LARA DEVGAN, MD, PLLC

PLASTIC & RECONSTRUCTIVE SURGERY
969 PARK AVENUE, NEW YORK, NY 10028
OFFICE 212.452.2400; FAX: 212.898.1391
INFO@LARADEVGANMD.COM

PATIENT INFORMATION

Name: ____ **Date of Birth**: ___/____/____ **Sex**: M/F
Marital Status: S/M/W/D

Home Address: ____
Street City State Zip Code

Cell #: ___________________________________ **Email**: _______________________________________
Home #: __________________________________ **Social Security:** ________________________________
Work #: __________________________________

Occupation: _______________________________ **Employer**: ____________________________________

Emergency Contact: _________________________ **Telephone #**: _________________________________

Person Financially Responsible:

☐ Patient ☐ Other
If other, please complete:
Name: _________________________________
Relationship: ____________________________
Address: ________________________________
____
Telephone #: _____________________________

INSURANCE:

Primary Insurance: ____________________________
Relationship to Subscriber: ________________________
Subscriber Date of Birth: __________________________

Secondary Insurance: ___________________________
Relationship to Subscriber: ________________________
Subscriber Date of Birth: __________________________

Referred By: ____
(How did you find Dr. Devgan? Doctor, friend, previous patient, magazine, newspaper, social media, internet, etc)

Primary Care Physician: ________________________________

Patient information release authorization, assignment of insurance benefits & financial responsibility

I, the undersigned, herby consent to care and treatment now and in the future. In the event that my insurance company is billed, I authorize payment of medical benefits to the physician(s) or supplier of rendered services. If my insurance company is not billed or if my insurance company fails to pay for services or does not pay a claim in full, I understand that I am responsible for payment of any charges or balances for services rendered. I understand that payment is due for services rendered and is non-refundable. I understand that there is no guarantee of satisfaction, outcome, or results with any medical consultation or intervention. I authorize the release of any medical information necessary to process my insurance claims. I allow Lara Devgan, MD, PLLC to act as my designated authorized representative to appeal any insurance bills on my behalf, including to release any medical information, until the conclusion of any appeals process.

Signature: ____________________________**Name**______________________________**Date**: ________________

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MEDICAL HISTORY

Name: ________________________________ Age: ______ Height: ______ Weight: ______
(Is your weight stable? Y/N)

Reason for consultation:

Please list ALL medical conditions:

____
____
____

Please list all prior surgical procedures and DATES:

____
____
____

MEDICATIONS:

____
____
____
____

ALLERGIES:

____
____
____
____

Do you have a FAMILY HISTORY of any medical problems?

____
____

SOCIAL HABITS:

Do you drink alcohol? If so, how much? ____
Do you smoke cigarettes or use other tobacco products? If so, how much? ____________________
Do you use nicotine patches, nicotine gum, or electric cigarettes? __________________________
Do you use recreational drugs? If so, which ones and how much? ___________________________

FOR WOMEN:

Number of pregnancies: _____ Births: _____ C-sections: _______ Miscarriages/ Abortions: ______

YES	NO	
☐	☐	Are you pregnant or trying to become pregnant?
☐	☐	Do you have problems associated with your menstrual period?
☐	☐	Are you nursing?
☐	☐	Are you taking birth control pills?

Date of last mammogram: ________________ Any abnormalities on your last mammogram?__________________

MEDICAL ISSUES:

