REGISTRATION

(PLEASE PRINT)

ALFRED COHEN, M.D., F.A.C.S.
414 North Camden Drive, Suite 800
Beverly Hills, California 90210
Telephone: (310) 275-5252

Date________________ Home Phone ________________

Patient____
Last Name First Name Initial

Responsible Party (if a minor) ________________

Street Address ________________

City________________ State________________ Zip________________

Sex ☐ M ☐ F Age________ Birthdate________________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By________________

Business Address ________________

Occupation________________ Business Phone________________

Spouse (or responsible party) Name ________________ Birthdate ________________

Business Name and Address ________________

Occupation________________ Business Phone________________

Who is responsible for this account? ________________ Relationship to Patient ________________

Social Security # ________________ Spouse's Social Security # ________________

Do you have Medical Insurance? ☐ No ☐ Yes ▶ If yes,

Name of Primary Insurer________________

Contract #________________ Group #________________ Subscriber # ________________

Name of Secondary Insurer (if any) ________________

Contract #________________ Group #________________ Subscriber # ________________

☐ Medicare ☐ Medicaid Claim ID # ________________

If Welfare, your number________________ County of________________

In case of emergency, who should be notified? ________________ Phone________________

How did you learn of our practice? ________________

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with ________________
Name of Insurance Company

and assign directly to Dr. ________________ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

________________________________ ________________
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. ________________ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

________________________________ ________________
Beneficiary Signature Date

#10501 — Medical Arts Press 1-800-328-2179

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MEDICAL HISTORY QUESTIONNAIRE

Name: ____________ **Age:** ____________ **Date:** ____________

Chief Complaint: ____________

Family History: Give age if living or age and cause of death.

Father ____________ Mother ____________

Siblings ____________ Children ____________

Is there an immediate family history (someone related by blood) of any of the following:

	YES	NO		YES	NO
Heart Trouble			Stroke		
Bleeding Tendency			Keloid Formation		
Diabetes			Cancer		
High Blood Pressure			Other		

ALLERGIES AND SENSITIVITIES: Indicate which, if any are present:

	YES	NO		YES	NO
Penicillin			Aspirin		
Other Antibiotics			Tetanus Toxoid		
Xylocaine			Adhesive Tape		
Codeine			Other		

MEDICATIONS: List all medications you currently take:	**Dosage**	**Frequency**
Cortisone, ACTH, other steroids		
Sedatives, Sleeping Pills, Tranquilizers		
Blood Pressure Regulators		
Digitalis, Nitroglycerine, Cardiac Drugs		
Thyroid		
Aspirin, Coumadin, Heparin		
Birth Control Pills/ Hormones		
Appetite Suppresants - Including Phen-Fen		
Herbal/Homeopathic		
Anti-Depressants		
Other:		

SOCIAL HISTORY

Tobacco: None____ 1 pack/day or less__________ 2 pks/day or more __________

Alcohol: None____ Socially __________ Daily __________

Drugs: None____ Marijuana _______ Cocaine __________ Other ________

SURGICAL HISTORY:

List all prior surgeries, as well as cosmetic (including chemical peels).

Type ____________________ Date __________ Surgeon ______________
Type ____________________ Date __________ Surgeon ______________
Type ____________________ Date __________ Surgeon ______________

Did you experience any problems or complications during or following above procedures?

No ______ Yes_____ Please explain ______________________________________

____

PAST MEDICAL HISTORY: List any prior hospitalizations below (e.g. accidents, surgeries etc.)

Purpose ____________________ Date __________ Physician ______________

Purpose ____________________ Date __________ Physician ______________

Purpose ____________________ Date __________ Physician ______________

Have you recently been under the care of a physician for any particular reason? Yes____ No _____

If yes, please explain: ____

Name of Personal Physician: ____

Address ______________________________________ Telephone ______________

REVIEW OF SYSTEMS: Check if any apply:

	Yes	**No**
Skin Disease		
Eye, Ear, Nose, Throat		
Thyroid		
Palpitations		
Diabetes		
Shortness of Breath		
Chronic Cough		
Asthma		
Chest Pain, Heart Murmur		

	Yes	**No**
High/Low Blood Pressure		
Rheumatic Fever		
Anemia, Bleeding Tendencies		
Arthritis		
Liver		
Psychiatric		
Tuberculosis		
Hepitits		
HIV		

Is there any history not noted of which the doctor should be aware of? Yes_____ No_____

If yes, please explain: ____

This information is correct and accurate to the best of my knowledge.

Signature of Patient: ______________________________ Date ______________

Guardian/Parent: ______________________________ Date ______________

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of 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 the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that 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 and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect: Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates: Required Uses and Disclosures; Under the law, 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 requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your 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, however, you may not inspect or copy 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 purposes of treatment, payment or healthcare operations. You may also request that any part or 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 this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician 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 have the right to request to receive confidential communications 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 alternatively, i.e., electronically.

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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:__________________________ Signature______________________________ Date________

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To respect your privacy, please give us the following numbers. Please indicate only those numbers we should call to communicate with you regarding **appointment reminders, lab results, etc...** Only list the phone number(s) you want us to access and use.

