

Patient Intake Forms

Welcome to our practice, and thank you for choosing Brownstein & Crane Surgical Services!

It is very important that **all** sections of these forms are filled out in order for us to accept you as a patient at this practice.

Please submit your completed intake forms along with a picture or copy of the front and back of your insurance card and driver's license to newpatient@brownsteincrane.com or via fax to 520-244-3400.

A picture or copy of your photo ID, school ID, or passport is acceptable in lieu of a driver's license.

If you are unsure of the accuracy of your answers, please mark a question mark (?) next to the areas you're uncertain of.

Please write in print as clearly and neatly as possible.

If you require assistance, please ask our front desk staff.

Patient Information

Patient Full Legal Name

First _____ Middle _____ Last _____

Patient Full Preferred Name (If Different from Above)

First _____ Middle _____ Last _____

Vital Information

Date of Birth _____ Social Security Number _____

Preferred Language _____ Driver's License Number _____

Employer / Occupation _____

Contact Information – If International, State Should be Considered Province or County, As Applicable

Country _____ Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Legal Guardian (If a minor) – If International, State Should be Considered Province or County, As Applicable

First _____ Middle _____ Last _____

Date of Birth _____ Social Security Number _____

Country _____ Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

E-MAIL NOTICE: Our office uses e-mail as a primary form of communication, by providing an e-mail address, you are acknowledging that we have your express permission to communicate with you through the e-mail address you've provided in the form of routine e-mail messages.

Your Insurance Coverage Information

FOUR TIPS TO HELP WITH THIS SECTION: **1)** An insurance “provider” is your insurance company (like Anthem Blue Cross, United Healthcare, etc.). **2)** Your “member ID #” is located on the front of your insurance card. **3)** The “policy-holder” is the person who’s paying for the insurance, and may be a parent, your spouse, or another family member; however, if you purchased your insurance directly, or it comes from your job, then *you are the policy-holder*. **4)** There is a legal difference between “Primary” and “Secondary” insurance policies, and the order you list them in matters. If you have more than one policy, but don’t know which is “Primary”, you need to call each and ask each of them to decide which is “Primary”.

Are you currently enrolled in any of the following? (A YES OR NO IS REQUIRED FOR #1-4)

- 1. Medicare** YES / NO
- 2. Tricare** YES / NO If yes, which region? _____
- 3. Medi-Cal** YES / NO
- 4. Medicaid** YES / NO If yes, which state? _____

What is your Primary Insurance Policy?

Primary Insurance Provider _____

Your Member ID # _____

Name of Policy-holder **SELF** **OTHER** _____

*If you are not the Policy-holder, what is their Date of Birth? _____

Do you have a Secondary Insurance Policy?

Secondary Insurance Provider _____

Your Member ID # _____

Name of Policy-holder **SELF** **OTHER**: _____

*If you are not the Policy-holder, what is their Date of Birth? _____

Do you have a Third Insurance Policy?

Secondary Insurance Provider _____

Your Member ID # _____

Name of Policy-holder **SELF** **OTHER**: _____

*If you are not the Policy-holder, what is their Date of Birth? _____

INSURANCE NOTICE: We require an image copy of the front and back of all your insurance cards. If your insurance changes, it is your responsibility to update us immediately, and submit a front and back image of the new card(s). Failure to do so may result in cancellation of scheduled surgeries, or the full financial cost of a surgery falling on you or your guardian.

Medical Information

Health & Physical Description

Height _____ Weight _____ Eye Color _____ Hair Color _____

Race / Ethnicity (This may be relevant to genetic health concerns)

- African American / Black
- American Indian / Alaskan Native
- Asian
- Caucasian / White
- Hispanic / Latin / Spanish
- Other _____
- Pacific Islander
- Prefer Not to Answer

Lifestyle Indicators

Your frequency of consuming Alcohol is _____ times per **week / month / year**

Your Alcohol consumption is most commonly **light / moderate / significant** when you drink

Your frequency of smoking Cigarettes or Cigars is _____ times per **week / month / year**

You smoke at least _____ Cigarettes or Cigars a day when you do smoke.

Your frequency of smoking Marijuana is _____ times per **week / month / year**

Known Allergies (Do Not Leave Blank – Write “None” If You Are Not Aware of Any)

Drug / Chemical _____

Food / Other _____

Your Medical History (Check All That Apply)

- Heart Disease High Blood Pressure Lung Disease Diabetes Anemia
- Liver Disease / Jaundice Kidney Disease Clotting Disorders Thyroid Disease
- Other _____
- Do you bruise easily or have bleeding problems?

