YARROW BAY
PLASTIC SURGERY

5209 Lake Washington Blvd., Suite 115 Kirkland, WA 98033
(T) 425-822-0300 (F) 425-822-4999

Today's Date: _____ Patient DOB: _____ Age: _____

Patient Name: _____ SSN: _____
(First) (MI) (Last)

Address: _____
(Street) (Unit/Apt#)

_____
(City) (State) (Zip)

Gender (please circle): M / F ☐☐ Marital Status (please circle): S / M / D / P / W / Other ☐☐☐☐☐☐

Phone Numbers: (Home) _____ (Work) _____ (Mobile) _____
May we leave a message? Y / N ☐☐ Y / N ☐☐ Y / N ☐☐

My preferred phone number is my (please circle): Home / Work / Mobile ☐☐☐

Email Address: _____ Referring Doctor, If Applicable: _____

Patient Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship to Pt: _____

How/From whom did you hear about Yarrow Bay Plastic Surgery? _____
If referred by a patient, may we thank them? Y / N ☐☐

COPY OF INSURANCE CARD(S) WILL BE PLACED HERE (IF APPLICABLE TO APPT)– PLEASE BRING INS CARD(S) AND PHOTO ID

If you are **NOT** the subscriber on your insurance policy, we need the following information of the **primary insured party**: ☐☐

Full First and Last Name: _____DOB: _____ Gender: M / F
Primary Insured Employer: _____ Relationship to patient: _____

If you have a Labor and Industries Claim, please provide the following:
Claim # _____ Date of Injury: _____Employer: _____ Phone: _____

I hereby authorize payment of any surgical and/or medical benefits be paid directly to the physician for services. I also agree to pay all charges that exceed or are not covered by insurance and authorize release of information to the insurance company. I also authorize the physician to disclose information to those individuals qualified for the purpose of medical quality and peer review.

Fees charged for your medical and surgical care are based upon what is usual and customary for our area as well as a relative value system. You are responsible for payment of fees regardless of any insurance company's arbitrary determination of what it feels is usual and customary. In the event that we place a claim for unpaid fees for collection, you agree to pay all costs of collection including, but not limited to, reasonable attorney's fees.

A fee of $25 will also be added to your account for any checks that are returned.

Signature: _____ Date: _____

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Today's Date:_____

Name: _____
First Middle Last "nickname"

Date of Birth: _____

Primary Concern/Procedure: _____

Allergies:

Drug(s): _____ Reaction(s): _____

_____

Latex Allergy: ☐ ☐ Y / N Environmental: _____

Primary Care Provider/Number: _____

Height: _____ Weight: _____ Goal Weight: _____ LMP: _____

Personal Health History: Please read through the following list and check each that applies to you past and/or present.

- ☐ Heart Disease
- ☐ Heart Murmur (beyond childhood)
- ☐ Mitral Valve Prolapse
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Stroke/TIA
- ☐ Blood Disorder:
- ☐ Bleeding Tendencies
- ☐ Blood Clots
- ☐ Anemia: *last checked:*
- ☐ Bleeding Gums
- ☐ History of Miscarriage
- ☐ Taken blood thinners:
  date last dose:
- ☐ Autoimmune Disease
- ☐ Lupus
- ☐ Arthritis
- ☐ Thyroid: *last checked:*
- ☐ Diabetes: *last Hgb a1c:*
- ☐ Migraines: *how often:*
- ☐ Headaches: *how often:*
- ☐ Seizures
- ☐ Paralysis
- ☐ HIV
- ☐ Hepatitis: type_____
- ☐ Herpes: type _____
- ☐ Cancer of: _____
- ☐ Other:
- ☐ Sleep Apnea / C-pap Y/N
- ☐ Difficulty Breathing
- ☐ Asthma
- ☐ Heartburn/Acid Reflux
- ☐ Swelling in hands / feet
- ☐ Numbness/Tingling hands/feet
- ☐ Skin: rashes/lumps
- ☐ Changes in: vision/hearing
- ☐ Recent: fever/vomiting/colds
  sinus congestion/infections
- ☐ Psychiatric Care
- ☐ Anxiety
- ☐ Depression
- ☐ Breast feeding (date stopped:)

