Winslow Facial Plastic Surgery

1. PATIENT CONSENT TO MEDICAL CONSULTATION AND TREATMENT

I request and authorize Winslow Facial Plastic Surgery and their respective agents and employees ("WFPS") who may attend me during my treatment to perform routine tests and procedures and to provide certain services as prescribed for my health and well-being in accordance with applicable laws and regulations. I acknowledge that no representations, warranties, or guarantees as to results of cures have been made to me by WFPS, nor have I relied upon any such representations, warranties, or guarantees. I also acknowledge and agree that no refunds are available.

_____ _____

Patient Signature Date

_____ _____

Witness Date

2. OTHER CONSENTS AND ACKNOWLEDGEMENTS

HIPAA

By signing below, I acknowledge that I have received a copy of the WFPS Patient Admission Packet, which includes but is not limited to the **HIPAA Notice of Privacy Practices ("Notice")**. I understand that I may obtain a written copy of this Notice at any time upon request or via the website at http://www.winslowfacialplasticsurgery.com.

LATE OR CANCELLED APPOINTMENTS/REFUND POLICY

By signing below, I hereby acknowledge that if I am more than fifteen (15) minutes late for a scheduled appointment, I will be asked to reschedule my appointment. I also agree that if I cancel any scheduled appointment with less than 48 hours prior notice, I will pay WFPS a $25.00 cancellation fee before a replacement appointment can be rescheduled. I also agree that if I miss or cancel any scheduled appointment with less than 24 hours prior notice, I will pay WFPS a $50.00 cancellation fee before a replacement appointment can be rescheduled. I understand that there are no refunds for aesthetic purchases or packages, prepurchases of injectables or aesthetic treatments.

INSUFFICIENT FUNDS

By signing below, I hereby agree that if I have a check returned for insufficient funds, I will pay WFPS a $25.00 a bad check fee before any subsequent appointments can be scheduled.

FINANCIAL AGREEMENT

By signing below, I hereby agree to pay WFPS their charges for all services rendered during my treatment plus I also agree to pay WFPS in full for any and all cosmetic procedures at least three (3) weeks in advance of the scheduled date of service. I shall also be responsible for any attorney fees required to collect for these services, to which may be added interest at the current legal rate. I hereby assign directly to WFPS payment of any health insurance benefits applicable to this treatment and authorize the collection of such funds on my behalf by WFPS. Such payments, however, shall not exceed my balance owed to WFPS. I acknowledge and understand that I and any guarantor signing on my behalf are personally responsible for all charges not otherwise paid by assignment to insurance benefits. **I also acknowledge and understand that WFPS will not accept responsibility for negotiating a settlement on any disputed claim. Past due accounts will be transferred to a collection agency and any such accounts will be assessed a thirty percent (30%) collection fee based upon the balance on the account. I shall be responsible for payment of the balance of my account, plus the thirty percent (30%) collection fee. I will also be responsible for all costs of collection including reasonable attorneys' fees and expenses.** I hereby certify that any information which I have given in applying for coverage under title XVII and/or Title XIX of the social Security Act, or any insurance or other information which I provided is true and correct.

_____ _____

Patient Signature Date

_____ _____

Witness Date

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Patient Information Questionnaire

Mr./Mrs./Ms./Dr.

Name _____Date of Birth_____ Age_____

Address_____ City_____

State _____Zip_____ SS#_____ Sex: M F Race_____

Home Phone _____ Cell _____ Work Phone _____

School/Employer_____ Occupation _____

Marital Status: M S D W Sep Height_____ Weight_____

***email_____

Please circle appropriate contact

**** MY PREFERRED METHOD OF CONTACT IS: **HOME PHONE** **CELL PHONE** **EMAIL**

I authorize Winslow Facial Plastic Surgery to call and leave voicemail or a message with a family member reminding me of future appointments.

