The surgical facility is owned and operated by

Frank J. Piro, MD
(650) 994-4800

Plastic, Reconstructive, & Hand Surgery
50 South San Mateo Drive, Suite 460
San Mateo, California 94401

John R. Griffin, MD
(650) 348-1503

Patient Registration Form

Today's Date: _____ Referring Physician: _____

New Patient: ☐ Existing Patient: ☐ Primary Care Physician: _____

Patient Information:

Email: _____ Male ☐ Female ☐

Name: _____ Date of Birth: _____ Age: _____
First *M.I.* *Last*

Address: _____
Street Number *Street Name* *Apt#*

_____
City *State* *Zip Code*

_____ _____ _____
Home Phone # *Work Phone #* *Mobile #*

If the patient is under 18 years of age, state name of parent, guardian, or responsible party below:

Our facility overrides advanced directives.
Initials_____

Social Security #: _____ Driver's License #: _____
Patient ID Number

Patient's Occupation: _____ Employed By: _____

Emergency Contact Information:

Emergency Contact: _____ Relationship to Patient: _____
Name of local relative or friend

Emergency Contact Address: _____ Phone #: _____

Insurance Information:

Name of Insurance: _____ Insurance Phone #: _____

Name of Subscriber: _____ Relationship to Patient: _____

Date of Birth: _____ Subscriber's Employer: _____ Employer's Phone#: _____

Subscriber's ID#: _____ Group Number: _____ Effective Date: _____

Is this a Worker's Comp Claim? Yes ☐ No ☐

Date of Injury: _____ Adjuster's Name: _____ Adjuster's Phone #: _____

WC Insurance Carrier: _____ Adjuster's Fax #: _____

WC Insurance Carrier Address: _____ Claim #: _____

Assignments of benefits and financial agreement: *I hereby give authorization for payment of insurance benefits to be made directly to the above doctor, for services rendered. I understand that I am financially responsible for* ***ALL CHARGES*** *whether or not they are covered by my insurance. In the event of default, I agree to pay* ***ALL COSTS*** *associated with collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original, including lifetime signature on file for filling the above medical claims for the above named patient.* ***Provider Release****: Our office will be submitting this document including our fee slip to a billing service for the sole intent of processing this claim for reimbursement to the carrier indicated above.* ***Privacy Notice****: I have received the "Notice of Privacy" brochure by the doctor's office.*

_____ _____ _____
Date *Patient's Signature* *Responsible Party's Signature*

FRANK J. PIRO, M.D. and JOHN R. GRIFFIN, M.D.

Medical History

Patient's Name:_____ Date of Birth:_____ Ht:_____ Wt:_____
Drug Allergies: _____
Do you smoke? (Please Circle) Yes No Are you an ex-smoker? Yes No

Current Medications (Including non-prescription drugs, vitamins, and/or herbals):

_____
_____
_____
_____

Please list previous surgeries or major illnesses and dates (including any plastic surgery):

_____
_____
_____
_____

FAMILY HISTORY:
Has any blood relative had any of the following?

Breast Cancer	Yes	No	High Blood Pressure	Yes	No	Kidney disease	Yes	No
Melanoma	Yes	No	Heart Diseases	Yes	No	Depression	Yes	No
Stroke	Yes	No	Diabetes	Yes	No			

PAST MEDICAL HISTORY:
Have you ever had the following?

Heart Disease	Yes	No	Cancer	Yes	No	Stomach Ulcer	Yes	No
Arthritis	Yes	No	Glaucoma	Yes	No	Kidney Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Thyroid Disease	Yes	No
Anemia	Yes	No	AIDS/HIV	Yes	No	Bleeding Problems	Yes	No

REVIEW OF SYMPTOMS:
Do you have or have you had the following within the last year?

Weight Change	Yes	No	Swollen Feet/Ankles	Yes	No	Seizures	Yes	No
Dry Eyes	Yes	No	Skin Rash	Yes	No	Joint or Muscle Pain	Yes	No
Chronic Cough	Yes	No	Chronic Diarrhea	Yes	No	Swollen Lymph Nodes	Yes	No
Chest Pain	Yes	No	Jaundice	Yes	No	Easy Bleeding	Yes	No
Rapid Heart Beat	Yes	No	Depression	Yes	No	Easy Bruising	Yes	No

WOMEN ONLY:
Have you ever had the following?

