LAVINIA K. CHONG, M.D. 1401 Avocado Ave., Suite 803, Newport Beach, CA 92660, Phone (949)644-1400 Fax (949)644-5988

Today's Date: _____

PATIENT INFORMATION:

_____
First Middle Initial Last

Address: _____
Street & Apt # City State Zip

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Email: _____ Contact Restrictions: _____

Age: _____ Birthdate: _____ SS#: _____ Gender: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married to: _____ ☐ Other: _____

PATIENT'S EMPLOYER:

_____ Occupation: _____
Company Name

Work Phone _____ Ext: _____ Is it okay to call you at work? ☐ Yes ☐ No

Address _____
Street & Suite # City State Zip

HOW DID YOU HEAR ABOUT DR. CHONG?

☐ Web_____
Name of Website

☐ Friend/Relative: _____ ☐ Doctor: _____ ☐ Other: _____

If you were referred by a specific person, may we thank them? ☐ Yes ☐ No

EMERGENCY CONTACT:

_____ Relationship to Patient _____
Name

Home Phone _____ Cell Phone _____ Other Phone _____

AREAS OF INTEREST (mark all that apply)

- ☐ Abdominoplasty (Tummy Tuck)
- ☐ Blepharoplasty (Eyelid Lift)
- ☐ Brachioplasty (Arm Lift)
- ☐ Breast Augmentation
- ☐ Breast Implant Exchange
- ☐ Breast Implant Removal
- ☐ Breast Reconstruction
- ☐ Breast Reduction
- ☐ Brow or Forehead Lift
- ☐ Earlobe Repair
- ☐ Face or Neck Lift
- ☐ Injectables (Botox, Juvederm, etc.)
- ☐ Lip Enhancement
- ☐ Liposuction
- ☐ Mastopexy (Breast Lift)
- ☐ Nipple Augmentation
- ☐ Otoplasty (Ear Pinning)
- ☐ Rhinoplasty (Nose Reshaping)
- ☐ Skin Care
- ☐ Skin Resurfacing (Laser, Peel, Etc.)
- ☐ Ultherapy

***I agree that a copy of my drivers license will be taken at this appointment.**

Patient Signature _____ **Date** _____

Health Information as of _____(enter today's date)

Patient Name:	DOB:	Age:	Height:	Weight:
Marital Status :	What procedure are you considering?:			

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? Please check all that apply.

☐	Heart Trouble	☐	Glaucoma or Eye Problems	☐	Piercing other than the ears
☐	Heart Attack	☐	Visual Disturbances	☐	Positive blood test for: HIV, AIDS, Hepatitis
☐	Heart Pain	☐	Error in Refraction	☐	Missed or irregular last menstrual period
☐	Palpitation or Irregular Pulse	☐	Other Eye Problems	☐	Family history of cancer, heart trouble, stroke
☐	Extra Heart Beats	☐	Hepatitis	☐	Loose teeth
☐	Stroke	☐	Yellow Jaundice	☐	Nervous Disorder
☐	Hypertension	☐	Gallstones or Gallbladder Trouble	☐	Insomnia
☐	Blood Pressure Abnormalities	☐	Cirrhosis of the Liver	☐	Drug Habit
☐	Abnormal EKG	☐	Alcoholism or Drug Dependency	☐	Self-Destructive Tendencies
☐	Rheumatic Fever	☐	Esophageal Varices	☐	Psychiatric Care / Depression
☐	Dropsy or Heart Failure	☐	Frequent Indigestion	☐	Thyroid Problems
☐	Digitalis Treatment	☐	Ulcers	☐	Kidney or Renal Disease
☐	Shortness of Breath	☐	Gastritis	☐	Heart murmur
☐	Chest Pain	☐	Colitis	☐	Airway Obstruction (Nasal)
☐	Asthma	☐	Problem Constipation	☐	Breast Cysts, Tumors, Abscesses
☐	Bronchitis	☐	Vomiting Blood	☐	Nipple Discharge (Apart from Normal Lactation)
☐	Pneumonia	☐	Tarry or Bloody Bowel Movements	☐	Kidney Disorder
☐	Tuberculosis	☐	Hemorrhoids	☐	Blood Transfusion
☐	Smokers Cough	☐	Goiter or Thyroid Disorders	☐	Seizures or convulsions or fainting spells
☐	Emphysema	☐	Diabetes	☐	Black outs
☐	Coughing or Spitting of Blood	☐	Skin Disorders	☐	Dentures, bridges, capped teeth or crowns
☐	Hay Fever	☐	Arthritis	☐	Nervous Breakdown
☐	Major Allergies	☐	Fracture of Neck or Spine	☐	Abnormal Bleeding after Tooth Extraction
☐	Palsy or Paralysis	☐	Bleeding Tendency or Disorder	☐	Shingles

