

REGISTRATION FORM: Please Print

Complete ALL sections that apply to the patient.

Missing information may result in charges billed directly to the patient. **PATIENT INFORMATION – PAGE 1**



Last Name:		First Name:		M.I.:		
Also known as or maiden name:						
Marital Status: Single Married		Date of Birth:		Age:		
Sex: M F		Social Security #*:				
Race/ Ethnicity: Black/ African American		White/ Caucasian		Native Hawaiian/ Other Pacific Islander		
Multiple Races		American Indian/Alaska Native		Asian Unknown Other or Prefer not to specify		
Preferred Phone #:			Home	Cell	Work	
Second Phone#:			Home	Cell	Work	
Street Address:				P.O. Box/ Apt#:		
City:		State:		Zip Code:		
E-mail Address:						
Employer:			Phone#:			
Primary Care Physician:			Phone#:			
Did a Physician refer you to this Office or did you Choose this office yourself?:				Physician	Self	
If a Physician, Please state who:						
Preferred Pharmacy:			Phone#:			
Pharmacy Location/ Cross Streets:						

INJURY INFORMATION

Non-Work Related Injury: Yes No If yes, please specify Date of Injury:					
Work Related Injury: Yes No If yes, please specify Date of Injury:					

IN CASE OF AN EMERGENCY

Emergency Contact:		Relationship to Patient:			
Home Phone#:		Work Phone#:			

Our electronic medical record system (EMR) requires your social security number as your unique identification number. Please help us provide you with the highest quality of care by sharing your social security number. This is very important because without your social security number as an identifier, your electronic medical record may not be complete or may contain inconsistencies. Please be confident your social security number is used only used for this purpose – it is never printed out. It is protected from misuse just as we protect your health information.



REGISTRATION FORM: Please Print

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Last Name:	First Name:	M.I.:
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INSURANCE INFORMATION – Please give your insurance card to the receptionist.

Guarantor Information: <i>Check here if same as patient</i>	
Responsible Party:	Date of Birth:
Address (if different from patient):	Home Phone#:
Occupation:	Employer:
Employer Address:	Phone #:

PRIMARY INSURANCE – Insurance Company Name:

Subscriber’s Name:	Subscriber’s SSN#:
Date of Birth:	Group #: Policy #:
Co-Pay: \$	Patient’s relationship to subscriber: Self-01 Spouse-02 Child-03 Other:

SECONDARY INSURANCE (IF APPLICABLE) - Insurance Company Name:

Subscriber’s Name:	Subscriber’s SSN#:
Date of Birth:	Group #: Policy #:
Patient’s relationship to subscriber:	Self-01 Spouse-02 Child-03 Other:
Is this a worker’s compensation claim:	Yes No

Medicare Secondary Reason Code (Must check one if Medicare is Secondary):

- 12 **Working Aged** Beneficiary or Spouse with Employer Group Health Plan
- 13 End-Stage Renal Disease Beneficiary in the Mandated coordination Period with an Employer’s Group Health Plan
- 14 No-fault Insurance including Auto is Primary
- 15 Worker’s Compensation
- 16 Public Health Service (PHS) or Other Federal Agency (Government Research Program)
- 41 Black Lung
- 42 Veteran’s Administration
- 43 **Disabled** Beneficiary Under Age 65 with Large Group Health Plan (LGHP-Employers with 50+ employees)
- 47 Other Liability Insurance is Primary (Homeowners)

PRIVACY CLAUSE: A person is liable for constructive invasion of privacy when they attempt to capture, any type of visual image, sound recording, or other physical impression of another individual engaging in a personal or familial activity under circumstance in which that individual had a reasonable expectation of privacy. A person who violates these provisions would be subject to a civil fine of not less than \$5,000 and not more than \$50,000 [California Civil Code, Section 1708.8].

Patient/ Guardian Signature

Date

No Show & Appointment Cancellation Policy:

If you are unable to keep a scheduled appointment, please call us at least 24 hours in advance. No shows or cancellations within 24 hours will incur a penalty of **\$75.00 (Seventy Five Dollars)**. This fee is not covered by insurance and you will be responsible for this.