☐ Have you ever had any difficulty with anesthesia? (explain) _____

Please list ALL previous Surgeries/Hospitalizations with dates:

_____

_____

_____

_____

Current Medications (including vitamins and supplements):

Family Medical History:

○ Cancer:	○ Heart Disease:	○ Diabetes:

○ Other:

Social History:

Use of tobacco/nicotine:

- ☐ I am a non-smoker who has never used tobacco/nicotine products.
- ☐ I am a former smoker who quit _____months / years ago.
- ☐ I am current smoker and/or user of nicotine products. I smoke _____ cigarettes / packs per day.

Use of alcohol:

- ☐ I never use alcohol.
- ☐ I am a regular user of alcohol. Approximately _____ drink(s) per day/week/month.

Use of drugs:

- ☐ I never use drugs, unless prescribed by my doctor.
- ☐ I use recreational drugs: (please list)_____

Exercise regime:_____

Type of employment:_____

I hereby declare that the information I have provided on this form is a true and accurate record of my health history, to the best of my knowledge.

Patient Signature Date

The following line is to be signed by your doctor or nurse.

Reviewed by: Date

6 month review/update with patient	Date

YARROW BAY
PLASTIC SURGERY

Notice of Privacy Practices Acknowledgement

We keep a record of the medical care services we provide you as well as your financial record pertaining to our care. You may, at any time, ask to see and/or receive a copy of that record (clerical fees may apply). You may also ask us to correct that record. We will not disclose your record, medical or financial, to others unless you authorize us to do so or the law authorizes or compels us to disclose your information.

Our NOTICE OF PRIVACY PRACTICES describes in more detail how your health information may be used or disclosed and how you can access your information. Our NOTICE OF PRIVACY PRACTICES is available in our office and on our website at www.yarrowbayplasticsurgery.com/patient-resources/patient-information.

My signature below acknowledges that I have received or have been offered the NOTICE OF PRIVACY PRACTICES upheld by YARROW BAY PLASTIC SURGERY.

_____
PRINTED PATIENT NAME

_____ _____
Patient or Legally authorized individual signature Date Time

_____ _____
Printed name of patient representative, if applicable Relationship to patient

Notation, if any, by Yarrow Bay Plastic Surgery Staff:

This form will be retained in your medical record
Last update February 7, 2017

YARROW BAY
PLASTIC SURGERY

SMOKING/NICOTINE POLICY ACKNOWLEDGMENT

Patient Name: _____ DOB: _____

___ I am a non-smoker and have never used nicotine or tobacco products.

___ I am a former smoker; I quit _____ months ago/ I quit _____ years ago.

___ I am a smoker; I smoke _____ cigarettes/_____ packs per day.

Today's Date: _____

I have been advised by Dr. McMillan/Dr. Liebertz and their staff that I must not smoke or use nicotine substitutes for a MINIMUM of six (6) weeks prior to my surgery and six (6) weeks post-op. I have also been advised that being in the presence of second-hand smoke can compromise my surgery and its outcome.

It has been explained to me that the risks of surgery are greater for smokers and even if I abstain from cigarette/nicotine product and/or substitute use for six (6) weeks before and after surgery, I still may experience the effects of nicotine.

There is a greater risk in smokers to experience bad scarring, hematoma formation, intraoperative bleeding, post-operative bleeding, poor or delayed healing, hair loss, sloughing of the skin (skin loss), infection, increased or prolonged bruising and hyperpigmentation.

I acknowledge that I have read and fully understand the above consent to operate, given my smoking status. I understand that the risks have been fully explained to me and I wish to proceed with surgery.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

WITNESS SIGNATURE DATE

YARROW BAY
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Sarah E. McMillan, M.D. and Daniel J. Liebertz, M.D.
5209 Lake Washington Blvd. Suite 115, Kirkland, WA 98033
425-822-0300(t) 425-822-4999(f)

Appointment No-Show and Cancellation Policy:

In order for Yarrow Bay Plastic Surgery to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner.