Breast Lump	Yes	No
Breast Discharge	Yes	No

Date of last Mammogram: _____
Number of pregnancies: _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

_____ _____
Signature of patient (or Parent if minor) Today's Date

Areas of Interest Questionnaire

DR. FRANK J. PIRO AND DR. JOHN R. GRIFFIN

BOARD CERTIFIED PLASTIC & RECONSTRUCTIVE SURGEONS

Please mark below if you are interested in any of the following procedures, and our Cosmetic Counselor, CiCi Askari will contact you to answer any questions you may have. Thank you!

Patient Name: _____ Date: _____

Email: _____ Phone Number: _____

FACE:

[ ] Face and/or Neck Lift
[ ] Eye Surgery (Upper and Lower Lids)
[ ] Forehead Lift
[ ] Nasal Surgery
[ ] Chin / Cheek Implants
[ ] Fat Grafting to the Face
[ ] SmartSkin CO2 Laser Skin Resurfacing
[ ] Botox Cosmetic
[ ] Juvederm (Dermal Filler)

BREAST:

[ ] Breast Enlargement: Silicone, Saline Implants, Fat grafting to the Breast
[ ] Breast Lift
[ ] Breast Reduction
[ ] Brest Reconstruction

BODY:

[ ] Abdominoplasty (Tummy Tuck)
[ ] Liposuction
[ ] SmartLipo Laser Liposuction
[ ] Body Contouring, after Bariatric Surgey
[ ] Mommy Makeover

[ ] Other, Please Specify: _____

50 South San Mateo Drive, Suite 460, San Mateo, CA 94401 (650) 348-5882

CONSENT FOR TAKING AND USE OF PHOTOGRAPHS AND COMPUTER IMAGES

Frank J.Piro, M.D. John R. Griffin, M.D.

Patient Name _____ Birth Date _____

I certify that I am the Patient or Legal Guardian of the above named patient, and hereby consent that photographs, and/or computer imaging may be taken of the above named patient or parts of such patient's body under the following conditions and used for the following reasons:

1) The photographs, and/or computer imaging may be taken at the consent of such patient's physician and shall be taken by the physician or staff approved by the physician.

2) I authorize the physician to use my photographs, and/or computer images for the following educational and/or scientific purposes.

- Lectures and presentations for an audience of medical professionals or for the general public;
- Medical, surgical and scientific journal articles or books;
- Selected education materials for the physician's office use;
- Patient education materials for the physician's office use;
- Patient/physician education through internet use on the physician's or other appropriately Designed websites;
- Any other purpose which may be deemed proper by the American Society of Plastic Surgeons (ASPS) or the American Board of Plastic Surgery (ABPS) in the interest of medical Education, knowledge, or research

3) I understand that all photographs, and/or computer imaging viewed whether of the patient or other individuals are demonstrative in purpose and are only a representation of the possible result that could be achieved through the proposed surgery. I further understand that imaging is used as an educational tool to benefit the patient and does not guarantee any result since plastic surgery is both an art and a science.

4) I understand that the patient will not be identified by name, but that such photographs or computer images reveal my identity. I accept this loss of anonymity.

5) This authorization is granted in furtherance of medical education, knowledge, research or the general public welfare, and as a voluntary contribution. I/we hereby waive all rights I/we might have such photographs, and /or imaging and do hereby release, discharge and save harmless John R. Griffin, M.D. or Frank J. Piro, M.D. the ASPS, and the ABPS from all claims and liabilities whatsoever in law and in equity arising from such use.

6) I hereby grant permission for the use of my medical records, illustrations, photographs or other imaging records created in my case, for use in examination, credentialing, and/or certifying proposes by the American Board of Plastic Surgery or the American Society of Plastic Surgeons.

