# CRESCENT PLASTIC & HAND SURGERY
## SHAHER W. KHAN, M.D.

**PATIENT REGISTRATION FORM**

PATIENT NAME: _____ SSN: _____

ADDRESS: _____

CITY: _____ STATE:_____ ZIP CODE:_____

DATE OF BIRTH: _____ AGE: _____ MARITAL STATUS: _____

HOME PHONE: (_____)_____ CELL PHONE: (_____)_____

EMAIL ADDRESS: _____ EMPLOYER: _____

EMPLOYER PHONE: (_____)_____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMERGENCY CONTACT NAME: _____Phone: (_____)_____

DATE OF INJURY: _____ WORK INJURY? _____ AUTO INJURY? _____

(If this is a work-related injury, please complete the following):

WORKERS' COMPENSATION INSURANCE CARRIER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CLAIM # _____ CONTACT PERSON: _____

**IF ANY OF THE FOLLOWING INSURANCE INFO IS LEFT BLANK, WE CANNOT BILL**:

PRIMARY INSURANCE: _____SUBSCRIBER NAME: _____
SUBSCRIBER'S EMPLOYER: _____ SUBSCRIBER'S S.S.#_____
SUBSCRIBER'S D.O.B. _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE: _____ SUBSCRIBER NAME: _____
SUBSCRIBER'S EMPLOYER: _____ SUBSCRIBER'S S.S.# _____
SUBSCRIBER'S D.O.B. _____ RELATIONSHIP TO PATIENT: _____

**REASON FOR VISIT TODAY**: _____

**IF ACCIDENT OR INJURY, DESCRIBE DETAILS**: _____

_____

## MEDICAL HISTORY

| CHECK ALL THAT APPLY: | YES | NO |
|---|---|---|
| HEPATITIS A, B, OR C: | ( ) | ( ) |
| HEART DISEASE: | ( ) | ( ) |
| HIGH BLOOD PRESSURE: | ( ) | ( ) |
| DIABETES: | ( ) | ( ) |
| ASTHMA: | ( ) | ( ) |
| JAUNDICE: | ( ) | ( ) |
| PROLONGED BLEEDING: | ( ) | ( ) |
| HEART ATTACK OR CHEST PAIN: | ( ) | ( ) |
| PACEMAKER OR DEFIBRILLATOR: | ( ) | ( ) |
| HIV VIRUS: | ( ) | ( ) |
| OPEN HEART SURGERY: | ( ) | ( ) |
| HEART CATHETERIZATION: | ( ) | ( ) |
| KIDNEY DIALYSIS: | ( ) | ( ) |
| SEVERE REACTION TO ANESTHESIA: | ( ) | ( ) |
| TAKE HEART MEDICATION: | ( ) | ( ) |
| ALLERGY TO LATEX: | ( ) | ( ) |
| CURRENTLY A SMOKER: | ( ) | ( ) |

CURRENT MEDICATIONS: _____

ALLERGIES TO MEDICATIONS: _____

PREVIOUS SURGERIES: _____

PRIMARY CARE PHYSICIAN NAME AND NUMBER: _____(_____)_____

CARDIOLOGIST'S NAME (If you have one): _____(_____)_____

WHO REFERRED YOU TO DR. KHAN? _____(_____)_____

**PATIENT AUTHORIZATION TO RELEASE MEDICAL AUTHORIZATION &CLAIM PAYMENT AUTHORIZATION:**
I HEREBY AUTHORIZE DR KHAN TO RELEASE ANY INFORMATION REGARDING SERVICES RENDERED BY HIM AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO FILE AN INSURANCE CLAIM. I HEREBY AUTHORIZE AND DIRECT PAYMENT FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY DR. KHAN TO BE MADE DIRECTLY TO HIM. I UNDERSTAND THE PHYSICIAN'S CHARGES MAY EXCEED MY INSURANCE CARRIER'S PAYMENT, AND, IF GREATER THAN SUCH PAYMENT, I WILL BE RESPONSIBLE FOR THAT AMOUNT AND ANY CHARGES REJECTED BY MY INSURANCE COMPANY. ALSO, BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES FORM, AND THAT I HAVE EITHER RECEIVED OR REJECTED THAT OFFER.

