HARRISON H LEE, MD, DMD, FACS
Diplomate of the American Board of
Facial Plastic & Reconstructive Surgery
120 S. Spalding Drive, Suite 350, Beverly Hills, CA 90212 • T 310 777 2627 • F 310 777 2632

PATIENT REGISTRATION FORM

Patient _____ (Last Name (Legal)) _____ (First Name (Legal)) _____ (Preferred Name)

Date of Birth _____ (Month) - _____ (Day) - _____ (Year) **Age** _____ **Male Female Non-Binary** (Circle One)

Home Address _____

City _____ **State** _____ **Zip** _____

Email Address _____

Home Phone _____ Cell _____

May we leave messages at home and/or on cell phone? (circle one) **YES NO**

May we send text messages to your cell phone? (circle one) **YES NO**

Employer Name _____ **Occupation** _____

Business Address _____

Referring Doctor or Person _____

EMERGENCY CONTACT

Name _____ **Relationship** _____

Address _____ **Phone** _____

I, _____ authorize Harrison H. Lee, M.D.,D.M.D., F.A.C.S. to examine and provide medical treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to Harrison H. Lee, M.D.,D.M.D., F.A.C.S. I authorize Harrison H. Lee, M.D.,D.M.D., F.A.C.S. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand it is my responsibility to know all rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, x-ray departments and specialists and specialist providers which are assigned to me according to my insurance policy rule. It is Beverly Hills Medical Center for Cosmetic Surgery Inc.'s procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction. NOTE: **ALL MEDICAL RECORDS ARE KEPT FOR A PERIOD OF THREE YEARS** FOLLOWING YOUR LAST VIST AFTER WHICH THEY ARE DESTROYED. PLEASE NOTIFY OUR OFFICE PRIOR TO THIS PERIOD IF YOU DESIRE COPIES OF ANY OF YOUR MEDICL RECORDS.

Patient or Responsible Party Signature _____ **Date** _____

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PERSONAL REPRESENTATIVE AUTHORIZATION FOR MEDICAL RELEASE FORM

I authorize Dr. Harrison H. Lee of the Beverly Hills Medical Center for Cosmetic Surgery, Inc. and its' employees/representatives to speak with the following family members or my personal representative regarding:

☐ All medical information, including but not limited to records pertaining to examinations, treatments, pre and post-surgical care, surgery, aftercare, office visits, medications, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurse's and doctor's notes, and any other non-medical information in my file.

☐ Only the following types of information:

_____

_____

The above medical information shall only be released to the following persons:

NAME:	**RELATIONSHIP:**
_____	_____
_____	_____
_____	_____

I understand that I may terminate this Medical Authorization form. I must notify this facility in writing regarding termination and effective date.

This authorization shall remain valid (check one)

☐ Until revoked in writing.

☐ Until (please provide date)

I know that I am entitled to receive a copy of this agreement.

Name _____ **Date** _____

Signature _____

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THE MEDICAL BOARD OF CALIFORNIA REQUIRED DISCLOSURE

The Medical Board of California requires all physicians to provide patients with the following information:

"For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided below. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public."

"The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov."

I _____ acknowledge recipt of this information.
Print Name

Signature _____ Date _____

Witness _____ Date _____

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HIPPA PRIVACY RULE RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

Acknowledgement of Receipt of Information Practices Notice (§ 164.520(a))

I, _____ ,(Patient's name) understand that as part of my healthcare, this facility originates maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand this facility's **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information.

I understand that:

- I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement;
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Print Name _____ Signature: _____ Date _____

For Office Use Only

We attempt to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but not be obtained because:

- ☐ Individual refused to sign
- ☐ An emergency situations prevented us from obtaining acknowledgement
- ☐ Communication barrier prohibited obtaining acknowledgement
- ☐ Other(Please specify.

HIPPA Officer Signature: _____ Date: _____

HIPPA PRIVACY RULE OF PATIENT AUTHORIZATION AGREEMENT

Authorization for the **Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations**(§164.508(a))

I, _____ (Patient's Name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care of treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- A means of communication among the health professionals who may contribute to my healthcare;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment, it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the patties designated by me.

PRIVACY RULE OF PATIENT CONSENT AGREEMENT

Consent to the **Use and Disclosure of Protected Health information for Treatment, Payment, or Healthcare Operations**(§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information prentice's prior to signing this consent;
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Print Name _____ Signature: _____ Date _____

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THE RISK OF SMOKING/ALCOHOL/RECREATIONAL DRUGS

[Smoking]

Smoking is known to increase the risk of complications both during and after surgery. It can have several negative effects on your body, such as reducing the oxygen levels in your blood, constricting blood vessels, and weakening your immune system's ability to fight infections. These effects can slow down the healing process and increase the likelihood of postoperative complications, such as infections, delayed wound healing, blood clots, and tissue death. To minimize these risks, it is strongly recommended that you quit smoking for at least two to four weeks before surgery and refrain from smoking during your recovery period.

