Dr. Christine Rodgers
DENVER PLASTIC SURGERY

Patient Registration Information

Patient Name: _____ Today's Date: _____
How would you like to be addressed? _____ Sex: ☐ M ☐ F Age: _____
Date of Birth: _____ Last 4 digits of SS #: _____ E-Mail: _____
Cell Phone: _____ Work Phone: _____ Home Phone: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Employer: _____ Position: _____
Relationship Status: ☐ Single ☐ Married/Domestic Partner ☐ Divorced ☐ Widowed
Partners Name: _____ Employer: _____

Responsible Party Information (Complete this section if someone other than yourself is financially responsible)

Responsible Party: _____ Relationship to Patient: _____
Date of Birth: _____ E-Mail: _____ Phone Number: _____
Address: _____ City: _____ State: _____ Zip Code: _____

Patient Insurance Information

Primary Insurance Company Name: _____ ☐ HMO ☐ PPO ☐ EPO ☐ POS
Insurance Address: _____ City: _____ State: _____ Zip Code: _____
Name of Insured _____ Date of Birth: _____
Insurance ID # _____ Group #: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Authorization to release Medical Records:

I hereby authorize Denver Plastic Surgery Associates to furnish any and all information, including but not limited to mental health records, drug and alcohol abuse records protected by law, and or HIV/AIDS test results to the provider specifically listed here: _____
This authorization is effective now and will remain in effect until _____.
I understand that I may receive a copy of this authorization.

Patient/Responsible Party: _____ Date: _____ Relationship: _____

Patient Acknowledgement

I understand and acknowledge that my insurance coverage is a contract between my insurance company and me and that I am personally responsible for all medical expenses incurred during evaluation and treatment by Denver Plastic Surgery Associates. I understand that as a courtesy my primary insurance will be billed, however, it is my responsibility to follow up on delinquent claims. If I am a member of a PPO or an HMO, I am required to make my co-pay and co-insurance payments in a timely fashion, and I am responsible for keeping my primary care physician referrals current. I authorize Denver Plastic Surgery associates to release all necessary medical information to my insurance carrier for processing my claims. I assign all benefits from said claims to Denver Plastic Surgery Associates. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient/Responsible Party: _____ Date: _____

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History and Physical

Patient's Name: _____ Today's Date: _____
Do you have a responsible adult to assist you during Recovery Period? Y □ N □ Relationship: _____
Name of Primary Care Physician: _____
Address: _____ Phone Number: _____
Date last seen by Primary Care Physician: _____
Preferred Pharmacy: _____ Phone Number: _____

Social

Smoke: **Y** □ **N** □ Amount: _____
Alcohol: **Y** □ **N** □ Amount: _____
Drugs: **Y** □ **N** □ Amount: _____

Caffeine: **Y** □ **N** □ Amount: _____
Daily Exercise: **Y** □ **N** □ Amount: _____
Ever abused drugs or alcohol? **Y** □ **N** □

Medications (Please list Name, dosage, and frequency pills per day. **If none, write N/A**)

Prescription Drugs

_____
_____
_____

Vitamins, Herbal Supplements, etc.

_____
_____
_____

Regular Aspirin Use? **Y** □ **N** □ Dosage & frequency: _____
NSA? (Advil, Motrin, Ibuprofen): **Y** □ **N** □ Dosage & frequency: _____
Cortisone Injections Past Year? Y □ **N** □ Date(s) and injection location: _____

Allergies/Drug Reactions

Drug Allergy?: **Y** □ **N** □ List drug(s) and type of reaction, if tested by an allergist:_____
_____
Latex Allergy? **Y** □ **N** □ Tape Allergy? **Y** □ **N** □
Anesthesia Reaction/Complication? **Y** □ **N** □ If yes, describe: _____

Family Medical History Please circle all that apply to any blood relatives:

□ Anemia
□ Anesthetic Problems
□ Autoimmune Disease
□ Bleeding Disorder
□ Blood Clots
□ Cancer
□ Diabetes
□ Fibromyalgia
□ Heart Attack
□ Heart Disease
□ Heart Murmur
□ High Blood Pressure
□ Hypertension
□ Kidney Disease
□ Multiple Sclerosis
□ Stroke
□ Tuberculosis
□ Other: _____

Please describe circled with an explanation: _____
_____

Medical History

Hearing aid? **Y** □ **N** □ Dentures?: **Y** □ **N** □
Have you ever received a blood transfusion? **Y** □ **N** □ If yes, what year? _____
Have you been tested for HIV? **Y** □ **N** □ If yes, what year? _____ Test results: □ **Positive** □ **Negative**
Are you having ongoing Dental Work? **Y** □ **N** □ Are you experiencing an ongoing infection? **Y** □ **N** □
If yes, explain: _____
Contact lenses? **Y** □ **N** □ Eyeglasses? **Y** □ **N** □ Cataracts? **Y** □ **N** □ Glaucoma? **Y** □ **N** □ Lasik? **Y** □ **N** □
Number of pregnancies: Number of Children: Did you breastfeed? **Y** □ **N** □ Last menstrual period:

Patient's Name: _____ Today's Date: _____

Surgical History List previous surgeries:

Surgery:	Date:
_____	_____
_____	_____
_____	_____
_____	_____

Medical History (Please circle all that apply.)

