The Vu Center for Plastic and Hand Surgery, PC | Dr. Kim-Chi Vu
15390 NW Cornell Road Suite 222, Beaverton, OR 97006 | P: 503-601-2910 F: 503-601-2914

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 The Vu Center 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 herby authorize The Vu Center for Plastic and Hand Surgery, PC to release any information requested by my caretaker/emergency contact, insurance company (reconstructive procedures), or to release information to any hospital, laboratory or physician 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 Dr. Kim-Chi Vu 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

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PATIENT HISTORY

Patient Name: _____ **Date of Birth**:_____
Date of Visit: _____ **Reason for Visit**: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS, IF SO WHAT?

_____

ARE YOU TAKING ANY MEDICATION? *PLEASE LIST MEDICATION NAMES AND DOSAGES*

1. _____ **3.** _____
2. _____ **4.** _____

CURRENT HEIGHT: _____ **WEIGHT:** _____

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?

	Yes	No		Yes	No
Anxiety/depression	___	___	HIV/AIDS	___	___
Bleeding disorder/clots	___	___	Hypertension	___	___
Cancer	___	___	Kidney disease	___	___
Diabetes	___	___	Liver disease	___	___
GI bleeding	___	___	Lung disease/Asthma/COPD	___	___
Hepatitis	___	___	Seizures	___	___
Sleep apnea	___	___	Stroke	___	___
Heart disease/attack	___	___			

If you have any **heart conditions**, who is your cardiologist? _____
Any recent **EKG** performed? Date and location: _____
Any other medical conditions? _____
If female: date of last menstrual period_____ Any possibility of pregnancy?_____

HAVE YOU HAD ANY SURGERY IN THE PAST? *PLEASE LIST SURGERY TYPE AND DATE*

1. _____ **3.** _____
2. _____ **4.** _____

ANY PROBLEMS WITH ANESTHESIA IN THE PAST? Yes or No
If yes, explain: _____

DO ANY OF YOUR FAMILY MEMBERS HAVE ANY OF THE FOLLOWING?
PLEASE INDICATE WHICH FAMILY MEMBER & IF MATERNAL OR PATERNAL RELATIVE

1. Bleeding disorder/clots_____ **4.** Heart disease_____
2. Cancer_____ **5.** Hypertension_____
3. Diabetes_____ **6.** Kidney disease_____
Any other medical conditions? _____

SOCIAL HISTORY

Smoke? How much?_____ Type of work you do:_____
Alcohol? How much? _____ Hobbies: _____
Recreational drug use? _____ Married or single? _____
(marijuana, methamphetamines, etc.)

DO YOU HAVE ANY RECENT SYMPTOMS OF THE FOLLOWING?

1. Fever/chills	yes/no	8. Heartburn	yes/no
2. Rashes/sores	yes/no	9. GI bleeding	yes/no
3. Nasal congestion/sore throat	yes/no	10. Body/joint pain	yes/no
4. Chest pain	yes/no	11. Headache	yes/no
5. Cough/shortness of breath	yes/no	12. Dizziness/fainting	yes/no
6. Swollen lymph nodes	yes/no	13. Anxiety/depression	yes/no
7. Nausea/vomiting	yes/no		

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PHOTO CONSENT FORM

FOR MEDICAL RECORD:

Patient understands that photographs will be taken before, during, and after Patient's procedure(s) as a routine part of medical care. Patient understands that these photographs will become part of the medical record which will remain the property of Dr. Kim-Chi Vu ("Dr. Vu") and The Vu Center for Plastic and Hand Surgery, P.C. ("The Vu Center") and will be kept strictly confidential as Protected Health Information. Patient authorizes Dr. Vu and The Vu Center and their representatives to take photographs of Patient to be used and disclosed in relation to Patient's medical care, including but not limited to the following circumstances: treatment; billing and payment; insurance purposes; appointments and test results; requests by any governmental body or agency; requests by medical providers; to report abuse; to comply with any state or federal law, regulation or rule; to avoid harm; and/or pursuant to authorized written requests. By signing below, Patient understands that Patient may revoke this consent at any time, in writing (not by e-mail, text message, or other electronic forms of communication), but that such revocation will have no effect on any actions taken prior to the date that revocation is received by Dr. Vu and The Vu Center.

