

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: _____

YARROW BAY

P L A S T I C S U R G E R Y

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.

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

Please list **ALL** previous Surgeries/Hospitalizations with dates: _____

Current Medications (including vitamins and supplements):

Family Medical History:

<input type="checkbox"/> Cancer:	<input type="checkbox"/> Heart Disease:	<input type="checkbox"/> Diabetes:
<input type="checkbox"/> 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



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]



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