SIEBER

PLASTIC SURGERY

**David A. Sieber MD**
Plastic Surgeon

450 Sutter Street
Suite #2630
San Francisco CA, 94108

(P) 415-915-9000 (F) 415-915-3000
www.SieberPlasticSurgery.com

# PATIENT INFORMATION

PLEASE COMPLETE ENTIRE PACKET

The information contained within this packet is confidential and will not be released without your consent

Today's Date: _____

Patient's Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone Numbers:

Home: _____ Cell: _____ Work: _____

Email Address: _____

Date of Birth: _____ Height: _____ Weight: _____ Female ◯

Age: _____ Male ◯

Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Separated

Emergency Contact Name: _____

Telephone: Home: _____ Cell: _____ Wk: _____

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What brings you to our office today? Please be as specific as possible.

_____

_____

How long has this concerned you?

_____

Have you had any previous treatment for this?

_____

If YES, how and when was this treated? Were you happy with the results of that treatment?

_____

**Review of systems:**

Do you have or have you had any of the following? (Please check yes or no)

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| AIDS or HIV positive | ☐ | ☐ | Cancer | ☐ | ☐ |
| Hepatitis | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ |
| Anemia | ☐ | ☐ | Chest Pains | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Seizures | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Colitis | ☐ | ☐ |
| Irregular Heart Beat | ☐ | ☐ | Shortness of Breath | ☐ | ☐ |
| Asthma | ☐ | ☐ | Diabetes | ☐ | ☐ |
| Kidney Problems | ☐ | ☐ | Skin Cancer | ☐ | ☐ |
| Back Problems | ☐ | ☐ | Ear/Eye Problems | ☐ | ☐ |
| Migraine Headaches | ☐ | ☐ | Stomach Problems | ☐ | ☐ |
| Blood Clots in legs | ☐ | ☐ | Stroke | ☐ | ☐ |
| Blood Disorders | ☐ | ☐ | Heart Problems | ☐ | ☐ |
| Nose/Throat Problems | ☐ | ☐ | Thyroid Problems | ☐ | ☐ |
| Bleeding Problems | ☐ | ☐ | Heart Murmur | ☐ | ☐ |
| Pneumonia | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Breathing Problems | ☐ | ☐ | Heart Palpitations | ☐ | ☐ |
| Mammogram | ☐ | ☐ | Blood Transfusion | ☐ | ☐ |

**Past Medical History:**
List all medical conditions and any major hospitalizations including dates:

_____

_____

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**Past Surgical History:**

List all past surgical procedures including dates:

_____
_____
_____

Are you allergic to or have you ever had a reaction to any medication or drug, local anesthetic, or general anesthetic? If so, please list medication and type of reaction:

_____
_____
_____

What medications do you take regularly?(aspirin, birth control pills, herbs, vitamins, etc.)

_____
_____
_____
_____

Do you have a problem with excessive scarring or keloid formation after being cut? ☐ Yes ☐ No

Is your general health good? ☐ Yes ☐ No

Have you ever had psychiatric problems, a nervous breakdown or been under the care of a psychiatrist, psychologist or mental health counselor? ☐ Yes ☐ No

If so, please list what condition you have been treated for:

_____
_____

**Family History:**
Do you have any diseases or conditions that run in your family? If yes, please list condition and which family member has been affected.

_____
_____
_____

Have you or a member of your family ever had a problem with anesthesia? ☐ Yes ☐ No
If yes, please explain

_____

**Social History:**

What is your profession?

_____

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Have you ever smoked? ☐ Yes ☐ No
If yes, how many packs per day? _____ For how many years?_____When did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No
If yes, how much? _____

How often? _____

Please list all of your doctors. Please include primary care physicians, specialists, and mental health
care professionals.

_____
_____
_____
_____
_____

How did you learn about us? (Please check all statements that apply)
____A friend referred me. (Name) _____
____A doctor referred me.(Name) _____
____I saw an ad in a magazine or newspaper.
____I visited your website. (Please check which site or all that apply)

☐www.SieberPlasticSurgery.com
☐RealSelf
☐Google
☐Yelp
☐Instagram
☐Other_____

Thank you for taking the time to complete this information.

I certify the above to be true to the best of my knowledge.

