving mental health or alcohol/substance abuse services on an inpatient behavioral health unit during this hospitalization, we will not disclose any information without your prior written authorization.

ADDITIONAL EXAMPLES OF HOW YOUR HEALTH INFORMATION WILL BE USED OR DISCLOSED

Marketing: Upon receiving your written authorization, we may use your health information to provide you with marketing information.

If you object to using your health information for the hospital directory, please contact:
The appropriate contact person for the Chicago Cosmetic Surgery site in question.

RIGHT TO FILE A COMPLAINT.
If you would like to report a Privacy Problem or want further information, PLEASE CONTACT:
The appropriate contact person for the Chicago Cosmetic Surgery site in question.

If you believe your privacy rights have been violated, you may file a complaint with Chicago Cosmetic Surgery, the Director of the office of Civil Rights (OCR) or the U.S. Secretary of Health and Human Services (HHS). We will not retaliate against you if you file a complaint with us or with the Directors of OCR or HHS.

DISCLAIMER:
THIS NOTICE OF PRIVACY PRACTICES HAS BEEN ADOPTED AS THE ONLY APPROVED NOTICE FORM FOR USE WITH CHICAGO COSMETIC SURGERY. ANY CHANGES ARE UNAUTHORIZED AND INVALID.