YES	NO	
☐	☐	Have you had any changes in your health in the past year? If so, please explain: ___________________________
☐	☐	GENERAL- Do you have diabetes or high blood pressure?
☐	☐	HEART- Have you had heart trouble, heart attack, angina, chest pain, arrhythmias, arteriosclerosis, rheumatic heart disease, damaged or artificial heart valves, heart murmur, or aneurysm?
☐	☐	LUNGS- Do you have asthma, lung disease, shortness of breath, bronchitis, emphysema, or tuberculosis?
☐	☐	GI- Have you had a hernia, stomach ulcer, hyperacidity, irritable bowel, or chronic constipation or diarrhea?
☐	☐	LIVER- Do you have liver disease, hepatitis, jaundice, or alcoholism?
☐	☐	KIDNEY- Do you have a history of kidney stones, urinary tract infections, kidney disease, or dialysis?
☐	☐	BRAIN- Have you had a stroke, fainting spells, seizures, migraines, depression, anxiety, or psychiatric issue?
☐	☐	ENDOCRINE- Do you have thyroid problems, Cushing's disease, or other endocrine problems?
☐	☐	BLOOD- Have you had any blood disorders, blood clots, anemia, abnormal bleeding, blood transfusions?
☐	☐	AUTOIMMUNE- Do you have an autoimmune disease, "collagen disease" (eg, Lupus, Rheumatoid Arthritis, Raynaud's disease), or any persistent swollen neck glands or lymph nodes?
☐	☐	CANCER- Do you have any history of cancer, growth, tumor, or history of radiation or chemotherapy?
☐	☐	INFECTION- Do you have any history of cold sores, tuberculosis, HIV, Hepatitis C, or MRSA infection?
☐	☐	HEALING- Do you have any history of steroid use, keloid scarring or poor wound healing?
☐	☐	Have you ever had a problem with general anesthesia?

If you answered "YES" to any of these questions, please explain:

____

____

____

SKIN QUESTIONNAIRE:

Please check any items that concern you:

- ☐ Fine lines/ wrinkles
- ☐ Sun spots/ melasma
- ☐ Acne
- ☐ Dull skin
- ☐ Large pores
- ☐ Uneven complexion
- ☐ Thinning of eyelashes/ eyebrows

Please check any services that interest you:

- ☐ Medical-grade skin care
- ☐ Botox for wrinkles
- ☐ Filler for tired eyes (tear troughs)
- ☐ Filler for mid-face (cheekbones, nasolabial folds)
- ☐ Filler for lips
- ☐ Microneedling
- ☐ Chemical peel

I certify that the above information is a complete and accurate representation of my medical history. I will not hold Lara Devgan, MD, PLLC or her designees responsible for any errors or omissions that I may have made in the completion of this form.

Signature: ________________________________**Name**_________________________________**Date**: _________________

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HIPAA PRIVACY NOTICE

Your Privacy is Important

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal statute that requires that all protected health information used or disclosed by Lara Devgan, MD, PLLC ("Practice") in any form, whether electronically, on paper, or orally, are kept confidential. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services ("PHI"). As required by HIPAA, this Notice of Privacy Practices ("Notice") describes how the Practice is required to maintain the privacy of your PHI and how it may use and disclose PHI. It also describes your rights to access and control your PHI.

Use and Disclosures of PHI: Your PHI is subject to use or disclosure by the Practice's physicians, office staff, employees or other third parties that are involved in your care and treatment, including electronic disclosures. It is the Practice's responsibility to ensure that all uses or disclosures are made in accordance with HIPAA and as further detailed below in this Notice. Required Disclosures: The Practice is required to disclose PHI to you directly when requested in accordance with your rights described below or the Department of Health and Human Services when investigating or determining the Practice's compliance with HIPAA.

NO AUTHORIZATION REQUIRED

Treatment: The Practice will use and disclose your PHI 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, consultation between physicians relating to your care, or your referral for health care to another physician. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to provide you the proper care or to a pharmacy to fill a prescription.

Payment: The Practice will use and disclose your PHI, as needed, as it relates to payment for your health care services. This may include obtaining reimbursement information for the health care services you are receiving, confirming coverage or co-pay amounts under your health plan, billing and collecting from you, an insurance company, or a third party for your health care services, or obtaining precertification or preauthorization for specific health care services. For example, the Practice may send a claim for payment to your insurance company and that claim may contain PHI such as a code describing your diagnosis or medical treatment.

