SQUIRES PLASTIC SURGERY
CONFIDENTIAL PATIENT INFORMATION

Date _____ (Must be updated yearly)
Updated by patient (date/initials) _____, _____,_____,_____

Last Name _____ First Name _____MI ____ Nickname _____

SSN# _____-_____-_____ DOB ____/____/_____ Age _____ Sex _____ Relationship Status _____

Home Address _____

City _____ State _____ZIP _____

Home Phone _____Work _____ Cell _____

Occupation _____ Employer/School_____

E-mail address _____@_____._____

Who **referred** you or how did you find out about us? _____☐

If you were referred by a specific person, may we thank them? _____ ☐Yes, ☐No.

SPOUSE/PARENT/SIGNIFICANT OTHER

Last Name _____ First Name _____ Relationship _____

Address _____

City _____State _____ ZIP _____

Home _____ Work _____ Cell _____

EMERGENCY CONTACT(s)

☐ Same as above, ☐ and, ☐ or …

1) Name _____ Relationship_____

Home _____Work _____Cell _____

2) Name _____ Relationship_____

Home _____Work _____Cell _____

SQUIRES PLASTIC SURGERY - MEDICAL HISTORY

(Must be updated yearly)
Updated by patient (date/initials) _____, _____,_____,_____
Last Name _____, First_____, DOB _____

Date _____ Reason for Visit _____

Please list all **medications, supplements, vitamins or herbs** you have taken within the last month.

Medication	**Dose**	**Indication**	**If stopped, when?**

Ever taken **Metabolife**? _____ If so, when last taken? _____, Ever taken **Accutane**? _____ If so, when last taken? _____

Allergies: Please list all medications, anesthetics, tapes, or other agents to which you have had an adverse reaction.

Name	**Reaction**	**Approximate date**

All hospitalizations and/or operations	**Hospital**	**Date**

Other Conditions?

☐Y, ☐N - High Blood Pressure	☐Y, ☐N - Anemia	☐Y, ☐N - Depression
☐Y, ☐N - Heart Disease / Heart Attack	☐Y, ☐N - Blood Clots (DVT)	☐Y, ☐N - Mental Disorders
☐Y, ☐N - Heart Valve Disorder(s), Murmur	☐Y, ☐N - Bleeding Disorders, Hemophilia	☐Y, ☐N - Dry Eyes
☐Y, ☐N - Chest Pains, Angina	☐Y, ☐N – Easy Bruising /Excessive Bleeding	☐Y, ☐N - Glaucoma
☐Y, ☐N - Irregular Heartbeat	☐Y, ☐N - Diabetes	☐Y, ☐N - Fainting Spells
☐Y, ☐N - Shortness of Breath	☐Y, ☐N - Kidney or Liver Problems	☐Y, ☐N - Stroke, TIA's
☐Y, ☐N - Asthma	☐Y, ☐N - Reflux – Hiatal Hernia	☐Y, ☐N - Exposure to hepatitis HIV, AIDS
☐Y, ☐N - Sleep Apnea, Bad Snoring	☐Y, ☐N - Herpes, Fever Blisters	☐Y, ☐N - History of IV drug use.

Please detail those listed above or **any other medical conditions** not listed.

_____
_____
_____

Please list any medical conditions that run in your **family**: ☐Blood clots, ☐Bleeding Disorders, ☐Breast Cancer
Other:_____

Have you or any family member had an unfavorable reaction to **anesthesia**? Yes_____, No_____.
If yes, what? _____

Physicians who care for you	**Specialty**	**Phone**

Latest **Mammogram** (date) _____or N/A, -- Latest **EKG** (date) _____ or N/A
Number of **Pregnancies**____, Live births ____, Ages of children _____, Any more planned? _____
Do you drink **Alcohol**? _____ If so, how many drinks per week? _____, Any other drugs? _____
Do you **Smoke cigarettes** ? _____ if so, how many packs per day? _____, how many years____If you quit, when? _____
Do you smoke **electronic cigarettes**_____ Do you smoke **marijuana**_____
Height _____, **Weight** _____, How much weight loss _____, or gain _____, have you had over the last 2 years

SQUIRES PLASTIC SURGERY
John R. Squires, MD, FACS
3003 E. Third Avenue # 206 • Denver, CO 80206
Phone (303) 321-3210 • Fax (303)321-6056

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and/or disclosed and how you may access this information. Please review it carefully. The Privacy of your information is important to us.

This Notice of Privacy Practices describes how Dr. John R. Squires and Squires Plastic Surgery may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. "Protected health information" is the information about you, including demographic information that may identify you and that related to your past, present or future physical or mental health or condition and related health care services. This notice also describes your rights to access and control your protected health information.

We are required to abide by the terms of the Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be in effect for all protected health information that we maintain at that time. If the notice changes, you may contact us and request that a revised copy be sent to you in the mail or you may ask for one at the time of your next appointment.

1. Uses & Disclosures of Protected Health Information

You will be asked to sign a consent form that allows the use and disclosure of your protected health information for treatment, payment, and health care operations. Your protected health information may be used and disclosed by Dr. John R. Squires and the Squires Plastic Surgery staff, and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of Squires Plastic Surgery, and any other use required by law.

Following are examples of the types of uses and disclosures of your protected health information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but describe the types of uses and disclosures that may be made by the office.