- □ Acid Regurgitation
- □ Anemia
- □ Anesthetic Problems
- □ Angina
- □ Arthritis
- □ Artificial Joints
- □ Asthma
- □ Autoimmune
- □ Bleeding Disorder
- □ Blood Clots
- □ Bronchitis
- □ Burns
- □ Cancer
- □ Chemotherapy
- □ Chronic Cough
- □ Cold Sores
- □ Colitis
- □ Connective Tissue Disorder
- □ Coronary Surgery
- □ Defibrillator
- □ Diabetes
- □ Dialysis
- □ Depression
- □ Fibromyalgia
- □ Fainting Spells
- □ Heart Attack
- □ Heart Disease
- □ Heart Murmur
- □ Hepatitis A, B or C
- □ High Blood Pressure
- □ Herpes Simplex
- □ HIV/AIDS
- □ Hypertension
- □ Irregular Heartbeat
- □ Irritable Bowel Syndrome
- □ Kidney Disease
- □ Migraines
- □ Multiple Sclerosis
- □ Pacemaker
- □ Radiation
- □ Raynaud's Disease
- □ Seizures
- □ Sleep Apnea
- □ Snoring
- □ Stroke
- □ Thyroid Disorder
- □ Tuberculosis
- □ Ulcers
- □ Ulcerative Colitis
- □ Weight Change past 12mos
- □ Other: _____

Please describe circled with an explanation. If none, **please write N/A**:

_____

_____

_____

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How did you learn about Dr. Rodgers?

Please check all statements that apply

☐ My friend _____ told me about Dr. Rodgers
☐ My family member _____ told me about Dr. Rodgers
☐ My Doctor _____ told me about Dr. Rodgers
☐ Your location is convenient to my home or office
☐ I noticed your ad in 5280 Magazine
☐ I heard Dr. Rodgers speak at _____
☐ I was referred by my insurance company
☐ Internet Search

- Google- Keywords: _____
- Yahoo: Keywords: _____
- Another Search Engine- Keywords_____
- Real Self
- DenverPlasticSurgery.com
- Reach Local
- Vitals
- Health Grades
- Association Website (I.e. American Association of Plastic Surgeons)
- Implant Company Website (Mentor, Sientra, Allergan)

☐ Other: _____

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Communication Consent

By choosing to use email or texting for communication with our office, you must agree to the following:

1. Email/text lines are an open network, which provide no protection for the confidential exchange of health-related information.

2. Email and texting must not be the primary means of communication.

3. Email and texting cannot be used to address medical urgencies or emergencies. Please contact the clinic staff at 303-320-8618 regarding time-sensitive and urgent issues.

4. Email sent from Denver Plastic Surgery Associates is encrypted using SSL technology but will only be sent this way if the receiving location support this method. Please contact your system administrator to see if this is available within your organization.

5. If you choose to reach our staff either by text messaging or email, you are putting your health information at risk and are doing so willingly and of your own accord. Denver Plastic Surgery Associates prefers communication by telephone and without the exchange of photos and personal health information. If you choose to send photos or private health information, you have potentially jeopardized your protected health information by subjecting It to a network that may not be secure.

Although Denver Plastic Surgery Associates uses secured encryption programs to help safeguard patient information, we cannot be certain that the networks used by our patients to communicate with us are fully protected. Therefore, we cannot be held liable for a breach of protected information if you choose to communicate through non-secured networking systems.

ATTESTATION:

I understand fully that texting and email networks are not secure and that if I choose to correspond with Denver Plastic Surgery Associates in this manner, any exchange of health-related information through these networks have the potential for compromise. I will not hold Denver Plastic Surgery Associates responsible or liable for a breach of HIPAA while utilizing these forms of communication.

_____ _____

Patient Signature Date

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DENVER PLASTIC SURGERY

Financial Agreement

Some of the procedures performed by Dr. Rodgers are considered totally or partially cosmetic.

There are no "usual, reasonable, and customary" charges for such procedures as they are not covered by insurance. If you have any questions regarding our charges, please discuss these with the Doctor prior to your treatment.
Payment is expected at, or prior to, the time of the service unless other arrangements have been made in advance.

_____ _____
Patient Signature Date

TO INSURANCE COMPANIES

I also request payment of medical benefits to the party below.

Christine M. Rodgers, M.D.

_____ _____
Signature Date

AUTHORIZATION AND FINANCE CHARGE

If I do not pay the entire new balance within 25 days of the monthly billing date, a finance charge can be added to the account for the current monthly billing period. The finance charge will be at a periodic rate of 1.5% per month or a minimum charge of $2.00 for a balance under $134.00 which is an annual percentage rate of 18% applied to the last months balance. In the case of default of payment, all costs of collection and reasonable attorneys fee will be added to this account.

_____ _____
Patient Signature Date

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian

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Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that by signing below I have been offered the ***Notice of Privacy Policies*** established for Denver Plastic Surgery Associates.

_____ _____

Patient Signature Date

DOCUMENTATION OF GOOD FAITH EFFORTS TO OBTAIN PATIENT'S ACKNOWLEDGEMENT THAT THEY HAVE RECEIVED PROVIDER'S NOTICE OF PRIVACY PRACTICES

****

(For use when acknowledgement cannot be obtained from the patient.)

This patient presented to our office on _____and was provided with a copy of our ***Notice of Privacy Policies***. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

☐ Patient refused to sign

☐ Patient was unable to sign or initial because: _____

☐ The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.

☐ Other reason: _____

_____ _____

Signature of employee Date