

Wang Plastic Surgery

We offer a full range of aesthetic services and procedures. In order to better serve you and addressing all your needs and concerns, please indicate areas of interests below. We will be happy to discuss these issues with you during your visit.

FACE

- | | |
|---|---|
| <input type="checkbox"/> FOREHEAD | <input type="checkbox"/> BOTOX |
| <input type="checkbox"/> EYELIDS/EYEBROWS | <input type="checkbox"/> PREVELLE/RESTYLANE/JUVEDERM/RADIESSE |
| <input type="checkbox"/> NOSE | <input type="checkbox"/> LASER GENESIS |
| <input type="checkbox"/> EARS | <input type="checkbox"/> VEIN TREATMENT |
| <input type="checkbox"/> LIPS | <input type="checkbox"/> LASER HAIR REMOVAL |
| <input type="checkbox"/> CHEEKS | <input type="checkbox"/> IPL |
| <input type="checkbox"/> CHIN | <input type="checkbox"/> THERMAGE |
| <input type="checkbox"/> NECK | <input type="checkbox"/> ASIAN EYELID SURGERY |
| <input type="checkbox"/> OTHER _____ | <input type="checkbox"/> ACCULIFT |
| | <input type="checkbox"/> LIQUID FACELIFT |

BREAST

- | | |
|---|---|
| <input type="checkbox"/> AUGMENTATION | <input type="checkbox"/> NON SURGICAL BREAST AUGMENTATION |
| <input type="checkbox"/> LIFT | <input type="checkbox"/> SCARLESS BREAST AUGMENTATION (TUBA) |
| <input type="checkbox"/> REDUCTION | <input type="checkbox"/> NATURAL BREAST AUGMENTATION W/ FAT GRAFT |
| <input type="checkbox"/> RECONSTRUCTION | |
| <input type="checkbox"/> OTHER _____ | |

BODY

- | | |
|---|---|
| <input type="checkbox"/> ARMS | <input type="checkbox"/> LASER LIPOSUCTION |
| <input type="checkbox"/> ABDOMENS | <input type="checkbox"/> TRIACTIVE LASER ENDERMOLOGIE |
| <input type="checkbox"/> BACK | <input type="checkbox"/> ULTRASOUND MASSAGE THERAPY |
| <input type="checkbox"/> CALF/ANKLES | <input type="checkbox"/> THERMAGE FOR BODY |
| <input type="checkbox"/> THIGH | <input type="checkbox"/> LEG VEIN TREATMENT |
| <input type="checkbox"/> BUTTOCK | |
| <input type="checkbox"/> OTHER _____ | |
| <input type="checkbox"/> SCAR REVISION | |
| <input type="checkbox"/> BUTTOCK AUGMENTATION | |
| <input type="checkbox"/> LIPOSUCTION | |
| <input type="checkbox"/> TUMMY TUCK | |

PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY

We are here to make sure your visit is informative and custom tailored to your needs. In order for us to provide you with the best service possible, please provide us with the following pertinent information:

Reason for Consultation: _____

Name: _____ Mr. Mrs. Ms. Dr.

How would you like to be addressed: _____

Your birth date: Month _____ / Day _____ / Year _____ Age: _____

Residence: _____

City _____ State _____ Zip _____

Occupation: _____

Employer: _____

What is the best way to reach you? _____

When is the best time to reach you? _____

Phone number: Cell () _____ - _____

Home () _____ - _____

Work () _____ - _____

Email: _____

Wang Plastic Surgery is making an effort to go green. We are doing so by incorporating paperless communication when acceptable.

Check here if you would like to receive **email messages** from us regarding appointments and exclusive email specials.

Check here if you would like to receive **text messages** from us to alert you with any unexpected or last minute changes with your appointments?

How did you hear about **Wang Plastic Surgery** or **Dr. Wang**?

If you found us on the internet, may we ask what website? _____

To whom may we thank for the Referral: _____

Who can we contact in the rare event of an emergency? _____

Relation to you _____ Phone: () _____ - _____

Wang Plastic Surgery

For your protection, we are required by law to provide you this notice regarding your privacy. We need you to read it and sign it before we are able to provide services to you.

NOTICE OF PRIVACY PRACTICES

1. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.** The notice is provided in two layers: This top layer briefly summarizes how we handle your health information, and the attached bottom layer provides further details of our policies and procedures.
2. **How we may use and disclose your health information.** We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you were referred. Information may be shared by paper, mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. But beyond those situations, we ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop any futures uses and disclosures.
3. **Your rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decision about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing you have the right to request that we correct the existing information or add the missing information.
4. **Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgment of receipt of this notice. We may change our privacy policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy policies, contact the person listed below.
5. **Privacy complaints.** If you are concerned that we have violated your rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.
6. Medical doctors are licensed and regulated by the Medical Board of California and can be reached at (800) 633-2322

If you have any questions or complaints, please contact the Privacy Officer, 1234 South Garfield Ave. suite #203, Alhambra, CA 91801

Acknowledgment of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date below to acknowledge that you have received both layers of this Notice and Privacy Practices.

Signature: _____

Print Name: _____ Date: _____

Wang Plastic Surgery
MUTUAL AGREEMENT TO MAINTAIN PRIVACY

Dr. Wang and Wang Plastic Surgery (collectively labeled “*Physician*”) agree to provide treatment to: _____ (“*Patient*”). The Physician takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are forbidden by law from receiving money for selling lists of patients or medical 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 medical information for the purpose of marketing directly to Patient. 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.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of “rating sites” in cyberspace, many fail to provide useful information. Let’s get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Physician has invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about the Physician - his practice, expertise, and/or treatment - on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

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 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. 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.

Date: _____

Patient Signature: _____

Print Name: _____

Dr. Stewart Wang and Wang Plastic Surgery