_____ _____
Patient (or legal guardian) Date

_____ _____
Reviewed by Physician Date

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## ***Consent for Use of Preoperative & Postoperative Photographs/Videos for Teaching and/or Website***

I hereby authorize Dr. David Sieber and Sieber Plastic Surgery, PC to use photographs and/or videos of me, and/or parts of my body, for use in patient education, medical education and/or publication in a professional medical journal and/or printed or electronic text and/or Website and/or social media.

I understand that all reasonable attempts to protect my anonymity will be made, and that my name will not be used to identify any photograph(s). I further acknowledge that anonymity cannot be guaranteed when the photograph(s) illustrate a portion of, or full photograph of my face.

Please select one box

☐ I consent for use of photos/videos for in office use only
☐ I consent for use of photos/videos for all purposes as stated above
☐ I do not consent to use of photos/videos

Patient Name (Print): _____

Signature of Patient, Parent or Legal Guardian: _____

Date: _____

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# PATIENT CONSENT TO TREATMENT

Please read each section carefully. You may request a copy of this form for your own records.

Patient Name _____Date_____

I, the undersigned, do hereby request and consent to an evaluation and treatment by Sieber Plastic Surgery. I wish to rely on Sieber Plastic Surgery to exercise judgment for my best interest, me or that of my dependent, the above-named patient, during the course of treatment. I will inform Sieber Plastic Surgery or his staff who is treating me or my dependent of any sensitive areas or adverse conditions that I or my dependent may have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment.

I clearly understand and agree that all services rendered to me or to my dependent, the above-named patient, may be charged directly to me and that I am personally responsible for full payment. I understand that even if I suspend or terminate treatment, any fees for professional services rendered to me or to my dependent up to the point of termination will be immediately due and payable.

I acknowledge that Sieber Plastic Surgery participates directly with several insurance plans (including managed care plans and Medicare) and that I am responsible for any outstanding fees for services provided to me or to my dependent, the above-named patient, by Sieber Plastic Surgery that are not reimbursed through insurance or other third party payers; this includes all co-payments, deductibles, and out of pocket costs. I understand that a potentially refundable deposit to cover fees for uncovered services may be required at the time of service or follow-up.

For cosmetic procedures, I understand that I will be responsible for all facility and anesthesia fees incurred for subsequent revision and/or emergency procedures performed on me or my dependent, the above-named patient, as well as necessary supplies including but not limited to implants, unless otherwise specified by VIP Plastic Surgery. Any surgeon's fee that may be incurred for subsequent revision and/or emergency procedures will be addressed on a case by case basis.

I authorize Sieber Plastic Surgery to submit all precertification and claims directly to the insurers on my behalf. I hereby authorize the release of my medical records and other information necessary to process insurance claims. I understand and agree that any and all monies received from insurance companies and/or other third party payers as reimbursement for services rendered to me or to my dependent, the above-named patient, by Sieber Plastic Surgery shall be forfeited in full to Sieber Plastic Surgery. Any other arrangements that may involve insurance billing, reimbursement, payment plan, or payment deferral, must be made in writing with the office manager and/or business manager of Sieber Plastic Surgery. Verbal agreements are not acceptable

Signature _____ Date _____

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# PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

YOU MUST PROVIDE YOUR INSURANCE CARD AND PICTURE IDENTIFICATION TO THE RECEPTIONIST FOR PHOTOCOPYING AT EACH APPOINTMENT. IN THE EVENT THAT NO INSURANCE IS AVAILABLE, OR IT HAS BEEN DETERMINED THAT THE PATIENT IS INELIGIBLE FOR COVERAGE OF SERVICES, THIS ACCOUNT WILL BE DETERMINED TO BE SELF-PAY AND PAYMENT IN FULL IS DUE AT THE TIME OF EACH SERVICE.

I hereby authorize Sieber Plastic Surgery to release medical information to my physicians and/or insurance company(ies). I further authorize direct payment from my insurance company(ies) to Sieber Plastic Surgery.

I understand that I am responsible for obtaining all necessary referrals prior to the scheduled appointment. All co-payments required by my insurance plan will be paid at the time of service. I further acknowledge that all deductibles, co-insurance and non-covered items as determined by my insurance plan will be due and payable upon notice either sent by U.S. mail in the form of a statement and/or telephone communication from Sieber Plastic Surgery.

After the first missed appointment without 24-hour notice given to Sieber Plastic Surgery, I will be responsible for a $50.00 NO SHOW fee.

