premier image COSMETIC & LASER SURGERY

DATE: _____ **AGE:**_____ **DATE OF BIRTH:** ____/____/_____ PHYSICIAN:_____

NAME: FIRST _____ LAST_____ COORDINATOR: _____

SEX: ☐ MALE ☐ FEMALE HOW DID YOU HEAR ABOUT US?_____

NOTES:

_____

_____

PHYSICIAN'S RECOMMENDATIONS:

PREVIOUS ILLNESS & SURGERIES

DATE_____ ILLNESS/SURGERY_____ PHYSICIAN_____

DATE_____ ILLNESS/SURGERY_____ PHYSICIAN_____

PREVIOUS COSMETIC SURGERIES

DATE_____ SURGERY_____ PHYSICIAN_____

DATE_____ SURGERY_____ PHYSICIAN_____

DATE_____ SURGERY_____ PHYSICIAN_____

HEALTH PROFILE (CHECK THOSE THAT APPLY AND EXPLAIN)

FAMILY HISTORY ☐ DIABETES ☐ BLEEDING ☐ HEART DISEASE ☐ ANESTHESIA PROBLEMS ☐ OTHER: _____

ALLERGIES (PLEASE LIST)

MEDICATIONS/DOSAGE (PLEASE LIST)

VITAMINS & SUPPLEMENTS (PLEASE LIST)

	YES	NO	IF YES EXPLAIN:
Do you smoke?			
Do you drink alcohol?			
Have you ever had a reaction to anesthesia?			
Are you/could you be pregnant?			
Have you ever taken Accutane?			
Do you get cold sores/fever blisters?			
Do you have a skincare regimen?			
Have you taken Cortisone or steroid in the past year?			
Are you a present carrier of a contagious disease? HIV/AIDS?			
Do you wear hard contacts?			
Do you have a pacemaker?			

CONSULTANT NOTES

PATIENT INFORMATION

HOME PHONE _____ CELL PHONE _____ EMAIL _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

MARITAL STATUS: ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ MARRIED SPOUSES NAME: _____

DO YOU REQUIRE AN INTERPRETER? ☐ YES / ☐ NO

PRIMARY PHYSICIAN _____ PHONE _____

PHARMACY _____ PHONE _____

EMPLOYER _____ OCCUPATION _____ PHONE _____

HEALTH HISTORY

☐ YES ☐ NO HEART DISEASE OR HEART TROUBLE
☐ YES ☐ NO HIGH BLOOD PRESSURE
☐ YES ☐ NO LUNG DISEASE
☐ YES ☐ NO HAY FEVER
☐ YES ☐ NO KIDNEY DISEASE
☐ YES ☐ NO LIVER DISEASE
☐ YES ☐ NO EPILEPSY/SEIZURES/NEUROLOGICAL PROBLEMS
☐ YES ☐ NO THYROID OR GOITER PROBLEMS
☐ YES ☐ NO CHEST PAIN
☐ YES ☐ NO CHRONIC COUGH
☐ YES ☐ NO RECENT RESPIRATORY INFECTION
☐ YES ☐ NO SKIN TROUBLE/INFECTIONS/ RASH/IRRITATIONS
☐ YES ☐ NO KELOID, BROWN OR WHITE SCARS
☐ YES ☐ NO GLAUCOMA
☐ YES ☐ NO PHLEBITIS
☐ YES ☐ NO PROBLEMS LYING FLAT
☐ YES ☐ NO NOSEBLEEDS
☐ YES ☐ NO FAINTING
☐ YES ☐ NO ASTHMA
☐ YES ☐ NO HAVE YOU CONSIDERED SEEING A PSYCHOLOGIST/THERAPIST?
☐ YES ☐ NO ARE YOU SEEING A THERAPIST NOW?
☐ YES ☐ NO ARE YOU ON A SPECIAL DIET?
☐ YES ☐ NO RECENT WEIGHT LOSS? AMOUNT: _____

