

Tamir Mosharrafa, M.D., P.C.
Aesthetic Plastic and Reconstructive Surgery
3301 North Second Street
Phoenix, Arizona 85012
www.experiencethebestofyou.com

Telephone
(602) 230-1464
FAX
(602) 230-1465

Cosmetic Consultation Form

PATIENT INFORMATION

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Age: _____ Sex: M F

Email Address: _____
(We will not give out your email address, it is for our own use)

Would you like to receive emails to inform you
about upcoming specials and events? YES NO

Home Phone: _____
May we leave a message at this number? YES NO

Work Phone: _____ Ext: _____
May we leave a message at this number? YES NO

Cell / Pager: _____
May we leave a message at this number? YES NO

Please list the names of people we may leave messages with:
(you may write "None" or "All")

Your Occupation: _____

Emergency Contact: _____

Phone: _____ Relationship: _____

Procedure(s) you are considering:

Height: _____ Weight: _____

Patient Signature: _____ Date: _____

MEDICAL HISTORY

Please list all medications you are currently taking:
(including non-prescription i.e. vitamins, herbal or diet pills)

Do you smoke? Y N Have you ever? Y N

How often? _____

Do you have any medical problems? _____

Please list any surgeries you have had: _____

Please list any medication allergies: _____

Are you allergic to Latex? Yes No

ADDITIONAL INFORMATION

How did you hear about Dr. Mosharrafa?

Patient Referral: Name: _____

Dr. Referral: Name: _____

Publication: Phoenix Magazine

Internet: lookingyourbest.com

implantinfo.com

Internet Search

ACKNOWLEDGMENT OF PRIVACY PRACTICES

Tamir Mosharrafa, M.D., PC
3301 N 2nd Street
Phoenix, Arizona 85012
(602) 230-1464 ° (602) 230-1465

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my healthcare services.
- Conduct normal healthcare operations such as quality assessment and improvement activities.

I have been informed of my healthcare provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my healthcare provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgment:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our *Notice of Privacy Practices* due to the following reason:

- | | |
|--|---|
| <input type="checkbox"/> The patient refused to sign | <input type="checkbox"/> Communication barriers |
| <input type="checkbox"/> Emergency situation | <input type="checkbox"/> Other _____ |

FINANCIAL TERMS AND POLICIES FOR COSMETIC SURGERY

Payment for Surgical Procedure:

Full payment at the time of scheduling is preferred, however a **non-refundable deposit of \$500** will reserve the scheduled day and time you have selected.

If you are scheduling within three weeks of your procedure, 50% of the fee is necessary at the time of scheduling.

Balance of all surgical fees (surgical facility and anesthesia costs included) is due **two weeks** prior to your scheduled surgery date.

Patient Initials

Cancellation Policy

Cancellation of a scheduled surgery must be done two (2) weeks prior to your scheduled surgery date. Dr. Mosharrafa's office reserves the right to retain 50% of the surgical procedure fees paid. This will be re-applied when the surgery is rescheduled. ***This portion is non-refundable if surgery is not rescheduled.***

Surgical Facility Cancellation Policy

If a patient cancels their surgery within 3 business (working) days of the scheduled surgery time, 50% of all surgical facility fees will be forfeited. If a patient cancels their surgery within 24 hours of the scheduled surgery time, 100% of the surgical facility fees will be forfeited. A patient may reschedule or cancel a second time without penalty (outside of the 3 business days). If they reschedule a third time, they will be charged a non-refundable scheduling fee of \$75.00.

Patient Initials

Revision Policy

Dr. Mosharrafa performs medically necessary revisions for up to one (1) year from the original date of surgery. Dr. Moharrafa's fee will be 10% of the initial surgery cost with a minimum of \$500 per revision. The revision fee does not include additional expenses for equipment such as, but not limited to; garments and implants. In addition, anesthesia and facility fees will apply.

This policy **does not apply** to breast enhancement patients that choose to increase or decrease the current implant size following their original surgical procedure. Normal surgical fees will be required.

I fully understand and agree with the above terms and policies.

Patient Signature

Date

Staff Initials

PHOTOGRAPHIC RELEASE AND CONSENT
FOR

Tamir Mosharrafa, M.D. and the specialists under the supervision of
Tamir Mosharrafa, M.D.; or within the practice of Tamir Mosharrafa,
M.D., P.C.
3301 North 2nd Street
Phoenix, Arizona 85012

I understand and accept that I might be recognized from my likeness or case history. Nevertheless, I authorize my plastic surgeon to take before and post-recovery pictures. *I understand that my face will not be shown in either my before or post-recovery pictures and that I am entitled to a copy of my before and post-recovery pictures.

**Does not include facelift, browlift, blepharoplasty, rhinoplasty, or patients treated with Botox®; skin care center or Collagen® patients.*

Please provide your initials next to each section you agree with and approve:

_____ I found it very helpful having an array of photographs to look at during my consultation; therefore, in order to assist my plastic surgeon with the education of future patients, I hereby authorize the use of my photographs for patient educational purposes.

_____ I authorize the use of my photographs, videotapes and case information for other educational settings, including lectures and multi-media presentations for an audience of medical professionals, at which members of the press may be present, and medical, scientific journal articles.

_____ I authorize my plastic surgeon to use my pre-operative and post-operative photographs in the following commercial/educational settings; magazine, newspaper articles, and television productions, that my plastic surgeon is involved in, my plastic surgeon's personal web site or web page.

_____ I also authorize my plastic surgeon's professional association, the not-for-profit **American Society for Aesthetic Plastic Surgery**, to use my photographs and case information in fulfilling its mission of public education, in any of the following settings: patient education brochures available for purchase; educational videotapes available for purchase; lectures and slide presentations available for purchase; information submitted by the society for periodicals, magazines and web sites for press or internet publication; television programs about plastic surgery; and case studies presented on the Society's web site at www.surgery.org.

_____ Print Name

_____ Patient Signature

_____ Date