

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: **treatment, payment and health care operations.**

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may 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.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this Notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or filing a complaint, please contact the following federal agency:

U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

PATIENT REGISTRATION FORM

Today's Date:		Patient Date of Birth:	
PATIENT INFORMATION:			
Name:		Age:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
Address:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
City:	State:	Zip Code:	Spouse's Name:
Email:		Occupation:	
Occupation:		Employer:	
Employer:			
PATIENT CONTACT INFORMATION:			
Type	Phone Number	OK To Leave Detailed Message?	OK To Receive TEXT Messages with Detailed Information?
Cell:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Work:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
What number do you PREFER we contact you with? <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other			
EMERGENCY & HIPAA CONTACTS:			
Please list your emergency contact(s) below. Please indicate who, if anyone, may have access and disclosure of your protected health information. HIPAA Note: If you select "Yes" for HIPAA Authorization, you authorize Guerra Plastic Surgery Center to discuss your protected health information for any purpose with the person(s) designated.			
Relationship	Name	Emergency Contact?	HIPAA Authorization?
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
REFERRAL INFORMATION: HOW DID YOU HEAR ABOUT US?			
Artificial intelligence (AI): <input type="checkbox"/> ChatGPT <input type="checkbox"/> Claude <input type="checkbox"/> Co-Pilot <input type="checkbox"/> Gemini <input type="checkbox"/> Perplexity <input type="checkbox"/> Grok			
Internet: <input type="checkbox"/> Microsoft Bing <input type="checkbox"/> DuckDuckGo <input type="checkbox"/> Google <input type="checkbox"/> Yahoo! <input type="checkbox"/> Apple / Safari <input type="checkbox"/> Android / Chrome <input type="checkbox"/> Other Search			
Social Media: <input type="checkbox"/> Facebook <input type="checkbox"/> Instagram <input type="checkbox"/> RealSelf <input type="checkbox"/> Reddit <input type="checkbox"/> SnapChat <input type="checkbox"/> TikTok <input type="checkbox"/> WhatsApp <input type="checkbox"/> X <input type="checkbox"/> YouTube			
Word of Mouth: <input type="checkbox"/> Co-Worker <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Influencer <input type="checkbox"/> Online Reviews <input type="checkbox"/> Patient <input type="checkbox"/> Physician Other: _____			
If you searched on the Internet, What KEYWORD(S) did you search for?			
VERIFICATION OF INFORMATION: I agree that the above information is true and correct to the best of my knowledge.			
Signature:		Date:	

NEW PATIENT MEDICAL HISTORY FORM

Name:	DOB:
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Today's Date:

CONSULTATION INFORMATION

Date of Last Physical Exam:	Ethnicity (Check all that apply):
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Doctor Who Performed Exam:	<input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian
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Do you have a Primary Care Doctor? <input type="checkbox"/> No <input type="checkbox"/> Yes: PCP Name:	<input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other:
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What procedures are you interested in?

<input type="checkbox"/> Breast Augmentation	<input type="checkbox"/> Tummy Tuck	<input type="checkbox"/> Body Lift	<input type="checkbox"/> Facelift	<input type="checkbox"/> Neck Liposuction	<input type="checkbox"/> Botox	<input type="checkbox"/> Latisse for Lashes
<input type="checkbox"/> Breast Lift	<input type="checkbox"/> Liposuction	<input type="checkbox"/> Thigh Lift	<input type="checkbox"/> Eyelid Surgery	<input type="checkbox"/> Buccal Fat Removal	<input type="checkbox"/> Dermal Fillers	<input type="checkbox"/> Hydrafacial
<input type="checkbox"/> Breast Reduction	<input type="checkbox"/> Mommy Makeover	<input type="checkbox"/> Arm Lift	<input type="checkbox"/> Neck Lift	<input type="checkbox"/> Labiaplasty	<input type="checkbox"/> Skincare	
<input type="checkbox"/> Breast Implant Exchange	<input type="checkbox"/> Breast Implants	<input type="checkbox"/> Brazilian Butt Lift	<input type="checkbox"/> Brow Lift	<input type="checkbox"/> Minimally Invasive Procedure	<input type="checkbox"/> Other:	

What would you like to discuss at your consultation?

