



Jaime S Schwartz MD FACS  
Plastic Surgery | Beverly Hills

### **NEW PATIENT WELCOME FORM**

**Welcome to our practice.** We are honored you have chosen Jaime Schwartz MD. We are committed to making your experience with us the finest possible. We respect your time and will do whatever we can to stay on schedule. We realize circumstances may keep you from your scheduled appointment, therefore:

**Please be on time.** If you arrive more than 15 minutes late, it is likely we will need to reschedule you for a later time or date. This allows us to give each patient our undivided attention.

**If you need to cancel your appointment,** please do so 24 hours in advance. Existing patients who **do not show up** to their appointment will be charged a **\$100 no-show fee**, which can be credited towards any procedures or products here in the office.

**Please sign to indicate that you agree**

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

2/8/22

Drusilla Arguijo

## **PATIENT FINANCIAL RESPONSIBILITY FORM**

Please read this form completely to understand our policies.

### **COSMETIC PROCEDURES & SURGERY**

- Cosmetic procedures & surgery is not a benefit that is paid by most health insurance plans. We expect full payment for these procedures on the payment schedule given to you by the patient care coordinator.

### **INSURANCE COVERAGE & CHANGES**

- It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by your insurance carrier.
- We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of your visit, the financial responsibility for payment is yours.
- If you have had any changes in your insurance coverage - even if there is only a small change in the co-payment amount or a change in the expiration date of the policy - you must notify us. Even a small discrepancy on the chain form can lead to a claim denial.

### **CO-PAYMENTS, CO-INSURANCE AND DEDUCTIONS**

- Co-insurance and co-payments are the patient's responsibility. Co-pays are due at the time of visit.
- Deductibles are patient's responsibility. The deductible is determined by the contract you have with your insurance carrier. We do not know how much each person's deductible is and how much has been met at the time of your visit.

### **INSURANCE PAYMENTS**

- If insurance payments are sent to you, you are responsible for forwarding them to our office with a copy of the explanation of Benefits (EOB) received.
- You are responsible for responding to any request from the insurance company for further information. Not doing so will result in a claim denial and you will be responsible for payment.

### **LABS/PATHOLOGY**

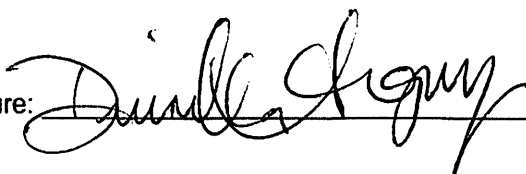
- If you are aware that your insurance carrier requires you to utilize certain labs for blood work or biopsies, it is your responsibility to inform our office prior to the lab being performed. Our office sends your insurance card information with the specimen to an outside facility. Lab or Pathology charges are separate charges from our office charges and you are responsible for them.

### **NON-COVERED SERVICE**

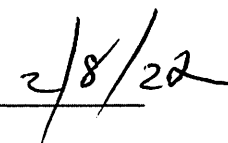
- All patients are responsible for "non-covered" services if denied by their insurance carrier.

**My signature below certifies that I have read and understand this agreement**

Patient Signature:



Date:



## **REQUEST FOR CONFIDENTIAL COMMUNICATION VIA EMAIL OR OTHER ONLINE APPLICATIONS**

Online communication is a form of communication using "secure" Web sites or e-mail applications that apply appropriate encryption technology designed to protect the transmission of confidential information. Online communication is an additional option for communication along with telephone, mail, and in-person. It is meant to replace other forms of communication with the doctor. I understand that under the Health Insurance Portability and Accountability Act of 1996, I have the right to make reasonable requests to receive confidential communications of my protected health information from Dr. Jaime Schwartz, Total Lipedema Care, TLC Surgical Center and Staff ("Practice") by alternative means or at alternative locations.

