Renaissance Cosmetic Laser & Surgery
Dr. Taek Y. Kim, M.D., FAACS & FACOG
17W300 22nd Street. Suite 202
Oakbrook Terrace IL, 60181
Phone: 630.322.9090
Fax: 630-971-0364
www.rclsurgery.com

PATIENT INFORMATION

Name: _____
First Name Middle Initial Last Name

Date of Birth: _____/___ /___ _ Age: _____ Sex: ☐ Male ☐ Female Marital Status: _____

Address: _____
Street **Apt#** **Town** **State** **Zip Code**

_____
Home Phone Cell Phone Work Phone

Email: _____ Preferred Contact: _____

Emergency Contact**:** _____Relationship: _____Cell #_____

Primary Care Physician: _____Phone #: _____

How were you referred: ☐ Event: _____ □ Patient: _____
☐ Magazine: _____ ☐ Website: _____
☐ Email ☐ Groupon ☐ Radio ☐ Living Social ☐ Dr. Kim's OB GYN ☐ RCL Employee: _____
☐ Physician: _ _____ ☐ Mailing: _____ ☐ Other: _____

INSURANCE INFORMATION

Primary Insurance: _____ Insured's Name: _____

Relationship to insured: _____ Insured's SS#: _____-_____ - _____

Insured's DOB: _____ /_____ / _____ Policy #: _____ Group #:_____

Phone#: _____Relationship to insured: _ _____Insured's SS#: _____-_____ -_____

Insured's DOB: _____/_____ / _____Policy #: _____ Group #: _____ Phone#: _____

I understand that I have insurance coverage with the above mentioned group and assign payment directly to Dr. Taek Y. Kim, M.D., S.C. In the event that my insurance is considered out-of-network with Dr. Kim, I am aware that I am financially responsible for all charges whether or not paid by insurance. I also understand that cosmetic procedures will not be eligible for insurance submission and that payment is due at the time which services are rendered. I am aware of the Renaissance Cosmetic Laser.

Patient Signature Cell # Date

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MEDICAL HISTORY FORM

Name: _____
First Name Last Name

DOB: _____ Age: _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____

Do you smoke: ☐ Yes ☐ No If yes, what type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Other _____

How much: _____ how often: _____

Do you drink: ☐ Yes ☐ No If yes, how much: _____ how often: _____

***FOR FEMALE PATIENTS ONLY:** Are you pregnant: ☐ Yes ☐ No Are you trying to conceive: ☐ Yes ☐ No

***FOR BREAST CONSULTATION PATIENTS ONLY** (over the age of 40): Date of Last Mammogram: _____

Are you currently under the care of another Physician: ☐ Yes ☐ No If so, please explain why and provide
Name of the Physician: _____
_____

Do you have any health conditions or disorders: ☐ Yes ☐ No If so, please list: _____
_____

Are you currently taking any medications, vitamins or herbal remedies: □ Yes □ No
If so, please list them:_____
_____

Medications	Dosage	How many times per day

Have you ever been Hospitalized: ☐ Yes ☐ No If so, please explain: _____
_____

Allergies: ☐ Aspirin ☐ Codeine ☐ Latex ☐ Norco ☐ Penicillin ☐ Please list ALL others:
_____

I certify that the above information is true and accurate to the best of my knowledge.

Patient Signature _____ Date: _____

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Are any of the following of interest to you? (Please check all that apply):

Patient Name _____ **Date**_____

Concerns

☐Acne
☐Scar Removal
☐Aging Skin
☐Body Contouring (areas) _____
☐Excess Hair (areas) _____
☐Facial Lines and Wrinkles (areas) _____
☐Facial Veins
☐Leg Veins
☐Loss of Facial Volume
☐Melasma / Hyperpigmentation
☐Rosacea / Facial Redness
☐Sagging / Loose Skin (areas) _____
☐Skin Care / Sunscreen Advice
☐ Sun Spots / Age Spots
☐ Under Eye Circles
☐ Uneven Texture
☐ Weight loss
☐ Other, _____ _____