How long have you considered this surgery?

Have you consulted other doctors? No Yes

Have you discussed surgery with your family? <input type="checkbox"/> No <input type="checkbox"/> Yes	Is your family supportive? <input type="checkbox"/> No <input type="checkbox"/> Yes
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ALLERGIES & MEDICATIONS

Are you currently taking any **MEDICATION**? No Yes, Please list medications below:

Medication	Dosage	How Long	Reason For Taking/Comments

Are you currently taking any **VITAMINS or HERBAL SUPPLEMENTS** (i.e. green tea, St. John's Wart, Vit C)? No Yes, Please list SUPPLEMENTS below:

Vitamin/Supplement	Dosage	How Long	Reason For Taking/Comments

Do you have any **ALLERGIES or ADVERSE REACTIONS to any MEDICATIONS**? No Yes, Please List Below

Medication	Reaction/Comments

Do you have any **ALLERGIES or SENSITIVITY** to any of the following:
 Iodine/Dyes/Shellfish? No Yes Tape/Adhesive? No Yes Latex? No Yes Creams/Lotions? No Yes

SOCIAL HISTORY

Do you use nicotine products (vape, cigarettes, cigars, lozenges)? No Socially 1-6 Cig/day 7 cig - 1 pack/day More than 1 Pack/Day

Have you quit smoking? No Less than 3 months ago 3-6 months ago 6-12 months ago More than 1 year ago

Do you drink alcohol? No 1-2 drinks/week 3-5 per week 6 or more per week

Do you drink caffeinated beverages? No 1-2 per day 3-4 per day 5 or more per day

Do you use "recreational drugs"? No Marijuana Cocaine Heroin Meth Other:

Name:	DOB:
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MEDICAL HISTORY

Current Height:	feet	inches	Weight: _____ lbs.	BMI:	Blood Type:
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Have you been diagnosed with any of the following **MEDICAL CONDITIONS** (Check all that apply)? NONE

Medical Condition	Details	Medical Condition	Details
<input type="checkbox"/> Blood Disorder/Clotting Disorder		<input type="checkbox"/> Asthma	
<input type="checkbox"/> Heart Disease/Stroke		<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Hypertension/High Blood Pressure		<input type="checkbox"/> Breast Cancer	
<input type="checkbox"/> Migraine Headaches		<input type="checkbox"/> Other Cancer	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> HIV/AIDS	
<input type="checkbox"/> Depression/Mental Illness		<input type="checkbox"/> Venereal Disease	
<input type="checkbox"/> Endometriosis		<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Polycystic Ovarian Syndrome		<input type="checkbox"/> Excessive Scarring	
<input type="checkbox"/> Hyperthyroid/Hypothyroid		<input type="checkbox"/> Delayed or Poor Healing	

FEMALE HEALTH QUESTIONS

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Is your Mammogram Current? Date of Last Mammogram: _____	Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal If Abnormal?
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Have you ever had an Ultrasound of the Breast?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Have you ever had a Breast Biopsy or Fine Needle Aspiration of the Breast? If yes, please list the date: _____	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Have you ever had a Lump in the Breasts?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Have you ever had any Breast Discharge ?	

SURGICAL, ER VISIT & HOSPITALIZATION HISTORY - Please fill in the dates below:

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Have you had any SURGERIES ? If yes, please list below.
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Have you ever had Mesotherapy, Lipo Dissolve or Laser Lipo ? If yes, please indicate which of these you have had done:
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Have you ever been HOSPITALIZED other than for pregnancy or surgery? If yes, please list below:
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Have you been to the EMERGENCY DEPARTMENT within the last 12 months for any reason? Please list below:

