East Bay Aesthetic Surgery

Eric P. Bachelor, M.D., F.A.C.S.

Certified by the American Board of Plastic Surgery

DATE: _____ **NEW PATIENT _____** **UPDATE: _____**

WHICH OFFICE WOULD YOU PREFER TO BE SEEN AT ON A REGULAR BASIS? **PLEASANTON _____** **DANVILLE _____**

WHO REFERRED YOU TO DR. BACHELOR? _____

PATIENT NAME

_____, _____, _____, _____
LAST FIRST MIDDLE INITIAL MAIDEN NAME

_____, _____, _____ _____
ADDRESS CITY STATE ZIP

BIRTHDATE _____/_____/_____ **AGE _____** **BIRTHPLACE _____**

SEX MALE / FEMALE **MARITAL STATUS M S D W** **SPOUSE'S NAME _____**

RACE/ETHNIC ORIGIN _____ **E-MAIL ADDRESS _____**

HOME PHONE (_____) _____ **CELL (_____) _____**

DRIVER'S LIC. # _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE # (_____) _____

EMPLOYMENT INFORMATIONFOR PATIENT

_____ _____ _____
EMPLOYER/STUDENT OCCUPATION PHONE NUMBER

_____, _____, _____ _____
ADDRESS CITY STATE ZIP

IF PATIENT IS A MINOR

GUARDIAN NAME _____ **PHONE (_____) _____**

RELATIONSHIP _____

PHARMACY INFORMATION

_____ _____ _____
NAME ADDRESS PHONE NUMBER

I UNDERSTAND THAT A FEE OF $100.00 IS DUE AT THE TIME OF SCHEDULING MY CONSULTATION. IF I WAS UNABLE TO PAY THIS CONSULTATION FEE AT THAT TIME, I WILL BE CHARGED AT THE TIME OF MY APPOINTMENT. I UNDERSTAND THAT IF I SCHEDULE SURGERY WITHIN 6 MONTHS OF MY CONSULTATION, THIS FEE WILL BE APPLIED TO THE SURGERY QUOTED. I UNDERSTAND THIS DOES NOT APPLY TO FACIAL INJECTIONS, HYPERTONIC SALINE INJECTIONS, EAR PIERCING, REMOVAL OF MOLES/LESIONS AND/OR SCAR REVISIONS. I UNDERSTAND THAT MY CONSULTATION IS "COSMETIC IN NATURE". DUE TO THIS, DR. BACHELOR'S OFFICE WILL NOT BILL MY INSURANCE.

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE

1387 Santa Rit1387 Santa Rita Road, Pleasanton, CA 94566
919 San Ramon Valley Blvd., Ste. 150, Danville, CA 94526
Phone: 925-462-3700 Fax: 925-462-4681
www.ericpbachelormd.com

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I HEREBY GIVE MY CONSENT FOR DR. ERIC P. BACHELOR, M.D. TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) ABOUT ME CARRY OUT TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS (TPO). ERIC P. BACHELOR, MD'S NOTICE OF PRIVACY PRACTICES PROVIDES A MORE COMPLETE DESCRIPTION OF SUCH USES AND DISCLOSURES.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Eric P. Bachelor, MD reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Eric P. Bachelor's Privacy Officer at 1387 Santa Rita Road, Pleasanton, CA 94566.

With this consent, Eric P. Bachelor, MD, and staff may call my home or other alternative locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With this consent physician peers may review my office and operating room charts for operative consent and the completeness of your chart.

With this consent, Eric P. Bachelor, MD, and staff may mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With this consent, Eric P. Bachelor, MD, and staff may e-mail to my home or other alternative locations any items that the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Eric P. Bachelor, MD restrict how it uses or discloses my PHI to carry out TPO. However, the practice and surgery center is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I have consented to Eric P. Bachelor, MD and The Plastic and Reconstructive Surgery Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. If I do not sign this consent, or later revoke it, Eric P. Bachelor, MD may decline to provide treatment to me.

_____	_____
Print Patient Name	**Date**
_____	_____
Sign Patient Name / Authorized Representative	**Date**

PHI = Protected Health Information
TPO = Treatment, Payment, and Operations

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