7) I understand that the information disclosed, or some portion thereof may be protected by state and/or the federal health insurance portability and accountability act of 1996 ("HIPPA"). I further understand because ASPS or ABPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPPA, the information described above may no longer be protected by HIPAA and may be redisclosed by ASPS or ABPS

Patient/Guardian Signature _____ Date_____

Relationship to Patient_____ Witness_____ Date_____

Plastic Surgery Associates
Dr. Frank Piro and Dr. John Griffin
50 South San Mateo Drive, Suite 460, San Mateo, CA 94401
650-994-4800 / 650-348-1503

Health Information Privacy via Electronic Messaging

The Privacy Rule allows covered health care providers to communicate electronically, such as through e-mail, with their patients, provided they apply reasonable safeguards when doing so. See 45 C.F.R. § 164.530. Note that an individual has the right under the Privacy Rule to request and have a covered health care provider communicate with him or her by alternative means or at alternative locations, if reasonable.

I, _____, hereby acknowledge the receipt of the aforementioned HIPAA Privacy Rule and know that I have a right to choose whether I want to communicate with Dr. Piro, Dr. Griffin or their staff regarding my healthcare. I will initial below to indicate my choice.

Options:

1. _____ I authorize electronic communication with the aforementioned Doctors and staff. I waive any and all rights to sue related to this method of communication. The Doctors and their staff at Plastic Surgery Associates may contact me and communicate with me at the following email addresses: (or as already completed on my registration sheet)

   Email 1: _____ Email 2:_____

2. _____ I choose not to have electronic communication with the aforementioned Doctors and staff. Instead, they can call me at :

   a. Phone number 1: _____
   b. Phone number 2:_____

Date: _____

Signature of patient:_____ DOB: _____

HIPAA Breach Notification Policy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security and Breach Notification Rules

Section 13407 of the HITECH Act Effective Sept 2013

The purpose of this policy is to define how Plastic Surgery Associates, John R Griffin, MD, and Frank J Piro, MD, will respond to security and/or privacy incidents or suspected privacy and/or security incidents that result in a breach of protected health information (PHI).

In the event of a breach following unsecured protected health information our office will provide notification of the breach to affected individuals. Contact will be made through first class mailing through the United States Postal Service. If correspondence is returned, we will contact you through your telephone number.

Breach notification requirements will be followed as stated through the HIPAA Privacy, Security and Breach Notification Rules.

These individual notifications will be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach and must include, to the extent possible, a description of the breach, a description of the types of information that were involved in the breach, the steps affected individuals should take to protect themselves from potential harm, a brief description of what the covered entity is doing to investigate the breach, mitigate the harm, and prevent further breaches, as well as contact information for the covered entity.

Acknowledgement of receipt of disclosure:

Patient: _____

Date: _____

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Authorization to Release Medical Records

This document must be signed by the patient or person authorized by law.

I authorize _____ **to release a copy of medical records**
Health Care Provider/Hospital or Institution

for

_____ _____
Name of Patient Date of Birth

_____ _____
Social Security Number Other identifying information if applicable (other names)

Transmission by facsimile or electronic means authorized to expedite transfer of records.

Release medical records to:

Name _____

Address _____

Address _____

Phone _____ Fax _____

The information will be used on my behalf for the following purpose(s):

_____

By initialing the spaces below, I authorize the release of the following records, if such exist:

___ Complete medical record (all information). The recipient understands that the entire record may be large and agrees to pay all reasonable copy charges.
___ All hospital/institution records (includes nursing records/progress notes
___ Transcribed hospital/institution records (includes surgical reports, history/physical exam, consultation reports, discharge summary reports)
___ Laboratory reports
___ Pathology reports
___ Diagnostic imaging reports
___ EKG/cardiac reports
___ Physical/occupational therapy reports
___ Billing statements
___ Physician office/clinical records
___ Implant information (including operative report)
___ Photographs
___ HIV/AIDS records
___ Mental health testing
___ Drug/Alcohol diagnosis, treatment (Federal Regulation, 42, CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Provide a specific description on the back side of the form.)
___ This authorization is limited to the following treatment

_____

This authorization is limited to treatment for worker=s compensation injuries of

_____

_____ _____
Date Signature of Patient or Person Authorized by Law