DC PLASTIC SURGERY BOUTIQUE
2440 M Street NW Suite 318 Washington DC 20007/ 7601 Lewinsville Rd Suite 400A McLean VA 22102
202.335.4700
www.dcplasticsurgeryboutique.com

PATIENT NAME: ______________________________ DOB: ____________ EMAIL: _____________________________________

ADDRESS: ____ PHONE: ____________________________________

REASON FOR VISIT: ____

HOW DID YOU FIND OUR PRACTICE? ____

PHARMACY NAME AND ADDRESS: ____

MEDICAL PROBLEMS:

_____________________ _____________________ _____________________ _____________________ _____________________

SURGERIES:

_____________________ _____________________ _____________________ _____________________ _____________________

FAMILY HISTORY:

_____________________ _____________________ _____________________ _____________________ _____________________

MEDICATIONS:

_____________________ _____________________ _____________________ _____________________ _____________________

ALLERGIES:

_____________________ _____________________ _____________________ _____________________ _____________________

SOCIAL HISTORY:

TOBACCO USE:	NEVER	PREVIOUSLY BUT QUIT	YES	PACKS/DAY _________________
USE OF ALCOHOL:	NEVER	PREVIOUSLY BUT QUIT	YES	AMOUNT _________________
USE OF “RECREATIONAL DRUGS”:	NEVER	PREVIOUSLY BUT QUIT	YES	WHAT? _________________

OCCUPATION: __________________________

FEMALE PATIENTS:

DATE OF LAST MENSTRUAL PERIOD: _____________________

NUMBER OF PREGNANCIES/ BIRTHS: _____________________

PLANS FOR FUTURE PREGNANCY: _____________________

HEIGHT: _____________________ **WEIGHT:** _____________________

BREAST PATIENTS:

CURRENT BRA SIZE: _____________________

PERSONAL HISTORY OF BREAST CANCER, MASSES, BIOPSIES, NIPPLE DISCHARGE, NIPPLE BLEEDING: _____________________

FAMILY HISTORY OF BREAST CANCER: __________________LAST MAMMOGRAM (DATE/RESULTS): _____________________

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FINANCIAL DISCLOSURES

Your cosmetic quote will include a fee estimate for your proposed procedure, which includes Dr. Kulkarni's surgical fee, the operating room fee, the anesthesiologist fee, and any special equipment such as implants or garments. This quote will be honored for 90 days from the time of delivery. Please be aware that surgical fees are estimated based on expected time in the operating room. We do our best to accurately estimate surgical time; however, if your procedure takes longer than anticipated, **you will be billed by the surgery center and anesthesiologist for any excess time**.

We accept cash, major credit cards, and cashiers checks for surgery. Payment for non-surgical treatments such as Botox® and fillers are made at the time of service. Cosmetic surgery is scheduled with a 20% non-refundable deposit. Full payment must be made at least 7 days prior to surgery. If surgery is cancelled or rescheduled within 7 days of surgery, a 50% charge is incurred. If a check is returned from the bank, the patient will be responsible for the amount of the check plus a $50.00 processing fee.

Statement of Financial Responsibility.

"I, the undersigned, have read the above & understand that I am responsible for all medical & surgical charges incurred by myself or my dependants. I authorize the release of any medical information necessary to process any claims that are processed on my behalf by the office of Dr. Kulkarni. I understand that my medical insurance contract is between my insurance company and myself and that the failure of the insurance company to pay my claim does not absolve my financial responsibility to Dr. Kulkarni. All court and attorney fees or other fees associated with the collection of my account are my financial responsibility."

Signature: ____ Date: _____/_____/______

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PHOTOGRAPHIC AUTHORIZATION

I consent to the taking of photographs/video by the Practice in connection with my medical care. I understand that such photographs/video shall become the property of the Practice and may be retained or released for the purpose of preoperative planning, medical records, and publication in print, visual or electronic media including: Facebook, Instagram, Twitter, Snapchat, and other social media.

Dr. Kulkarni has my express permission to utilize my photos, with identifying features excluded when possible, in her book and on her website. I will not be identified by name in any published photograph/video. I waive right to compensation for use of my photographs.

Privacy: I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because Dr. Kulkarni is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA. I release the Practice from all rights that I may have in the photographs/videos and from any claim that I may have relating to such use, including any claim for payment in connection with publication of the photographs/videos. Further, I authorize the Practice to respond to any online reviews that I post regarding my treatments & services.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

Signature:____ Date: _____/_____/______

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NOTICE OF PRIVACY PRACTICES

DC Plastic Surgery Boutique LLC adheres to the highest standards of protecting patient privacy. Our team complies with all state and federal regulations regarding the privacy of individual health care information, including HIPPA (Health Care Insurance Privacy and Protection Act). We are required by law to offer you a copy of the "Notice of Privacy Practices" regarding your Personal Health Information (PHI).