[Consuming alcohol or using recreational drugs]

Consuming alcohol or using recreational drugs for at least two weeks before your surgery. It's important to note that the use of recreational drugs is never approved. The consumption of these substances can have a significant impact on your healing process, potentially leading to an extended healing period and unfavorable outcomes. Therefore, it is crucial to follow the instructions of your healthcare provider and make any necessary lifestyle changes before and after surgery to ensure a successful outcome.

Patient Name (print)_____ **Date** _____

Patient/Parent/ Guardian Signature_____

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PHOTOGRAPHIC RELEASE AND CONSENT

I hereby give my authorization and consent for Dr. Lee, his representatives, and all parties acting under his license and authority to use my photographs, and case information for educational and commercial purposes. The following settings are included:

1. My surgeon's office patient education materials.
2. My surgeon's file of pre- operative and post-operative patient photographs available to prospective patients for viewing in the office.
3. Newspaper and magazine articles in which my surgeon participates.
4. Television programs in which my surgeon participates.
5. My surgeon's personal web site or web sites.
6. Design web sites or pages.
7. TV Commercials and lectures and multimedia presentations given by surgeon for the general public.

I understand that my photographs and case information may be used perpetually in the aforementioned settings, and that I may be recognized for my likeness or case history. I release and discharge Dr. Lee and all parties acting under his license and authority from any claim I may have relating to the use and publication of the photographs, including any claim for payment in connection with distribution or publication of the photographs.

In addition, I authorize my surgeon's professional associations to use my photographs and case information for public education in any of the following settings:

- Patient education brochures available for purchase
- Lectures and slide presentations available for purchase
- Information submitted by professional associations to consumer periodicals and magazines for publication
- Television programs about plastic surgery
- Cases that he has presented on the web sites designated by my surgeon

Furthermore, I give my consent to having before and after photos taken for personal use only.

I certify that I have read and fully understand the terms of this authorization and release, and that I provide this consent voluntarily.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

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HISTORY AND PHYSICAL

Name _____ Weight: _____ Height: _____
When was your last Chest- X Ray? _____ Your Last EKG? _____
When was your last Physical Exam? _____
Physician's Name : _____ Phone Number: _____
Are you Currently under a Doctor's Care? Yes: ____ No: ____
If Yes, for what Medical Condition? _____
If Yes, for what Medical Condition? _____
List all operations or serious illnesses with dates: _____

PLEASE CIRCLE THE CORRECT RESPONSE

Do you have history of the following:

a) Heart Attack, Stroke, Rheumatic Fever High Blood Pressure, Chest Pain, Other?	YES	NO
b) Do your ankles Swell?	YES	NO
c) Do you have shortness of breath when lying down, or use extra pillows to sleep	YES	NO
d) Asthma	YES	NO
e) Hives, Rashes, Skin Diseases	YES	NO
f) Fainting Spells of Seizures	YES	NO
g) Diabetes	YES	NO
h) Hepatitis, Liver Disease	YES	NO
i) Stomach Ulcers	YES	NO
j) Kidney Problems	YES	NO
k) Persistent Cough	YES	NO
l) Cough Associated with Blood	YES	NO
m) Sexually Transmitted Disease or HIV	YES	NO
n) Emotional illness	YES	NO
o) Abnormal Bleeding w/ Surgery	YES	NO
p) Anemia or Blood Disorders	YES	NO
q) Cancer of any Organ System	YES	NO
r) Treatment for Tumor Growth	YES	NO
s) If yes, to any of the above please explain:	YES	NO

_____
_____

Gynecological Problems

Are you Pregnant?	YES	NO
Do you take Birthcontrol Pills?	YES	NO
Do you have Breast Problems?	YES	NO
Do you have Mentrual Problems?	YES	NO
Are you Breast Feeding?	YES	NO

Do you use ALCOHOL?
NO YES QTY: _____

Do you use TOBACCO?
NO YES QTY: _____

Do you use RECREATIONAL DRUGS?
NO YES TYPE: _____

Are You Taking Any:

Antibiotics	YES	NO
Blood Thinners	YES	NO
Diet Pills	YES	NO
Blood Pressure Meds	YES	NO
Steroids	YES	NO
Asprin	YES	NO
Tranquilizers	YES	NO
Heart/ Cardiac Meds	YES	NO

If Yes, to any of the above, give name of dose, & how often taken:

_____
_____

Allergy or Drug Sensitivity To:

Local Anesthesia	YES	NO
General Anesthesia	YES	NO
Penicillin, Antibiotics	YES	NO
Sedatives, Barbiturate	YES	NO
Demerol, Codeine	YES	NO
Iodine, Adhesive Tape	YES	NO

Other: _____

Family History: Please list any serious illnesses or causes of death for parents, siblings, or children: _____

_____

Signature of Patient: _____ Date: _____