Non-Invasive Procedures

☐ BOTOX® Cosmetic (Botulinum Toxin Type A)
☐ Chemical Peels
☐ CO2 Fractional Laser Resurfacing
☐ Dermaroller
☐ Facials
☐ IPL
☐ Injectable Fillers (Artefill, Juvéderm, Restylane, Sculptra)
☐ Laser Hair Removal
☐ Laser Leg Vein Treatments
☐ Latisse Eyelash Growth Kit
☐ Lip Augmentation
☐ Microdermabrasion
☐ Photorejuvenation
☐ Skin Care Products
☐ Skin Tightening
☐ Therapeutic Ultrasound
☐ Vampire Face Lift
☐ Other_____

Surgical Procedures

☐ Breast Augmentation
☐ Breast Lift
☐ Eyelid Surgery
☐ Liposuction (areas) _____
☐ Labioplasty
☐ Mini Tummy Tuck
☐ Neck Rejuvenation
☐ Tummy Tuck
☐ Vaginal Rejuvenation
☐ Other _____

When looking at my face, the first thing I notice is:

When looking at my body in the mirror, the first thing I notice is:

Do you have any additional comments, questions or concerns that you would like to discuss with the doctor?

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HIPAA AUTHORIZATION FORM

I _____ HEREBY acknowledge receipt of the Notice of Privacy for RCL Surgery regarding my private health information. I have read and understand the manner in which my private health information will be maintained and utilized by RCL Surgery. I also consent to the right of RCL Surgery to disclose this information to the third party companies mentioned below. I understand my rights contained therein the Notice of Privacy Practices and I acknowledge my right to revoke this authorization at any point in time, only by submitting written notice to RCL Surgery.

I also consent to the release of my private health information by RCL Surgery to the following people.

Name: _____ Relationship: _____

Contact # _____ Additional Information: _____

_____

Name: _____ Relationship: _____

Contact # _____ Additional Information: _____

_____

Name: _____ Relationship: _____

Contact # _____ Additional Information: _____

_____

I acknowledge I have read and understood the contents of this form:

Patient Print Name _____ Date _____

Patient Signature _____ Date: _____

Witness Signature _____ Date _____

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Notice of Privacy Practices

Effective Date: **September 20, 2012**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

1. Summary of Rights and Obligations Concerning Health Information. Renaissance Cosmetic Laser is committed to preserving the privacy and confidentiality of your health information, which is required by law. We are required by law to provide you with this notice of our legal duties, your rights, and our privacy practices, with respect to using and disclosing your health information that is created or retained by Renaissance Cosmetic Laser. We may use and disclose your health information to plan and provide your care/treatment, communicate with other providers such as referring physicians and receive payment from you or your health insurance provider. We may also use and disclose your health information to make you aware of services and treatments that may be of interest to you, make quality assessments and work to improve the care we render and the outcomes we achieve, known as health care operations and comply with state and federal laws that require us to disclose your health information.

We may also use or disclose your health information where you have authorized us to do so. Although your health record belongs to Renaissance Cosmetic Laser, the information in your record belongs to you. You have the right to:

Ensure the accuracy of your health record, request confidential communications between you and the employees of Renaissance Cosmetic Laser, request limits on the use and disclosure of your health information and request an accounting of certain uses and disclosures of health information we have made about you.

We are required to: Maintain the privacy of your health information, abide by the terms of our most current *Notice of Privacy Practices*, notify you if we are unable to agree to a requested restriction. We are also required to provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you..

We reserve the right to change our practices and to make the new provisions effective for all your health information that we maintain. Should our information practices change, a revised *Notice of Privacy Practices* will be available upon request. If there is a material change, a revised Notice of Privacy Practices will be distributed to the extent required by law. We will not use or disclose your health information without your authorization, except as described in our most current *Notice of Privacy*.

2. We may use or disclose your medical information in the following ways:

A. Treatment. We may use and disclose your protected health information to provide, coordinate and manage your care. That may include consulting with other health care providers about your health care or referring you to another health care provider for treatment. For example, we will release your protected health information to a specialist to whom you have been referred to ensure that the specialist has the necessary information he or she needs to diagnose and/or treat you.

B. Payment. We may use and disclose your health information so that we may bill and collect payment for the services that we provided to you. For example, we may contact your health insurer to verify your benefits, and may need to disclose to it some details of your expected course of treatment. The information on or accompanying the bill may include information that identifies you and your diagnosis, as well as services rendered, any procedures performed, and supplies used.