This is to attest that I understand and agree to the following forms and documents (which are also available online at www.fresno-plasticsurgery.com under the "FORMS" tab OR you can also request a printed copy):

1. No Show & Appointment Cancellation Policy
2. Authorization for Release of Patient Photographs
3. Agreement and Authorization for Services Consent Form
4. Financial and Billing Policies
5. Notice of Privacy Practices

Patient's Name in Print

Date

Patient's Signature

AUTHORIZATION FOR RELEASE OF PATIENT PHOTOGRAPH

I consent to the taking of photographs by **Dr. Sian** (or his designee) of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by **Dr. Sian**.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of **Dr. Sian** and may be retained by **Dr. Sian** or released by **Dr. Sian** for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to medical journals, textbooks and website, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in very rare circumstances the photographs may portray features that may make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information but will not affect the health care services I presently receive, or will receive, from **Dr. Sian**.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so, it won't have any effect on any actions taken prior to my revocation.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I release and discharge **Dr. Sian** and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

Agreement and Authorization for Services Consent Form

I. Consent for Diagnosis and Treatment

I acknowledge and understand that, in presenting myself for treatment and medical care to Fresno Plastic Surgery, I authorize and consent to the administration and performance of all tests and treatments which may be ordered by the physician (and/or designated assistant) and carried out by members of the Fresno Plastic Surgery medical staff and personnel. I am aware that medicine is not an exact science and I acknowledge that no guarantees have been made to me regarding the results of treatment.

II. Retention of Information

I understand that Fresno Plastic Surgery may record medical and other information concerning my treatment in electronic and other physical form. Such information regarding my treatment and may be released by Fresno Plastic Surgery for the purposes authorized on this form. I understand that portions of my records may be disclosed to qualified non-Fresno Plastic Surgery personnel for purposes of conducting scientific or statistical research, management or financial audits, licensure and program evaluation, etc. I will not be identified by name or other personally identifying information in any report of such research, audit or evaluation without my express written consent.

III. Assignment of Benefits and Guarantee of Payment

In consideration of Fresno Plastic Surgery and medical services provided to me, I hereby assign Fresno Plastic Surgery and Dr. Kenty Sian all of my rights and claims for reimbursement under Medicare, group accident or health insurance policy for which benefits may be available for payment of the services provided. I agree to pay Fresno Plastic Surgery and Dr. Kenty Sian the balance due of all charges not paid for by the above mentioned coverage (excluding those charges not collectible pursuant to Medicare regulation). This may include costs of collection and/or reasonable attorneys' fees.

Agreement and Authorization for Services Consent Form

I have read each of the foregoing, I-III and fully agree to each of the statements and agreements herein, which may include inpatient treatment after emergency or outpatient care, by signing below as my free and voluntary act.

Financial and Billing Policies

Thank you for choosing **Dr. Kenty U Sian**. We are committed to clinical excellence in meeting your health care needs. We participate with a variety of insurance plans and will directly bill your insurance under these plans.

We understand that billing and payment for health care services can be confusing and complicated. It is important for you to know the information contained in your specific health plan, including any co-payments and other provisions. If you have any questions, call your health plan's member services department. Their number is listed in your benefit plan booklet or on your ID card.

Inform us of changes: If you are a current patient, please inform us if your personal or insurance information has changed since your last visit. The lack of current information may cause delays in care and payments.

Bring your health information: Bring your health insurance information to every visit. This includes identification, all insurance cards, and authorization/referral forms. We will ask you to sign forms such as a release of information, assignment of benefits and possibly additional forms dependent on your visit.

Co Payments, Deductibles and Coinsurance: Co-pays are due at the time of your visit. Under the terms of our contract with the insurance plans, we cannot waive any amounts that are the patient's responsibility. If you have any questions regarding your copayments or deductibles, please call your insurance company. For your convenience, we accept cash, checks, debit, VISA and MasterCard.

Deposits: For certain procedures not covered by insurance, you may be required to pay a deposit or pay for the service in full prior to treatment.

Prior Authorization: Most health plans require authorization for elective services. If your insurance company decides your service was not medically necessary, is pre-existing, or is not a covered service, you will be asked to pay prior to the time of service.

HMO/Managed Care Plans: It is your responsibility to make sure a current referral has been obtained for your care with our physician. If a referral has not been obtained by your appointment, you may need to reschedule your visit. We are sorry for the inconvenience, but without the proper referral, our physician will not be reimbursed for the service provided.

Workers Compensation: Please bring your claim number, date of injury, adjustor's name and phone, and employers/work compensation information. Your claim needs to be valid for your medical condition and the reason of your visit.

Patient Responsibility Balances: All patient balances are billed at the beginning of each month. Balances are due within 30 days. You will receive your statement once your insurance has paid their portion of the bill.

Confidentiality: Our Patient Account Representatives will only speak with the patient or the person designated in writing by the patient to receive the bills on behalf of the patient.

