Nobhill
MEDICAL & AESTHETICS

PATIENT REGISTRATION

Patient Name	Today's Date	Date of Birth	Sex
Patient's Social Security Number	Email		
Home Address	City	State	Zip
Mailing Address if Different	City	State	Zip
Home Telephone Number	Work Telephone Number		
Occupation	Employer's Name		
Spouse Name			
Whom May We Thank for Referring You to Our Practice?			
NOTIFY IN CASE OF EMERGENCY			
Name	Relationship		
Home Telephone	Work Telephone		

Please Read Our Financial Policy Statement and Agreement

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal health care information (PHI). Please read it carefully before signing.

___Konstantin Bukov M.D.___, will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure.

By signing this authorization you acknowledge and agree that Konstantin Bukov M.D. may use or disclose Medical Records for the purpose(s) of Referral / Consultation.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Konstantin Bukov M.D.'s HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Konstantin Bukov M.D. has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Konstantin Bukov M.D. at any of its offices or by sending a written request with return address to:

Konstantin Bukov M.D.
909 Hyde St Suite 415
San Francisco CA 94109

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Konstantin Bukov M.D. for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Konstantin Bukov M.D. has taken action in reliance on it. A revocation is effective upon receipt by Konstantin Bukov M.D. of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization; (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA; (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity; or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

Konstantin Bukov M.D. will provide _____ with a copy of this signed authorization.
(Patient Name)

Acknowledged and agreed to by:

Signature:_____ DATE:_____

FINANCIAL POLICY

Patient Name: _____ Date of Birth: _____

BASIC POLICY Pay for service is due in full at the time service is provided in our office.
FOR PATIENTS WITH INSURANCE We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.
MEDICARE PATIENTS We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments or deductibles are due and payable at the time service is provided.
SURGERY FEES All copays, deductibles, and payments for noncovered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier.
NONCOVERED SERVICES Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.
PERSONAL INJURY CASES This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.
YEARLY HEALTH CHECKS Periodic preventive health checks may or may not be covered under your health insurance policy; however, they may be required by your physician.
MISSED APPOINTMENTS In fairness to other patients and the doctor, we required at least 24 hours' notice to cancel appointments. You may be charged $50 no show fee for missed appointments. After 3 no shows you may be discharged from the practice. The above applies to online cancelations as well.

I have paid my insurance deductible for the calendar year _____ ☐ Don't know

ASSIGNMENT OF INSURANCE BENEFITS Patients with insurances please read and sign below. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Dr. Bukov. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: _____ Date:

I have read, understood, and agreed to the above financial policy for payment of professional fees.
The patient is ultimately responsible for all professional fees.

Signature:_____Date:_____

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Name: _____ Date of Birth: _____

Preferred **Pharmacy Name**: _____

Pharmacy Location: _____ Pharmacy Phone: _____

Reason for today's visit: _____

Drug Allergies:

_____

_____

_____

Past Medical History (please check all that apply)**:**

- o Anxiety
- o ADD/ADHD
- o Arthritis
- o Atrial fibrillation
- o Bone Marrow Transplant
- o Breast Cancer
- o BPH
- o Colon Cancer
- o COPD
- o Coronary Artery Disease
- o Autism Spectrum Disorder
- o Anemia
- o Depressions
- o Diabetes
- o End Stage Renal Disease
- o GERD
- o Hearing Disorder
- o Hepatitis _____
- o High Blood Pressure
- o HIV/AIDS
- o High Cholesterol
- o Organ Transplant
- o Bleeding Disorder
- o Hyperthyroidism
- o Hypothyroidism
- o Leukemia
- o Lung Disease/Cancer
- o Lymphoma
- o Prostate Cancer
- o Radiation Treatment
- o Seizures
- o Stroke

Other _____

Past Surgical History (please include dates/year):

_____

_____

_____

Past Hospitalizations (please include condition, dates/year):

_____

_____

_____

Family History (include illness and familial relationship):

_____

_____

_____

***Page OVER →

Social History: (Please circle all that apply)

Cigarette Smoking:
Current every day smoker Current *someday* smoker
Former smoker Never smoked

Alcohol Use (Circle One): NONE
less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Exercise # of times/week: _____
Do you use recreational drugs? _____

Medications: (Please enter all current medications including vitamins, dose not required) ***If none, circle:*** **NONE**

_____
_____
_____

Please check all that apply:

- ☐ Exhaustion
- ☐ Low Energy
- ☐ Acne/Breakouts
- ☐ Sun damaged skin
- ☐ Brown spots
- ☐ Hormone Therapy
- ☐ Wrinkles
- ☐ Discoloration of the skin
- ☐ Weight Management
- ☐ Hormone Replacement
- ☐ Establish Primary Care
- ☐ Urinary Incontinence (leakage)
- ☐ Problems Sleeping/Insomnia
- ☐ Anti-Aging Maintenance
- ☐ Laser Vaginal Therapy
- ☐ Skin Firmness/Skin Laxity
- ☐ Bio-Identical Hormone Balance
- ☐ Laser Hair Removal
- ☐ Botox/Fillers
- ☐ Skin Care
- ☐ Women's Health
- ☐ Impaired libido (Sex Drive)
- ☐ Thyroid or hormonal concerns

Women Only

Date of Last Menstrual Period: _____ Regular/Normal Cycle? _____ Spotting? _____

Last Pap Smear: _____ **Last Well Woman Exam:** _____ **Last Mammogram:** _____

Number of Pregnancies? _____ **# of Vaginal Births?** _____ **Birth Control Method**_____

Have you experienced (in the past or currently) - Urinary Incontinence? _____