Exclusively Faces Cosmetic Surgery and MediSpa

Patient Demographic Information Sheet

PATIENT NAME	GENDER M F	DATE OF BIRTH
MAILING STREET ADDRESS	MARITAL STATUS S M W D	PHARMACY
CITY / STATE / ZIP CODE		HOME TELEPHONE
WHAT NUMBER IS BEST TO LEAVE A MESSAGE? HOME WORK CELL		WORK TELEPHONE
E-MAIL ADDRESS		CELL TELEPHONE | CARRIER

PREFERRED CONTACT FOR REMINDER OF MY APPOINTMENT:

TELEPHONE AND MY NUMBER IS ______________________ YES ☐

TEXT MESSAGE AND MY NUMBER IS ______________________ YES ☐

EMAIL AND MY EMAIL ADDRESS IS ______________________ YES ☐

PATIENT EMPLOYER	OCCUPATION
EMERGENCY CONTACT NAME / RELATIONSHIP	TELEPHONE

HOW DID YOU HEAR ABOUT OUR OFFICE?

Notice of Privacy Practices HIPPA (page 4)

I have been given or offered a copy of the Notice of Privacy Practices. I have read this form or have had it read to me, and it has been explained to my satisfaction. I understand this form is only valid for (1) year from the date I sign it.

I further agree that Exclusively Faces Cosmetic Surgery and Medispa, can discuss my medical condition/information and/or appointments with the following:

	YES	NO		YES	NO
Spouse	☐	☐	Children	☐	☐
Parent(s)	☐	☐	Friend(s)	☐	☐

Individual name(s) and relationship to me that I agree you can discuss my medical information with:

X ____

____
Patient Name (Print)

______________________________ ______________
Patient or Responsible Party Signature Date

____
Responsible Party's Relationship to Patient

I witnessed the signature: ______________________ ____________ ____________
Employee Signature Title Date

Exclusively Faces Cosmetic Surgery and MediSpa

PATIENT INFORMATION & HEALTH HISTORY FORM

For surgical patients: you are required to stop using any aspirin-containing medications, nonsteroidal anti-inflammatory drugs, alcohol, and particularly tobacco for 2 weeks before and after the operation. Additionally, certain vitamins and the newer herbal remedies, such as vitamin E or gingko biloba, are discontinued during this period as well. Preoperative medications include vitamin C help to enhance healing in the early postoperative period.

Name: ______________________________ Date: ____________________

How did you first hear about us? ______________________________
Were you referred by someone, if so, who? ______________________________
May we send a thank-you referral letter to them? ______________________________
What area(s) of the face are you interested in having improved? ______________________________
____
What motivated you to come see us today? ______________________________
What are your concerns you would like to discuss? ______________________________
How long have you been considering cosmetic enhancement? ______________________________
What are your cosmetic goals? ______________________________
List skin care products you currently use? ______________________________

My surgical time frame is: ASAP ______ 1-3 months ______ 3-6 months ________ 6-9 months______

I have determined a budget for my care: Yes ___No ___ Estimate: $ ____________________

HEALTH HISTORY (General)

How is your general health? ______________________________
Are you presently being treated for any medical conditions? ______________________________
When was your last physical examination? ______________________________

If applicable, are you pregnant?	☐ Yes	☐ No
Do you feel for any reason you may be at risk for AIDS?	☐ Yes	☐ No
Have you tested for MRSA in the past?	☐ Yes	☐ No

If answered yes what area(s) tested positive for MRSA and the time frame? ____________________

Do you suffer from cold sores/herpes outbreak?	☐ Yes	☐ No

EYE

Visual loss (one or both eyes?)	☐ Yes	☐ No
"Dry" eyes?	☐ Yes	☐ No
Itching or irritation of eyes?	☐ Yes	☐ No
Blurred or double vision?	☐ Yes	☐ No
Crossed or lazy eyes?	☐ Yes	☐ No
Cornea problems?	☐ Yes	☐ No
Thyroid problems?	☐ Yes	☐ No
Wear glasses or contacts?	☐ Yes	☐ No
Previous eye or eyelid surgery (if yes, what type)?	☐ Yes	☐ No

____
____

(cont.)

