WEST END PLASTIC SURGERY
Paul G. Ruff IV, MD. F.A.C.S.

2440 M Street NW, Suite 200
Washington, DC 20037
P 202-785-4187
F 202-785-1370
www.westendplasticsurgery.com

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?		
EMERGENCY CONTACT		
Name:	Relationship:	
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	

PROCEDURES OF INTEREST

BODY	**BREAST**	**FACE**	**IN OFFICE**
O Liposuction	O Breast Augmentation	O Nose Surgery	O Botox
O Body Contouring after major weight loss	O Breast Implant Revision	O Breathing Problems	O Juvederm
O Tummy Tuck	O Breast Reduction	O Eyelid Lift	O Restylane
O Buttock Lift	O Breast Lift	O Brow Lift	O Radiesse
O Thigh Lift	O Breast Lift w/Augmentation	O Face Lift	O Kybella
O Buttock Enlargement	O Nipple Reduction	O Ear Pinning	O Sculptra
O Correction of tummy tuck or liposuction	O Correction of Inverted Nipples	O Neck Lift	O Latisse
O Arm Lift	O Male Chest Reduction	O Submental Liposuction	O Skin Care
O Body Lift	O J-Plasma	O Chin Enlargement	O Scar Revision
O Hernia Repair	O Other:	O Buccal Fat Removal	O Mole Removal
O Labia Repair		O J-Plasma	O Laser Hair Removal
O J-Plasma		O Other:	O Other:
O Other:			

SURGERY & ANESTHESIA HISTORY	
Have you ever had surgery? O No O Yes	
If yes, please describe:	
Do you have a blood relative who has had anesthesia complications of any kind? O No O Yes	
If yes, please describe:	
MEDICAL HISTORY	
Are you pregnant? O No O Yes	If yes, due date:
Height:	Weight:

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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			
MEDICATIONS			
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 **currently** taking:			
ALLERGIES & SENSITIVITIES			
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			
SOCIAL HISTORY			
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:_____

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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:

O Home Telephone (_____)_____

O YES

O NO

O Written Communication

O YES

O NO

O Cell Phone (_____)_____

O YES

O NO

O Email _____

O YES

O NO

O Work Telephone (_____)_____

O YES

O 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

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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 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 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:_____

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PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL PHOTOGRAPHS/SLIDES AND/OR VIDEOSTAPES

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)**

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

Patient's Name in Print: _____

Patient's Signature: _____ **Date:** _____

Full Name of Witness: _____

Signature of Witness: _____ **Date:** _____