Brandon K. Richland, M.D.
Plastic and Reconstructive Plastic Surgery

HISTORY AND PHYSICAL
PLEASE COMPLETE ALL AREAS!
(Black/Blue Ink Only)

PATIENT INFORMATION

Patient Name:____________________________________ Today's Date:____________________
Date of Birth:_______________ Age:_______ Height:_______Weight:_________ Male / Female
Address:____ Apt#__________
City____ State__________ Zip Code_______________

Home Phone:_________________________________ Ok to Contact? Yes or No (Please Circle)
Work Phone:_________________________________ Ok to Contact? Yes or No (Please Circle)
Cell Phone:__________________________________ Ok to Contact? Yes or No (Please Circle)
E-Mail Address:______________________________ Ok to Contact? Yes or No (Please Circle)

Place of Employment:_________________________ Occupation: _______________________________
Social Security #: ____________________________ Primary Care Physician:_____________________
Pharmacy Name: _____________________________ Pharmacy Ph#:______________________________

In case of emergency contact: Name:____
Phone:_________________________________ Relationship to patient:___________________________

Whom may we thank for referring you?____
Marital Status: Married Single Divorced Widowed

INSURANCE INFORMATION:

Is your insurance an: HMO / PPO / POS?
Name of Insurance Co:___________________ If an HMO, for which group:_______________________
Responsible party:____
Phone:___________________________________
Date of Birth:___________________ Age_________ Relationship to patient:_____________________
Social Security Number__________________
Address (If different than patient's): _______________________________________
City:________________________________State:____________________ Zip:_____________________
Employer:____________________________________ Phone Number:_______________________________

LIST PREVIOUS SURGERIES:

Procedure	Year	Complications	Type of Anesthesia

ALLERGIES AND ALLERGIC REACTIONS TO MEDICATIONS:

____

____

____

MEDICATIONS YOU ARE TAKING NOW:

Name of Medication	Dose / How often	Reason for taking:

VITAMINS AND HERBAL REMEDIES YOU ARE TAKING NOW:

Name of Medication	Dose / How often	Reason for taking:

PLEASE ANSWER ALL QUESTIONS BELOW:

Yes No

☐ ☐ Do you use Aspirin or medications containing Aspirin?

☐ ☐ Do you use Blood Thinners, (i.e. Coumadin, Heparin, Aspirin, or Ibuprofen)?
If yes, name of medication used and dose: ____

☐ ☐ Have you used diet pills in the last 2 weeks? If yes, which one: _____________________________

☐ ☐ Have you taken steroids in the last year? If yes, which one: _________________________________

☐ ☐ Have you ever smoked?
If yes, # of packs per day______ # of years: _______
If you quit, when: _____________?

☐ ☐ Do you drink alcohol? If yes, how much: _________________ How often: _______________

☐ ☐ Do you use recreational drugs?
If yes, type: _______________________________ How often: _______________?

☐ ☐ Have you or your immediate family had unusual reactions, problems or complications associated with anesthesia? If yes, describe: ____

☐ ☐ Do you or your family have malignant hyperthermia?

☐ ☐ Do you exercise? If yes, how often: __________________ How long: ________________________

☐ ☐ Is your level of activity related to health limitations? If yes, explain: _________________________

☐ ☐ Do you have caps, bridges, dentures, loose teeth? If yes, explain______________________________

☐ ☐ Do you have dry eyes? ______________________

☐ ☐ Do you use herbal medications, such as: St John's wart, ginkgo biloba, ginseng, garlic, echinacea etc?
If yes, describe ____

☐ ☐ Do you have a history of breast cancer?

☐ ☐ Do you have a history of bleeding disorders?

☐ ☐ Do you have a history of autoimmune or connective tissue disorder?

☐ ☐ Have you ever been treated/diagnosed for psychiatric disorders?
If yes, describe ____

FAMILY HISTORY:

Yes No

☐ ☐ Do you have a family history of breast cancer? Which family member? ______________________

☐ ☐ Do you have a family history of bleeding disorders? Which family member? ___________________

☐ ☐ Do you have a family history of autoimmune or connective tissue disorder? Which family member? _______________________

☐ ☐ Do you or any immediate family remembers have a history of adverse reactions to anesthesia?
If so, please list the reaction: ____

MEDICAL HISTORY: Have you ever had any of the following? Check all that apply.