Health care Operations: The Practice will use and disclose your PHI, as needed, in order to support the business operations of the Practice. These activities include, but are not limited to, quality assessment and improvement activities, auditing functions, cost-management analysis, or training. For example, the Practice may use or disclose your PHI during an audit of its billing practice or HIPAA compliance. In addition, the Practice may use a sign-in sheet at the registration desk where you will be asked to sign your name. The Practice may also call you by name in the waiting room when your physician is ready to see you. The Practice may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Practice may also contact you for the Practice's fundraising purposes which you will have the opportunity to opt-out.

Business Associates: The Practice will use and disclose your PHI, as needed, to business associates. There are some services provided in the Practice through contracts with business associates (i.e., the Practice may disclose PHI to a company who bills insurance companies on the Practice's behalf to enable that company to assist in obtaining payment for the healthcare services provided). To protect your PHI the Practice will require its business associates to appropriately safeguard the information.

Other Uses or Disclosures: The Practice may also disclose your PHI for the following additional purposes without your authorization: when required by law (statute, law enforcement, judicial or administrative order); for public health activities (to public health or legal authorities charged with preventing or controlling disease, injury, disability, child abuse or neglect, etc., as required by law); when there is a belief you are a victim of abuse, neglect, or domestic violence; for health oversight activities (to public agencies or legal authorities charged with overseeing the health care system, government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights); for judicial or administrative proceedings (pursuant to court order or subpoena if assurances are received); for law enforcement purposes; to funeral directors, coroners, or organ procurement organizations; for research; if there is a belief of a serious threat to health and

safety; for certain essential government functions (national security, military, etc.); to comply with workers' compensation; and as part of a limited data set pursuant to a data use agreement for research, public health or health care operations.

AUTHORIZATION REQUIRED

Any uses or disclosures outside the scope described above will be made only with your written authorization. Most uses or disclosures of psychotherapy notes, and of PHI for marketing purposes and the sale of PHI require an authorization. You may revoke such authorization in writing at any time and the Practice is required to honor and abide by that revocation, except to the extent that it has already taken actions relying on your authorization.

Your Rights for PHI: You have the right to obtain a paper copy of this Notice and you may exercise any of the rights described below by contacting the Practice and requesting to speak with the Privacy Officer. You have the right to make reasonable requests to receive confidential communications of your PHI from the Practice by alternative means or at alternative locations. You have the right to request restrictions on uses and disclosures of PHI for treatment, payment or healthcare operations, or disclosures to family members, other relatives, close personal friends, or any other person identified by you. Generally, the Practice is not legally required to agree to a requested restriction. However, if the request is made to restrict disclosure to a health plan for purposes of carrying out Payment or Health Care Operations and the PHI pertains solely to a health care item or service for which you have paid out of pocket in full, the Practice is legally required to agree to the requested restriction. You have the right to read or obtain a copy of your PHI or choose to get a summary of your PHI in lieu of a copy. There are some reasons why the Practice may deny such a request which will be delivered to you in writing stating the reason. If a summary or a copy of your PHI is provided, you may have to pay a reasonable fee. You have the right to request the Practice to amend or correct your PHI to the extent legally and ethically permissible. If the Practice denies the request, it will do so in writing and you will have the ability to file a statement of disagreement. You also have the right to amend your records by providing us with a written addendum with respect to any item or statement in your record that you believe to be incomplete or incorrect (limited to 250 words per alleged incomplete or incorrect item). You have the right to receive an accounting of the disclosures of PHI by the Practice in the last six years but it will not include certain disclosures including those made for treatment, payment, healthcare operations or where you specifically authorized a use or disclosure.

Complaints: You have recourse if you feel that the privacy of your PHI has been violated. If you feel there has been a violation, you have the right to file a complaint by submitting your complaint in writing by mail to the address above or by fax at the number above. You may also contact the Practice directly by telephone. For all complaints, please ask for or direct attention to the Privacy Officer. There will be no retaliation for filing a complaint. You may also file a complaint with or contact the Department of Health and Human Services, Office for Civil Rights.