PATIENT SIGNATURE (or guardian if minor) _____DATE: _____

**CRESCENT PLASTIC & HAND SURGERY**
**SHAHER W. KHAN, M.D.**

**PHOTOGRAPHIC AUTHORIZATION**:

I consent to the taking of photographs or videotapes of myself or parts of my body by Crescent Plastic & Hand Surgery in connection with any and/or all plastic surgery procedure(s) to be performed by Dr. Shaher Khan.
I understand that photographs may be required by my insurance company for the purpose of prior authorization and consent to the release of any requested images for this purpose.
I understand that such photographs, videotapes or case histories may be published by Dr. Shaher Khan and/or any party acting under his license and authority with Crescent Plastic & Hand Surgery in any print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and internet websites, for the purpose of informing the medical profession or the general public about plastic surgery methods.
Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable.
I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) years from the date written below.
I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Crescent Plastic & Hand Surgery.
I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").
I release and discharge Dr. Shaher Khan and Crescent Plastic & Hand Surgery including all parties acting under his license and authority from all rights that I may have in the photographs, videotapes or case histories and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these materials in any medium.
I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

_____/____/_____

Patient Signature Date Physician/Witness Signature

I have read the above Authorization and Release. I am the parent, guardian or conservator of _____ a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

_____/____/_____

Parent, Guardian or Conservator Signature Date Physician/Witness Signature

**CRESCENT PLASTIC & HAND SURGERY**
**SHAHER W. KHAN, M.D.**

**PATIENT PARTNERSHIP PLAN**

Dear Patient,

Welcome to Crescent Plastic & Hand Surgery. We hope to provide you with the care and service that you expect and deserve. Achieving your best possible health requires a "partnership" between you and your doctor. As our "partner in health", we ask you to participate in your care in the following ways:

I WILL KEEP FOLLOW-UP APPOINTMENTS AND RESCHEDULE MISSED APPOINTMENTS.
I understand that Dr. Khan and his clinical staff will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

I WILL CALL THE OFFICE WHEN I DO NOT HEAR THE RESULTS OF LABS AND OTHER TESTS.
I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

I WILL INFORM MY DOCTOR IF I DECIDE NOT TO FOLLOW HIS RECOMMENDED TREATMENT PLAN.
I understand that after examining me, my doctor may make certain recommendations that are based on what he feels are best for my health. This might include prescribing medication, referring me to another specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his recommendations so that he may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, seek an explanation, report symptoms, or discuss concerns. If you need more information about your health or condition, please ask.

_____/____/_____

Patient Signature Date Physician Signature

# CRESCENT PLASTIC & HAND SURGERY
# SHAHER W. KHAN, M.D.

## NOTICE OF PRIVACY PRACTICES

At the practice of Crescent Plastic & Hand Surgery, your privacy is a very important part of our mission and plays a very big factor in your experience. Dr. Khan and his staff adhere to the highest standards of respecting and protecting patient privacy and the confidentiality of your health care information. Additionally, the team complies with all state and federal regulations regarding the privacy of individual health care information, including HIPAA (Health Care Insurance Privacy and Protection Act), enacted on April 14, 2003.
As of April 14th 2003, we are required by law to offer you a copy of the "Notice of Privacy Practices" regarding your Personal Health Information (PHI).
Your PHI, also known as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and the nation
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

The "Notice of Privacy Practices" details the following:

- How we may use/disclose your PHI to carry out treatment, payment or health care operations.
- How you may request copies of your healthcare information.
- How you may verify the accuracy of this information.
- How you may request an accounting of certain external disclosures of your PHI.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
Please acknowledge that you have been offered a "Notice of Privacy Practices" by signing below:

"I have been offered a Notice of Privacy Practices by the office of Shaher W. Khan, M.D of Crescent Plastic & Hand Surgery. I fully understand and accept the terms of this consent."
Signature: [Patient, Parent or Guardian]

_____Date:____/____/_____

# CRESCENT PLASTIC & HAND SURGERY
# SHAHER W. KHAN, M.D.

## 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.

### WHO WILL FOLLOW THIS NOTICE?

This Notice describes the practices that will be followed by all of Dr. Khan's workforce members who handle your medical information.

### OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION

Dr. Khan and his staff understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We maintain our records and conduct our treatment environment with a goal of providing the highest level of protection for your medical information, while still providing you with the highest level of medical care. This Notice applies to all of the records of your medical care, which are received or created by Dr. Khan and his staff.

Your other medical treatment providers (e.g., doctors, hospitals, home health agencies, etc.) may have different policies or notices regarding the use and disclosure of your medical information.

This Notice will tell you about the ways in which Dr. Khan may use and disclose medical information about you. Your medical information, also referred to as "protected health information," is that information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health information and related health care services.

In this Notice, we also describe your rights and certain obligations Dr. Khan has regarding the use and disclosure of your protected health information. We are required by law to:

- Make sure that medical and other information that identifies you (protected health information) is kept private
- Give you this Notice of our legal duties and privacy practices with respect to protected health information about you
- Follow the terms of the Notice that is currently in effect.

### USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

By becoming a patient of Dr. Khan, you are giving consent for Dr. Khan to use your protected health information for certain activities, including treatment, payment and other health care operations. Sometimes, you may hear these three activities referred to as "TPO."

We may use and disclose protected health information about you so that Dr. Khan and his medical professionals can treat you. For example, we may use your past medical information in order to diagnose your present condition or we may provide information regarding your medical condition to another doctor to whom we refer you for additional care.

We may also use and disclose protected health information about you so that we may be compensated for the medical treatment we provide you. For example, we will submit protected health information about you to your insurance company in order to receive payment for services we have provided to you. We may also use and disclose protected health information about you for Dr. Khan's health care operations, in other words, those other tasks that we need to perform to make sure that you are provided the highest quality of medical care.

For example, we may use your protected health information to evaluate how we can better meet your needs or we may provide protected health information about you to an auditor who reviews our books so that we can keep our license to provide medical services in Michigan.

**OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION**
The following uses of your protected health information may be made without any additional authorization from you. (Not every use of disclosure is listed, but be assured that all uses and disclosures made by Dr. Khan are only those, which are permitted under the law):
• Submission to the American Board of Plastic Surgery as part of Board Certification/Recertification
• Research Studies and Professional Lecture Courses

**USES AND DISCLOSURES FOR APPOINTMENT REMINDERS**
We may use and disclose your medical information to contact you as a reminder that you have an appointment at the office. If you request that such communications be made confidentially, please contact our office. We will accommodate all reasonable requests.

**USES AND DISCLOSURES TO OTHERS INVOLVED IN YOUR HEALTH CARE**
We may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your medical care. If you are unable to agree or object to this disclosure, we may disclose such information as necessary if we determine that it is in your best interests based on our professional judgment. We may also use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

**USES AND DISCLOSURES IN EMERGENCY SITUATIONS**
We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician will attempt to obtain your acknowledgment of this notice as soon as reasonably practicable after the delivery of treatment.

**USES AND DISCLOSURES FOR HEALTH-RELATED BENEFITS OR SERVICES**
Dr. Khan and Crescent Plastic & Hand Surgery may use and disclose protected health information to tell you about certain health-related benefits or services that may be of interest to you.

**USES AND DISCLOSURES REQUIRED BY LAW**
We will use or disclose protected health information about you when required to do so by federal, state, or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if the law requires us to do so, of any such uses or 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 law.

**USES AND DISCLOSURES FOR PUBLIC HEALTH ACTIVITIES**
We may disclose your protected health information for public health activities and disclosure for such purposes will be to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for purposes such as controlling disease, injury or disability. Disclosures to public health authorizes may include disclosure to a foreign authority that is working with the public health authority.

**USES AND DISCLOSURES RELATED TO COMMUNICABLE DISEASES**
We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**DISCLOSURES FOR HEALTH OVERSIGHT ACTIVITIES**
We may disclose protected health information to a health oversight agency for activities authorized by law. These activities include, for example, audits, investigations, and inspections. These activities are necessary for the government to monitor the health care system, the delivery of health care, government benefit programs, other government regulatory programs and civil rights laws.

**DISCLOSURES OF ABUSE OR NEGLECT**
We may disclose your protected health information to a public health authority authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to a governmental entity or agency authorized to receive such information. In such cases, the disclosure will only be made in accordance with PA law.