All returned checks shall be assessed a $40.00 bank processing fee, for which I will be responsible.

I acknowledge that a 1.5% per month interest charge may be added to any balance unpaid after 90 days of aging. I further acknowledge that I will be held responsible for any and all expenses incurred by Sieber Plastic Surgery for a 30% collection fee and/or a 30% attorney fee on any balance referred to an attorney for collection as a result from my delay in payment for services rendered by Sieber Plastic Surgery.

I further agree that if this account is not paid when due I will be responsible for a collection expense of 35% on the balance, plus any court costs incurred by Sieber Plastic Surgery, in addition to interest accrued after the initial 90 days of debt at 1.5% monthly.

Sieber Plastic Surgery reserves the right to assess a charge for telephone calls when medical care is dispensed in lieu of an office visit.

_____ _____

Signature of Patient (or legal guardian) Date

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# COSMETIC SURGERY CANCELLATION POLICY

Sieber Plastic Surgery makes every effort to ensure that appointments are scheduled and completed in an efficient manner, and the hospital will contact you on the business day prior to your appointment to confirm the details. Preparing and scheduling with the surgery center involves a significant amount of time for the physician and staff.

Our office requires a 25% deposit of the total fee be made in order to reserve a surgery date.

If you cancel your surgery anytime after your surgery date has been reserved and/or deposit has been made, a $500 administrative and consultation, non-refundable fee will apply.

If you cancel your surgery 7 business days to 48 hours prior to surgery, you will be charged 25% of the total surgical costs.

If you cancel your surgery between 48 and 24 hours, you will be charged 50% of the total surgical costs.

Cancellations within 24 hours of surgery will be charged at 100% of the total fee.

Patients who are cancelled by Dr. David Sieber (or any other providing physicians, i.e. anesthesia) for medical reasons will be rescheduled without financial penalty. This policy only applies to Sieber Plastic Surgery and is not the policy of the anesthesia provider or the surgery center.

We appreciate your cooperation in this matter.

I have read the above policy and agree to its terms.

_____

Patient Name (Please Print)

_____ _____

Patient Signature (or legal guardian) Date

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# NOTICE OF PRIVACY PRACTICES SUMMARY

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 medical or enable other health care providers to provide 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 office properly. We are required by law to maintain the privacy of protected health information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This summary of the Privacy Practices lists how we may use and disclose your medical information. It also lists your rights and our legal obligations with respect to your medical information. If you have any questions about the Notice, please contact our Privacy Officer.

## A. How This Office May Use or Disclose Your Health Information

This office collects health information about you and stores it in a chart and/or computer. This is your medical record. The law permits us to use or disclose your health information for the following purposes.

1. Treatment
2. Payment
3. Health Care Operations
4. Appointment Reminders
5. Notification and Communication with family
6. Required by Law
7. Public Health
8. Health Oversight Activities
9. Judicial and Administrative proceedings
10. Law Enforcement
11. Coroners
12. Organ and Tissue Donation
13. Public Safety
14. Specialized Government Functions
15. Workers Compensation
16. Change of Ownership

## B. When This Office May or May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this office will not use or disclose health information which identifies you without your written authorization. If you do authorize this office 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
2. Right to Request Confidential Communication
3. Right to Inspect and Copy
4. Right to Amend or Supplement
5. Right to an Accounting of Disclosures
6. You have a right to a paper copy of the complete Notice of Privacy Practices

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, you may contact our Privacy Officer at (415)915-9000. Our Privacy Officer is available during normal business hours to discuss your privacy questions, concerns or complaints.

## 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 will apply to all protected health information that we maintain, regardless of when it was created or received. A copy will be available.

## E. Complaints

Complaints about this Notice of Privacy Practices or how this office handles your health information should be directed to the licensed healthcare professional. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to the Department of Health and Human Services.

EFFECTIVE DATE: This notice was published and becomes effective on 01/17

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# WRITTEN ACKNOWLEDGMENT OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose Private Healthcare Information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I have read and/or received a copy of the Notice of Privacy Practices of David SIeber MD, and Sieber Plastic Surgery PC.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to David Sieber MD, and Sieber Plastic Surgery PC if I do not understand any information contained in the Notice of Privacy Practices.

_____

Patient Name (Please Print)

_____ _____

Patient Signature (or legal guardian) Date