

DR. KIM-CHI VU, M.D., P.C.
Cosmetic Reconstructive and Hand Surgery
9555 SW Barnes Road, Suite 275
Portland, OR 97225
503.297.8555

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can access this information. PLEASE REVIEW CAREFULLY.

Dr. Kim-Chi Vu knows that the information we collect about you and your health is private. Dr. Vu is required by Federal and State law to protect this information. The information in this notice tells you how we may use or disclose information about you. Not all situations are described. We are required to give you notice of our privacy practices regarding the information we collect and keep about you.

Dr. Vu may use and disclose information without your written authorization under the following circumstances:

- Treatment- We may use or disclose information with health care providers who are involved in your treatment or care. Information may be shared to carry out a plan for your diagnosis and treatment.
- Payment- We may disclose information to receive payment or to pay for health care services you receive. Information may be provided to your health plan for billing purposes.
- Appointments and Test Results- We may send you reminders for your medical care and results of medical testing we may order in the course of your treatment.
- State or Federal Requests- We may use and disclose information when required by federal or state law, or by a court order.
- Abuse- Information required by law to report suspected abuse may be disclosed to appropriate government agencies.
- Government Programs- Information for public benefits under government programs, such as Supplemental Security Income (SSI).
- To Avoid Harm- Information to law enforcement agencies to avoid serious threat to the health and safety of persons or the public.
- Family- We may disclose information to your family of others who are involved in your medical care. YOU HAVE THE RIGHT TO OBJECT TO THE SHARING OF INFORMATION IN THIS SITUATION.

Other uses and disclosures require your written authorization. At your request you will be given a Request for Restriction On Use and Disclosure of Health Information form to complete. You may cancel this authorization at any time in writing.

You will be asked to sign acknowledgement of this disclosure. We thank you for your cooperation in protecting your privacy.

DR. KIM-CHI VU – COSMETIC INTEREST QUESTIONNAIRE

Patient Name: _____

What is your reason for your visit today?

Date : _____

Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply.

<input type="checkbox"/> Skin care advice	<input type="checkbox"/> Facial veins	<input type="checkbox"/> Neck wrinkles
<input type="checkbox"/> Skin care products	<input type="checkbox"/> Facial redness	<input type="checkbox"/> Breast size
<input type="checkbox"/> Obagi <input type="checkbox"/> Jane Iredale	<input type="checkbox"/> Brown spots/age spots/freckle	<input type="checkbox"/> Abdominal area
<input type="checkbox"/> Topix <input type="checkbox"/> _____	<input type="checkbox"/> Blotchy skin	<input type="checkbox"/> Buttock/Hips
<input type="checkbox"/> Injectable Treatments	<input type="checkbox"/> Drooping brow	<input type="checkbox"/> Legs
<input type="checkbox"/> (Juvederm/Artifill) Dermal Fillers	<input type="checkbox"/> Drooping eyelids	<input type="checkbox"/> Facial Contouring
<input type="checkbox"/> (Botox) Facial fine lines/wrinkles	<input type="checkbox"/> Nose size or shape	<input type="checkbox"/> Body Contouring
<input type="checkbox"/> (Latisse) Insufficient eyelashes	<input type="checkbox"/> Facial fullness/drooping	<input type="checkbox"/> Unwanted Hair
<input type="checkbox"/> Thin lips	<input type="checkbox"/> Mole removal	<input type="checkbox"/> Extra skin of Labia Minora
<input type="checkbox"/> Chemical peel	<input type="checkbox"/> Scar revision	<input type="checkbox"/> Loss of pleasure during intercourse
<input type="checkbox"/> Make up Product or Lessons		

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		True Age		Older Than
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

How did you hear about us?