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
☐	☐	Heart Attack	☐	☐	Asthma	☐	☐	Artificial Joint
☐	☐	Coronary Artery Disease	☐	☐	Prosthesis			Which Joint?________________
☐	☐	Angina, Chest Pain	☐	☐	Sleep Apnea	☐	☐	Neck Pain
☐	☐	Shortness of breath w/ exertion	☐	☐	Snoring	☐	☐	Back Pain
☐	☐	Trouble walking 2 flights of stairs	☐	☐	Emphysema	☐	☐	Implanted defibrillator
☐	☐	Bronchitis	☐	☐	Congestive heart Failure			

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
☐	☐	Poor circulation	☐	☐	Blood clot in lung	☐	☐	Abnormal past EKG
☐	☐	Neck Pain	☐	☐	Diabetes	☐	☐	Pacemaker
☐	☐	Leg Pain	☐	☐	Hyperthyroidism	☐	☐	Bleeding Disorder
☐	☐	Abnormal sensations w/Exertion	☐	☐	Hypothyroidism	☐	☐	Easy Bruising
			☐	☐	Hypoglycemia	☐	☐	Frequent nosebleeds

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
☐	☐	Chest Pain	☐	☐	High Cholesterol	☐	☐	Anemia
☐	☐	Arm Pain	☐	☐	Blood in Urine	☐	☐	Heartburn
☐	☐	Neck Pain	☐	☐	Painful Urination	☐	☐	Dialysis
☐	☐	Irregular heart rate	☐	☐	Kidney stones	☐	☐	Change in bowel habits
☐	☐	High Blood Pressure	☐	☐	Urinary infection	☐	☐	Irritable Bowel
☐	☐	Heart murmur	☐	☐	Myasthenia Gravis	☐	☐	Bleeding w/bowel movement
☐	☐	Heart valve problems	☐	☐	Paralysis	☐	☐	Blood transfusion Date:__________
☐	☐	Swelling feet/ankles	☐	☐	Arthritis	☐	☐	Motion Sickness
☐	☐	Breast Disease	☐	☐	Stroke	☐	☐	Multiple Sclerosis
☐	☐	Prostate Disease	☐	☐	Seizures			**Do you have any specific needs?**
☐	☐	Cancer/Malignancy	☐	☐	Headaches	☐	☐	Hearing
		Location:_______________	☐	☐	Fainting	☐	☐	Vision
☐	☐	Radiation Therapy	☐	☐	Weakness	☐	☐	Living alone
☐	☐	Chemotherapy	☐	☐	Numbness	☐	☐	Transportation

If Female, is there a possibility of being pregnant? When was your last menstrual period? __________________

LIST ANY MEDICAL CONDITIONS NOT LISTED ABOVE

____

As a courtesy, our office will make every attempt to collect insurance benefits regarding your care with Dr. Richland, however, it has come to our attention that more insurance companies are now denying claims they have previously authorized. We therefore are obliged to inform you that you are ultimately responsible for any bills incurred with Dr. Richland.

A. AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I authorize payment directly to the undersigned physician of any surgical and / or medical benefits, if any otherwise, payable to me for his services.

B. AUTHORIZATION TO RELEASE MEDICAL INFORMATION:
I hereby authorize the undersigned physician to release any information acquired during the course of my examination and treatment.

To the best of my knowledge, the information contained in the above history and physical is complete, true and correct.

Patient Signature____
Date____________________________

COVID-19 Treatment Consent Form

I understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact, and as a result, federal and state health agencies recommend social distancing. I recognize that Dr. Brandon Richland and all the staff at Dr. Richland's practice and surgery centers are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment/procedure/surgery.

I understand that, even if I have been tested for COVID-19 and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID-19 after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms, proceeding with this treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in the following: a positive COVID-19 test, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital. I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself. I have been given the option to defer my treatment/procedure/surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery

I confirm that I have not experienced any of the following symptoms of COVID-19 in the past 14 days: fever, shortness of breath, loss of taste or smell, dry cough, runny nose, sore throat.

I confirm that I have had no exposure to anyone who has tested positive to COVID-19 within the past 14 days

I understand this is a rapidly evolving situation and there may be unforeseen circumstances outside of my or my provider's control.