1. **Please list all present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, and weight loss drugs. **Include over-the-counter medications.**

_____

_____

Patient Signature _____ **Date** _____

2. Do you have an allergic reaction to any medication? ☐ Yes ☐ No Please specify: _____

3. Do you react abnormally to any medication? ☐ Yes ☐ No Please specify: _____

4. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?
☐ Yes ☐ No If yes, when and where? _____

5. Have you ever been on cortisone or steroid treatment? ☐ Yes ☐ No When? _____

6. Do you consume regular amounts of alcoholic beverages, including beer or wine? ☐ Yes ☐ No

If so, how much? _____

7. Do you smoke? ☐ Yes ☐ No If so, how much? _____ For how long? _____

8. Are you pregnant? ☐ Yes ☐ No When was you last normal menstrual period? _____

9. How many pregnancies? _____ Births? _____ Breast Fed? ☐ Yes ☐ No How long? _____

CHILDREN (list names and ages/birthdays): _____

10. When was your last physical exam? _____ By whom? _____

11. When was your last eye examination? _____ By whom? _____

12. When and where was your last chest x-ray? _____ EKG? _____ Mammogram? _____ Pap? _____

13. Who is your personal physician, if any? _____ Please list all physicians presently caring for you

_____

14. Have you ever been under psychiatric care? ☐ Yes ☐ No When? _____ Why? _____

15. Have you had any recent blood work done? ☐ Yes ☐ No Where? _____

16. Is there anything else you think the doctor should know? _____

17. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:

SURGICAL OPERATIONS (include where, when and why for each surgery): _____

_____

_____

HOSPITALIZATIONS (include where, when and why for each admission): _____

_____

18. What do you want to achieve? _____

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I authorize Lavinia K. Chong, M.D., and/or her staff, to take photographs, slides or videotapes of me or parts of my body for medical purposes to be used for my care, medical presentations and/or articles.

In addition, I authorize the use of these images, without compensation to me for the following specific purposes. Please check appropriate box:

Yes	No	Medium
☐	☐	in the office **photo album** for prospective patients.
☐	☐	in office **seminars** for prospective patients.
☐	☐	on our **website** for prospective patients.
☐	☐	on our **social media** for prospective patients.

Additional comments: ___

I understand that:

1. Such photographs, slides or videotapes may be published by Dr. Chong and/or Lavinia K. Chong, M.D. in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that such uses may also include marketing on behalf of Dr. Chong , for which Dr. Chong may be receive direct or indirect remuneration.
2. I will not be identified by name in any of the media described above; however, I also understand that in some circumstances the photographs, slides, or videotapes may display features that identify me.
3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to the office of Dr. Lavinia Chong at 1401 Avocado Ave. Suite 803, Newport Beach, CA 92660.
4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Chong and/or Lavinia K. Chong, M.D..
5. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.
6. A copy of this Authorization is valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

I release and discharge Dr. Chong and/or Lavinia K. Chong, M.D. from all liability, including liability for negligence, that in any way arises out of:

- *any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization; and*
- *any claim that I may have or may have had relating to such use and disclosure of those photographs, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.*

This Authorization is made as a voluntary contribution in the interest of public education and certify that I have read this Authorization and Release carefully and fully understand its terms.

If I have questions about the use or disclosure of my photographs, slides, or videotapes, I can contact Dr. Lavinia Chong and/or her office staff at (949) 644-1400

Signature: _____ Date: _____

OFFICE POLICIES FOR LAVINIA K. CHONG, M.D.

1. Patient Information form, Physician-Arbitration Agreement, and Office Policy must be completed before seeing Dr. Chong.

2. Proof of Payment/Insurance Card and Photo I.D. are required for all patients.

3. We accept the following forms of payment:
   cash, check, VISA, MasterCard, Discover, American Express, Care Credit, and Alphaeon.

4. Charges for laboratory and pathology services are separate and additional. Patients are responsible for these items.

5. A deposit of 20% is required to reserve surgery dates. Once your date has been reserved this deposit is non-refundable and the date cannot be moved or rescheduled without forfeiting your deposit.

6. Returned checks have a $35.00 fee for insufficient funds. For credit cards, there will be a charge (of up to 5% of the original charge) for crediting back funds.

7. The adult accompanying a minor and the parents (or guardians) are responsible for full payment.

8. If you arrive 30 minutes past your scheduled appointment you may be asked to reschedule.

9. Dr. Chong is **NOT** a contracting provider with any insurance companies at this time. As a courtesy to you we will bill any PPO/POS medical plan for insurable medical procedures if authorized by your insurance company. If you plan to seek reimbursement from your insurance company for billable charges, please notify our Practice Administrator at the time of scheduling. **The patient is responsible for the balance in full before the procedure. This does not apply to GNP patients.** Patients seeking treatment from out of network providers are reimbursed at a lesser rate than those using in network providers. If you have any questions, please contact your insurance company.