<input type="checkbox"/> My physician	Full name:
<input type="checkbox"/> My insurance company provider	Name:
<input type="checkbox"/> The yellow pages	Specify Ad:
<input type="checkbox"/> A friend or family member	Name: <i>Dr. Vu's Patient:</i> Yes No
<input type="checkbox"/> Internet	Website:
<input type="checkbox"/> The Physician/Practice website	Website:
<input type="checkbox"/> Seminar	Date/location:
<input type="checkbox"/> Other	

<input type="checkbox"/> Approval to contact you.	Best phone number to reach you:
<input type="checkbox"/> Approval to send you information on products and services (including special offers)	Email address:

I'm not interested in any additional services provided at this time

↓ For Staff Use Only ↓

Physician / provider : Dr. Kim-Chi Vu	Kristin	Linzy	Patrice	Lisa
<i>Follow-up</i>	<i>Date</i>			<i>Completed by (name)</i>
<input type="checkbox"/> Initial Inquiry/Information Given				
<input type="checkbox"/> Contact in future – give date				
<input type="checkbox"/> Products				Date Sold:
<input type="checkbox"/> Free or Paid consultation				Paid: \$
<input type="checkbox"/> Procedure scheduled				
<input type="checkbox"/> Procedure completed				

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PATIENT INFORMATION

Name _____ MI _____ DOB _____ Age _____

Parent/Guardian if patient is a minor _____

S.S # _____ Male _____ Female _____ Single _____ Married _____

Address _____ City _____ State _____ Zip _____

**May we send correspondence by mail to the above address? (circle) YES / NO*

Home Ph# _____ Cell # _____ Work # _____

**May we leave a message on the above phone numbers? (circle) YES / NO*

Email _____

**Would you like to communicate by email & receive our e-newsletter or promotional emails?
(circle) YES / NO*

CARETAKER/EMERGENCY CONTACT INFORMATION

Name _____

Relationship to you: (circle) Spouse / Friend / Parent / Grandparent / Child

Address _____ City _____ State _____ Zip _____

Phone# _____ Cell # _____ Work # _____

**Do you allow Kim-Chi Vu, MD and Staff to disclose medical information regarding your treatment?
(circle) YES / NO initial _____*

Referred By _____ Phone _____

PCP _____ Phone _____

PLEASE READ AND SIGN BELOW:

AUTHORIZATION FOR RELEASE OF INFORMATION:

I hereby authorize Kim-Chi Vu, MD, PC to release any information requested by my caretaker/emergency contact, insurance company (reconstructive procedures), or to release information to any hospital, laboratory or Technician I may be referred to by this office. I also acknowledge that I have received a copy of the privacy practices.

I hereby consent and authorize examination and treatment by Patrice Worman and such assistant or staff as may be assigned by her.

“To the best of my knowledge I have provided above and on the following page , regarding my medications, past medical history, allergies, and smoking history is accurate, complete and honest. I understand that failure to disclose this information may be detrimental to my condition and treatment and accept responsibility for any omissions.”

A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Relationship: (circle one) Self Parent Guardian

FOR OFFICE USE ONLY
 NEW PATIENT
 ESTABLISHED PATIENT
 CONSULTATION
 REPORT SENT:

PATIENT INTAKE HISTORY

DATE:

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

GYNECOLOGIC HISTORY

	PHYSICIAN'S NOTES
LAST NORMAL MENSTRUAL PERIOD (FIRST DAY):	
AGE PERIODS BEGAN:	
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING):	
NUMBER OF DAYS BETWEEN PERIODS:	
ANY RECENT CHANGES IN PERIODS?	
ARE YOU CURRENTLY SEXUALLY ACTIVE?	
HAVE YOU EVER HAD SEX?	
NUMBER OF SEXUAL PARTNERS (LIFETIME):	
SEXUAL PARTNERS ARE <input type="checkbox"/> MEN <input type="checkbox"/> WOMEN <input type="checkbox"/> BOTH	
PRESENT METHOD OF BIRTH CONTROL:	
HAVE YOU EVER USED AN INTRAUTERINE DEVICE (IUD) OR BIRTH CONTROL PILLS?	
IF YES, FOR HOW LONG?	
WHEN WAS YOUR LAST PAP TEST?	
WHAT WAS THE RESULT?	
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?	
DO YOU DO REGULAR BREAST SELF-EXAMINATIONS?	

