Miguel A. Delgado, Jr, M.D., F.A.C.S.

Diplomate, American Board of Plastic Surgeons
Cosmetic & Plastic Reconstructive Surgeon

165 Rowland Way, Suite 300, Novato, CA 94945 (415) 898-4161
450 Sutter Street, Suite 2433, San Francisco, CA 94108 (415) 989-2221

Welcome to our office. We are committed to the best, most comprehensive care possible. We encourage you to ask questions, let us know your concerns and communicate openly with us. Please assist us by providing the following information. All information is confidential and is only released with your consent.

PATIENT INFORMATION: **TODAY'S DATE:**

PATIENT'S LEGAL NAME	DATE OF BIRTH		
HOW SHALL WE ADDRESS YOU?	Dr. Mr. Mrs. PREFERRED NAME:		
GENDER IDENTIFICATION (CIRCLE) MALE FEMALE NEUTRAL			
MAILING ADDRESS	CITY	STATE	ZIP / POSTAL CODE
CELL TELEPHONE	HOME TELEPHONE	WORK TELEPHONE	
OCCUPATION	EMPLOYER'S NAME		
EMAIL ADDRESS			
ARE YOU INTERESTED IN FINANCING?	MARITAL STATUS	SPOUSE'S NAME	

How were you referred to our Practice? YouTube Yelp RealSelf Gynecomastiaspecialist.com Google.com Gynecomastia.org Website Friend or Family Member _____

Key term for online search: _____

May we mail to this address? **Yes No**

May we send you email/text confirmation of your next appointments? **Yes No**

May we ad you to our email list for special offers? **Yes No**

PLEASE CHECK THE PROCEDURES THAT YOU ARE INTERESTED IN DISCUSSING

☐ Arm Lift	☐ Eyelid Lift	☐ Liquid Face Lift	☐ Thigh Lift
☐ Body Lift	☐ Face Lift	☐ Mommy Makeover	☐ Top Surgery FTM
☐ Botox	☐ Fat Transfer	☐ Neck Lift	☐ Top Surgery MTF
☐ Breast Augmentation	☐ Fillers	☐ Pinning of Ears	☐ Tummy Tuck
☐ Breast Lift/Revision	☐ Gynecomastia	☐ Scar Revision	Other _____
☐ Brow Lift	☐ Liposuction	☐ Skin Care	

Ideally, when would you like to have your procedure/surgery? _____

What is your greatest concern about undergoing plastic surgery? _____

_____

Have you had any plastic or cosmetic surgery before? (if yes, please provide details) _____

_____

PLEASE READ OUR FINANCIAL POLICY STATEMENT AND AGREEMENT

Payment for professional fees are due at the time services are provided in our office. Co-payment and deductibles are due at the time of your office visit. Charges for cosmetic medical care are not billable to insurance and also due at the time of your office visit.

FOR PATIENTS WITH INSURANCE

We bill many of the major insurance plans for our patients having medically necessary procedures, with co-payments and deductibles due from the patient at the time service is provided. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why they paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from the patient. We bill secondary insurances.

FOR SURGERY

All professional fees for cosmetic and plastic surgeries are due 14 days before your scheduled surgery date. For your convenience, we do accept cash, check, Visa, MasterCard, Discover, American Express and Care Credit. We can also provide resource information if you wish to finance your procedure.

Payment for professional fees are due at the time services are provided in our office. Co-payment and deductibles are due at the time of your office visit. Charges for cosmetic medical care are **not** billable to insurance and also due at the time of your office visit.

ALL PATIENTS MUST SIGN HERE

I have read, understand, and agree to the above financial policy for payment of professional fees. I am ultimately responsible for all professional fees.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

NOTICE TO CONSUMERS

Medical Doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

Please print and sign below to acknowledge that Dr. Miguel Delgado is licensed and regulated by the Medical Board of California:

Print Name: _____

Signature: _____ Date: _____

HIPAA NOTICE OF PRIVACY

Marin Cosmetic Surgery Center, Miguel A. Delgado, JR, M.D., F.A.C.S
165 Rowland Way, Suite 300 Novato, CA 94945
450 Sutter Street, Suite 2433 San Francisco, CA 94108

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 relatives to your past, present or future physical or mental health or condition and related health 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 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 Operation

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. The activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, 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 in 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 or Drug Administration requirements , Legal Proceedings, Law Enforcements, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity , Military Activity and National Security, Worker's Compensation, Inmates. Required Uses and 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 requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures

Other permitted and require uses and disclosures will be made only with Your Consent, Authorization or Opportunity to object unless require by law.

You May Revoke This Authorization
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 .

2. 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
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 of your protected health information not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices, You requested must state the specific restriction requested and to whom you want the restrictions to apply.

Your physician is not required to agree to a restriction that you may request. If a 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 use by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us.
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 for 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 the office of Dr. Miguel A. Delgado, or Marin Cosmetic Surgery Center. 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 office phone number.

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

Print Name:_____

Signature:_____Date:_____