Treatment: We will use and disclose protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health information with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. Disputed credit card or credit company charges will require release of any requested protected health information necessary to obtain payment for services rendered.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct day-to-day activities, certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging, for other business activities. For example, we disclose your protected health information to medical professional students who see patients at our office. In addition, we may use a sign-in-sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when Dr. Squires or the staff is ready to see you. We may use or disclose your protected health information, as necessary, to contact you concerning your medical care or appointments by telephone, voice mail, email, text message or mail.

We may also share your protected health information with third party "Business Associates" that perform various activities such as billing, and transcription services for our practice. Whenever possible an arrangement is made with the "Business Associate" that your Protected Health Information will be protected.

Other Permitted and Required Uses and Disclosures: Other uses of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

We will disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to the personal involvement of your care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is your best interest based on our professional opinion.

Unless you object, we may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits or services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about or practice and the services we offer. We may also send you information on products or services that we believe may be beneficial to you. You may opt out of receiving further such information by contacting our office.

We may also use or disclose your protected health information in the following situation without your authorization. These situations include: Required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse & Neglect, Food and Drug Administration Requirements, Legal Proceeding, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, and Required Uses and Disclosures.

We may also use or disclose your protected health information in the following situation without your authorization: In the event that you dispute or decline credit card, financing or other charges or stop check or other payment.

You may revoke this authorization at any time in writing. However, your decision to revoke the authorization will not affect or undo any use, disclosure of information, credit card or financing charges that occurred before you notified us of your decision to revoke your authorization.

2. Patient Rights

Following is a statement of your rights with respect to your Protected Health Information.

You have the right to inspect and copy your Protected Health Information. Under federal law you may inspect or copy your protected health information, except for the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your Protected Health Information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or health care operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom your want the restriction to apply.

Dr. Squires is not required to agree to a restriction that you may request. If Dr. Squires believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You may have the right to have your physician amend your Protected Health Information: If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

SQUIRES PLASTIC SURGERY

NOTICE OF PRIVACY PRACTICES

You have the right to receive an accounting of certain disclosures we have made, if any, of your Protected Health Information. The right applies to disclosure for purposes other than treatment, payment or health care operations as described in this notice. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice electronically.

For any questions regarding or in invoking your rights, you may contact our HIPAA Privacy Contact at 303-321-3210.

3. Complaints:

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Squires Plastic Surgery
3003 E. Third Avenue, Suite 206
Denver, CO 80206

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address above. In addition you may complain to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You will not be penalized or otherwise retaliated against for filling a complaint.

Contact Person: The name & address of the person you can contact for further information concerning our privacy practices is the privacy manager or the doctor.

John R. Squires, MD, FACS
3003 E. Third Avenue, Suite 206
Denver, CO 80206
Phone#: (303) 321-3210

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Name _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices provides information about how we may use and disclose protected health Information about you. The Notice contains a Patient Rights section describing your rights under law. Please review this Notice before signing this form. The terms of our Notice may change. You may obtain a copy of the Notice at any time by contacting our office. Your privacy is very important to us and we strive to maintain confidentiality throughout our normal course of business.

I acknowledge that I have been provided the opportunity to read and understand the Notice of Privacy Practices from Squires Plastic Surgery and Dr. John R. Squires.

I consent to the use or disclosure of my protected health information by Dr. John R. Squires and the Squires Plastic Surgery staff for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, and to conduct health care operations. You may revoke this consent in writing and signed by you. However, such a revocation shall not affect any disclosures we have already made based on your prior consent.

I understand that it may be necessary for Dr. John R. Squires and/or the Squires Plastic Surgery staff to use a variety of methods to communicate with me which may include providing information to those who accompany me to an appointment and/or procedures, leaving voice messages regarding appointments and/or sending text messages or email. I acknowledge that all methods of medical communication carry some level of risk and that online communication is not encrypted and particularly vulnerable to interception by unintended recipients.

I understand that I have a right to:

(A) Inspect and copy my protected health information.
(B) Request a restriction of my protected health information.
(C) Request to receive confidential communication from us by alternative means or at alternative location.
(D) Obtain a paper copy of this notice from us.
(E) Request my physician amend my protected health information.
(F) Receive an accounting of certain disclosures we have made, if any, of my protected health information.

_____ Date _____
Signature of Patient

SQUIRES PLASTIC SURGERY

Protected Health Information Communication Preferences

Name _____ Date _____

With whom may we discuss your medical treatments, appointments, or other protected information?

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Initial below:

_____I acknowledge that all methods of communication carry some level of risk of unintended disclosure of protected health information and that email and text communication are not encrypted and particularly vulnerable to interception by unintended recipients.

Methods listed below where we can leave confidential messages:

Home Phone: ____Yes, ____No
Work Phone: ____Yes, ____No
Cell Phone: ____Yes, ____No
Text message ____Yes _____No
E-mail: ____Yes, ____No

How would you prefer that we contact you?
____ Home phone, ____ Work phone, ____Cell phone, ____E-mail

Are there any limitations on how we can contact you? ____Yes ____No

List any: _____

_____ _____
Signature of Patient Date

Updated
Date: _____ _____ _____ _____ _____
Initials:_____ _____ _____ _____ _____

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