PATIENT INTAKE HISTORY (Continued)

OBSTETRIC HISTORY

		NUMBER			NUMBER			NUMBER
PREGNANCIES			ABORTIONS			MISCARRIAGES		
PREMATURE BIRTHS (<37 WEEKS)			LIVE BIRTHS			LIVING CHILDREN		
NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)	COMPLICATIONS?		
1.								
2.								
3.								
4.								
PHYSICIAN'S NOTES ON OBSTETRIC HISTORY:								

CURRENT MEDICATIONS
(including hormones, vitamins, herbs, nonprescription medications)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

FAMILY HISTORY

MOTHER: <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED CAUSE:		AGE:	FATHER: <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED CAUSE:		AGE:
SIBLINGS: NUMBER LIVING:		NUMBER DECEASED:	CAUSE(S)/AGE(S):		
CHILDREN: NUMBER LIVING:		NUMBER DECEASED:	CAUSE(S)/AGE(S):		
ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET		PHYSICIAN'S NOTES	
DIABETES	<input type="checkbox"/>				
STROKE	<input type="checkbox"/>				
HEART DISEASE	<input type="checkbox"/>				
BLOOD CLOTS IN LUNGS OR LEGS	<input type="checkbox"/>				
HIGH BLOOD PRESSURE	<input type="checkbox"/>				
HIGH CHOLESTEROL	<input type="checkbox"/>				
OSTEOPOROSIS (WEAK BONES)	<input type="checkbox"/>				
HEPATITIS	<input type="checkbox"/>				
HIV/AIDS	<input type="checkbox"/>				
TUBERCULOSIS	<input type="checkbox"/>				
BIRTH DEFECTS	<input type="checkbox"/>				
DRINKING OR DRUG PROBLEMS	<input type="checkbox"/>				
BREAST CANCER	<input type="checkbox"/>				
COLON CANCER	<input type="checkbox"/>				
OVARIAN CANCER	<input type="checkbox"/>				
UTERINE CANCER	<input type="checkbox"/>				
MENTAL ILLNESS/DEPRESSION	<input type="checkbox"/>				
ALZHEIMER'S DISEASE	<input type="checkbox"/>				
OTHER	<input type="checkbox"/>				

PATIENT INTAKE HISTORY (Continued)

SOCIAL HISTORY

	YES	NO	PHYSICIAN'S NOTES
EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:	<input type="checkbox"/>	<input type="checkbox"/>	
ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK:	<input type="checkbox"/>	<input type="checkbox"/>	
RECREATIONAL DRUG USE	<input type="checkbox"/>	<input type="checkbox"/>	
SEAT BELT USE	<input type="checkbox"/>	<input type="checkbox"/>	
REGULAR EXERCISE: HOW LONG AND HOW OFTEN?	<input type="checkbox"/>	<input type="checkbox"/>	
DAIRY PRODUCT INTAKE/CALCIUM SUPPLEMENTS: QUANTITY	<input type="checkbox"/>	<input type="checkbox"/>	
HEALTH HAZARDS AT HOME OR WORK?	<input type="checkbox"/>	<input type="checkbox"/>	
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE?	<input type="checkbox"/>	<input type="checkbox"/>	

PERSONAL PROFILE

SEXUAL ORIENTATION: <input type="checkbox"/> HETEROSEXUAL <input type="checkbox"/> HOMOSEXUAL <input type="checkbox"/> BISEXUAL
MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> LIVING WITH PARTNER <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
NUMBER OF LIVING CHILDREN:
NUMBER OF PEOPLE IN HOUSEHOLD:
SCHOOL COMPLETED: <input type="checkbox"/> HIGH SCHOOL <input type="checkbox"/> SOME COLLEGE/AA DEGREE <input type="checkbox"/> COLLEGE <input type="checkbox"/> GRADUATE DEGREE <input type="checkbox"/> OTHER
CURRENT OR MOST RECENT JOB:
TRAVEL OUTSIDE THE U.S.? LOCATION:

PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
ASTHMA		<input type="checkbox"/>	<input type="checkbox"/>	
PNEUMONIA/LUNG DISEASE		<input type="checkbox"/>	<input type="checkbox"/>	
KIDNEY INFECTIONS/STONES		<input type="checkbox"/>	<input type="checkbox"/>	
TUBERCULOSIS		<input type="checkbox"/>	<input type="checkbox"/>	
SEXUALLY TRANSMITTED DISEASE		<input type="checkbox"/>	<input type="checkbox"/>	
HIV/AIDS		<input type="checkbox"/>	<input type="checkbox"/>	
HEART ATTACK/PROBLEMS		<input type="checkbox"/>	<input type="checkbox"/>	
DIABETES		<input type="checkbox"/>	<input type="checkbox"/>	
HIGH BLOOD PRESSURE		<input type="checkbox"/>	<input type="checkbox"/>	
STROKE		<input type="checkbox"/>	<input type="checkbox"/>	
RHEUMATIC FEVER		<input type="checkbox"/>	<input type="checkbox"/>	
BLOOD CLOTS IN LUNGS OR LEGS		<input type="checkbox"/>	<input type="checkbox"/>	
EATING DISORDERS		<input type="checkbox"/>	<input type="checkbox"/>	
COLLAGEN VASCULAR DISEASE (LUPUS)		<input type="checkbox"/>	<input type="checkbox"/>	
CHICKENPOX		<input type="checkbox"/>	<input type="checkbox"/>	
CANCER		<input type="checkbox"/>	<input type="checkbox"/>	
REFLUX/HIATAL HERNIA/ULCERS		<input type="checkbox"/>	<input type="checkbox"/>	
DEPRESSION/ANXIETY		<input type="checkbox"/>	<input type="checkbox"/>	
ANEMIA		<input type="checkbox"/>	<input type="checkbox"/>	
BLOOD TRANSFUSIONS		<input type="checkbox"/>	<input type="checkbox"/>	
SEIZURES/CONVULSIONS/EPILEPSY		<input type="checkbox"/>	<input type="checkbox"/>	
BOWEL PROBLEMS		<input type="checkbox"/>	<input type="checkbox"/>	
GLAUCOMA		<input type="checkbox"/>	<input type="checkbox"/>	
CATARACTS		<input type="checkbox"/>	<input type="checkbox"/>	
ARTHRITIS/JOINT PAIN/BACK PROBLEMS		<input type="checkbox"/>	<input type="checkbox"/>	
BROKEN BONES		<input type="checkbox"/>	<input type="checkbox"/>	
HEPATITIS/YELLOW JAUNDICE/LIVER DISEASE		<input type="checkbox"/>	<input type="checkbox"/>	
THYROID DISEASE		<input type="checkbox"/>	<input type="checkbox"/>	

PATIENT INTAKE HISTORY (Continued)

REVIEW OF SYSTEMS (Continued)