Thank you for reviewing our billing policies. All billing inquiries are handled by our billing staff. If you have questions, please call Tracy or one of her staff members at (559) 253-2802. Staff members are available and ready to help you, Monday through Friday from 8:30 AM to 4:00 PM.

I have read, understand and agree to the above Billing Policies. I understand charges not covered by my insurance company, as well as applicable copayments and deductibles, are my financial responsibility.

I authorize my insurance benefits to be paid directly to **Kenty U. Sian, MD Inc.**. I authorize Dr. Sian to release medical information to my insurance company as necessary. I have given complete and accurate information and agree to inform Dr. Sian and his staff of any changes regarding my personal billing information or my insurance billing information.

NOTICE OF PRIVACY PRACTICES

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

If you have any questions about this notice or would like to request further information about our privacy policies and procedures, please contact our office at:

Kenty U. Sian, MD
1855 E. Alluvial Avenue, Suite 101
Fresno, CA 93720
(559) 797-0501

WHO WILL FOLLOW THIS NOTICE?

This notice describes information about our privacy practices followed by our employees, staff, office personnel, and other members of our workforce. The practices described in this notice will also be followed by all healthcare providers with whom you might consult with by telephone (when your regular healthcare provider from our office is not available) and by those who provide “call coverage” for your healthcare provider.

OUR RESPONSIBILITIES AS REQUIRED BY LAW

This notice applies to the information and records we have about your health, health status, and the healthcare and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose protected health information about you and describes your rights and our obligations regarding the use and disclosure of that information. We shall maintain the privacy of protected health information and provide you with notice of our legal duties and privacy practices with respect to your protected health information. As part of our obligations, we shall notify affected individuals following a breach of unsecured protected health information. We have the right to change our Notice of Privacy Practices and we will apply the change to your entire health information, including information obtained prior to the change. We shall abide by the terms of the Notice of Privacy Practices currently in effect. We will post a notice of any changes to our Privacy Policy in our office lobby, on our practice website, and make a copy available to you upon request. In circumstances where state or federal law may further restrict the disclosure of your protected health information, we shall follow the more stringent law.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following describes different ways that we may use or disclose your protected health information. For each, we will explain what we mean and provide an example of such use or disclosure. Please be aware that not every use or disclosure in a particular category will be listed. Nevertheless, all of the ways in which we are permitted to use or disclose your protected health information will fall into one of the categories below.

For treatment. We may use protected health information about you to provide you with medical treatment or services. We may disclose protected health information about you to physicians, allied health professionals, technicians, trainees, volunteers, office staff, or other personnel who are involved in your healthcare.

For example, your physician may be treating you for a heart condition and may need to know if you have any other health problems that could complicate your treatment. The physician may use your medical history to decide what treatment is best for you. The physician may also tell another physician about your condition so that physician can help determine the most appropriate care for you.

Different personnel in our office may share protected health information about you and disclose protected health information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering X-rays. Family members and other healthcare providers may be part of your medical care outside this office and may require information about you that we have.

For payment. We may use and disclose protected health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about a service you received so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Healthcare Operations. We may use and disclose protected health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your protected health information to evaluate the performance of our staff in caring for you. We may also use protected health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders. We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives. We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services. We may tell you about Health-Related Products or services that may be of interest to you.

Central California Health Information Exchange. We participate in the Central California Health Information Exchange (the “Exchange”), which is an electronic health record that is shared with other healthcare providers who participate in the Exchange and, in other certain limited circumstances, with other healthcare providers who are not Exchange participants, such as a specialist to whom you have been referred. Your electronic health record may also be available electronically for healthcare providers to access when it is determined that you require emergency care. You may opt-out of having your health information shared through the Central California Health Information Exchange.

SPECIAL SITUATIONS

We may use or disclose protected health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations.

To Avert a Serious Threat to Health or Safety. We may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would only be to someone able to help or prevent the threat.

Required by Law. We will disclose protected health information about you when required to do so by federal, state, or local law,

Research. For research purposes under certain limited circumstances. Research projects are subject to a special approval process. Therefore, we will not use or disclose your health information for research purposes until the particular research project, for which your health information may be used or disclosed, has been approved through this special approval process. This process may include asking for your authorization.

Organ and Tissue Donation. If you are an organ donor, we may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence. If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required

by military command or other government authorities to release protected health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' compensation. We may release protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risk. We may release protected health information about you for public health reasons in order to prevent or control disease, injury, or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications, or problems with products; or to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities. We may release protected health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. This disclosure may be necessary for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with civil rights laws.