Your PHI, also known as your health or medical record, serves as a:
-Basis for planning your care and treatment
-Means of communication among the many health professionals who contribute to your care
-Legal document describing the care you received
-Means by which you or a third-party payer can verify that services billed were actually provided
-A tool in educating heath professionals
-A source of data for medical research
-A source of information for public health officials charged with improving the health of this state and the nation
-A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

The "Notice of Privacy Practices" details the following:
-How we may use/disclose your PHI to carry out treatment, payment or health care operations.
-How you may request copies of your healthcare information.
-How you may verify the accuracy of this information.
-How you may request an accounting of certain external disclosures of your PHI.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax, email, mail, or phone.

"I have been offered a Notice of Privacy Practices by DC Plastic Surgery Boutique LLC and I fully understand and accept the terms of this consent."

Signature: ____ Date: _____/_____/______

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NOTICE OF PRIVACY PRACTICES

WHO WILL FOLLOW THIS NOTICE?
This Notice describes the practices of DC Plastic Surgery Boutique and the staff members who handle your medical information.

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION
Dr. Kulkarni and her staff understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We maintain our records and conduct our treatment environment with a goal of providing the highest level of protection for your medical information, while still providing you with the highest level of medical care. This Notice applies to all of the records of your medical care, which are received or created by Dr. Kulkarni and her staff. Your other medical treatment providers (e.g., doctors, hospitals, home health agencies, etc.) may have different policies or notices regarding the use and disclosure of your medical information. This Notice will tell you about the ways in which Dr. Kulkarni may use and disclose medical information about you.

Your medical information, also referred to as "protected health information," is that information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health information and related health care services. In this Notice, we also describe your rights and certain obligations Dr. Kulkarni has regarding the use and disclosure of your protected health information.
We are required by law to:
-Make sure that medical and other information that identifies you (protected health information) is kept private.
-Give you this Notice of our legal duties and privacy practices with respect to protected health information about you.
-Follow the terms of the Notice that is currently in effect.

USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS
By becoming a patient of Dr. Anita Kulkarni, you are giving consent for Dr. Kulkarni to use your protected health information for certain activities, including treatment, payment and other health care operations. Sometimes, you may hear these three activities referred to as "TPO." We may use and disclose protected health information about you so that Dr. Kulkarni and her medical professionals can treat you. For example, we may use your past medical information in order to diagnose your present condition or we may provide information regarding your medical condition to another doctor to whom we refer you for additional care. We may also use and disclose protected health information about you so that we may be compensated for the medical treatment we provide you. For example, we will submit protected health information about you to your insurance company in order to receive payment for services we have provided to you. We may also use and disclose protected health information about you for Dr. Kulkarni's health care operations, in other words, those other tasks that we need to perform to make sure that you are provided the highest quality of medical care.

OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION
The following uses of your protected health information may be made without any additional authorization from you. (Not every use or disclosure is listed, but be assured that all uses and disclosures made by Dr. Kulkarni are only those, which are permitted under the law).

NOTICE OF PRIVACY PRACTICES USES AND DISCLOSURES FOR APPOINTMENT REMINDERS
We may use and disclose your medical information to contact you as a reminder that you have an appointment at the office. If you request that such communications be made confidentially, please contact our office. We will accommodate all reasonable requests.

USES AND DISCLOSURES TO OTHERS INVOLVED IN YOUR HEALTH CARE
We may 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 that person's involvement in your medical care. If you are unable to agree or object to this disclosure, we may disclose such information as necessary if we determine that it is in your best interests based on our professional judgment. We may also use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.
USES AND DISCLOSURES IN EMERGENCY SITUATIONS

We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician will attempt to obtain your acknowledgment of this notice as soon as reasonably practicable after the delivery of treatment.

USES AND DISCLOSURES FOR HEALTH-RELATED BENEFITS OR SERVICES
Dr. Kulkarni may use and disclose protected health information to tell you about certain health-related benefits or services that may be of interest to you.

USES AND DISCLOSURES REQUIRED BY LAW
We will use or disclose protected health information about you when required to do so by federal, state, or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if the law requires us to do so, of any such uses or disclosures. We must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the law.

USES AND DISCLOSURES FOR PUBLIC HEALTH ACTIVITIES
We may disclose your protected health information for public health activities and disclosure for such purposes will be to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for purposes such as controlling disease, injury or disability. Disclosures to public health authorities may include disclosure to a foreign authority that is working with the public health authority.

USES AND DISCLOSURES RELATED TO COMMUNICABLE DISEASES
We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

DISCLOSURES FOR HEALTH OVERSIGHT ACTIVITIES
We may disclose protected health information to a health oversight agency for activities authorized by law. These activities include, for example, audits, investigations, and inspections. These activities are necessary for the government to monitor the health care system, the delivery of health care, government benefit programs, other government regulatory programs and civil rights laws.

DISCLOSURES OF ABUSE OR NEGLECT
We may disclose your protected health information to a public health authority authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to a governmental entity or agency authorized to receive such information. In such cases, the disclosure will only be made in accordance with DC, VA, and/or MD law.