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
2. EYES				
DOUBLE VISION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SPOTS BEFORE EYES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
VISION CHANGES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
GLASSES/CONTACTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. EAR, NOSE, AND THROAT				
EARACHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
RINGING IN EARS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HEARING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SINUS PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SORE THROAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MOUTH SORES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DENTAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. CARDIOVASCULAR				
PAINFUL BREATHING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHEST PAIN OR PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DIFFICULTY BREATHING ON EXERTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SWELLING OF LEGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
RAPID OR IRREGULAR HEARTBEAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. RESPIRATORY				
WHEEZING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SPITTING UP BLOOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHRONIC COUGH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. GASTROINTESTINAL				
FREQUENT DIARRHEA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BLOODY STOOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NAUSEA/VOMITING/INDIGESTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CONSTIPATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INVOLUNTARY LOSS OF GAS OR STOOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. GENITOURINARY				
BLOOD IN URINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PAIN WITH URINATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
STRONG URGENCY TO URINATE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FREQUENT URINATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INCOMPLETE EMPTYING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INVOLUNTARY/UNINTENDED URINE LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
URINE LOSS WHEN COUGHING OR LIFTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ABNORMAL BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PAINFUL PERIODS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PREMENSTRUAL SYNDROME (PMS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PAINFUL INTERCOURSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FIBROIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INFERTILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DES EXPOSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ABNORMAL VAGINAL DISCHARGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. MUSCULOSKELETAL				
MUSCLE WEAKNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

PATIENT INTAKE HISTORY (Continued)

REVIEW OF SYSTEMS (Continued)

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
B. MUSCULOSKELETAL (Continued)				
MUSCLE OR JOINT PAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9a. SKIN				
RASH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SORES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DRY SKIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MOLES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9b. BREASTS				
PAIN IN BREAST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NIPPLE DISCHARGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
LUMPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. NEUROLOGIC				
DIZZINESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NUMBNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TROUBLE WALKING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SEVERE MEMORY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FREQUENT OR SEVERE HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I 1. PSYCHIATRIC				
DEPRESSION OR FREQUENT CRYING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SEVERE ANXIETY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. ENDOCRINE				
HAIR LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HEAT/COLD INTOLERANCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ABNORMAL THIRST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HOT FLASHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. HEMATOLOGIC/LYMPHATIC				
FREQUENT BRUISES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CUTS DO NOT STOP BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ENLARGED LYMPH NODES (GLANDS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. ALLERGIC/IMMUNOLOGIC				
MEDICATION ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
IF ANY, PLEASE LIST ALLERGY AND TYPE OF REACTION:				
OTHER ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PLEASE LIST ALLERGY AND TYPE OF REACTION:				
FORM COMPLETED BY: <input type="checkbox"/> PATIENT <input type="checkbox"/> OFFICE NURSE <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> OTHER:				
SIGNATURE OF PATIENT:				
DATE REVIEWED BY PHYSICIAN WITH PATIENT:			PHYSICIAN SIGNATURE:	
ANNUAL REVIEW OF HISTORY				
DATE REVIEWED:			PHYSICIAN SIGNATURE:	
DATE REVIEWED:			PHYSICIAN SIGNATURE:	
DATE REVIEWED:			PHYSICIAN SIGNATURE:	
DATE REVIEWED:			PHYSICIAN SIGNATURE:	

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COSMETIC PHOTOGRAPHY CONSENT

I consent to the taking of photographs of video tapes of me or parts of my body, by Dr Vu or her designee, in connection with the following plastic surgery procedure(s) _____ to be performed by Dr Vu. I further consent to the release by Dr vu to the American Society for Aesthetic Plastic Surgery, Inc. (“ASPS”) of such photographs, videotapes or case histories.

I understand that such photographs, videotapes or case histories may be published by Dr Vu and/or ASAPS and/or any party acting under their license and authority in any print, visual or electronic media including, but not limited to, medical textbooks and journals, scientific presentations, 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 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 Dr Vu.

I understand that the information disclosed, or some portion thereof, may be protected by the state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (“HIPPA”). I further understand that, because ASPS 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 and may be re-disclosed by ASPS.

I release and discharge Dr Vu, ASPS, and all parties acting under their license and authority from all rights that I may have in photographs, videotapes or case histories and 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 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.

Signature/Date

Witness/Physician

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PAYMENT POLICY
LASER VAGINAL REJUVINAIION SURGERY

Thank you for allowing us to provide the services you desire in cosmetic and reconstructive surgery. As part of cosmetic surgery, our policy is that payment in full is due prior to commencement of surgery. The following guidelines have been set to allow you to fully understand our policy. We are committed to you to assist you in anyway to make your surgery as comfortable as possible. Please read the following outlines and initial each statement to acknowledge that you have read our guidelines. Please do not hesitate to ask us if you have any questions, as we hope to make your surgery as favorable as possible so that we may continue to provide the services that you may desire. Thank you.