Effective January 1st, 2015, if you miss your appointment or cancel with less than 48-hour notice, Yarrow Bay Plastic Surgery reserves the right to bill you $45.00 for each no-show and late cancellation. This fee will be your responsibility and will **not** be billed to your insurance. We also reserve the right to reschedule your appointment if you arrive more than 15 minutes past your scheduled time, but will not charge a fee in this instance.

In addition to the $45.00 fee, we will notify you if you have missed more than 3 appointments and remind you of our policy. Additionally, we reserve the right to terminate our relationship with you after 5 or more occurrences. Good medical care and a positive doctor-patient relationship are dependent upon consistent consultation and treatment. This cannot be accomplished with frequent missed appointments.

We thank you for working with us to ensure services are provided to you in the best possible way.

_____ _____
Patient Signature Date

_____ _____
Witness Date

YARROW BAY
PLASTIC SURGERY

Medical Information Release Form

Name:_____ DOB:_____/_____/_____

Release of Information

- I hereby authorize Yarrow Bay Plastic Surgery and its employees and agents, to release my personal health information (e.g. information relating to the diagnosis, treatment, payments and health care services provided or to be provided to me). This information may be released to:
    - Spouse: _____
    - Child(ren): _____
    - Other: _____

      _____

- Information is not to be released to anyone.

* This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call: ☐ my home ☐ my work ☐ my cell

If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return call
- ☐ Other: _____

Patient Signature: _____ Date: ____/_____/_____

Witness: _____ Date: ____/_____/_____

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Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. With this is mind, some answers to common questions and our financial policy guidelines are listed below.

Effective January 1, 2015:

What Is My Financial Responsibility for Services?

- Copays are due at check-in.
- Patient balances must be paid in full within 30 days of your insurance company's payment for services.
- A pre-payment for services will be due at check-in for surgical pre-operative appointments. The payment required is $250.00.

How May I Pay?

We accept payment by cash, check, VISA, Mastercard, and Discover

_____ _____
Patient Signature Date

_____ _____
Witness Date

.

YARROW BAY
PLASTIC SURGERY

COVID-19 INFORMED CONSENT AGREEMENT

☐ I, the undersigned patient, consent to an in-person consultation and/or to have my Doctor and/or his/her staff (hereinafter collectively "my Doctor") perform medical procedures, whether regarded as necessary, elective or aesthetic, during the time of the COVID-19 pandemic and after. I understand in-person consultations and/or having my procedure performed at this time, despite my own efforts and those of my Doctor, may increase the risk of my exposure to COVID-19. I am aware that exposure to COVID-19 can result in severe illness, intensive therapies, extended intubation and/or ventilator support, life-altering changes to my health, and even death. I am also aware of the possibility that the procedure itself, whether performed in my Doctor's office or in a hospital, may result in a more severe case of COVID-19 than I might have had without the procedure.

☐ I also understand in-person consultations and/or having my procedure performed at this time increases the risk of my transmission of COVID-19 to my Doctor. This virus has a long incubation period, there may be as yet unknown aspects of its transmission, and I realize that I may be contagious, whether or not I have been tested or have symptoms. To reduce the possibility of COVID-19 exposure or transmission at my Doctor's office, I accept that my Doctor will implement infection-control procedures with which I must comply, before, during and after my consultation and/or procedure, for my own protection as well as that of my Doctor. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures are necessary.

☐ I have informed my Doctor of any COVID-19 testing I or any person living with me during the past 14 days has received, as well as the results of that testing, and if I am tested between now and the date of my procedure, I will immediately provide the results of that testing to my Doctor. I understand my Doctor may require that I be tested, possibly at my own expense and regardless of any prior testing, and that the results of that testing must be satisfactory to my Doctor, before I may receive my procedure.

