



## Patient Information

Name:		DOB:	Today's Date:
Address:			
City:		State:	Zip:
Home Phone:		Cell Phone:	
Email Address:			
Social Security Number:		Marital Status:	
Employer Name:		Work Phone:	
Who is your Primary Care Physician?			
How did you hear about West End Plastic Surgery?			
<b>EMERGENCY CONTACT</b>			
Name:		Relationship:	
Address:			
City:		State:	Zip:
Home Phone:		Cell Phone:	
<b>PROCEDURES OF INTEREST</b>			
<b>BODY</b>	<b>BREAST</b>	<b>FACE</b>	<b>IN OFFICE</b>
<input type="checkbox"/> Liposuction <input type="checkbox"/> Body Contouring after major weight loss <input type="checkbox"/> Tummy Tuck <input type="checkbox"/> Buttock Lift <input type="checkbox"/> Thigh Lift <input type="checkbox"/> Buttock enlargement <input type="checkbox"/> Correction of tummy tuck or liposuction <input type="checkbox"/> Arm Lift <input type="checkbox"/> Body Lift <input type="checkbox"/> Hernia Repair <input type="checkbox"/> Labia Repair <input type="checkbox"/> Other:	<input type="checkbox"/> Breast Augmentation <input type="checkbox"/> Breast Implant Revision <input type="checkbox"/> Breast Reduction <input type="checkbox"/> Breast Lift <input type="checkbox"/> Breast Lift w/Augmentation <input type="checkbox"/> Nipple Reduction <input type="checkbox"/> Correction of inverted nipples <input type="checkbox"/> Male Chest Reduction <input type="checkbox"/> Other:	<input type="checkbox"/> Nose Surgery <input type="checkbox"/> Breathing Problems <input type="checkbox"/> Eyelid Lift <input type="checkbox"/> Brow Lift <input type="checkbox"/> Face Lift <input type="checkbox"/> Ear Pinning <input type="checkbox"/> Neck Lift <input type="checkbox"/> Submental Liposuction <input type="checkbox"/> Chin Enlargement <input type="checkbox"/> Buccal Fat Removal <input type="checkbox"/> Other:	<input type="checkbox"/> Botox <input type="checkbox"/> Juvederm <input type="checkbox"/> Latisse <input type="checkbox"/> Skin Care <input type="checkbox"/> Scar Revision <input type="checkbox"/> Mole Removal <input type="checkbox"/> Laser Hair Removal <input type="checkbox"/> Other:

<b>SURGERY &amp; ANESTHESIA HISTORY</b>	
Have you ever had surgery? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, please describe:	
Do you have a blood relative who has had anesthesia complications of any kind? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, please describe:	
<b>MEDICAL HISTORY</b>	
Are you pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes      If yes, due date:	
Height:	Weight:



Do you have a history of the following:	Yes	No	Description:
Asthma/ Frequent or Chronic Cough			
Emphysema			
High Blood Pressure			
Heart Trouble			
Hepatitis or Liver Trouble			
Kidney Trouble/ Urinary Problems			
Diabetes			
Epilepsy or Seizures			
Stroke			
Problem Scarring			
Blood Clots			
Spontaneous Abortions			
Psychiatric Care			
Others Not Listed			
<b>MEDICATIONS</b>			
Are you taking any of the following:	Yes	No	Description:
Blood pressure medication			
Antidepressants			
Tranquilizers or Sedatives			
Blood thinners			
Steroids			
Diabetes medication			
Seizures			
Heart medication			
Aspirin or aspirin-containing meds			
Ketoprofen (Alleve)			
Ibuprofen (Motrin, Advil)			
Vitamin E or Fish Oil			
Other			
Please list the medications you are <b>currently</b> taking:			
<b>ALLERGIES &amp; SENSITIVITIES</b>			
Any history of skin reaction or other illness after contact with:			
	Yes	No	Description:
Penicillin, Sulfa or other antibiotics			
Morphine, Codeine or Demerol			
Novocain, Lidocaine (local anesthesia)			
Adhesive tape			
Iodine or Betadine			
Latex			
Other			
<b>SOCIAL HISTORY</b>			
Do you smoke? O No O Yes How much?			
Do you drink? O No O Yes How much?			

**I have read this questionnaire and disclosed my medical history to the best of my knowledge.**

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



# Communication Consent Form

In order to comply with HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, we ask that our clients review and sign this *Communication Consent Form*.