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### **IMPORTANT INFORMATION ABOUT EMAIL**

THIS NOTICE DESCRIBES THE RISKS ASSOCIATED WITH UNENCRYPTED EMAIL.  
PLEASE REVIEW IT CAREFULLY.

#### **SECURITY RISKS**

Most standard email providers such as Gmail, Yahoo, Hotmail, etc. do not provide a secured or encrypted means of communication. As a result, there is risk that any protected health information contained in an email may be disclosed to, or intercepted by, unauthorized third parties. Additionally, email messages accessible through personal computers, laptops, or phones have inherent privacy risks especially when the email account is provided by an employer, when the account is not password protected, or the account is shared. Use of more secure communications, such as phone, fax or mail is preferred and always an available alternative. I understand that all medical communications carry some level of risk. While the likelihood of risks associated with the use of online communication in a secure environment is substantially reduced, the risks are nonetheless real and very important to understand. These risks include, but are not limited to:

- *It is easier for online communication to be forwarded, intercepted, or even changed without my knowledge.*
- *Online communication is easier to falsify than handwritten or signed hard copies. Backup copies may exist on a computer or in cyberspace, even after both of us have deleted our copies.*
- *I will use a secure network. I will not use standard e-mail or e-mail systems provided by employers. I understand that employers have a right to inspect and keep online communication transmitted through their system.*
- *Online communications become part of my medical record.*

#### **RESPONSIBILITY**

When consenting to the use of email through such unsecured or unencrypted systems, you are accepting responsibility for any unauthorized access or disclosure to protected health information contained within the message. The Practice will not be responsible for unauthorized access of protected health information while in transmission and will not be responsible for safeguarding information once it is delivered. The Practice will take steps to ensure that any email with protected health information is protected prior to being sent to the requested address and will use the minimum necessary amount of protected health

information when communicating with you. I agree to take precautions to keep online communication confidential, including but not limited to the following:

- *I will keep my password confidential.*
- *I will not store messages on an employer-provided computer.*
- *I will not leave messages on my screen for others to read.*
- *I will review my message before sending to make sure that they are clear and that all relevant information is included.*
- *I will update my contact information as soon as it changes.*


#### **ADDITIONAL INFORMATION**

It is important to understand that emails will not be used to replace or facilitate communications between you and your physician and will not be considered private communications. There is no guarantee that the Practice will be actively monitoring the inbox so responses and replies sent to or received by you or the Practice may be hours or days apart. Email messages may be inadvertently missed or errors in transmissions may occur. The Practice will not be responsible for any issues caused by delays in communications. If you have an immediate need or an emergency, you must contact the Practice by telephone or dial 9-1-1 if applicable. Practice staff will be utilized to monitor the inbox in order to properly direct or respond to communications received. Therefore, any information considered sensitive should not be included in your communications. At the Practice's discretion, any email message received or sent may become part of your medical record.

#### **I acknowledge and agree to the following:**

- I have received and reviewed the "Important Information About Email" notice; had an opportunity to ask questions and have had such questions answered to my satisfaction; and understand the information contained within the notice.
- Despite the possibility that my email system may not be encrypted or secure and there are no assurances of confidentiality, I consent to the Practice communicating with me via email.
- The email address I provided in my patient account is accurate and it is my responsibility to update the Practice of any changes.
- I may withdraw this consent at any time by delivering written notice to the Practice.
- Alternative methods of communication (i.e., telephone, in-person, mail) are still available to me.
- I am responsible for taking steps to protect myself from unauthorized use of online communication. The doctor is not responsible for breaches of confidentiality caused by an independent third party or me.
- I understand that online communication should not be used for emergencies or time sensitive matters.
- I understand that it is my responsibility to determine if an unanswered online communication was received.
- My healthcare provider and I have agreed to correspond using electronic mail (e-mail). This form provides guidelines for the intended use of this type of communication and documents my consent.

**By reviewing and signing this form, I am requesting "Practice" communicate with me via email or other online applications.**

Patient Signature:  Date: 2/8/22