☐ I confirm neither I nor any individual living with me has any of the COVID-19 symptoms listed by the Centers for Disease Control https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf, which website I have consulted; neither I nor any individual living with me during the past 14 days has experienced any such symptoms; and that I and all persons living with me for the past 14 days have practiced all personal hygiene, social distancing and other COVID-19 recommendations contained within all governmental orders issued by my city and state. I understand I must honestly disclose this information to avoid putting myself and others at risk.

☐ All topics above have been discussed with me, and all my questions have been answered to my satisfaction. Being fully informed, I accept the risk of COVID-19 exposure and I will bear the cost of any COVID-19 treatments required. I have been given the opportunity to postpone my in-person consultation and/or procedure until the COVID-19 pandemic is less prevalent, but I choose to have my in-person consultation and/or procedure performed now. If I am the parent, guardian or conservator of the patient, I hold his/her health care power of attorney. I have read this COVID-19 Informed Consent Agreement and am authorized to consent on the patient's behalf.

☐ _____ _____
Patient/Authorized Representative Signature and Initials Print Name & Date **[First encounter]**

☐ _____ _____
Patient/Authorized Representative Signature and Initials Print Name & Date **[Day of procedure]**

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TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical information is used for diagnosis, consultation treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

Patient
Initials

_____ I understand that telehealth involves the communication of my medical information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

_____ I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of Washington at the time of this service.

_____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include, but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

_____ I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

_____ I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____ I understand that Skype, FaceTime, Zoom, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

_____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

_____ The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

_____ I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

_____ I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he/she is my healthcare provider.

_____ I understand that electronic communication cannot be used for emergencies or time-sensitive matters.

_____ I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

_____ I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

_____ I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.

_____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

_____ I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

_____ To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.

_____ I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

For electronic communication between Dr. Sarah McMillan, Dr. Daniel Liebertz, Yarrow Bay Plastic Surgery staff and _____
(Patient's name)

_____ _____
Patient or Legal Representative Signature/Date/Time Relationship to Patient

_____ _____
Print Patient or Legal Representative Name Witness Signature/Date/Time

I certify that I have explained the nature of this agreement to the patient/patient's legal representative. I have I have answered all questions fully, and I believe the patient/patient's legal representative fully understands what I have explained.

_____
Healthcare Provider Signature/Date/Time

_____ Copy given to patient _____ Original in chart

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Name: _____ Date: _____

This questionnaire asks about concerns with physical appearance. Please read each question carefully and circle the answer that is true for you. Also, write in answers where indicated.

1) Are you worried about how you look? ☐ Yes ☐ No

– If YES: Do you think about your appearance problems a lot and wish you could think about them less? ☐ Yes ☐ No

– If YES: Please list the body areas you don't like: _____

_____

_____

Examples of disliked body areas include: your skin (for example acne, scars, wrinkles, paleness, redness); hair; the shape or size of your nose, mouth, jaw, lips, stomach, hips, etc.; or defects of your hands, genitals, breasts, or any other body part.

NOTE: If you answered "No" to either of the above questions, you are finished with this questionnaire. Otherwise, please continue.

2) Is your main concern with how you look that you aren't thin enough or that you might get too fat? ☐ Yes ☐ No

3) How has this problem with how you look affected your life?

- Has it upset you a lot? ☐ Yes ☐ No
- Has it often gotten in the way of doing things with friends, dating, your relationships with people, or your social activities? ☐ Yes ☐ No

  If Yes, describe how: _____

  _____
- Has it caused you any problems with school, work, or other activities? ☐ Yes ☐ No

  If Yes, what are they? _____

  _____
- Are there things you avoid because of how you look? ☐ Yes ☐ No

If Yes, what are they? _____

_____

4) On an average day, how much time do you usually spend thinking about how you look? (Add up all the time you spend in total in a day, then circle one)

☐ a. Less than 1 hour a day ☐ b. 1-3 hours a day ☐ c. More than 3 hours a day