Your Family Medical History (Check All That Apply)

- Heart Disease High Blood Pressure Lung Disease Diabetes Anemia
- Liver Disease / Jaundice Kidney Disease Clotting Disorders Thyroid Disease
- Other _____
- Do your biological parents or siblings bruise easily or have bleeding problems?

Medical Information, Continued

Are you currently on any hormone treatments?

Product Name _____ Dosage _____ Frequency _____

Product Name _____ Dosage _____ Frequency _____

What other medications are you currently taking?

Product Name _____ Dosage _____ Frequency _____

Product Name _____ Dosage _____ Frequency _____

Product Name _____ Dosage _____ Frequency _____

Product Name _____ Dosage _____ Frequency _____

Have you had any surgeries previously?

Type of Surgery _____ Date _____ Surgeon _____

Type of Surgery _____ Date _____ Surgeon _____

Type of Surgery _____ Date _____ Surgeon _____

Type of Surgery _____ Date _____ Surgeon _____

Transgender Patient Medical Information

Have you completed the following?

An established relationship with at least two mental health providers? **YES / NO**

At least one year of continuous hormone therapy? **YES / NO**

Can you secure clinical support letters prior to surgery from these providers? **YES / NO**

Which procedures are you most interested in?

Chest Masculinizing Surgery (Top Surgery)

Glansplasty

Metoidioplasty

Penile Implants

Phalloplasty

Breast Augmentation

Facial Feminization (FFS)

Orchiectomy

Penectomy

Vulvoplasty

Vaginectomy

Vaginoplasty

Other _____

HIPAA Notice of Privacy Practices

PLEASE NOTE: *This notice describes how medical information about you may be used and disclosed, in accordance with state and federal regulations, and how you can get access to this information.*

The *Health Insurance Portability & Accountability Act* of 1996 (“HIPAA”) is a federal law which requires all of your medical records and information shared or retained by our office be kept secure and confidential at all times. This law gives you (or your legal representative or guardian) the right to understand and control how your *protected health information* (“PHI”) is used. It establishes strict guidelines, including penalties for any misuse of your PHI.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose that information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

To elaborate on each:

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor, such as our practice.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review (prior authorization). An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

In addition, HIPAA allows for the following uses of your PHI:

- The practice may also be required or permitted to disclose your PHI to law enforcement, or for other legally established reasons. In all situations, we shall do our best to assure its continued confidentiality to the best extent possible.
- We may also create and distribute de-identified health information by removing all references to individually identifiable information.
- We may contact you by phone, email, or in writing, to provide appointment reminders or information about treatment alternatives, or other health-related benefits and services.

The following are other uses of your PHI which would require written consent by you, prior to use:

- Most uses and disclosures of psychotherapy notes
- Uses and disclosures of your PHI for marketing purposes; including subsidized treatment and health care operations
- Disclosures that constitute a sale of PHI under HIPAA
- Other uses and disclosures not described in this notice
- You may revoke any written consent previously granted and we are required to honor your request

HIPAA Notice of Privacy Practices, Continued

You may also have the following rights regarding your PHI under HIPAA regulations:

- The right to request restrictions on certain uses and disclosures of your PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. However, we are not required to honor a request for restriction except in limited circumstances which we shall explain to you if you ask. If we do agree to the restrictions, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI by alternative means or at alternative locations
- The right to inspect and copy your PHI
- The right to amend your PHI
- The right to receive an accounting of disclosures of your PHI
- The right to obtain a paper copy of this notice from us upon request
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed
- If you have paid for services “out of pocket”, in full and in advance, and you request we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you this notice of our legal duties and our privacy practices with respect to PHI. This notice is effective as of September 23rd, 2013, and it is our intention to abide by the terms of the Notice of Privacy Practices, and HIPAA regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practices from our office.

You have recourse if you feel your PHI protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

I am a patient (or legal representative or guardian thereof) of Brownstein & Crane Surgical Services, and I hereby acknowledge receipt and understanding of this Notice of Privacy Practices (parent/legal guardian’s signature required if the patient is a minor).

Patient’s full legal name (print) _____

Patient’s signature _____ Date _____

Parent/Legal Guardian’s full legal name (print) _____

Parent/Legal Guardian’s signature _____ Date _____

Release of Medical Information Consent

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for staff of Brownstein & Crane Surgical Services to discuss your medical considerations with members of your family, or other individuals that you designate, we must obtain your authorization prior to doing so. Please identify specific persons or entities you authorize us to share your medical information with. We will not discuss your medical information with a parent, family member, or spouse unless you authorize us to.