*****TO BE SIGNED ELECTRONICALLY AT THE TIME OF YOUR APPOINTMENT*****

CONSENT TO ADDITIONAL USES OF PHOTOGRAPHS

In addition to the MEDICAL RECORD, Patient agrees and authorizes Dr. Vu and The Vu Center to use and disclose photographs of Patient to be used and disclosed in relation to the following:

Note: The Vu Center does not disclose any Patient's name. Patient can request to have their face removed from photographs if applicable.

PHOTO ALBUM

Photographs of Patient may be used and disclosed by Dr. Kim-Chi Vu ("Dr. Vu") and The Vu Center For Plastic And Hand Surgery, P.C. ("The Vu Center") for the purpose patient education and information, including but not limited to their use during patient consultations in a "photo album" to inform patients about plastic surgery procedures and methods, provided Patient will not be identified by name or date of birth. By initialing this paragraph and signing below, Patient agrees to waive any and all claims and rights relating to the use of these photographs as described herein, including but not limited to any claims for remuneration. Patient further agrees to release and discharge Dr. Vu and The Vu Center, their employees, and any facility in which Patient's medical procedure(s) were performed, from any and all claims or actions that Patient has or may have relating to their use as described herein. Patient understands that Patient may revoke this consent at any time, in writing (not by e-mail, text message, or other electronic forms of communication), but that such revocation will have no effect on any actions taken prior to the date that revocation is received by Dr. Vu and The Vu Center.

WEBSITE

Photographs of Patient may be used and disclosed by Dr. Vu and The Vu Center on their internet website for to educate and inform the public about plastic surgery procedures and methods, provided Patient will not be identified by name or date of birth. By initialing this paragraph and signing below, Patient agrees to waive any and all claims and rights relating to the use of these photographs as described herein, including but not limited to any claims for remuneration. Patient further agrees to release and discharge Dr. Vu and The Vu Center, their employees, and any facility in which Patient's medical procedure(s) were performed, from any and all claims or actions that Patient has or may have relating to their use as described herein. Patient understands that Patient may revoke this consent at any time, in writing (not by e-mail, text message, or other electronic forms of communication), but that such revocation will have no effect on any actions taken prior to the date that revocation is received by Dr. Vu and The Vu Center.

MEDICAL EDUCATION

Photographs of Patient may be used and disclosed by Dr. Vu and The Vu Center for the purpose of medical education and training, including but not limited to their publication in medical websites, medical journals and medical textbooks, provided Patient will not be identified by name or date of birth. By initialing this paragraph and signing below, Patient agrees to waive any and all claims and rights relating to the use of these photographs as described herein, including but not limited to any claims for remuneration. Patient further agrees to release and discharge Dr. Vu and The Vu Center, their employees, and any facility in which Patient's medical procedure(s) were performed, from any and all claims or actions that Patient has or may have relating to their use as described herein. Patient understands that Patient may revoke this consent at any time, in writing (not by e-mail, text message, or other electronic forms of communication), but that such revocation will have no effect on any actions taken prior to the date that revocation is received by Dr. Vu and The Vu Center.

ALL MEDIA

Photographs of Patient may be used and disclosed by Dr. Vu and The Vu Center in any print or broadcast media, including but not limited to any and all print media, internet media, broadcast media, pamphlets, and presentations, in order to inform the public about plastic surgery procedures and methods. By initialing this paragraph and signing below, Patient agrees to waive any and all claims and rights relating to the use of these photographs as described herein, including but not limited to any claims for remuneration. Patient further agrees to release and discharge Dr. Vu and The Vu Center, their employees, and any facility in which Patient's medical procedure(s) were performed, from any and all claims or actions that Patient has or may have relating to their use as described herein. Patient understands that Patient may revoke this consent at any time, in writing (not by e-mail, text message, or other electronic forms of communication), but that such revocation will have no effect on any actions taken prior to the date that revocation is received by Dr. Vu and The Vu Center.