10. Copies of patient records are available upon request by the patient. A $50 printing fee and any applicable delivery fees may be applied. Color copy fees for photos will be charged by the page. Please allow 72 hours to process any records requests.

11. This office strictly prohibits electronic recording or videotaping of any kind in consideration of the privacy and confidentiality of the physician-patient relationship.

_____	_____	_____
Patient Signature	Date	Patient Printed Name

PLEASE READ CAREFULLY

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean _____.

"Physician" shall be understood to mean **Lavinia K. Chong, M.D.**

I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the Physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the ***American Board of Plastic Surgery.***

I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the ***American Board of Plastic Surgery*** and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and Patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

_____	_____
Physician Signature	Patient Signature
_____	_____
Effective from Date of Treatment	Date of Signature

PRIVACY PRACTICES ACKNOWLEDGEMENT AGREEMENT

ACKNOWLEDGEMENT FORM

Attached you will find a copy of the office's Notice of Privacy Practices. Please sign below acknowledging your receipt of the packet. Read the Agreement thoroughly. If you have any questions please feel free to contact the office.

I have received the Notice of Privacy Practices and/or have been provided an opportunity to read it.

Name _____ Date of Birth _____

Signature _____ Today's Date _____

MUTUAL AGREEMENT TO MAINTAIN PRIVACY

Lavinia K. Chong, M.D. (collectively labeled "*Physician"*) agree to provide treatment to:_____("Patient"). The Physician takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are almost always forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Even after recent Congressional attempts to tighten this restriction, however, there are still loopholes that some medical practices can use to profit from marketing activities. For example, there are exceptions for drugs currently prescribed to the patient and for recommending items or services covered by the patient's health plan. More importantly, there is no prohibition against a physician putting his patient on the spot and asking for permission to allow third parties access to information to market to patients, which could authorize essentially unlimited unwanted marketing information. Even to the extent still allowed, Physician agrees not allow others access to use Patient's medical information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's permission for a third party to market directly to Patient.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Physician has invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about the Physician - his practice, expertise, and/or treatment - on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary. Importantly, Physician agrees to abide by a Code of Internet Ethics. What that means: Physician agrees to enforce no rights enabled by the assignment if Patient's commentary conforms to typical Internet Rating Sites' Terms of Use (such as Google Maps –see http://www.google.com/help/terms_maps_earth.html). Such terms include, as examples, no obscenity, no personal attacks, and the like. To be clear, constructive commentary, even if negative, helps us build a better practice. The Code of Internet Ethics encourages posting of all constructive commentary, good, neutral, and even, negative.

This Agreement shall be in force and enforceable for a period of five years from Physician's last date of service to Patient. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship.

Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

_____ _____

Print Patient's Name Patient's Signature

_____

Date

_____ _____

Physician's Name Physician's Signature

_____

Date

Version 2.0.6T

PATIENT'S RIGHTS & RESPONSIBLITIES

PATIENTS' RIGHTS

- Exercise these rights without regard to sex, cultural, economic, educational, religious background, or the source of payment for care.
- Patients are given equitable, unbiased, considerate, and respectful care.
- Patients are provided appropriate privacy regarding medical records and during interviews, examinations, treatment, and consultation. Medical information will not be released without patient's written consent.
- Patients are given the opportunity to participate in decisions involving their health care.
- Patients are in receipt of sufficient information in advance if feasible, to allow a patient to give informed consent or to refuse any proposed treatment or procedure.
- Patients are provided, to the degree known, complete information concerning their diagnosis, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
- Patient should have knowledge of the name of the physician primarily responsible for care, and the names and roles of any other physicians involved in their care.
- Patients, prior to treatment, are informed of their financial responsibility and are provided with a receipt and explanation of their bill, regardless of source of payment.
- Patients have ability to have their complaints addressed, and to receive an appropriate response.
- Facility should provide information to patients and staff concerning:
    1. Services available at the facility
    2. Provision for after-hour and emergency care
    3. Fees for services and payment policies
    4. Methods for expressing grievances and suggestion to the facility

PATIENTS' RESPONSIBLITES

- Participate in, and follow agreed-upon plan of care.
- Fully participate in decisions involving their own health care.
- Cooperate with physician and ask questions if not understanding instruction or information.
- Provide physician with complete and accurate history about illnesses, hospitalizations, medications, and other matters related to your health.
- Notify facility if there is any problem or dissatisfaction with care or services.
- Treat personnel with respect, consideration, and dignity.
- Give timely notice when canceling an appointment.

_____ _____ _____

Signature Date Printed Name