Lawsuits or Disputes. If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose protected health information about you in response to a subpoena.

Directory Information. We may disclose limited information regarding your name and location for directory purposes to those persons who ask for you by name or to a member of the clergy. You may request that we not include your name in the directory.

Vaccine Registry. We may use and disclose vaccine information about you or your child to help maintain a regional registry that will assist counties with maintaining continuity and coordination of services.

Law Enforcement. We may release protected health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar processes, subject to all applicable legal requirements.

Coroners, Medical Examiners, and Funeral Directors. We may disclose protected health information regarding a deceased person to: 1) coroners and medical examiners to identify cause of death or other duties, 2) funeral directors for their required duties, and 3) procurement organizations for purposes of organ and tissue donations.

Information Not Individually Identifiable. We may use or disclose protected health information about you in a way that does not individually identify you or that has been de-identified in accordance with applicable federal and state laws and regulations.

Fundraising and Marketing. We may contact you with information as part of our fundraising efforts, but you have a right to opt-out of receiving such communication.

Business Associates. There are some services provided to our organization through contracts with business associates, such as billing or transcription services. We may disclose your health information to our business associates so that they can perform these services. We require the business associates to safeguard your information in a manner consistent with applicable federal and state laws and regulations.

Family and Friends. We may disclose protected health information about you to your family members or friends if we obtain your verbal agreement to do so, or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose protected health information to your family or friends if we can infer from the circumstances, based on professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your protected health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose protected health information relevant to that person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

DISCLOSURE REQUIRING AUTHORIZATION

We will not use or disclose protected health information for any purpose other than those identified in the previous sections without your specific, written Authorization. The following uses and disclosures will be made only with your authorization: 1) most uses and disclosures of psychotherapy notes, if recorded by a cover entity; 2) uses and disclosures of protected health information for marketing purposes; 3) disclosures that constitute a sale of protected health information; and 4) other uses and disclosures not described on this Notice of Privacy Practices.

If we have highly protected health information, such as, HIV, substance abuse, or mental health information about you, we cannot release that information without a special signed, written authorization (different from the authorization mentioned above) from you (i.e. you must specify the type of sensitive information we are allowed to disclose).

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

You have the rights regarding protected health information we maintain about you:

Right to Inspect a Copy. You have the right to inspect and copy your protected health information that we use to make decisions about your care. Usually these include medical and billing records, but not psychotherapy notes and information compiled for legal proceedings. You must submit a written request to the Privacy Officer, in order to inspect and/or copy your protected health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend. If you believe the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to the Privacy Officer. We will respond to your request for an accounting of disclosures within sixty (60) days of receipt of your written request, unless additional time is needed to respond, at which time we may extend our response deadline for up to an additional thirty (30) days and provide you with an explanation as to the reason for the delay. We may deny for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that 1) we did not create, unless the person or entity that created the information is no longer available to make the amendment; 2) it is not part of the health information that we keep; 3) you will not be permitted to inspect and copy; or 4) is accurate and complete.

Right to an Accounting of Disclosure. You have the right to request an “accounting of disclosure”. This is a list of the disclosures we made of protected health information about you, except those disclosures made for: 1) treatment, payment, or healthcare operations; 2) pursuant to a valid authorization; and 3) as otherwise provided in applicable federal and state laws and regulations. To obtain this “accounting of Disclosure”, you must submit your request in writing to the privacy Officer. Your request must state a time period, which may not be longer than six (6) years prior to the date on which the accounting is requested. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting in any twelve (12) month period is free of charge. Additional requests for accounting of disclosures may result in charges to you for the cost of providing such accounting. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred. We will respond to your request for an accounting of disclosure within sixty (60) days of receipt of your written request, unless additional time is needed to respond, at which time we may extend our response deadline for

up to an additional thirty (30) days and provide you with an explanation as to the reason for the delay.

Right to Request Restrictions. You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. If you have paid for services out-of-pocket, in full, and request that we not disclose your protected health information, related solely to those services, to your health plan, we shall accommodate your request except where the disclosure is required by law.

You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose about a surgery you had. We are not required to agree to your request.

To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information to the Privacy Officer.

Right to Request Confidential Communication. You have the right to request that we communicate with you about healthcare matters in a certain way and at a certain location. For example, you can ask that we only contact you at work or only contact you by mail at a specifically identified address. Notwithstanding the foregoing, we will typically communicate with you in person; or by letter, email, fax, and/or telephone.