☐ YES ☐ NO EXPOSURE TO A COMMUNICABLE DISEASE IN THE LAST 3 WEEKS?
☐ YES ☐ NO MITRAL VALVE PROLAPSE
☐ YES ☐ NO DIABETES
☐ YES ☐ NO MUSCLE WEAKNESS
☐ YES ☐ NO DIFFICULTY URINATING
☐ YES ☐ NO JAUNDICE
☐ YES ☐ NO HEADACHE OR DIZZY SPELLS
☐ YES ☐ NO BOWEL/COLON DISEASE
☐ YES ☐ NO SHORTNESS OF BREATH
☐ YES ☐ NO BACK OR NECK TROUBLE
☐ YES ☐ NO ULCERS/STOMACH TROUBLE
☐ YES ☐ NO DO YOU USE EYE DROPS?
☐ YES ☐ NO TREATMENT OF GENITAL AREA
☐ YES ☐ NO ARE YOU EASILY DEPRESSED?
☐ YES ☐ NO HIATAL HERNIA
☐ YES ☐ NO BLOOD TRANSFUSION
☐ YES ☐ NO ANKLE SWELLING
☐ YES ☐ NO FACIAL FRACTURES
☐ YES ☐ NO ANEMIA
☐ YES ☐ NO DRUG OR ALCOHOL DEPENDENCY
☐ YES ☐ NO AUTOIMMUNE DISEASE
☐ YES ☐ NO HIV/AIDS
☐ YES ☐ NO HEPATITIS
☐ YES ☐ NO PULMONARY EMBOLISM/BLOOD CLOT
☐ YES ☐ NO PSORIASIS/VERTILIGO

HEIGHT: _____ WEIGHT: _____

OTHER MEDICAL CONCERNS:

_____

_____

PREVIOUS ILLNESS & INJURIES:

_____

_____

I AM INTERESTED IN THE FOLLOWING TREATMENTS:

☐ YES ☐ NO BOTOX
☐ YES ☐ NO FILLER
☐ YES ☐ NO SKIN TONING
☐ YES ☐ NO FAT LOSS
☐ YES ☐ NO LASER FACIAL PEELS
☐ YES ☐ NO ACNE TREATMENT
☐ YES ☐ NO FINE LINES AND WRINKLES TREATMENT
☐ YES ☐ NO BROWN, AGE AND SUNSPOT TREATMENT

☐ YES ☐ NO FACIAL PLASTIC SURGERY
☐ YES ☐ NO LASER HAIR REMOVAL
☐ YES ☐ NO ROSACEA TREATMENT
☐ YES ☐ NO MELASMA TREATMENT
☐ YES ☐ NO CHEMICAL PEELS
☐ YES ☐ NO HYDRATING FACIALS
☐ YES ☐ NO TATTOO REMOVAL

MEDICAL RECORD ACKNOWLEDGEMENT

I hereby give my permission to Premier Image Cosmetic and Laser Surgery, Louis M. DeJoseph, M.D. and Paul Daraei, MD. or any assistant he/she may designate, to take photographs for diagnostic purposes, to enhance the medical report, during surgery, and postoperatively for evaluation purposes. I agree that these photographs will remain property of Premier Image.

Signature: _____

CONSENT TO COMMUNICATE
COMMUNICATION BY EMAIL & TEXT MESSAGE

It may become useful during the course of treatment to communicate by email, text message (e.g. SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Premier Image Cosmetic & Laser Surgery there is a reasonable chance that a third party may be able to intercept those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages.
- Your employer, if you use your work email to communicate.
- Third parties on the Internet such as server administrators and others who monitor Internet traffic.

