2121 Main Street, Suite 207
Buffalo, NY 14214

BUFFALO PLASTIC SURGERY
DR. TAMARA B. DAWLI

phone 716.821.2935
info@buffaloplasticsurgery.com

PATIENT INFORMATION

Name:_____Age:_____
DOB:_____ Height: _____ Weight: _____
Marital Status: S/M/W/D Spouse's Name:_____

Home Address:_____
City:_____State:_____Zip Code:_____
Home Telephone:_____
Cell Number:_____
Email Address:_____

You may contact me by: Cell, Home, Phone, Mail, Email, All
(Please Circle all that apply)

Do we have Permission to leave a message on your phone or cellular voice mail YES/ NO

Social Security #: _____
Occupation:_____
Employers Name and Address _____
_____

Person to contact in case of emergency:
Name:_____
Telephone #:_____Relationship:_____

Referred by:_____
Telephone Number:_____

Primary Care Physician:
Name:_____
Telephone Number:_____

Pharmacy Details:
Name:_____
Address:_____
Telephone Number:_____

Insurance Information

Primary Insurance:_____
Members ID Number: _____
Group Name:_____
Primary Subscriber Name:_____
DOB:_____
(If subscriber is other than the patient)

Person Financially Responsible for Patient
Name:_____DOB:_____
Address:_____
Telephone:_____
Email address: _____

Why are you here to see Dr Dawli?
_____

Medications: _____
_____
_____

Allergies: _____
Medical Conditions:_____
_____

Past Surgeries: (Please list ALL surgical procedures and dates)
_____
_____
_____

Do you take, Aspirin, Plavix, Coumadin or any other blood thinner: Yes □ No □
Have you or a family member ever had a problem with anesthesia or bleeding or clotting disorder? Yes □ No □
Do you smoke: No □ Yes □ how many packs a day?:_____
Drug use? _____
Do you drink alcohol on a regular basis: No □ Yes □
If so how much?: _____
Family History
_____

Medical History

Are you in good health?	Yes □ No□
Have you ever had high blood pressure?	Yes □ No□
Have you had any heart disease?	Yes □ No□
Do you have lung disease or asthma?	Yes □ No□
Do you have sleep apnea?	Yes □ No□
Do you have liver disease or Hepatitis?	Yes □ No □
Do you have diabetes?	Yes □ No□
Have you had epilepsy or seizures?	Yes □ No□
Do you have thyroid problems?	Yes □ No□
Do you have any history of cancer?	Yes □ No□
Have you had a hernia?	Yes □ No□
Do you have a history of skin cancer?	Yes □ No□
History of cold sores?	Yes □ No□
Any history of radiation therapy?	Yes □ No□
History of auto-immune diseases?	Yes □ No□
Do you have any history of keloid scarring?	Yes □ No□
History of neurological disorders?	Yes □ No□
Any history of Psychiatric problems?	Yes □ No□
Have you had chest pain or shortness of breath?	Yes □ No□
Do you have a history of kidney problems?	Yes □ No□
Do you have a collagen vascular disease?	Yes □ No□

HIV Status: _____ Hepatitis C Status: _____
WOMEN
Number of pregnancies:____Births:____C-sections:_____
Are you pregnant?Yes □ No□ birth control? Yes □ No□
Are you nursing? Yes □ No□
Date of last mammogram?_____Results?_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's or Guardian's Signature:_____ 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 Tamara Dawli, MD, 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.

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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.

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 Tamara Dawli, MD 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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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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MEDICAL PHOTOGRAPHY

I consent to the taking of photographs by Tamara Dawli, MD, 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. Dawli 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. Dawli 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**: _____

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Assignment of Benefits, Financial Agreement, HIPPA

You will be responsible for paying your annual deductible, co-payments, and charges for any non-covered procedure.

The entire unpaid balance left after payment from your insurance company will be billed to you.

If co-payments and/or deductibles are required by my insurance company, I agree to pay them to Dr. Tamara Dawli.

Returned checks and credit card payments will result in a $20 fee in addition to the outstanding balance.

It is understood that the undersigned and/or patient are primarily responsible for the payment of my bill.

It may become necessary to release your protected health information to financial parties, credit cards entities, banks, and financial companies when requested to facilitate your payment.

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 pf rendered services. If my insurance company is not billed or if my insurance company fails to pay for services or does not pay the claim in full, I understand that I am responsible for payment of charges for services rendered. I authorize the release of any medical information necessary to process my claim. I request that payment of authorized Medicare benefits and other insurance benefits on my behalf to Dr. Tamara Dawli. I authorized any holder of medical information about me to release to the Centers of Medicare and Medicaid Services and its agents and information needed to determine these benefits and benefits payable to related services.