To request confidential communications, you may complete and submit the Request for Registration on Use/Disclosure of Medical information and/or Confidential Communication to the 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.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact the Privacy Officer.

Right to Revoke Authorization. You have the right to revoke an authorization to use or disclose your protected health information at any time, except where action has already been taken.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right-hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office. You may also file a complaint with the Secretary of the Department of Health and Human

Services. To file a complaint with our office, contact the Privacy Officer at the address and telephone number listed on the first page of this notice. You will not be retaliated against or penalized for filing a complaint.

The contact information for the Secretary of Health and Human Services is:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Telephone: 1-877-696-6775

Dr. Sian complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.



Kenty U. Sian, M.D., F.A.C.S.
Cosmetic & Reconstructive Plastic Surgery

Kenty U. Sian, MD FACS

1855 E. Alluvial, Suite 101, Fresno, Ca 93720
Phone: 559-797-0501 • Fax: 559-797-0504 • Email:
kusian@hotmail.com
www.fresno-plasticsurgery.com

Welcome to **Fresno Plastic Surgery**. My staff and I look forward to meeting you and we will do our very best to care for you with compassion, respect and the highest degree of professionalism.

Before your appointment, please take a moment to fill out the enclosed questionnaire; this will not only help us better understand your health status but will also expedite your registration process.

Please mail back the stapled pages a week before your appointment if possible. Keep this page for your records.

Once again, my office staff and I welcome you to my practice and we are eager to serve you.

YOUR INITIAL APPOINTMENT IS FOR CONSULTATION ONLY. If you have been referred to me for a procedure other than a biopsy, your procedure will be performed at a later date that is mutually agreed upon.

The scope of my practice covers both cosmetic and reconstructive plastic surgery. I see new patients on Wednesdays and Fridays. I perform surgery at Clovis Community Medical Center.

Finally, let me introduce myself. I have been in Fresno since 2002. I graduated from the University of Philippines, College of Medicine and completed my general surgery training at the State University of New York (SUNY) - Brooklyn. I obtained my plastic surgery training at Indiana University and underwent additional aesthetic surgery fellowship training under John Owsley, MD at the CPMC-Davies Campus in San Francisco (a UCSF affiliate hospital).

I am certified by the American Board of Plastic Surgery. I am a member of the following organizations: American Society of Plastic Surgeons (ASPS), American Society for Aesthetic Plastic Surgery (ASAPS), American College of Surgeons (ACS) and the California Society of Plastic Surgeons (CSPS).

If you need more information about my practice, kindly visit

www.fresno-plasticsurgery.com

An appointment has been schedule for you on:

_____at_____am/pm

If you are unable to keep this appointment or need to reschedule, please call and let us know.

Dr. Sian sees new patients on Wednesdays and Fridays.

Map and Driving Instructions to FRESNO PLASTIC SURGERY



Driving Instructions

From San Francisco/Madera:

Take Hwy 99 South and take the Herndon exit
Turn left on Herndon and head east until you reach Maple Ave. (9.2 miles)
Turn left on Maple Ave. and head north until you reach Alluvial Ave. (0.7 miles)
Turn into the building complex at the Southwest corner of Maple & Alluvial Avenue

From Los Angeles/South Fresno:

Take Hwy 99 North and exit at Hwy 41 North
Stay on Hwy 41 North and take the Herndon exit (8 miles)
Turn right on Herndon and head east until you reach Maple Avenue (2 miles)
Turn left on Maple Ave. and head north until you reach Alluvial Ave. (0.7 miles)
Turn into the Building complex at the Southwest corner of Maple & Alluvial Avenue



Kenty U. Sian, M.D., F.A.C.S.
Cosmetic & Reconstructive Plastic Surgery

Are you interested in learning more about any of the following procedures?

Botox (smoothes wrinkles) _____

Chemical Peel _____

Juvederm (to fill wrinkles/folds, reshape the face) _____

Latisse (helps eyelashes grow longer and thicker) _____

Plastic/Cosmetic Surgery of:

Face (eyes, nose, ears, etc.) _____

Breast (augmentation, reduction, lift) _____

Body (tummy tuck, liposuction, etc.) _____

***How would you like to be notified of future appointments?
(Please choose all methods that will work for you)**

Telephone Telephone No. _____

E-mail E-mail Address _____

***Periodically, we run special promotions on products at a discounted price.
Would you like to receive emails from us regarding these promotions?**

Yes, I would like to receive emails regarding these offers.

Please provide your email address: _____

No, please do not send me any emails

Print Name and Signature

Date