Signature_____ Date_____

Please include me in your standard mailing list. Yes No

Patient Medical Information

Attending Physician:_____ Phone:_____

Address:_____

Preferred Pharmacy:_____ Phone:_____

Address:_____

Responsible Party/Emergency Contact

Name:_____ Phone:_____

Address:_____

Billing Information of Patient or Guarantor as Responsible Party

****Please provide receptionist with insurance card or ID****

Name:_____ Address:_____

SSN# (if applicable):_____ Insurance Name:_____

Secondary Insurance (if applicable):_____

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CONSENT TO PHOTOGRAPH OR FILM

Upon admission, I gave consent that Dr. Winslow can photograph or film me but only to the extent necessary and so long as the images are used solely for purposes of (a) identifying me as a patient or for purposes of documenting my health status, diagnosis and treatment while a patient of Dr. Winslow; (b) conducting education and training, quality assurance and performance improvement functions for and on behalf of Dr. Winslow and its professional staff; and (c) publishing the results of my treatment on Dr. Winslow's website which, in this particular case, required me to sign the attached HIPAA authorization form.
The purpose of this form is to obtain my prior written consent so that Dr. Winslow may photograph or film me for one or more of the following purposes listed below for which I do hereby consent.

Circle NO if you refuse an option:

If no is NOT indicated, then you hereby give your consent to use your photos for all purposes below.

NO 1. Use or disclosure of image by Dr. Winslow for marketing or advertising purposes and patient education

NO 2. Use or disclosure of image by Dr. Winslow for medical specialty board in formulating its examination of applicant physicians

NO 3. Use or disclosure of image by Dr. Winslow in a professional presentation or journal publication

Unless earlier revoked, this authorization will expire on the end of the treating physician's practice of facial reconstructive surgery, except there will be no expiration for the purpose of medical or scientific research or use in specialty board examinations.
Revocation: This consent may be revoked by providing written, signed (by patient or legal representative) revocation to:
WFPS
2000 E. 116th St Ste 200
Carmel, IN 46032
Revocation will have an immediate effect for any display/advertising submitted AFTER revocation.
I also agree to sign the attached HIPAA authorization form which permits Dr. Winslow to use or disclosure these images but only to the extent permitted by HIPAA and other applicable laws and regulations.
Computer Imaging Disclaimer
Computer imaging may be used to better educate you about your upcoming surgery. Although an approximation of intended results is to be displayed, I realize that there are differences in graphic artistic ability and surgical technique. I realize that computer imaging does not constitute and should not be construed to be an exact representation of post-surgical results. I understand that it is impossible to guarantee intended results. I understand that the alteration of any images is purely for the purpose of education, illustration and discussion.

_____ _____
Patient (or Patient's Legal Representative*) Signature Date

_____ _____
Witness Signature Date

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Medical History

List ANY allergies or previous adverse reactions to medications:
_____

List ALL medications you are taking (including over-the-counter, Herbal Supplements or Vitamins):
_____

_____

Previous
Surgeries_____

Current
Illnesses_____

Are you currently being treated by a psychiatrist? **Yes** **No** (Name_____ Phone_____)

Smoker: **Yes** **No** **Packs per day**_____ **Alcoholic Drinks per week:** _____

Do you have a history of?

_____Heart Disease
_____Diabetes
_____Asthma
_____Hepatitis
_____Nicotine Replacement
_____Arthritis
_____Epilepsy
_____Depression
_____Blood Disorders
_____MRSA
_____High Blood Pressure
_____Bronchitis/Emphysema
_____Heart Murmur
_____Facial Paralysis
_____Autoimmune Disease_____
_____Mitral Valve Prolapse
_____Other _____

_____Alcoholism
_____Tuberculosis
_____Breathing Problems
_____Nose Bleeds
_____Dry Eyes or Eye Problems
_____Stomach Problems/Reflux
_____Headaches
_____Thyroid Problems
_____Seizures
_____Cold Sores
_____Bad Scarring
_____Easy Bruising or Prolonged Bleeding
_____Immunosupression
_____Blood Clots
_____Accutane Use(Past or Present) Date Discontinued _____
_____Previous Post Operative Complications

_____Heart Attack
_____Stroke
_____Chest Pain
_____Glaucoma
_____Skin Cancer
_____Other Cancer
_____Latex Allergy
_____Keloid
____Cataracts
____Eye Surgery

Please specify if you checked any medical history:
_____

Reason for Consultation?

_____

_____

How did you hear about our office?:

_____Television
_____Phone Book
_____Internet
_____Friend (name) _____
_____Doctor (name) _____

_____Magazine
_____Newspaper
_____Spa/Salon (specify)_____

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Authorization for Disclosure of Information

I authorize Dr. Winslow to disclose complete information concerning her medical findings and treatment of the undersigned, from initial office visit until the date of the conclusion of such treatment, to those individuals who, in Dr. Winslow's sole determination, are required to receive such information *for the purpose of medical treatment, medical quality assurance and peer review.*

Patient's Signature_____ Date_____

Witness_____