- *All cosmetic consultations are \$50.00, nonrefundable.*

- *You will be provided with a written estimate of fees at your consultation. The quote will include surgeon's fee, operating room fee, and anesthesia fee. This estimate is subject to change, since we do not have control over the fees for operating room and anesthesia. Once you have decided to proceed with surgery confirmation of fees from the facility and anesthesiologist will be confirmed. Fees for additional items which may include but not limited to hospital stay, implants, garments, cosmetic insurances, pain pump are not included in the fee quote and may be billed separately. Post surgical recovery and autologous blood, if needed, are not included in this quote.*

- *After scheduling your surgery date, you will be scheduled for a preoperative visit prior to surgery. At that time, we ask that you pay the remaining balance on your account.*

- *If an EKG, lab work or pathology report is found to be medically necessary before or after your surgery it will be billed separately by the hospital or laboratory. *Post surgical recovery and autologous blood, if needed, are not included in the fee quote.*

- *We are not responsible for the operating room fee, facility fee, and anesthesia fee, but it is included in the estimated quote. It is your responsibility to set up payment arrangements with them or we will be more than willing to disburse the funds on your behalf, whichever you prefer.*

- *Prescription medications vary from patient to patient; they are a separate expense and are not included in the quote. Your health insurance will typically pick up these expenses with your routine co-pay.*

- *If reversionary procedures are deemed necessary, a surgeon's fee may apply depending on each individual case; however the cost of the operating room, facility, supplies and anesthesia would be your responsibility.*

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- *There will be a \$500.00 scheduling fee due upon the time you decide to schedule your surgery, which will be applied to Dr. Vu's surgeon fee. If you need to reschedule there will be an additional nonrefundable fee of \$250.00. If you cancel your surgery within ten (10) business days before your surgery you will be charged 25% of the surgeon's fee. If your surgery is cancelled before 10 business days, we will refund your money minus the original \$500 deposit fee. Please understand that such changes affect not only your surgeon, the surgical facility, the anesthesiologist, but other patient as well.*

- *We do have Financing Programs available to assist you with paying for your surgery. If you wish to have more information, please do not hesitate to ask us, for we will gladly provide you with the proper information.*

- *Payment for Botox, injectable fillers, Thermage, microdermabrasion ,or laser in clinic is paid in full on the day of your procedure.*

- *There will be a \$50.00 charge for all returned checks.*

- *Skin care products purchased are nonrefundable, unless there is a legitimate contamination or tampering of the product.*

- *Procedures purchased as package treatment programs are at a discounted rate, and must be paid in full at the time of your first treatment. Should you decide to cancel your treatments at any time during your treatment package program, then each treatment session performed will be charged at the individual treatments full price and any remaining balance will be refunded back to you.*

- *You will be directly billed for all services provided. If you do not pay the patient balance within 30 days after receiving the initial statement, we will contact you to establish a payment plan.*

- *After 60 days, if we have not received payment form you or been contacted about payments, your bill will be submitted to a collection agency or small claims court, depending on the amount due.*

- *All outstanding balances will have a reoccurring administrative fee of \$7.50 per month. You are able to dispute the charges after the entire principal balance is paid in full, but it is on a case by case basis. Please speak to your billing representative for further questions.*

- *There will also be a \$25.00 collection fee if account gets transferred into collection agency.*

DR. KIM-CHI VU, M.D., P.C.
Cosmetic Reconstructive and Hand Surgery
9555 SW Barnes Road, Suite 275
Portland, OR 97225
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AGREEMENT AS TO RESOLUTION OF CONCERNS

“I”, “Patient/Guardian” shall be understood to mean _____.
Patient Name

“Physician” shall be understood to mean Kim-Chi Vu, MD.