Date	Reason for Surgery/Hospitalization/ER Visit	Hospital Name	Findings/Outcome

Name:		DOB:
REVIEW OF SYSTEMS: Please mark any of the following disorders YOU currently have or had issues with: <input type="checkbox"/> None <input type="checkbox"/> Yes, Please Check All Issue That Apply To YOU		
Constitutional	Immunological	Lung/Cardiovascular
<input type="checkbox"/> Change in Appetite	<input type="checkbox"/> Lupus Erythematosus	<input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Weight Change	<input type="checkbox"/> Neurological	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Difficulty Concentrating	<input type="checkbox"/> Rheumatoid Arthritis/Joint Pain	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Hot Flashes/Night Sweats	<input type="checkbox"/> Auto-Immune Disorder Fibromyalgia	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Multiple Sclerosis (MS)	<input type="checkbox"/> Chronic Bronchitis
Central Nervous System	Hematological	Endocrine
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Anemia	<input type="checkbox"/> Excessive Hair Growth
<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Sickle Cell Anemia or Trait	<input type="checkbox"/> Heat Intolerance
<input type="checkbox"/> Head Trauma	<input type="checkbox"/> Other:	<input type="checkbox"/> Cold Intolerance
<input type="checkbox"/> Poor Sense of Smell	Genitourinary	<input type="checkbox"/> Excessive Thirst or Hunger
EENT	<input type="checkbox"/> Bladder Infections	<input type="checkbox"/> Rash
<input type="checkbox"/> Problems With Head, Eyes, Ears, Nose, Throat	<input type="checkbox"/> Kidney Infections	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Visual Problems	<input type="checkbox"/> Other Kidney or Bladder Problems	<input type="checkbox"/> Nipple Discharge
<input type="checkbox"/> Other:	Gastrointestinal	<input type="checkbox"/> Hypoglycemia (Low Blood Sugar)
	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Hyperglycemia (High Blood Sugar)
	<input type="checkbox"/> Stomach or Intestinal Problems, Ulcers	Last HbA1C: _____ Date: _____
QUESTIONNAIRE		
<input type="checkbox"/> No <input type="checkbox"/> Yes Do you consider yourself a healthy person?		<input type="checkbox"/> No <input type="checkbox"/> Yes Do you have frequent pains in your chest?
<input type="checkbox"/> No <input type="checkbox"/> Yes Has a doctor ever said you have "heart trouble"?		<input type="checkbox"/> No <input type="checkbox"/> Yes Do you have or have you had chest or lung problems?
<input type="checkbox"/> No <input type="checkbox"/> Yes Have you ever had liver, gall bladder or yellow jaundice problems?		<input type="checkbox"/> No <input type="checkbox"/> Yes Do you experience poor circulation in your fingers or toes?
<input type="checkbox"/> No <input type="checkbox"/> Yes Do you have frequent skin irritations, infections or rashes?		<input type="checkbox"/> No <input type="checkbox"/> Yes Do you worry about your health?
<input type="checkbox"/> No <input type="checkbox"/> Yes Have you ever had fever blisters, cold sores, or canker sores?		<input type="checkbox"/> No <input type="checkbox"/> Yes Have you ever taken hormones?
<input type="checkbox"/> No <input type="checkbox"/> Yes Have you ever been treated for abuse of alcohol or drugs?		<input type="checkbox"/> No <input type="checkbox"/> Yes Do you usually feel unhappy or depressed?
<input type="checkbox"/> No <input type="checkbox"/> Yes Have you ever been treated for anemia or any problems with your blood?		<input type="checkbox"/> No <input type="checkbox"/> Yes Have you ever had a nervous breakdown?
<input type="checkbox"/> No <input type="checkbox"/> Yes Do you tend to hold a grudge when someone angers you?		<input type="checkbox"/> No <input type="checkbox"/> Yes Are you easily upset or irritated?
<input type="checkbox"/> No <input type="checkbox"/> Yes Have you ever considered consulting a psychiatrist or psychologist?		
<input type="checkbox"/> No <input type="checkbox"/> Yes Do you have any other medical problems that have not been covered?		
<input type="checkbox"/> No <input type="checkbox"/> Yes Do you accept the fact that every medical/surgical treatment is associated with risks and unknowns?		
<input type="checkbox"/> No <input type="checkbox"/> Yes Do you consent to and authorize the recommended diagnostic, medical, surgical, anesthetic and other diagnostic services that the clinic deems beneficial while you are under our care?		

