FIALA
AESTHETICS

Patient Information Form

Please take time to complete and correct the following information

First Name: Last Name:

Date of Birth: Age:

Address 1: Address 2:

City: State:

ZIP: Home Phone:

Work Phone: Cell Phone:

Cell Carrier: SSN:

Florida Resident?

Email Address:

How did you hear about us?

What is the reason for your consultation?

EMPLOYER INFORMATION

Employer Name: Occupation:

EMERGENCY CONTACT

Marital Status: Spouse's Name:

Emergency Contact Name: Relationship:

Phone:

ASSIGNMENT AND RELEASE

I, _____, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistant or staff as may be assigned by him.

The time spent at the office for a consultation may take upwards of one hour. Patients "pressed for time" may wish to reschedule their appointment with the front desk. In the event that a patient has more than the "average" amount of questions or would like to discuss additional procedures, a second consultation may be scheduled for further discussion. Patients more than 15 minutes late to any appointment may be rescheduled.

"To the best of my knowledge, the information I have provided above and on the following page, regarding my medications, past medical history, allergies and smoking history is accurate, complete and honest. **I understand that failure to completely disclose this information may be detrimental to my condition and treatment and I accept full responsibility for any omissions."** I understand that photography is a necessary part of planning and evaluating cosmetic surgery. I authorize that taking of photographs at the direction of my surgeon and under such conditions as may be approved by him. These photographs will be used solely for documentation purposes and will be kept confidential.

A copy of this authorization shall be considered as valid as the original.

Signature of Insured/Guardian | Printed Name | Date

Relationship (Circle One) ❒ SELF ❒ SPOUSE ❒ PARENT ❒ GUARDIAN

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Patient History Form

In this time of rapidly expanding medical knowledge and the increasing specialization associated therewith, there exists a very real risk of the specialist physician not being aware of the general health and medical background of the patient. On occasion such information may critically affect what procedures we may safely undertake on you and under what circumstances. We therefore ask that you give us the following medical information.

Age: **Height:** **Weight:** **Today's Weight:**

Initials (Nurse):

Are you taking any medications, vitamins or herbal supplements (in the past 6 months)? ❒ NO ❒ YES *(Please List)*

Are you allergic to any medications or local anesthesia? ❒ NO ❒ YES *(Please List)* ❒ LATEX

Are you a smoker? *(Includes vaping, marijuana)* ❒ NO ❒ YES **Ex smoker?** ❒ NO ❒ YES

How much are (or were) you smoking? **For how long?**

When did you quit?

Do you drink alcohol? ❒ NO ❒ YES

How many days per week?

Is there a possibility you may be pregnant at this time? ❒ NO ❒ YES **How many pregnancies have you had?**

How many children? **How many babies have you had over 8 pounds?**

Have you ever had surgery (including plastic surgery)? ❒ NO ❒ YES *(Describe)*

Do you, or does anyone in your family, have a history of cancer? ❒ NO ❒ YES *(Describe)*

Have you or anyone in your family ever had unusual reactions to anesthesia (muscle weakness, jaundice, breathing problems or unexpected fevers)? ❒ NO ❒ YES *(Describe)*

Do you have *(check all that apply)*:

❒ Loose or Chipped Teeth
❒ Caps
❒ Dentures
❒ Contact Lenses
❒ Metal Body Piercings
❒ None

Have you ever seen a cardiologist? ❒ NO ❒ YES **Physician:** **Date of Last EKG:**

Have you ever seen a psychiatrist? ❒ NO ❒ YES **Physician:** **Date of Last Appt:**

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

Patient Signature **Date**

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Patient History Form (Continued)

	NO	YES	DESCRIPTION
Do you bruise easily or bleed excessively?	❒	❒	
Have you ever had a blood clot in your legs or lungs (DVT or pulmonary embolism)?	❒	❒	
Has any close relative had a DVT or pulmonary embolism?	❒	❒	
Do you have thickening of scars or keloids following injury or surgery?	❒	❒	
Have you ever had herpes simplex (cold sores)?	❒	❒	
Have you ever had low iron/hemoglobin/ anemia?	❒	❒	
Have you ever had any weakness of the face or drooping of any part of the face?	❒	❒	
Have you ever had "dry eyes" or eye infections?	❒	❒	
Have you ever had fainting spells, black outs, TIA's or strokes?	❒	❒	
Do you have problems with motion sickness or nausea after anesthesia?	❒	❒	
Do you have problems with pain medications?	❒	❒	
Have you ever received a blood transfusion?	❒	❒	
Do you have any infectious diseases?	❒	❒	