I understand that I am entering into a contractual relationship with the 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 Society of Plastic Surgeons.

I agree the expert will be obligated to adhere to the guidelines or code of conduct defined by the American Society of Plastic Surgeons.

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 his/her counsel shall have the right and be free to depose the other party’s expert witness(es) at least 120 days before any scheduled trial date.

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

Physician

Patient/Guardian

Effective from Date of Treatment:

Date of Signature

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MUTUAL AGREEMENT TO MAINTAIN PRIVACY

Kim-Chi Vu, MD, PC agree to maintain Privacy of _____ as outlined in
Patient name

the HIPAA form. The Physician takes pride in being able to extend a greater degree of privacy than is required by HIPAA, state confidentiality mandates, and common law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, HIPAA forbids physicians from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician believes this is improper and may not be in the patients' best interest. Accordingly, Physician agrees not to provide any list for marketing or be paid for selling patient lists or protected health information to any party for the purpose of marketing directly to patients. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

In consideration for treatment and the above noted patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Physician and his practice, expertise and/or treatment unless explicitly mandated by law. Publishing is intended to include attribution by name, by pseudonym, or anonymously. Physician has invested significant financial and marketing resources in developing the practice. In addition, Patient will not denigrate, defame, disparage, or cast aspersions upon the Physician; and (ii) will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in any such activity. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage Physician's practice.

Physician feels strongly about Patients' privacy as well as the practices' right to control its public image and privacy. Both Physician and Patient will work to prevent the publishing or airing of commentary about the other party from being accessed via Internet, blogs, or other electronic, print, or broadcast media without prior written consent. Finally, 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 to Maintain Privacy 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. In addition to compensation for consequential damages, 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.

Patient Name

Date

COSMETIC INSURANCE POLICY

*Disclaimer: This form was solely provided to you as a courtesy.
We do not bill insurance of any kind for these procedures.*

1. Contact your insurance pre-authorization department and determine if this procedure requires pre-authorization. The number is located on the back of your insurance card.

ICD-9 Code: _____

CPT Code: _____

2. If it is determined that pre-authorization is necessary, ask your insurance what documentation is needed to support your case in medial review.
3. Contact our office and sign a medical release form. We will then provide you with the necessary documents you need to move forward.
4. If approved and you choose to submit your insurance to the facility and anesthesiologist you will be responsible for those fees if your insurance denies payment.
5. After surgery, our office will supply you with the operative report. This will aid you in filling a claim for the % amount your insurance allows towards your reimbursement for Dr. Vu's fees.

NOTES:

Signature of Patient

Date

COSMETIC SURGERY SCHEDULING FORM

Patient Name: _____ DOB: _____

Consult Appt: _____ Date of Surgery Scheduled: _____ By: _____

Preop Date Appt: _____ Post OP Date: _____ Ambassador (s): _____

PROCEDURE(S):

Surgery Date: _____ Check-In Time: _____ Surgery Time: _____

Location: TOPS ___ Tuality Main OR ___ St. Vincent ___ Good Sam ___ Other ___

Implants: Saline ___ Gel ___ Size ___ Date Ordered: ___ BIFS ___

CosmetAssure Input Date: _____

Garment Measurement: _____ Garment Ordered: _____

COSMETIC CHARGES:

Consult Fee: _____ Date Paid: _____

Deposit: _____ Date Paid: _____

Total Charge: _____

Balance due @ Preop: _____ Date Due: _____

PAID IN FULL DATE: _____

Anesthesiologist Payment Date/amt: _____ Operating Rm Payment Date/amt: _____

List Pre-OP Folder

- Ambassador
- Consent
- Surgery Center H&P/Consent Forms
- Lab Req
- RX
- Post-op Appt
- Directions to Surgery Center (check in time & surgery instructions)
- Cosmet Assure