Signature: _____

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I consent to allow Premier Image Cosmetic and Laser Surgery to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Appointment Reminders
- Health Related Information
- Marketing Offers

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that message & data rates may apply. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Signature: _____

PLEASE MARK THE WAYS THAT YOU CONSENT TO US COMMUNICATING WITH YOU REGARDING APPOINTMENT REMINDERS AND PERSONAL HEALTH INFORMATION:

☐ I AUTHORIZE PREMIER IMAGE COSMETIC & LASER SURGERY TO CONTACT ME BY **PHONE**

☐ I AUTHORIZE PREMIER IMAGE COSMETIC & LASER SURGERY TO **LEAVE VOICEMAIL**

☐ I AUTHORIZE PREMIER IMAGE COSMETIC & LASER SURGERY TO CONTACT ME BY **TEXT**

☐ I AUTHORIZE PREMIER IMAGE COSMETIC & LASER SURGERY TO CONTACT ME BY **EMAIL**

☐ I AUTHORIZE PREMIER IMAGE COSMETIC & LASER SURGERY TO CONTACT ME BY **MAIL**

☐ I AUTHORIZE PREMIER IMAGE COSMETIC & LASER SURGERY TO **TEXT & EMAIL SPECIAL OFFERS**

IF IT'S OK TO LEAVE A MESSAGE WITH ANOTHER PERSON PLEASE LIST _____

IF IT'S OK TO DISCUSS APPOINTMENT DETAILS WITH ANOTHER PERSON PLEASE LIST _____

Signature: _____

EMERGENCY CONTACT

EMERGENCY CONTACT _____ ADDRESS _____

MOBILE PHONE _____ 2ND PHONE _____ RELATIONSHIP_____

I ☐ DO / ☐ DO NOT AUTHORIZE THE DISCLOSURE OF PERSONAL HEALTH INFORMATION TO CERTAIN DESIGNATED INDIVIDUALS OTHER THAN MYSELF AS LISTED BELOW:

☐ SAME AS ABOVE NAME _____ RELATIONSHIP_____ PHONE _____

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____

EDUCATION AND MARKETING

At Premier Image Cosmetic and Laser Surgery, we pride ourselves on delivering the very best, most natural results. We protect our patients right to privacy, including name and medical history. As an American Academy of Facial Plastic Surgery Fellowship Director, Dr. Louis DeJoseph is a contributing author, frequent lecturer, and honorably holds academic appointment as Clinical Instructor at Emory University. We ask that you consent to the release of your before and after photos for both educational and marketing use.

CONSENT TO RELEASE PHOTOS

I grant my full permission to Premier Image Cosmetic & Laser Surgery, Dr. Louis DeJoseph, or any other provider or assistant that may be designated to take photographs for diagnostic and medical purposes for my medical report. I agree that these photographs will remain their property. I further authorize them to use such photographs for teaching purposes or to illustrate scientific papers, books, or lectures, if in their judgement, medical research educations, public education, or science will be benefited by their use. It is specifically understood that in any such publication or use I shall not be identified by name.

I also have the right to rescind consent for use by making my request known in writing. The use of photography, filming, and other forms of reporting are not under control of Premier Image Cosmetic and Laser Surgery and I understand that once I provide consent to news media, I will not have the right to rescind unless the media agrees.

In addition to my medical chart, I authorize the use of photographs for Premier Image Cosmetic & Laser Surgery use of my image for:

☐ Website

☐ Print Materials

☐ Educational Video

☐ Broadcast & News Media

Signature: _____ **Date: _____**

CONSENT TO TREAT MINOR (IF APPLICABLE)

As a rule, we require the consent of a parent or legal guardian in order to provide services to a minor child (under the age of 18). We will not povide care to a child who comes to our clinic alone or accompanied by an adult other than a parent or legal guardian if we cannot reach you or don't have advanced consent to treat.

This form will be kept in your child's medical record for use as necessary. The consent will remain in effect until revoked in writing. You may request the revocation form from any member of our staff.

FATHER NAME _____ DOB _____

PHONE _____ EMAIL _____ OK TO CONTACT ☐ YES ☐ NO

MOTHER NAME _____ DOB _____

PHONE _____ EMAIL _____ OK TO CONTACT ☐ YES ☐ NO

I, _____ am the ☐ MOTHER ☐ FATHER ☐ LEGAL GUARDIAN

of _____ and I consent for Premier Image Cosmetic & Laser Surgery to provide treatment to my child. I understand that this authorization will be in effect until revoked in writing by me.

Signature: _____ **Date: _____**