Family & Friends

Name _____ Relation to You: _____

Primary Phone _____ Email _____

Name _____ Relation to You: _____

Primary Phone _____ Email _____

Name _____ Relation to You: _____

Primary Phone _____ Email _____

Name _____ Relation to You: _____

Primary Phone _____ Email _____

Other Entities (Employer, Social Worker, Etc.)

Name _____ Relation to You: _____

Primary Phone _____ Email _____

Name _____ Relation to You: _____

Primary Phone _____ Email _____

I am a patient (or legal representative or guardian thereof) of Brownstein & Crane Surgical Services, and I hereby acknowledge receipt and understanding of this Release of Medical Information Consent (parent/legal guardian's signature required if the patient is a minor).

Patient's full legal name (print) _____

Patient's signature _____ Date _____

Parent/Legal Guardian's full legal name (print) _____

Parent/Legal Guardian's signature _____ Date _____

Release of Reimbursement Agreement, Part 1

Brownstein & Crane Surgical Services accepts patients from every part of the world, and performs surgery in a number of facilities in different parts of the United States. This release form is required for us to proceed with your scheduled surgery date, and it serves to release our company from any financial loss in travel or hotel accommodations you may incur, in the event that we must cancel or reschedule your surgery date, even up to the date of surgery. Such changes may become necessary for many reasons, including changes or difficulties with your insurance, facility, availability of physicians, pre-operative lab results, etc.

To prevent fiscal loss from such eventualities, please make your travel and local stay accommodations as fully refundable as possible. Most vendors offer a flexible booking option with an additional fee, and some allow purchasing arrangements using flexible spending credits. In all cases it is highly advisable to ask in advance what a vendor’s reimbursement policies are, prior to booking your arrangements. It is also advisable to determine what they consider reasonable justifications for requesting refunds, and if they require any supporting documentation from us.

Unfortunately, on rare occasion, surgical scheduling changes take place after travel has occurred. In those events, our office will extend whatever courtesy possible to accommodate a rescheduled date. However, we do not provide reimbursement for loss of funds from travel and hotel accommodations. We can offer to generate a letter of support to the vendors you use, if they require documentation of why your arrangements have changed, in order to gain whatever refund is possible.

INSURING YOUR ACCOMMODATIONS

Our office highly recommends that you purchase additional travel or stay insurance as available when you book accommodations. This affords you the most flexibility in the event you need to make changes to your arrangements, such as if the operative date changes. Such changes are very common when you reschedule (such as losing insurance coverage, are offered and accept an earlier date, have an urgent procedure, have to stay longer post-operatively, etc.).

I am a patient (or legal representative or guardian thereof) of Brownstein & Crane Surgical Services, and I hereby acknowledge receipt and understanding of this Agreement (parent/legal guardian’s signature required if the patient is a minor).

Patient’s full legal name (in print) _____

Patient’s signature _____ Date _____

Parent/Legal Guardian’s full legal name (print) _____

Parent/Legal Guardian’s signature _____ Date _____

Release of Reimbursement Agreement, Part 2

PROCEEDING AS SELF PAY

It is particularly important that Self Pay patients be aware that quoted rates only involve the components of the surgery which were actually quoted, such a Provider Fees, Facility Fees, or Anesthesiology Fees. A quote may include some or all of these components. A quote does not include unforeseen additional costs, such as labs, necessary additional pre or post-operative procedures, additional inpatient stay or skilled nursing facility stay, or any associated changes to travel or hotel costs.

Patients from the U.S...

Though insurance may not cover your primary procedures, we strongly recommend that you retain current medical coverage, and that we are provided the most updated insurance information on file. Insurance may cover the types of unforeseen additional costs mentioned above.

Patients from Abroad...

Though many nations do not offer the type of insurance options available in the United States, many of our patients from abroad are covered through their respective national ministries. However, it is always recommended that patients from abroad retain as comprehensive of Traveler's Insurance as possible, including whatever medical care coverage is available, to cover the types of unforeseen additional costs listed above.

This applies to both Ministry and Self Pay patients from abroad. We highly recommend you obtain as much additional medical coverage as possible to reduce the potential for unforeseen medical costs.

PLEASE NOTE: *Though you may not intend to proceed as Self Pay at this time, we require this form be signed to cover the eventuality that you become a Self Pay patient in the future.*

I am a patient (or legal representative or guardian thereof) of Brownstein & Crane Surgical Services, and I hereby acknowledge receipt and understanding of this Agreement (parent/legal guardian's signature required if the patient is a minor).

Patient's full legal name (in print) _____

Patient's signature _____ Date _____

Parent/Legal Guardian's full legal name (print) _____

Parent/Legal Guardian's signature _____ Date _____