- Home ______________________________ OK to leave message _________
- Work ______________________________ OK to leave message _________
- Mobile/Cell __________________________ OK to leave message _________
- Other ______________________________ OK to leave message _________

Thank you for helping us to respect the confidentiality of your information. Please update these records should your phone contact numbers change.

____ Patient's Name

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Cosmetic Interest Questionnaire

Name: ______________________________ E-Mail: __________________________________

Health issues of interest to you (please check all that apply):

◊ Surgical Procedure: Face, Neck, Brow, Eyelids, Nose, Cheeks, Chin, Ears

◊ Juvederm™, Restylane™ or other injectable therapy_________________________
please specify

◊ Botox

◊ Fraxel™ Laser Treatments

◊ AHA and Glycolic Peels

◊ Revitalash

◊ Skin Care Products (sunscreen, moisturizers, etc)

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number:

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger		True Age		Older
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

How did you hear of our office?

____

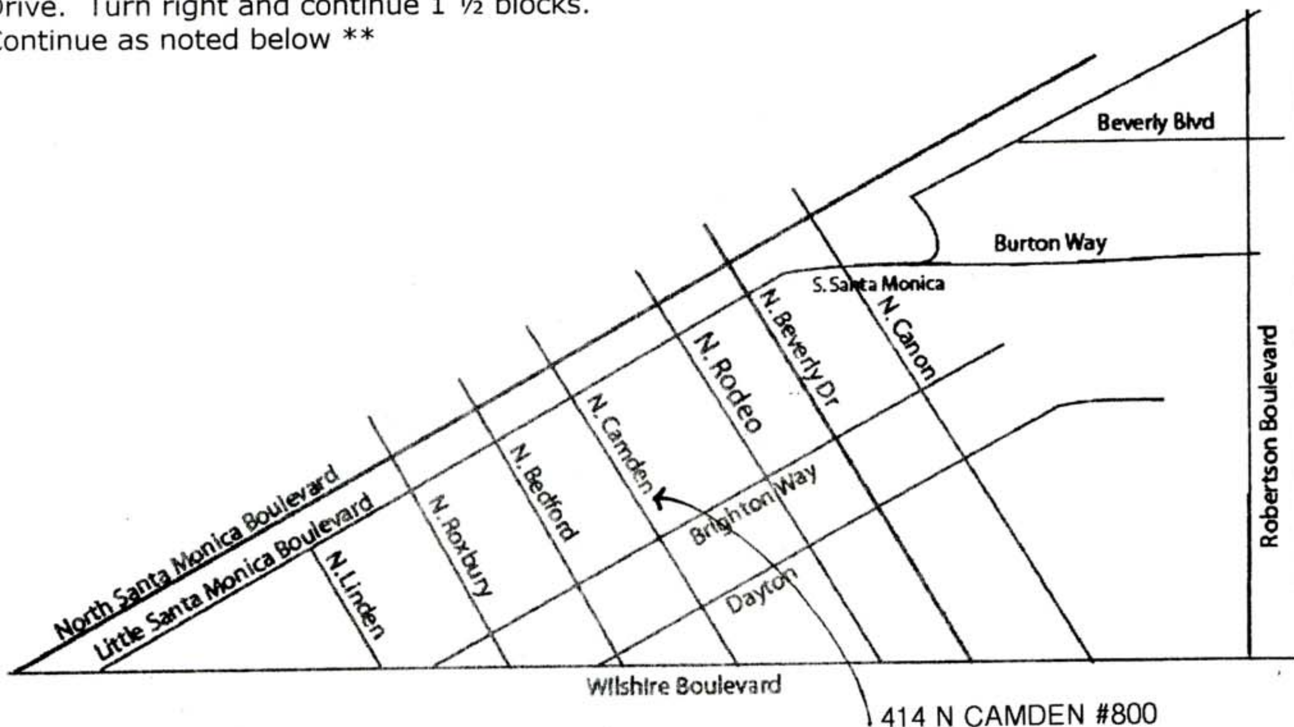
____

Directions
Camden Surgery Center
Offices of Alfred Cohen, MD
414 North Camden Drive #800
Beverly Hills, CA 90210

From the South: Proceed North on the San Diego (405) Freeway to the Wilshire Boulevard exit (towards Westwood). Continue heading East on Wilshire Boulevard into Beverly Hills. Take a left turn on Camden Drive and continue 1 ½ blocks.
Continue as noted below **

From the North: Proceed South on the San Diego (405) Freeway to the Wilshire Boulevard exit. Continue heading East on Wilshire Boulevard into Beverly Hills. Take a left turn on Camden Drive and continue 1 ½ blocks.
Continue as noted below **

From the Santa Monica (10) Freeway: Take the Robertson Exit and proceed North, towards the mountains, to Wilshire Boulevard. Take a left turn on Wilshire and continue West to Camden Drive. Turn right and continue 1 ½ blocks.
Continue as noted below **



** Our office is a black high rise medical building on the right side of the street, just past Brighton Way. If you wish to park within the building, parking is available, however, we do not validate. If you proceed about halfway down the block, there is a Beverly Hills public parking structure, on the same side of the street, where parking is available and without charge for one hour. Walk back towards our building and take the elevator to the 8th floor.