Patient's Name:_____

Relationship to patient: Self or other:_____

Patient's or Guardians Signature: _____Date: _____

NOTICE OF YOUR LEGAL RIGHTS TO MEDICAL INFORMATION AND PRIVACY

Your medical information in this office is used only in specific instances governed by law. Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), patients have certain legal rights to privacy regarding their healthcare information.

Understand that this information is limited to:

- Communication with other medical providers to conduct plan, and participate in the treatment of your healthcare directly or indirectly in emergency and non-emergency situations.
- Conduct normal healthcare operations from insurance companies.

Your medical information will **not** be used for any other purpose unless this office receives written permission from you.
I have read and understand my Notice of Privacy Rights to Medical Information privacy.

Patient's Name:_____

Relationship to patient: Self or other:_____

Signature:_____ Date:_____

BUFFALO PLASTIC SURGERY
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FINANCIAL POLICY

Financing Companies
We have partnered with Care Credit, which offers financing plans for cosmetic patients. Dr. Dawli does not participate in all Care Credit plans. Please consult with the office staff and inquire about which plans are offered.

Cash or Check
Personal check, cashier's check, or cash accepted.

Credit Cards
We accept Visa, American Express, and MasterCard.

Office Consultation Fee
The fee for your comprehensive consultation with Dr. Dawli is $50. The consultation fee is applied toward your procedure should you decide to have a procedure performed by Dr. Dawli.

Scheduling Fee for Cosmetic Surgery
When you schedule your Cosmetic surgery, a non-refundable scheduling fee of $500.00 is required to reserve a date for your surgery. This fee will be applied toward your surgeon's fee.

Surgical Fees
You will receive a copy of the surgical fee schedule which is good for the year it was provided in. It expires at the end of the year. The surgical fee is the fee due to Buffalo Plastic Surgery. It does not cover the anesthesia fees, operating room fee, the cost of prescriptions, or other supplies. You will be charged separately for those items.

Cosmetic Payment Policy
Full payment for surgery is due at the time of your pre-operative appointment, two to three prior to surgery date. This surgical fee is non-refundable. Payment with a personal check, cashiers check, cash, American Express, Visa, or Mastercard is accepted. Please note that a returned or rejected item will incur a $50 processing fee.

If your surgery is canceled due to positive nicotine test, your surgical fee will not be refunded.

Testing Before Surgery
The patient is responsible for lab fees, EKG if required, and pre and post-operative prescriptions. All other follow up office appointments are included in the surgical fee.

Hospital or Facility Fee Costs
Payment of the hospital or facility fee for your cosmetic procedure is also due 2 weeks prior to your procedure. Payment for the hospital or facility fee, where your procedure is performed, is your responsibility. As a courtesy to you, Dr. Dawli may collect and pay the facility directly for you. Any additional hospital or facility fees incurred as a result of any complication, which may arise, are the patient's responsibility.

Anesthesia Fees
Fees for Anesthesia services are also due two weeks prior to your procedure. As a courtesy to you, Dr. Dawli, may collect the anesthesia fee and pay the anesthesiologist directly. The fee is the responsibility of the patient. Any additional anesthesia fees, as a result of any complications, which may arise, are the patient's responsibility.

Revision Policy:
When performing cosmetic surgery, perfection is always our goal. We recognize that sometimes- surgical revisions are necessary to obtain optimal results. When this occurs the patient will be charged for the facility, anesthesia costs, and surgical revision fee of performing the revision.

Insurance Coverage
Please provide us with your current insurance card and notify us of any changes. We will request a copy of your insurance card to copy and keep on file for our records.
Because healthcare benefits and coverage options become increasingly complex, we have developed this policy to help you better understand your responsibilities as a patient. We will do our best to assist you with understanding your proposed treatment and in answering questions related to your insurance claim for reimbursement. Your health insurance policy is a contract between you and your health insurance company. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals and/or pre-authorizations. You should be knowledgeable of any deductibles, copayments and/or coinsurance. If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket expenses, and coverage limits.

Self-Pay-Medically Necessary
Self-pay accounts are patients without insurance coverage and patients covered by insurance plans in which the office does not participate. It is your responsibility to know if our office participates with your plan. Self-pay patients are required to pay at the time of service.

Assignment of Benefits and Responsibility to Pay
I hereby assign all medical and surgical benefits to which I am entitled. I hereby authorize and direct my insurance to issue payment directly to Buffalo Plastic Surgery and Dr. Tamara Dawli for medical services to myself and/or my dependents. I have also read and understand the financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

I acknowledge that I am financially responsible for all charges. By signing this form, I fully understand and agree to the terms and conditions of the Financial Policy of Buffalo Plastic Surgery, Dr. Tamara Dawli.

_____
Patient Name

_____ Date_____Time _____
Patient Signature

_____ Date_____Time _____
Witness