Trenton C. Jones M.D.

Patient Information

Cascade Cosmetic Surgery Center ~ 1375 East 800 North, Suite 205, Orem, Utah 84097

Patient's Name:

_____

First Middle Last

Address

_____

Street & Apt# City State Zip

Home Phone _____ Cell Phone _____

Is it okay to call/leave a message at your home? ___ No ___ Yes E-mail _____

Age _____ Birthdate ____/____/_____ SS#_____-____-_____ Sex ___F ___M

Marital Status ___ Single ___ Married Spouse's Name: _____

Patients Employer _____Occupation_____

Work Phone _____Ext:_____ Is it okay to call you at work? __ Yes __No

Emergency Contact 1

Name _____Relationship to Patient_____

Home Phone _____ Work Phone _____

Emergency Contact 2

Name _____Relationship to Patient _____

Home Phone _____ Work Phone _____

Reason for Visit

Procedure: _____

How did you hear about Dr. Jones?

_____

What most influenced you to consult with Dr. Jones?

_____

Are you interested in financing? ___yes ___no

Due to the nature of our practice we do not accept health insurance.

I verify that all the information is true and correct, and is my own personal information. If it becomes necessary to refer the account to a collection agency, I agree to pay all collection costs and fees. I further agree to pay all court costs and attorney fees should legal action become necessary. I understand that my contract is between Dr. Jones and myself.

Signature _____ **Date** _____

Trenton C. Jones, MD
Cascade Cosmetic Surgery Center
1375 E. 800 N., Ste. 205 ● Orem, UT 84097 ● 801-418-8172

Policy and Patient Consent

Co-payment & Deductible Policy

Co-payments are determined by your insurance company. They are a legal obligation of your insurance policy and are due when service is rendered.
Deductibles are determined by your insurance company as well. They are a legal obligation of your insurance policy. Your deductible will be calculated and collected prior to your surgery and/or applicable office services.

Cosmetic & Insurance Consultation Policy

Dr. Jones is pleased to offer a complimentary consultation for cosmetic procedures.
Cosmetic procedures are operations that are not covered by traditional insurance due to their cosmetic nature. Cosmetic procedures might include Breast Augmentation, Liposuction, Abdominoplasty, Facelift, Rhinoplasty, etc. Additionally, cosmetic procedures are paid for by the patient, prior to surgery.
Insurance procedures are those commonly covered by traditional health insurance. Some might include: breast reduction, carpal tunnel release, scar revision, reconstruction, etc. If the office pre-authorized or attempts to pre-authorize a procedure with your insurance company, you will be charged for a consultation. If you request a letter for any reason, you will be charged for the consultation and letter.

Attorney consultations are an evaluation by the doctor for purposes of fighting a claim or pursuing a lawsuit. These are not cosmetic consultations and will incur a charge. An additional charge will exist for a letter or summary of the doctor's findings. Payment is collected at the time of the consultation.

If you have a question regarding your procedure and financial responsibility, please ask the office staff before your consultation.

Patient Consents

The Department of Health and Human Services has established a APrivacy Rule@ to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients= consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need for your health care information and information about treatment, payment, or health care operations, in order to provide the health care that is in you best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your personal health information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

I agree that all photographs and reproduction hereof are and shall remain the property of Trenton C. Jones, MD. I hereby grant permission of the use of any record, illustration, photograph or other imaging record created in my case, for any use deemed appropriate including but not limited to the use in examination, testing, credentialing and/or certifying purposes by the American Board of Plastic Surgery, Inc.

You have the right to review the privacy notice, to request restrictions and revoke consent in writing after you have reviewed the privacy notice.

Patient **Parent or Legal Guardian** **Date**

Trenton C. Jones, M.D.
Cascade Cosmetic Surgery Center

Patient Medical History (please read carefully, if something does not apply, please write none or no)

Please list any medications you are currently taking, both prescriptions and over-the-counter (including Aspirin, Ibuprofen, Aleve, Advil, or any other anti-inflammatory medications):

Please list any surgeries you have had, the dates of the surgeries, and the physician who performed them:

Please list any allergies to **medications**:

Please circle if you have ever had any of the following conditions:

Anemia
Ankle Swelling
Arthritis
Asthma
Bipolar Disease
Bleeding Excessively
Blood Disorders
Blood Clots
Bruise Easily
Cancer or Tumor
Chest Pain
Changes in Vision
Chemotherapy
Diabetes
Difficulty Breathing
Emphysema
Epilepsy or Seizure Disorder
Excessive Scarring
Fainting
Frequent Nose Bleeds
Glaucoma
Heart Disease
Heart Murmur
Heart Palpitations
Hepatitis
High Blood Pressure
High Cholesterol
HIV Positive/ AIDS
Infection Problems
Jaundice
Kidney Disease
Liver Disease
Migraines
Miscarriage
Multiple Sclerosis
Neurological Problems
Night Sweats
Numbness in extremities
Pneumonia
Radiation Treatment
Recent Cold or Cough
Rheumatic Fever
Skin Conditions (rashes, etc)
Stroke
Thyroid Disease
Tuberculosis
Ulcers
Unexplained Weight Loss/Gain

Do you smoke?_____
> How much do you smoke a day?_____
_____
Do you consume alcohol regularly? _____
_____
Number of Pregnancies_____
Number of Children_____
Are you currently pregnant?___
Do you take birth control?_____
Approximate height _____
Approximate weight_____

Please explain anything you checked above, or anything that is not listed above:

Patient Signature: **Date:** **Witness:**