West End Plastic Surgery will not release confidential and/or other Protected Health Information (PHI) by home mailing, home telephone, answering machine, work telephone, voice mail, and/or cell phone. When we place telephone calls and an answering machine responds, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

I, \_\_\_\_\_ authorize West End Plastic Surgery to contact me and/or named authorized person(s) and to convey PHI by the following methods and assume responsibility to notify West End Plastic Surgery whenever this information changes:

**Home Telephone (\_\_\_\_)\_\_\_\_\_**

- YES
- NO

**Written Communication**

- YES
- NO

**Cell Phone (\_\_\_\_)\_\_\_\_\_**

- YES
- NO

**Email \_\_\_\_\_**

- YES
- NO

**Work Telephone (\_\_\_\_)\_\_\_\_\_**

- YES
- NO

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Uses and disclosures may be permitted without prior consent in an emergency.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Birthdate



# HIPAA Information and Consent Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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. 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. Please visit [www.hhs.gov](http://www.hhs.gov) for additional information. We have adopted the following policies:

- ✓ 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.
- ✓ 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.
- ✓ 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.
- ✓ 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.
- ✓ You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
- ✓ Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
- ✓ We agree to provide patients with access to their records in accordance with state and federal laws.
- ✓ 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: \_\_\_\_\_ Date: \_\_\_\_\_



## West End Plastic Surgery & WE MedSpa Policies

**CONSULTATION:** We are dedicated to helping you achieve your aesthetic goals. Towards that end, our physicians offer consultations, \$150, and our WE MedSpa Clinicians offer consultations, \$50, to better understand your individual needs. Based on a private analysis and conversation, we will design a customized treatment plan that will best meet your expectations.

**SCHEDULING:** Appointments are **required** for our physicians, and preferred for WE MedSpa Clinicians, but not always necessary. If we have available WE MedSpa Clinicians, we will be happy to provide your desired treatment. However, most procedures are booked several weeks in advance.

**ARRIVAL:** Check-in with the front desk at least 15 minutes prior to your scheduled appointment to prepare for your treatment. As we are a plastic surgery practice and medical spa, we require that all new guests fill out a brief medical and skin care history and applicable treatment consent forms.

**LATE ARRIVALS:** Our scheduling is designed to permit the correct amount of time to complete your service. A late arrival will deprive you of precious treatment time. In fairness to others, your treatment must end on time in order to minimize the impact on others. If you are unable to be on time, we will do our best to complete as much of your treatment as possible, however with some treatments, it may be necessary to reschedule you. **If you are 20+ minutes late for your scheduled facial, you will be considered a "no-show" and charged for 100% of your service fee. For all other scheduled treatments if you are 10 minutes late you will be considered a "no show" and charged 100% of your service fee.**

**CANCELLATIONS:** Your scheduled appointment is reserved exclusively for you. **Should you need to cancel or reschedule your appointment, please notify us 24 hours in advance to avoid a charge for 50% of your scheduled treatment. All services that are rescheduled or cancelled on the day of the appointment, or missed without notice will be charged.** A deposit of 20% is required to schedule your surgery with our physicians. Full payment is required at your pre-operative visit, which is scheduled at least 2-3 weeks prior to surgery. Surgical procedures with West End Plastic Surgery physicians that are rescheduled within 14 days of surgery will incur a \$350 rescheduling fee. If you cancel your surgery within 14 days of the scheduled surgery day, you will forfeit any fees paid at that time.

**PRODUCT RETURNS:** Your satisfaction is our utmost concern. If you are not satisfied with one of your products, please bring us the product, and your receipt, within **two weeks** of the purchase date. We will gladly exchange the full value of the returned product for a product or products that are more suited to your desired result. If you do not wish to have a product exchange, we will be happy to give you a credit towards one of our services or a refund credited back to you in the same method of payment used for purchase.

**PAYMENT:** West End Plastic Surgery & WE MedSpa accepts cash, Visa, MasterCard, Discover, American Express, and Care Credit. Payment by check is also accepted. We have financing packages available for surgery and several of our other treatments.

**STANDARD POLICY:** A credit card number is required to secure all appointments, however it will not be charged until the time of your appointment.

**VALUABLES:** We are not responsible for lost or stolen items and encourage you to leave valuables at home.

*We want your experience at West End Plastic Surgery and WE MedSpa to be pleasant and relaxing. Please be courteous towards others waiting for appointments by turning off cell phones. Please inform our front desk staff if you have any special needs or concerns and allow us to ensure your time spent with us is a memorable experience. Thank you for choosing West End Plastic Surgery and WE MedSpa!*

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**PATIENT AUTHORIZATION**  
**FOR RELEASE OF MEDICAL PHOTOGRAPHS/SLIDES**  
**AND/OR VIDEOTAPES**

**INTRODUCTION**

Medical photographs/slides and videotapes may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images.

Additionally, patients may consent to release these medical photographs/slides, and videotapes for a stated purpose.

**CONSENT TO RELEASE PHOTOGRAPHS/SLIDES/VIDEOTAPES**

I hereby authorize \_\_\_\_\_ M.D. and/or his/her associates or licensees ***to use*** pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks for purposes of medical education or promotion for the center, patient education, lay publication, or during lectures to medical or lay groups.

I understand and fully accept that I ***will not*** be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

I understand the use for pre-operative planning, post-operative evaluation and documentation of result and authorize the release of the following for: **(PLEASE CHECK)**

- Educational use or Publication in Journals.
- Use as Examples of Results for Potential Patients.
- Website Gallery (Before/After).
- Public Marketing (Social Media)
- I decline the Release of my Photos.

Patient's Name in Print: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Full Name of Witness: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_