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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. **PLEASE KEEP FOR YOUR RECORDS.**

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.
- Responsibility – Your healthcare is your own. We encourage you to ask questions and take responsibility for your health and healing.
- Release of Information – If you request we submit Dr. Vu's notes to a third party other than another a physician's office we require that you sign a release.
- Request for Restriction on Use and Disclosure – If you have a restriction you wish The Vu Center to be aware of we will provide you with a form to sign. Please see a staff member.

Other uses and disclosers require your written authorization. At your request you will be given a Request fro Restriction. 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.

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MUTUAL AGREEMENT TO MAINTAIN PRIVACY

Kim-Chi Vu, MD, PC agree to maintain Privacy of _____ (PATIENT NAME) as outlined in 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.

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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.

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COSMETIC PAYMENT POLICY

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. We require a credit card to hold all consultations. If you need to cancel your consultation you must do so 24 hours prior to your appointment. If you cancel without giving the office 24 hour notice your card will be charge a nonrefundable fee of $75. If you do not arrive to your consultation and you do not call your card will be charged a $75 nonrefundable fee.*

- *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. Pre/post lab work, 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.* ***We accept all major credit cards.*** *We also accept CareCredit, Cash, Check and Money Order.*

- *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. Pre/Post lab work, surgical recovery - 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.*

- *We offer interest free payment plan options to all of our patients. You have a choice of a 3 or 6 month payment plan.* ***Your surgery must be paid off before you may have it performed****. There will be a $500 nonrefundable scheduling fee due upon the time you schedule and enter into a payment plan agreement.*

- *Within this payment plan agreement, if you need to reschedule there will be an additional nonrefundable fee of $250.00. You have (10) business days from the day you enter into a payment plan agreement to cancel and you will be refunded all money minus the original $500 deposit. This deposit will be held for you for one year at which time you may use only towards another surgery. If you cancel your surgery after this period you will be charged 15% of the amount collected up until that point, not including the $500 deposit.*

- *CANCELATION POLICY: All of our patients who cancel appointments or surgeries do so for legitimate, honest reasons such as a death in the family, illness of a child, loss of job, etc. Nonetheless, Dr. Vu's time is valuable thus we must uphold our policy evenly and across-the-board without judging whether one patient's reason for cancellation is more valid than another's.*

- *There will be a $500.00 nonrefundable 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. This deposit will be held for you for one year at which time you may use only towards another surgery. Please understand that such changes affect not only your surgeon, the surgical facility, the anesthesiologist, but other patients as well.*

- *We do have Financing Programs available to assist you with paying for your surgery. If you wish to learn more we will gladly provide you with the proper information. We accept certain plans with Care Credit, Medical Financing and Chase Health Advance. These options of payment are only accepted when paying full price for surgeries.*

- *We occasionally have specials on our cosmetic surgeries and treatments. If there is a surgery you are interested in that is currently on special you may only pay with credit card, check or cash. We will not accept payments from third party financing companies for surgeries on special. We also do not accept American Express.*

- *Payment for Botox, injectable fillers, products, 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.*

- *An administration fee may be applied to the surgeon's fee due at your pre operative appointment when paying in any form other than cash or check. The administrative fee is a percentage and will be determined at your consultation.*

- *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.*

- *If we feel our patient is not physically or mentally ready or prepared to undergo a surgical procedure we reserve the right to cancel the surgery or refuse to schedule.*

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The Vu Center for Plastic and Hand Surgery, PC does not bill any insurance for these procedure and/or services.

I, _____(patient name), have read the above COSMETIC PAYMENT POLICY and guidelines. By signing electronically for this COSMETIC PAYMENT POLICY, I understand and will comply to my cosmetic financial responsibilities. I understand that no cosmetic procedure, under any circumstance, will be billed to my insurance by The Vu Center for Plastic and Hand Surgery, PC or Dr. Kim-Chi Vu.

By signing this waiver I also acknowledge that The Vu Center for Plastic and Hand Surgery, PC has advised me not to submit a bill on my own to my insurance in any way. I agree to be personally responsible for paying the financial charges for any cosmetic services, treatments or procedures I have.

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