GUERRA
Plastic Surgery & Medspa

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

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

20240216 Notice of Privacy Practices

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PATIENT REGISTRATION FORM

Today's Date:	**Patient Date of Birth:**
PATIENT INFORMATION:	
Name:	Age: Gender: ▢ Female ▢ Male
Address:	Marital Status: ▢ Single ▢ Married ▢ Divorced ▢ 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:		▢ Yes ▢ No	▢ Yes ▢ No
Home:		▢ Yes ▢ No	▢ Yes ▢ No
Work:		▢ Yes ▢ No	▢ Yes ▢ No
Other:		▢ Yes ▢ No	▢ Yes ▢ No

What number do you **PREFER** we contact you with? ▢ Cell ▢ Home ▢ Work ▢ 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?	Phone Number
		▢ Yes ▢ No	▢ Yes ▢ No	
		▢ Yes ▢ No	▢ Yes ▢ No	

REFERRAL INFORMATION:

*** How did you hear about Guerra Plastic Surgery, Dr. Aldo Guerra or Dr. Scott Ogley?**	

Do you follow us on Social Media? ▢ No ▢ Yes, which platforms:

▢ Instagram @DrAldoGuerra ▢ Instagram @ScottOgleyMD ▢ Instagram @AZBreasts ▢ Facebook ▢ X ▢ 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:**
Today's Date:	

CONSULTATION INFORMATION

Date of Last Physical Exam:	Ethnicity (Check all that apply):
Doctor Who Performed Exam:	▢ African American ▢ Asian ▢ Caucasian
Do you have a Primary Care Doctor? ▢ No ▢ Yes: PCP Name:	▢ Hispanic ▢ Native American ▢ Other:

What procedures are you interested in?

▢ Breast Augmentation	▢ Tummy Tuck	▢ Body Lift	▢ Facelift	▢ Neck Liposuction	▢ Botox	▢ Latisse for Lashes
▢ Breast Lift	▢ Liposuction	▢ Thigh Lift	▢ Eyelid Surgery	▢ Buccal Fat Removal	▢ Dermal Fillers	▢ Hydrafacial
▢ Breast Reduction	▢ Mommy Makeover	▢ Arm Lift	▢ Neck Lift	▢ Labiaplasty	▢ Skincare	
▢ Breast Implant Exchange	▢ Breast Implants	▢ Brazilian Butt Lift	▢ Brow Lift	▢ Minimally Invasive Procedure	▢ 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? ▢ No ▢ Yes	Is your family supportive? ▢ No ▢ Yes

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:**	
MEDICAL HISTORY			
Current Height: feet inches **Weight: _____** lbs.		**BMI:**	**Blood Type:**
Have you been diagnosed with any of the following MEDICAL CONDITIONS (Check all that apply)? ▢ NONE			
Medical Condition	Details	Medical Condition	Details
▢ Blood Disorder/Clotting Disorder		▢ Asthma	
▢ Heart Disease/Stroke		▢ Hepatitis	
▢ Hypertension/High Blood Pressure		▢ Breast Cancer	
▢ Migraine Headaches		▢ Other Cancer	
▢ Diabetes		▢ HIV/AIDS	
▢ Depression/Mental Illness		▢ Venereal Disease	
▢ Endometriosis		▢ Arthritis	
▢ Polycystic Ovarian Syndrome		▢ Excessive Scarring	
▢ Hyperthyroid/Hypothyroid		▢ Delayed or Poor Healing	
FEMALE HEALTH QUESTIONS			
▢ No ▢ Yes Is your **Mammogram** Current? Date of Last Mammogram: Results: ▢ Normal ▢ Abnormal If Abnormal?			
▢ No ▢ Yes Have you ever had an **Ultrasound** of the Breast?			
▢ No ▢ Yes Have you ever had a **Breast Biopsy or Fine Needle Aspiration** of the Breast? If yes, please list the date:			
▢ No ▢ Yes Have you ever had a **Lump** in the Breasts?			
▢ No ▢ Yes Have you ever had any **Breast Discharge**?			
SURGICAL, ER VISIT & HOSPITALIZATION HISTORY - Please fill in the dates below:			
▢ No ▢ Yes Have you had any **SURGERIES?** If yes, please list below.			
▢ No ▢ Yes Have you ever had **Mesotherapy, Lipo Dissolve or Laser Lipo**? If yes, please indicate which of these you have had done:			
▢ No ▢ Yes Have you ever been **HOSPITALIZED** other than for pregnancy or surgery? If yes, please list below:			
▢ No ▢ 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: ▢ **None** ▢ **Yes**, Please Check All Issue That Apply To YOU		
Constitutional	**Immunological**	**Lung/Cardiovascular**
▢ Change in Appetite	▢ Lupus Erythematosus	▢ Low Blood Pressure ▢ High Blood Pressure
▢ Weight Change	▢ Neurological	▢ Mitral Valve Prolapse
▢ Difficulty Concentrating	▢ Rheumatoid Arthritis/Joint Pain	▢ Rheumatic Fever
▢ Hot Flashes/Night Sweats	▢ Auto-Immune Disorder Fibromyalgia	▢ Lung Disease
▢ Fatigue	▢ Multiple Sclerosis (MS)	▢ Chronic Bronchitis
Central Nervous System	**Hematological**	**Endocrine**
▢ Dizziness	▢ Anemia	▢ Excessive Hair Growth
▢ Seizures/Convulsions	▢ Sickle Cell Anemia or Trait	▢ Heat Intolerance
▢ Head Trauma	▢ Other:	▢ Cold Intolerance
▢ Poor Sense of Smell	**Genitourinary**	▢ Excessive Thirst or Hunger
EENT	▢ Bladder Infections	▢ Rash
▢ Problems With Head, Eyes, Ears, Nose, Throat	▢ Kidney Infections	▢ Thyroid Disorder
▢ Visual Problems	▢ Other Kidney or Bladder Problems	▢ Nipple Discharge
▢ Other:	**Gastrointestinal**	▢ Hypoglycemia (Low Blood Sugar)
	▢ Liver Disease	▢ Hyperglycemia (High Blood Sugar)
	▢ Stomach or Intestinal Problems, Ulcers	Last HbA1C: Date:

QUESTIONNAIRE			
▢ No ▢ Yes	Do you consider yourself a healthy person?	▢ No ▢ Yes	Do you have frequent pains in your chest?
▢ No ▢ Yes	Has a doctor ever said you have “heart trouble”?	▢ No ▢ Yes	Do you have or have you had chest or lung problems?
▢ No ▢ Yes	Have you ever had liver, gall bladder or yellow jaundice problems>	▢ No ▢ Yes	Do you experience poor circulation in your fingers or toes?
▢ No ▢ Yes	Do you have frequent skin irritations, infections or rashes?	▢ No ▢ Yes	Do you worry about your health?
▢ No ▢ Yes	Have you ever had fever blisters, cold sores, or canker sores?	▢ No ▢ Yes	Have you ever taken hormones?
▢ No ▢ Yes	Have you ever been treated for abuse of alcohol or drugs?	▢ No ▢ Yes	Do you usually feel unhappy or depressed?
▢ No ▢ Yes	Have you ever been treated for anemia or any problems with your blood?	▢ No ▢ Yes	Have you ever had a nervous breakdown?
▢ No ▢ Yes	Do you tend to hold a grudge when someone angers you?	▢ No ▢ Yes	Are you easily upset or irritated?
▢ No ▢ Yes	Have you ever considered consulting a psychiatrist or psychologist?		
▢ No ▢ Yes	Do you have any other medical problems that have not been covered?		
▢ No ▢ Yes	Do you accept the fact that every medical/surgical treatment is associated with risks and unknowns?		
▢ No ▢ 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:

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	▢	▢	▢	▢	▢	▢
Heart Disease	▢	▢	▢	▢	▢	▢
Stroke	▢	▢	▢	▢	▢	▢
Hypertension/High Blood Pressure	▢	▢	▢	▢	▢	▢
Diabetes	▢	▢	▢	▢	▢	▢
Depression/Mental Illness	▢	▢	▢	▢	▢	▢
Endometriosis	▢	▢	▢	▢	▢	▢
Hyperthyroid	▢	▢	▢	▢	▢	▢
Hypothyroid	▢	▢	▢	▢	▢	▢
Migraine Headaches	▢	▢	▢	▢	▢	▢
Asthma	▢	▢	▢	▢	▢	▢
Hepatitis	▢	▢	▢	▢	▢	▢
Breast Cancer	▢	▢	▢	▢	▢	▢
Other Cancer:	▢	▢	▢	▢	▢	▢
Arthritis	▢	▢	▢	▢	▢	▢
Excessive Scarring	▢	▢	▢	▢	▢	▢
Delayed or Poor Healing	▢	▢	▢	▢	▢	▢

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: _____

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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

20240216 Notice of Privacy Practices Acknowledgement

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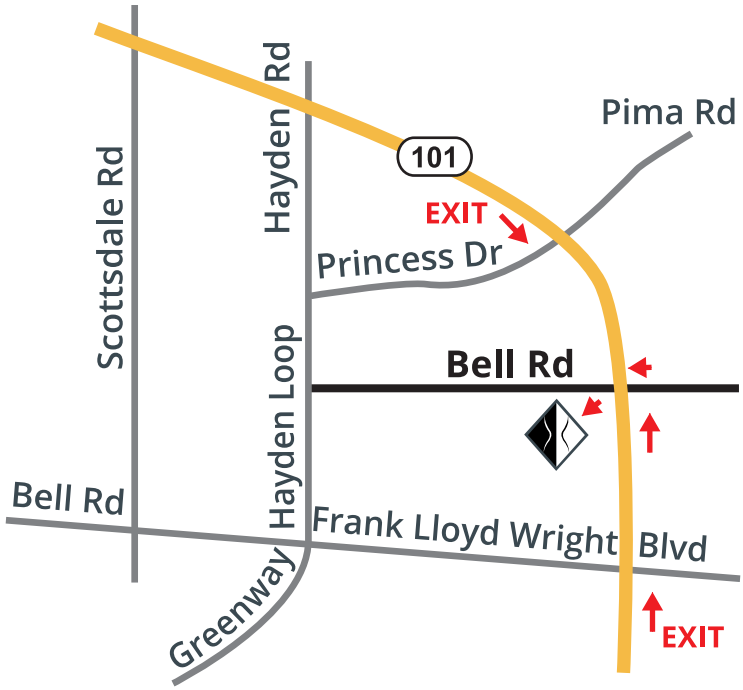

Heading 101 East

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.

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