Name:	DOB:
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FAMILY HISTORY

Does anyone in your family have any of the following medical conditions? None I Do **NOT** Know My Family History Yes, Please Check Conditions Below

Medical Condition	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather
Blood Disorder/Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension/High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperthyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Cancer:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Scarring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delayed or Poor Healing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT NOTES/COMMENTS

VERIFICATION OF INFORMATION

I agree that the above information is true and correct to the best of my knowledge. I have answered the questions to the best of my ability, and verify that all of my answers are truthful.

Signature: _____ Print Name: _____ Date: _____



Guerra Plastic Surgery Center
8765 E. Bell Rd., Ste. 104
Scottsdale, AZ 85260
480-970-2580 Office
480-513-2175 Fax

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

- Conduct, plan and direct my **treatment** and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain **payment** from third-party payers.
- Conduct normal **healthcare operations** such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address(es) 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 health care operations. I also 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 Signature: _____

Date: _____

Print Patient Name: _____

FOR INTERNAL OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

_____	_____	_____
Date	Initials	Reason



8765 E Bell Road, Suite 104
Scottsdale, AZ 85260

Communication Acknowledgement

By providing your phone number and email you agree to receive SMS text and email messages for appointment reminders, healthcare, and marketing purposes like review requests from Guerra Plastic Surgery Center. Message & Data rates may apply. Reply STOP to unsubscribe or HELP for help.

I agree to receive SMS and email communications from Guerra Plastic Surgery Center.

Mobile Number: _____

Email: _____

Patient Name (Print)

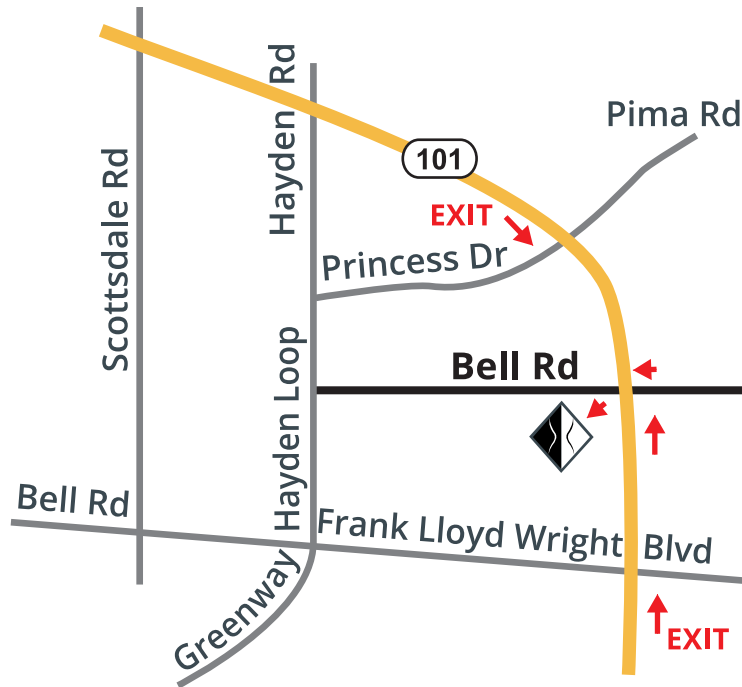
Patient Signature

Date



GUERRA

Plastic Surgery & Medspa



Heading 101 East

Exit #36 PRINCESS / PIMA. Stay in the middle lane.
Proceed straight at the 1st light PRINCESS / PIMA.
Proceed straight at the 2nd light BELL.
Make a quick right turn into the Desert Fairways parking lot.

Heading 101 North

Exit #38 FRANK LLOYD WRIGHT. Stay in the middle lane.
Proceed straight at the 1st light FRANK LLOYD WRIGHT.
Make a left on your 2nd light BELL.
Make an immediate left turn as you go under the freeway.
Make a quick right turn into the Desert Fairways parking lot.