J. Timothy Katzen, MD
Body by Katzen

Combining the Art and Science of Aesthetic Surgery

9735 Wilshire Blvd, Suite 407, Beverly Hills, CA 90212 (888) KATZEN-0 or (310) 859-7770

Patient Information Questionnaire

Date: ____________________

First Name: ___________________________ Last Name: ___________________________________

Address: ____ Apt#_______

City: _________________________________ State: ____________ Zip: _____________________

Date of Birth: M _____ D ______ Y ______ Age: ______ Sex: F ____ M _____

Home Phone: _____________________________________
May we contact you at this number? ☐ Yes ☐ No
May we leave a message at this number? ☐ Yes ☐ No

Cellular Phone: ___________________________________
May we contact you at this number? ☐ Yes ☐ No
May we leave a message at this number? ☐ Yes ☐ No

E-mail Address: ____
What type of information would you like to receive at this address?

- ☐ Upcoming appointments or procedures
- ☐ Dr. Katzen seminars and conferences
- ☐ New products or services
- ☐ Other information that we think may be of interest to you

Your Social Security Number: ___________________ Driver License: _________________________

Your Employer: ____

Work Phone: _______________________________________
May we contact you at this number? ☐ Yes ☐ No
May we leave a message at this number?☐ Yes ☐ No

Your Spouse or Parent's Name: ______________________________ Phone: ___________________

Emergency Contact: _______________________________________ Phone: ___________________

Physical Examination
I am interested in the following areas:

□ FOREHEAD	□ EYEBROWS	□ EYELIDS	□ NOSE
□ CHEEKS	□ LIPS	□ CHIN	□ NECK
□ BREASTS	□ ARMS	□ ABDOMEN	□ HIPS
□ INNER LEGS	□ OUTER LEGS	□ CALVES	□ BUTTOCKS
□ TEETH	□ VEINS	□ POSTURE IMPROVEMENT	
□ OTHER			

If you decide to have surgery would you be interested in donating your excess skin? □ Yes □ No

Can Musculoskeletal Transplant Foundation contact you regarding this donation? □ Yes □ No

Chief Complaint ____

____

____

Who may we thank for referring you? ______________________________

How did you hear about us?

□ Friend (List name) ______________________________

□ Another Physician (List name) ______________________________

□ Internet (Please be specific) ______________________________

□ Seminar / Support Group (List location) ______________________________

Who is your Primary Doctor?

Name: ____ Phone #: _________________

Address: ____

Height: __________

Present Weight: ______________________ How long have you been at this weight? ____________

What was your heaviest weight? ________________________________ When? ___________

Your Total Weight Lost from Bariatric Surgery: ____

Natural color of eyes as a child: __________ Natural color of hair as a child: _________________

Past Medical History

Please tell us if you have had the following:

			(Explain, if necessary)	Still Have
Blood Pressure Problems:	☐ Yes	☐ No	______________________	☐
Heart Problems/Chest Pain:	☐ Yes	☐ No	______________________	☐
Hepatitis:	☐ Yes	☐ No	______________________	☐
Jaundice:	☐ Yes	☐ No	______________________	☐
Bleeding/Bruising Problems:	☐ Yes	☐ No	______________________	☐
Diabetes:	☐ Yes	☐ No	______________________	☐
Epilepsy/Seizures:	☐ Yes	☐ No	______________________	☐
Stroke/Nerve Damage:	☐ Yes	☐ No	______________________	☐
Asthma/Breathing Problems:	☐ Yes	☐ No	______________________	☐
Blood clots or Phlebitis:	☐ Yes	☐ No	______________________	☐
Other:			______________________	☐

____

____

List any major illness (other than childhood illnesses) that you have had:

____

____

Have you had any of the following tests within the last year?

Chest X-Ray ☐ Yes ☐ No   Blood Test ☐ Yes ☐ No
Mammogram ☐ Yes ☐ No   EKG ☐ Yes ☐ No

Any abnormal findings? If so please explain.
____

____

Past Surgical History

Please List ALL Surgeries

Operation	Date	Type of Anesthesia	Problems

If you had Bariatric Surgery, who was your Surgeon? _______________________

Do you scar poorly? ☐ Yes ☐ No

If so, please explain _______________________________

Did you have complications during any of your surgeries? ☐ Yes ☐ No

If so, please explain _______________________________

Date of Bariatric Surgery: M _____ D ______ Y ______
Type of Bariatric Surgery: ☐ Roux-En-Y ☐ Duodenal Switch ☐ Lap Band ☐ Fobi Pouch ☐ Other

Medications

What medications are you taking?

(Do not forget such as aspirin, cortisone, blood pressure medication, thyroid, tranquilizers, hormones, birth control pills, laxatives, vitamins, herbs, etc.)