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

Patient Signature **Date**

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Patient History Form (Continued)

	NO	YES	DESCRIPTION
Have you ever had/do you currently have diabetes?	❒	❒	
Have you ever had/do you currently have asthma?	❒	❒	
Have you ever had a heart attack?	❒	❒	
Have you ever had/do you currently have high blood pressure?	❒	❒	
Are you currently on Accutane?	❒	❒	
Have you ever been on Accutane?	❒	❒	
Are you currently on Retin-A?	❒	❒	
Have you ever been on Retin-A?	❒	❒	
Are you allergic to any products? *(If yes, please list)*	❒	❒	
Do you have any metal implants in your body?	❒	❒	
Do you have a pacemaker or defibrillator?	❒	❒	
Are you currently using any skincare products? *(If yes, please list)*	❒	❒	

Do you take any of these medicines? *(Check all that apply)*

- ❒ADD/ADHD Medications
- ❒Aspirin/ASA
- ❒Seizure Medicines
- ❒Insulin/Diabetic Medicines
- ❒Birth Control Pills/Hormones
- ❒Arthritis Medications
- ❒Steroids
- ❒Vitamin E

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

Patient Signature **Date**

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Consent to Communicate

There are many methods of communication and it is important to us to keep in contact with our patients. If any problems or issues arise please contact us. If an emergency arises, keep us updated so we may help with any necessary treatments. The main number, 407-339-3222, is answered by the Answering Service after hours. If calling any of our back line phone numbers, please do not leave a message after hours or on weekends on the office answering machine as there is a delay in retrieving such messages. All attempts will be made to preserve your privacy in accordance with HIPAA rules. We use emails and text messages to remind our patients about their upcoming appointments and to inform you about exciting new events and specials. Reminders for appointments where we need to provide important instructions will be handled with a phone call in addition to the text and email message.

Please check your e-mail or text messages for appointment reminders, news, specials and/or events on a regular basis. If you choose not to receive text messages and emails, no reminders will be sent and it is your responsibility to keep track of your appointments. Also, please make us aware of any address or contact information that may have changed so that we may update our records.

Please mark the ways that you consent to us communicating with you:

METHOD	OKAY TO LEAVE VOICEMAIL?	OK TO LEAVE MESSAGE WITH ANOTHER PERSON?	PREFERRED CONTACT METHOD(S)	BEST TIME TO CALL?
❒ Call Work Phone	❒ Yes ❒ No	❒ Yes ❒ No	❒	
❒ Call Cell Phone	❒ Yes ❒ No	❒ Yes ❒ No	❒	
❒ Call Home Phone	❒ Yes ❒ No	❒ Yes ❒ No	❒	
❒ Send Email			❒	
❒ Email Appointment Reminders				
❒ Email Medical Information				
❒ Email Office Specials and Newsletters				
❒ Send Regular Mail			❒	
Mail to which Address: ❒ Home ❒ Other (Please List):				
❒ Send Text Message - If OK, please list cell carrier *(ex: Verizon, T Mobile, etc.)*:			❒	
❒ Text Appointment Reminders				
❒ Text Office Specials				

If it's OK to leave a message with another person, please list all names:

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

Patient Signature

Date

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General Practice Policies

APPOINTMENT CANCELLATIONS

We require at least 48 hours advance notice for cancellations or last minute appointment reschedules. We reserve the right to charge $100.00 if the notice is insufficient. This represents our standard consultation fee.

CELL PHONES

Please turn cell phones to silent prior to entering our office. Any person using a cell phone that distracts a patient's appointment will be asked to turn off the device or take the device outside of the office.

CHILDREN AND OUR OFFICE

"Children are lovely and like to play, so please keep them home on appointment day."

Our practice is not suited for small children. Please make arrangements for the care of your children prior to your appointment. If you arrive with a child or children, you may be asked to reschedule your appointment. If you have another person with you, that person will be expected to care for the child(ren) during your appointment. Out of respect to our other patients, we request children are taken outside of our waiting room.

Patient Signature

Date

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HIPAA Information and Consent Form

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 available 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.
9. 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.
10. In the event of a billing dispute involving a bank or credit card company, you agree to waive HIPAA protection to the extent needed for the resolution of the billing issue.

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.

_____ _____

Patient Signature **Date**