____
Print Name

____________________________________ ________________________
Patient Signature or Representative Date

HIPAA Acknowledgement and Communication Form

We value you right to privacy; therefore, we would like you to determine how to handle our communications with you. We routinely call patients for the following reasons:

1. To confirm appointments
2. To review test results
3. To reply to your questions and/or concerns

If we attempt to contact you and you are not available, we may leave information for you by the following methods:

Leave information on an answering machine/voicemail

Leave information by email

Leave information with family members

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains Patient Rights section describing your rights under the law. You have the right to review the Notice before signing this Consent. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, billing, health care operations and other purposes in the Notice. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

I acknowledge that I have been offered and declined a copy of Notice of Privacy Practices.

____
Print Name

________________________________ ______________________
Patient Signature or Representative Date

Photo, Video, and Media Consent and Release

I hereby consent to be interviewed, recorded, photographed, videotaped, or filmed by Dr. Brandon Richland and/or representatives of Dr. Brandon Richland and I hereby voluntarily grant Dr. Brandon Richland, his affiliates, employees, representatives, and agents (collectively, "Dr. Richland") authorization to use and reproduce my name, likeness, voice, photographic image, videographic image, and oral or recorded statements and testimonials of any nature ("Depictions of Me") for purposes of publication, display or broadcast, including, but not limited to print, web, digital display and all other forms of media or social media.

I agree that any Depictions of Me produced or taken by Dr. Richland and/or representatives of Dr. Richland are the sole property of Dr. Richland and his successors and assigns. I understand that in some circumstances the Depictions of Me may portray features that could make my identity recognizable.

I hereby release all rights I may have in the Depictions of Me. I also hereby waive all claims, and release and discharge Dr. Richland from any and all claims, demands, costs, and liabilities, that may arise from the use of the Depictions of Me, including any claim for reimbursement or compensation.

I acknowledge that Dr. Richland will rely on this consent and release in producing, broadcasting, and distributing materials containing Depictions of Me, and that I will receive no money or remuneration of any kind from Dr. Richland related to this consent and release, or the materials covered by this consent and release.

I understand that in some instances once released, Depictions of Me may be copied by other parties beyond Dr. Richland's control. Even if the original is taken down, these copies may remain.

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Richland.

I understand that the information disclosed, or some portion thereof may be protected by State Law and/or Federal Health Insurance Portability and Accountability Act of 1996 (HIPPA).

I acknowledge that I have read this consent form in its entirety, or it has been read (or translated) to me, and I have had the opportunity to ask questions about it and understand it.

____
Print Name

____________________________________ ________________________
Patient Signature or Representative Date

PRACTICE POLICIES

We understand you have options when selecting medical providers and are grateful that you have decided to entrust your care to Dr. Richland and his team. We aim to surpass your expectations by delivering outstanding care and service, thus providing a comfortable and hassle-free experience.

Our objective is to offer timely and top-notch medical care. To achieve this, we have established an appointment/cancellation policy. This policy enables us to optimize the use of available appointments for patients who require medical attention. If you have any questions concerning our policies, please don't hesitate to contact our office.

OFFICE HOURS

Monday through Thursday 8:30am to 5:00pm
Fridays 8:30am to 4:00pm
Saturdays 8:30am to 3:30pm – may be available on request for select med spa and esthetician services

CONTACT INFORMATION

Phone: (714) 241 0646
General inquiries: reception@richlandmd.com
Cosmetic consult requests and inquiries: concierge@richlandmd.com
Med spa inquiries: concierge@richlandmd.com
Reconstructive or insurance inquires: scheduling@richlandmd.com

Our practice utilizes an after-hours and weekend answering service for emergencies only, that may be reached by calling our phone number and leaving a message with the answering service. Your call will be returned by one of our practitioners.

In the event of a true medical emergency, you should immediately go to the emergency department.

For non-urgent matters such as scheduling an appointment, prescription refills or test results, please call during regular business hours.

APPOINTMENTS

Our practice is committed to providing quality care to our patients. To ensure timely continued care, we require patients to schedule appointments in advance.

While we strive to schedule appointments appropriately, emergencies and delays can and do occasionally occur. For this reason, we kindly request your patience and understanding should a delay or rescheduling become necessary for your appointment date. We will do our best to accommodate you to the next available date.