Medicine	Dose	Average Frequency

Allergies

Are you allergic to any medications? ☐ Yes ☐ No

Medication________________________ Reaction____

Medication________________________ Reaction____

If you get rashes, where are they? ____

How long have you had these rashes? ____

Have you ever seen a physician for these rashes? _______________________________________

Name of Physician ____ Date: ____________

Treatment / Name of Medication Prescribed: ____

If you have not seen a physician, how have you treated these rashes? ________________________

____

Family History

Does anyone in your family has or had:

Cancer ☐ Yes ☐ No

Breast Cancer ☐ Yes ☐ No

High Blood Pressure ☐ Yes ☐ No

High Cholesterol ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

If any of the above is present, please explain how it was treated?

____

____

Has any blood relative ever had difficulty or problem with Anesthetics (e.g. malignant hyperthermia) ☐ Yes ☐ No

Social History

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor

Do you smoke? ☐ Yes ☐ No

If yes, how many a day ____________

Have you ever smoked? ☐ Yes ☐ No

If so, for how long ___________ months/years

Do you drink alcohol? ☐ Yes ☐ No

If so, how many drinks _________ day/week

Do you write with your right hand? ☐ Yes ☐ No

Have you ever seen a psychiatrist? ☐ Yes ☐ No

Psychiatrist Name: ________________________________ Phone Number ___________________________

Address: ____

City______________________________________ State _______________ Zip Code ___________________

If you are Female

Are you considering becoming pregnant soon? ☐ Yes ☐ No
Have you ever been pregnant? ☐ Yes ☐ No
If so, how many times have you been pregnant? ____________________
How many children do you have? ____________________
Date of your last period: ____________________
What bra size are you now? ____________________
What bra size do you want to be? ____________________
What was your largest breast size? ____________________

If you are considering breast surgery, do you have?

Lumps/bumps/cysts/masses in either breast ☐ Yes ☐ No
Breast Asymmetry (difference in size) ☐ Yes ☐ No
Bra strap groove pain ☐ Yes ☐ No
Neck pain ☐ Yes ☐ No
Upper back pain ☐ Yes ☐ No
Rashes under your breasts ☐ Yes ☐ No
If so did you try topical creams? ☐ Yes ☐ No
If you are female, have you ever breast fed? ☐ Yes ☐ No
How many months for each child? ____________
Have you ever had a mammogram? ☐ Yes ☐ No
If yes, date of last test. ____________________
Do you have difficulty performing your monthly breast exam? ☐ Yes ☐ No
Did you ever see a physician for any of the above problems? ☐ Yes ☐ No
If so, Who? ____________________ When? ____________________
Has any physician or chiropractor ever suggested breast reduction surgery? ☐ Yes ☐ No
If so, Who? ____________________ When? ____________________

Do you have any family members with breast cancer?
If so, Who? ____________________ Was she given ☐ Chemotherapy ☐ Radiation

Other Treatment ____

Insurance Information

☐Blue Shield ☐ CCN ☐ Blue Cross ☐Aetna ☐ Cigna ☐ Champus ☐ No Coverage ☐ Cash Patient

☐ Other: ____

Is your Insurance ☐ PPO ☐ HMO ☐ EPO ☐ POS ☐ Other: __________________________

If you have an HMO Insurance, you do not need to fill out the following questions.

Group No: ____________________ Insured ID Number: _________________________

Insurance Company's Phone # ____

Insurance Address: ____

Name of Insured: __________________________ Relationship to Patient: ___________

Birth Date: ____

Do you have additional Insurance? ☐ PPO ☐ HMO ☐ EPO ☐ POS Other: ______________

If you have an HMO Insurance, you do not need to fill out the following information.

Insurance Name ____

Address: ____

Insurance Company's Phone # ____

Group No: __________________________ Insured ID Number: ___________________

Your consultation today is free of charge. However if you decide that you would like Dr. Timothy Katzen's office to submit your information to your Insurance company for pre-determination on an anticipated surgery, we will be billing your Insurance company for the visit. Keep in mind we will accept what insurance pays as payment in full. You will not be held responsible for this cost or balance.
In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

I hereby authorize J. Timothy Katzen, M.D. to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment check(s) directly to the physician(s) rendering the covered services for the next 12-month period. I authorize J. Timothy Katzen, M.D. to furnish complete information to my insurance carrier or its intermediaries regarding services rendered. Payment Default: In the event of payment default, I agree to be responsible for any and all collection fees.

Signature: ____________________________________ Date: _______________________

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and n01 by a lawsuit or resort to court process except as California law-provides for judicial review of arbitration proceedings. Both parties to this contract, by entering Into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service 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. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement. not supplant. any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the Intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if. asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant falls to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation**: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition. Article 6: **Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services.

____
Patient's or Patient Representative's Initials

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.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT 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 CONTRACT.