C. Health Care Operations. We may use and disclose your health information to assist in the operation of our practice. For example, members of our staff may use information in your health record to assess the care and outcomes in your case and others like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services we provide. We may use and disclose your health information to conduct cost-management and business planning activities for our practice.

D. Appointment Reminders. We may use and disclose Information in your medical record to contact you as a reminder that you have an appointment. We will call you at the specified phone number provided, two days before your appointment and leave a message on your answering machine or with an individual who you have agreed upon receiving certain health information. However, you may request that we call you only at a certain number or that we refrain from leaving messages and we will endeavor to accommodate all reasonable requests.

E. Treatment Options. We may use and disclose your health information in order to inform you of alternative treatments.

F. Release to Family/Friends. Our staff, using their professional judgment, may disclose to a family member or close personal friend, your health information to the extent it is relevant to that person's involvement in your care or payment related to your care. We may disclose the health information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law. However, please note that under Illinois state law, if a child age eighteen (18) or older requests that their medical information not be disclosed to a parent or guardian, we must comply with their request.

G. Newsletters and Other Communications. We may use your personal information in order to communicate to you via newsletters, emails, mailings, or other means regarding treatment options, health related information and promotional events.

H. Marketing. In most circumstances, we are required by law to receive your written authorization before we use or disclose your health information for marketing purposes. Under no circumstances will we sell our patient lists or your health information to a third party without your written authorization.

I. Public Health Activities. We may disclose medical information about you for public health activities such as reports of births and deaths, prevention or control of disease, injury, or disability and reports of child abuse or neglect. We may also disclose medical information about you for public health such as notifications to people who may have been exposed to a disease or may be at risk for contracting or spreading a disease, organ or tissue donation and notifications to appropriate government authorities if we believe a patient has been the victim of abuse or domestic violence.

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J. Food and Drug Administration (FDA). We may disclose to the FDA and other regulatory agencies of the federal and state government health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing monitoring information to enable product recalls, repairs, or replacement.

K. Research. We may disclose your health information to researchers when the information does not directly identify you as the source of the information.

L. Workers Compensation. We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

M. Law Enforcement. We may release your health information in response to a court order, subpoena, warrant, summons, or similar process of authorized under state or federal law, to identify or locate a suspect, fugitive, material witness, or similar person and about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement. We may also release your health information in regards to criminal conduct at Renaissance Cosmetic Laser, to coroners or medical examiners and to authorized federal officials for intelligence, counterintelligence, and other national security authorized by law;

3. Your Health Information Rights. You have the following rights regarding medical information we gather about you:

A. Right to Obtain a Paper Copy of This Notice. You have the right to a copy of this Notice of Privacy Practices at any time.

B. Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes medical and billing records. To inspect and copy medical information, you must submit a written request to Renaissance Cosmetic Laser.

C. Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may submit a written request to Renaissance Cosmetic Laser. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that was not created by us or it is accurate and complete.

D. Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures of your health information made by us. To request an accounting of disclosures, you must submit your request in writing to Renaissance Cosmetic Laser.

E. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. Cosmetic procedures will not be disclosed to a health plan. We will comply with your request unless the restricted information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to Renaissance Cosmetic Laser.

F. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by e-mail. To request confidential communications, you must make your request in writing to your provider or our privacy officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

G. Right to Receive Notice of a Breach. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include a brief description of the breach, including the date of the breach and the date of its discovery, if known, a description of the type of Unsecured Protected Health Information involved in the breach and steps you should take to protect yourself from potential harm resulting from the breach. The notice is also required to include a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches, contact information, including a toll-free telephone number, e-mail address, web site or postal address to permit you to ask questions or obtain additional information. We are required to immediately notify the Secretary of the breach of patient's private health information.

4. Complaints If you believe your privacy rights have been violated, you may file a complaint with us or with the Privacy Officer at the Healthcare and Family Services, P.O. Box 19159, Springfield, Illinois 62794-9159. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred. For a copy of the revocation form please visit http://www.hfs.illinois.gov/hipaa/forms.html. See the Office for Civil Rights website, www.hhs.gov/ocr/hipaa/ for more information. You will not be penalized for filing a complaint.