To ensure quality care, our practice does not treat patients we have not seen, or have not been seen within the past year (i.e., we will not call in prescriptions or offer medical advice for patients prior to their initial visit, or if it has been over a year since your last visit). Should you require a prescription or medical advice, please feel free to schedule an appointment to ensure that we can offer you quality care.

ADVANCE CANCELATION POLICY

In order to be respectful of the needs of our patients please be courteous and let us know promptly if you are unable to attend or must cancel an appointment. This time will be reallocated to someone who is in need of treatment. Appointments are in high demand, and your early cancellation will allow another person the ability to have access to an appointment.

"NO SHOW" AND LATE CANCELATION POLICY

A “no show” is someone who misses an appointment, while a late cancelation is someone who cancels their appointment less than 72 hours in advance. No-shows and late cancelations greatly inconvenience patients who require access to medical care in a timely manner.

In the event of a no show or late cancelation less than 72 hours in advance, there will be a $250 fee for visits scheduled with Dr. Richland, or a $150 fee for visits scheduled with other providers in our practice.

****PLEASE NOTE THAT NO-SHOW AND LATE CANCELATION CHARGES ARE PATIENT RESPONSIBILITY AND WILL NOT BE BILLED TO YOUR INSURANCE COMPANY**

VIRTUAL CONSULTS

For virtual consults there is a $100 charge, which can be used towards the cost of surgery or treatment being provided.

INSURANCE

If your visit is regarding a covered medical condition under your health insurance plan, please provide your insurance information at the time of scheduling your consultation.

Additionally please bring a copy of your drivers license or identification and health insurance card to the visit.

Should you have any questions about which insurances Dr. Richland is in network with, feel free to contact your insurance provider or our office at (714) 241-0646.

If you have any questions regarding your insurance bill, please contact our billing company at (714) 895-5614.

PAYMENT

Our practice accepts cash, cashier's checks, personal checks, and most major credit cards including MasterCard, Discover, Visa and American Express.

FINANCING

Our practice participates in Care Credit and Patient-Fi, which is a third party company for financing of cosmetic and plastic surgery procedures. For more information, please see our financing page (link).

RETAIL ITEMS RETURNS & EXCHANGES

If you wish to return a retail item for refund or exchange you may do so within 1 week of purchase. Items must be unopened, unused and in original packaging. We reserve the right to deny any return/exchange if item(s) do not meet these criteria. Sale items are non-returnable and considered final sale. We do not refund or reimburse return shipping costs.

FORMS & LETTERS

We understand that at times, various forms or letters may be required to assist you with your healthcare needs. Our staff will be happy to complete forms and write medical letters as necessary upon your request. We can commonly complete these requests within 1-2 business days, but please allow up to 7-10 business days in some cases.

MEDICAL RECORD

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form for release of medical information must be completed prior to receipt of these materials. Please use this link (link) for our HIPAA release form and return the completed form to our office. We can commonly complete these requests within 1-2 business days of receiving your completed form, but please allow up to 7-10 business days in some cases.

All patients can request a copy of their medical records one time, free of charge. For additional copies beyond the first, charges may apply.

PRESCRIPTION REFILLS & PHARMACY INFORMATION

Please inform our office of which pharmacy you use and update us if this should change. Please allow 1-2 business days for refill requests. We encourage our patients to closely monitor their medication supply, especially before weekends and holidays to ensure they don't run out.

Please note that due to federal regulations we are not able to fill controlled substances including narcotic pain control medications over the phone, on weekends, on holidays or after normal business hours.

____

Print Name

______________________________________ _________________________

Patient Signature or Representative Date

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

INSURANCE PATIENTS

I understand that with regards to my insurance coverage, I am coming to Dr. Richland for medical care and treatment. I understand that Dr. Richland's office will attempt to submit pre-authorization for the service, if required, to my insurance company, however any verbal or written pre-authorization by my insurance company does not guarantee that the service will be covered and paid for. If my insurance declines coverage and reimbursement for the service, it will be my responsibility to pay for the services in full.

Even if the service is covered by my insurance company, I understand I am responsible for all co-payments, deductibles and out of pocket maximum as it pertains specifically to my insurance plan. I understand that any services not covered or not reimbursed by my insurance will be billed to me and I will be financially responsible for it.