By:___________________________ Date __________

Physician's or Authorized Representative's Signature

____

Print or Stamp Name of Physician, Medical Group
Or Association Name

By:________________________________ Date __________

Patient or Patient Representative's Signature

By:____

Print Patient Name or Name of Representative and
Relationship to Patient

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

CONDITIONS OF TREATMENT

FINANCIAL RESPONSIBILITY: **I understand that I am individually responsible for any charges for services rendered by Dr. Katzen.** Furthermore, I accept personal responsibility for payment of all charges payable to Dr. Katzen and that the payment is due at the time the services are rendered. I further understand that after thirty days, interest at the rate of seven percent per month may be imposed on the outstanding balance.

INSURANCE COVERAGE: **I understand that although I may have health insurance coverage, the medical services are rendered and charged to the patient. Although Dr. Katzen may bill the insurance company as a courtesy to the patient, it is my responsibility to see that the bill is paid. I understand that I would be responsible for any balance that the insurance company does not pay.**

INSURANCE NOTIFICATIONS: I understand that Dr. Katzen may submit insurance claim forms and request pre-authorizations from insurance companies as a courtesy to his patients. However, I will not hold Dr. Katzen responsible for any nonpayment of claims or denial of services due to any real or perceived errors or inaccuracies associated with the filing of this information with the insurance company. Furthermore, Dr. Katzen is not responsible for collecting payments from any insurance company or for negotiating any type of settlement on a disputed claim.

THIRD PARTY RESPONSIBILITY: I understand that, although not found to be responsible for the payment of the medical services that are rendered and charged to me, it is my responsibility to see that the bill is paid in accordance with the above section of financial responsibility.

MANAGED CARE: **I understand that Dr. Katzen has no contract with any managed care health plan. This means that Dr. Katzen is not a provider for my plan and is not responsible to and is not governed by any contract that I may have with my health plan.** I will not hold Dr. Katzen responsible for any nonpayment of claims or denial of services due to any real or perceived errors or inaccuracies associated with obtaining pre-authorization for medical care from my health care plan. I specifically understand that I am individually responsible for any charges for services rendered by Dr. Katzen.

RELEASE OF MEDICAL RECORDS: I authorize the release of information from my medical record to any insurance company, organization or other agency which is or may be liable for payment of any portion of the charges of Dr. Katzen.

PEER REVIEW: I authorize Dr. Katzen to disclose complete medical information concerning my treatment to those physicians who will conduct medical quality assurance and peer review.

PERSONAL VALUABLES: I understand that Dr. Katzen is not responsible for any valuables in the form of money, jewelry, or other possessions of worth that are left in the office and not specifically given to the office staff for safekeeping and documented with a written receipt.

CONSENT FOR PHOTOGRAPHY: I give my full consent and approval for medical photography to be used for medical treatment, scientific research, education, or other purposes.

EXPOSURE INCIDENTS: I consent to the taking of my blood for laboratory testing which could include, but is not limited to, the testing for infectious diseases such as AIDS, hepatitis, or sexually transmitted diseases. I also give consent for Dr. Katzen and his staff to have knowledge of these results.

____ ____________________

Patient/Parent or Guardian Signature Date

CONSENT TO TREATMENT: I hereby give my consent for evaluation and treatment by Dr. Katzen. If I am the parent or guardian of a minor, then I give consent for Dr. Katzen to treat and provide follow-up care for this person.

MEDICARE AND/OR MEDI-CAL ASSIGNMENT: If I am covered by Medicare and/or Medi-Cal, I request that payment of Medicare and/or Medi-Cal benefits be made to Dr. Katzen on my behalf for any medical service furnished to me by Dr. Katzen. I also acknowledge that I am being notified that there may be physician services provided that are charged to Medicare and/or Medi-Cal which may be determined to be "non-covered" and that if these charges are disallowed as "non-covered" by Medicare and/or MediCal, then I agree to accept full financial responsibility for payment of these services

INSURANCE ASSIGNMENT: I hereby assign to Dr. Katzen the insurance benefit to which I am entitled for medical services that are billed but not to exceed my indebtedness to Dr. Katzen.

I have read both pages of this form and acknowledge receipt of a copy of this form. I agree that a copy of this form and contained authorizations shall be as valid as the original. I understand all of the elements of the above policy and agree to be bound by them and agree that they are irrevocable.

Patient/Parent or Guardian Signature   Date   Drivers License Number   State

Witness Signature   Date

RESPONSIBLE PERSON:

I accept personal financial responsibility for payment of all charges payable to Dr. Katzen and that the payment is due at the time the services are rendered. I understand that I am individually responsible for any charges for services rendered by Dr. Katzen. I further understand that after thirty days, interest at the rate of seven percent per month may be imposed on the outstanding balance.

I agree that, in the event of nonpayment of charges, I will bear the cost of collection, including collection agency fees, reasonable legal fees and court costs, should they be required.

I understand that although I may have insurance coverage or other third party coverage, the medical services that are rendered will be charged to me. It is my responsibility to see that the bill is paid in full.

Responsible Person Printed Name   Patient Name (if different)

Address   Phone

Responsible Person Signature   Drivers License Number   State

Witness Signature   Date