ASHKAN GHAVAMI, M.D.
PLASTIC SURGEON

Last Name: _____First Name: _____ Middle Initial: _____

Address: _____City:_____State: _____ Zip: _____

Home Phone: _____Cell Phone: _____Other Phone: _____

Email Address: _____

Are there any restrictions in contacting you? ___ (No) ___ (Yes) Explain _____

Date of Birth: _____ Age: _____

Drivers License: _____ Social Security: _____

Marital Status:Married ___ Single ___ Divorced ___Other__ Gender: (circle one) Male / Female

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Personal Physician _____ Physician's Phone _____

May we contact your physician if need be for medical records purposes? _____

Responsible Party Information
(IF DIFFERENT FROM ABOVE)

Name: _____Home Phone: _____Cell Phone: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____Bus. Phone: _____Cell Phone: _____

How did you hear about Dr. Ghavami?

___ Referred by a Friend /Relative ___ TV ___ Magazine ___ Real Self

___Referred by a Doctor / Physician ___ Internet ___ You Tube ___ other

Name of Referral: _____

I hereby certify that all of the information stated above is true. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I further agree that a photocopy or scanned electric copy of this agreement shall be as valid as the original. Unless otherwise stated, I agree to receive information (quarterly newsletter, special events, promotions, healthcare tips, etc.) from Ghavami Plastic Surgery via mail and electronic mail.

_____ _____

Patient/Guardian Signature **Date**

Ashkan Ghavami, M.D., A Medical Corporation
www.ghavamiplasticsurgery.com
433 N. Camden Dr. Suite 780
Beverly Hills, CA 90210

GHAVAMI PLASTIC SURGERY

Patient Name:	Date:
Reason for today's visit:	Area of main concern?
Have you had any surgeries within the past year?	Please list:

Do you now have or have you ever had: (please check all that apply to you)

❑ Heart Disease	❑ Stroke	Do you smoke? Yes or No
❑ High Blood Pressure	❑ Epilepsy	If so, How long? Quit?
❑ Lung Problems	❑ Arthritis	
❑ Bleeding Disorder	❑ Cancer	Are you pregnant? Yes or No
❑ Intestinal Disease	❑ Depression or Anxiety	
❑ Diabetes	❑ GERD (Reflux)	Last Menstrual Period:
❑ Asthma/ Bronchitis	❑ Hepatitis	

Please list any health problems?

_____

_____

_____

Have you or anyone in your family ever had problems with General Anesthesia? If so, what occurred?

_____

Past Surgical History?

_____

_____

Any complications?

_____

_____

Allergies (List medications/foods you are allergic to and what happens when you take them):	**Please list any medications your currently taking including vitamins and etc.**
_____ _____ _____ _____	_____ _____ _____ _____
Do you take Aspirin or Ibuprofen? Yes or No	**Do you have an allergy to latex?** Yes or No

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HIPAA Privacy Rule of Receipt of Notice of Privacy Practices Written Acknowledgement Form

Ashkan Ghavami, M.D. A Medical Corporation

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

I, _____ (Patient's Name) understand that as a part of my health care, Ashkan Ghavami, M.D. A Medical Corporation 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 acknowledge that I have been provided with and understand that AG, M.D. A Medical Corporation **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 AG, M.D. A Medical Corporation Notice *of* Privacy Practices prior to signing this acknowledgement;

▪ AG, M.D. A Medical Corporation 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.

Signature *of* Individual (OR) Legal Representative Witness: _____

Printed Name of Individual (OR) Legal Representative Witness: _____

Date: _____

FOR OFFICE USE ONLY

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

□ Individual refused to sign
□ Communication barrier prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining acknowledgement
□ Others (please specify)

_____
_____

_____ _____
Ashkan Ghavami, M.D. Date
Privacy Official

HIPAA Privacy Rule of Patient Authorization Agreement

Ashkan Ghavami, M.D. A Medical Corporation

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

I, _____ (Patient's Name) understand that as part of my health care, AG, M.D. A Medical Corporation 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 health care;
- 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 health care operations such as assessing quality and reviewing the competence of health care 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 AG, M.D. A Medical Corporation notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties 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 AG, M.D. A Medical Corporation Notice of Information practices prior to signing this consent;
- That AG, M.D. A Medical Corporation, 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 object to the use of my health information for directory purposes;
- 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 AG, M.D. A Medical Corporation is not required by law to agree the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that AG, M.D. A Medical Corporation has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness: _____

Printed Name of Patient or Legal Representative Witness: _____
Date: _____

Physician-Arbitration Agreement

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician and the physician's agents and independent contractors, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.
All claims for monetary damages exceeding the jurisdictional limit of small claims court against the physician, and the physician's partners, associates, association, agents, independent contractors, corporation or partnership, and the employees, agents and the estate of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death and emotional distress. Filing of any action in court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all the parties. The arbitration shall be conducted before a retired judge at JAMS ENDISPUTE in Los Angeles, California. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damages upon written request of the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action again such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections and 3333.1 and 3332.2. Any party may bring before the arbitrator a motion for summary judgment or summary adjudication in accordance with Code of Civil Procedure Section 1283.05.

Article 4: **General Provisions**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if accessed in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided fork the arbitration shall be governed by the California Code of Civil provisions relating to arbitration.

Article 5: **Revocation**: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered at any time for any condition.

Article 6: **Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment), patient should sign below:

Effective as of the date of first medical services

Patient's or Patient's Representative's Signature: _____

If any provision of this arbitration agreement is held invalid or unenforceable the remaining provisions shall remain in full force and shall not be affected by the invalidity or any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OR MEDICAL MALPRACTICE DECIDED BY A NEUTRAL ARBITRATOR AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Ashkan Ghavami, M.D.
.

By: _____
Doctor or Doctor's Representative
Ashkan Ghavami, M.D. A Medical Corp.

By: _____
Patient's or Patient's Representative's Signature

Date: _____

Ashkan Ghavami, M.D
_____
Print or Stamp Name of Physician

By: _____
Print Patient's Name

_____
(If Representative – Print Name and Relationship to Patient)

GHAVAMI PLASTIC SURGERY

Patient Name:	Date:

It is our goal to assist our patients in every way possible; Dr. Ghavami also offers non-surgical cosmetic procedures that can be discussed during your consultation as well. Please let us know what other procedures are of interest to you so that we can provide you with additional information.

Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply

❑ ***Latisse***	❑ Facial veins	❑ Neck wrinkles
❑ **Juvederm / Perlane**	❑ Facial redness	❑ Breast size
❑ **Radiesse / Restylane**	❑ Brown spots/age spots/freckle	❑ Abdominal area
❑ ***Botox***	❑ Drooping brow or eyelids	❑ Hips
❑ **Chemical Peels**	❑ Nose size or shape	❑ Legs
	❑ Facial fullness/drooping	❑ Facial Contouring
	❑ Mole removal	❑ Body Contouring

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 Than		*True Age*		*Older Than*
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