COSMETIC PATIENTS

Surgeon's Fee

The surgeon's fee entitles the patient to one full year of pre and post-operative visits with Dr. Richland. However, the patient is responsible for any and all additional fees necessary prior to or after surgery including but not limited to: labs, EKG, pre-operative testing or imaging, prescriptions, medical clearance and pathology etc. In addition, any and all unforeseen expenses related to surgery including but not limited to: emergency room/hospital fees, additional medications, complications or additional surgery are not covered under this agreement. No refunds, revisions will require additional fees as well.

Surgery Center and Anesthesia Fees

The estimated surgery center and anesthesia fees are shown in this estimate, but are paid separately to both the facility and the anesthesia provider the day of surgery (unless your surgery is at Precision Surgical Arts). These fees are only finalized after the operation and may be either higher or lower than the original estimate depending on the final operative time.

Cancellation Policy

If you cancel your surgery more than twenty-one days in advance of your surgery date, you will be subject to a 20% non-refundable administrative fee, or $1000, whichever is greater.

If you cancel your surgery less than twenty-one days in advance of your surgery date, you will be subject to a 50% non-refundable administrative fee.

If you have rescheduled your surgery previously and then choose to cancel, you will be subject to the 50% non-refundable administrative fee.

Re-scheduling Policy

If you re-schedule your surgery more than twenty-one days in advance of your surgery date, this fee can be transferred to your next scheduled surgery date.

If you re-schedule your surgery less than twenty-one days, but more than seven days in advance of your surgery date, you will be subject a 20% non-refundable administrative fee, or $1000, whichever is greater.

If you re-schedule your surgery seven days or less in advance of your surgery date, you will be subject to a 50% non-refundable administrative fee.

If you used a credit card, or financed your surgery through any credit agency such as Care Credit and wish to cancel or reschedule your surgery and/or loan, you will be responsible for any fees charged.

Late Arrival Notice

The operating room and anesthesiologist have been booked for the duration of your surgery. If you are more than 15 minutes late to your scheduled arrival time, your surgery may be canceled. If your surgery is canceled, you will be responsible for all fees including the surgeons fee and possibly the facility fee and anesthesia fee depending on the policy of the surgery center.

For office based procedures or appointments, if you arrive more than 15 minutes late to your scheduled arrival time, your procedure/appointment will be canceled. You will be subject to a non-refundable $150-$250 cancelation fee. If you are late, but less than 15 minutes, your procedure/appointment time will be reduced to stay within the scheduled procedure appointment time.

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Print Name

_____________________________________ _________________________

Patient Signature or Representative Date

PATIENT-PHYSICIAN ARBITRATION AGREEMENT

ARTICLE 1: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contractual agreement were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contractual agreement, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2: I understand and agree that this Arbitration Agreement binds me and anyone else who may have a claim arising out of or related to all treatment or services provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn at the time of the occurrence giving rise to any claim. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress, or punitive damages. I further understand and agree that if I sign this Agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound by this Agreement, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this Agreement relates to claims against the physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete resolution of any dispute arbitrated under this Agreement, as set forth in the Medical Arbitration Rules of the California Medical Association and the California Hospital Association.

ARTICLE 3: I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

ARTICLE 4: On behalf of myself and all others bound by this Agreement as set forth in Article 2, agreement is hereby given to be bound by the Medical Arbitration Rules of the California Medical Association and the California Hospital Association, as they may be amended from time to time, which Rules are hereby incorporated into this Agreement. A copy of these Rules is included in the pamphlet in which this Agreement is found. Additional copies of the Rules are available from the California Medical Association, 1201 J Street, Suite #200 Attention: Publication Department, Sacramento, CA 95814 or at www. cmanet.org. I understand that disputes covered by this Agreement will be covered by California law applicable to actions against health care providers, including the Medical Injury Compensation Reform Act of 1975 (including any amendments thereto).

ARTICLE 5: I have read and understand all of the information in this pamphlet, including the Introduction to the Patient-Physician Arbitration Agreement, this Agreement, and the Rules. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACTUAL AGREEMENT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS AGREEMENT.

____ Dated: __________
(Patient, Parent, Guardian or Legally Authorized Representative of Patient)

If signed by other than patient, indicate relationship: ______________________________

Brandon Richland MD Inc
9900 Talbert Ave, Suite 101
Fountain Valley, CA 92708