Effective Date: The Practice is required by law to maintain the privacy of your PHI, to provide you with notice of its legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. This Notice is effective as of March 21, 2016. The Practice reserves the right to change the terms of this Notice and to make any such changes or amendments effective for all PHI that it maintains. The Practice will periodically post from time to time, and you may request a written copy of, any updated versions of this Notice.

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PHYSICIAN-PATIENT ARBITRATION

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 New York law, and not by a lawsuit or resort to court process except as New York law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights 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 the treatment or service provided by the physician including 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.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party’s pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party’s own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to 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 against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of New York 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 3333.1 and 3333.2Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.02; however, depositions may be taken without prior approval of the neutral arbitrator.

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 of notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable New York 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 for, the arbitrators shall be governed by the New York Code of Civil Procedure provisions relating to this 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 initial below:
Effective as of the date of first medical services. _____ Patient/ Guardian Initials

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 of any other provision. I understand that I have the right to receive the copy of this arbitration agreement. NOTICE: By signing this contract you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. See article one of this contract.

Signature: ________________________________**Name**__________________________________**Date**: _________________

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COMMUNICATION BY EMAIL/ TEXT

Security Risks

Most standard email providers such as Gmail, Yahoo, Hotmail, etc. and most cellular providers do not provide a secured or encrypted means of communication. As a result, there is risk that any protected health information contained in an email or text message may be disclosed to, or intercepted by, unauthorized third parties. Additionally, email and text messages accessible through personal computers, laptops, or phones have inherent privacy risks especially when the email or cellular account is provided by an employer, when the account is not password protected, or the account is shared. Use of more secure communications, such as phone, fax or mail is preferred and always an available alternative.

Responsibility

When consenting to the use of email or text through such unsecured or unencrypted systems, you are accepting responsibility for any unauthorized access or disclosure to protected health information contained within the message. The Practice will not be responsible for unauthorized access of protected health information while in transmission and will not be responsible for safeguarding information once it is delivered. The Practice will take steps to ensure that any email or text message with protected health information is protected prior to being sent to the requested address and will use the minimum necessary amount of protected health information when communicating with you.

Additional Information

It is important to understand that emails and text messages will not be used to replace or facilitate communications between you and your physician and will not be considered private communications. There is no guarantee that the Practice will be actively monitoring emails and text messages, so responses and replies sent to or received by you or the Practice may be hours or days apart. Email and text messages may be inadvertently missed or errors in transmissions may occur. The Practice will not be responsible for any issues caused by delays in communications. If you have an immediate need or an emergency situation, you must contact the Practice by telephone or dial 9-1-1 if applicable. Practice staff will be utilized to monitor the inbox in order to properly direct or respond to communications received. Therefore, any information considered sensitive should not be included in your communications. At the Practice's discretion, any email or text message received or sent may become part of your medical record.

By completing and signing this form, or by initiating contact with the Practice via email, text, or web form, I am accepting that Lara Devgan, MD, PLLC may communicate with me via email or text message via the provided contact information and acknowledge the inherent limitations therein.

Signature: ________________________________**Name**_________________________________**Date**: _________________

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MEDICAL PHOTOGRAPHY

I consent to the taking of photographs by Lara Devgan, MD, PLLC or her designee ("the Practice") of me or parts of my body in connection with my medical care. I understand that such photographs shall become the property of the Practice and may be retained or released for the purpose of preoperative planning, medical records, and publication in print, visual or electronic media. I will not be identified by name in any published photograph. I understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation.

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 further understand that, because Dr. Devgan is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA. I release Dr. Devgan and her designees from all rights that I may have in the photographs and from any claim that I may have relating to such use, including any claim for payment in connection with publication of the photographs.

Signature: ________________________________**Name**_________________________________**Date**: _________________