NOSE

Difficulty breathing through nose?	☐ Yes	☐ No
Previous injury to nose?	☐ Yes	☐ No
Nasal allergies?	☐ Yes	☐ No
Nose bleeds?	☐ Yes	☐ No
Sinus conditions?	☐ Yes	☐ No
Previous nasal or sinus surgery (if yes, what type)?	☐ Yes	☐ No

____

____

Previous face or neck surgery (if yes, what type)?	☐ Yes	☐ No

____

____

Irradiation to face or neck?	☐ Yes	☐ No
Facial paralysis or weakness?	☐ Yes	☐ No

CARDIOVASCULAR

Coronary or heart attack?	☐ Yes	☐ No
Congenital heart disease?	☐ Yes	☐ No
Heart murmur?	☐ Yes	☐ No
Palpitations or irregular heart beat?	☐ Yes	☐ No
Hypertension?	☐ Yes	☐ No
Stroke?	☐ Yes	☐ No

CHEST

Shortness of breath?	☐ Yes	☐ No
Chronic lung disease?	☐ Yes	☐ No
Chronic cough?	☐ Yes	☐ No
Asthma?	☐ Yes	☐ No

PSYCHIATRIC

Have you ever received psychiatric treatment?	☐ Yes	☐ No
If yes, were you hospitalized?	☐ Yes	☐ No
Has there been any recent crisis in your life?	☐ Yes	☐ No
Have you been treated for drug or alcohol dependency?	☐ Yes	☐ No

OTHER

Headaches?	☐ Yes	☐ No
Liver disorder including hepatitis or cirrhosis?	☐ Yes	☐ No
Kidney or bladder disorders or chronic infections?	☐ Yes	☐ No
Spinal or back disorders?	☐ Yes	☐ No
Previous blood clots or thrombophlebitis?	☐ Yes	☐ No
Any bleeding disorders in self or family?	☐ Yes	☐ No
Blood transfusion?	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No
Autoimmune disease (e.g. lupus, rheum arthritis)?	☐ Yes	☐ No
Any unusual scarring or keloid formation?	☐ Yes	☐ No

(cont.)

ALLERGIES

Any drug allergies (Including local anesthetics & codeine)?	☐ Yes	☐ No
Tape allergy?	☐ Yes	☐ No
Is there any known latex allergy?	☐ Yes	☐ No

If yes, please list drug and reaction type?____

MEDICATION

List any medications you are currently taking and dosage (specifically within the last month)?

Are you taking aspirin or medication containing aspirin?	☐ Yes	☐ No
Have you taken any steroid preps over the past year?	☐ Yes	☐ No

SOCIAL

Do you smoke?	☐ Yes	☐ No
If so, how many packs a day? _______________		
Do you drink more than 2 drinks per day?	☐ Yes	☐ No
If more than 2 drinks, how many drinks a day? _______________		

List below any comments and/or questions you would like to specifically discuss during your consultation.

____

Patient or Responsible Party Signature

Date

Responsible Party's Relationship to Patient

____

HIPPA Privacy Act Patient Consent Form

The Health Insurance Portability and Protection Act, H.I.P.P.A requires that all medical providers, insurance companies and others, put in place controls to ensure that your personal medical information is safe.

Our office requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Name of Patient: ________________________________ **Patient Date of Birth** ______________

Signature of Patient or Guardian: ____________________________ **Date** ________________

Authorization to Release Information to Family Members and/or Friends

Many of our patients allow family members such as their spouse, parents or others such as friends to call and request appointment times, rescheduling of appointment times for the patient, to go over insurance benefits, and/or the request results of tests and procedures. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have this information released to family members and/or friends you must sign this form. Signing this form will only give consent to release appointment times, rescheduling of patient appointment times, to go over insurance benefits, and/or the results of tests and procedure to the family members and/or friends indicated below. This consent form will not allow our office to release any other information about you. This H.I.P.P.A consent is valid up to one year. However, you have the right to revoke this consent, in writing prior to expiration of that one year, except where we have already made disclosures in reliance on your prior consent.

I authorize this office to speak with the below listed individuals regarding my appointment times, rescheduling of appointment times, to go over insurance benefits, and/or the results of tests and procedures.

1. Individual Name____________________________ Relation to Patient: __________________

2. Individual Name____________________________ Relation to Patient: __________________

Signature of Patient or Guardian: __________________________ **Date** _________________

Leaving Messages with Household Members/Answering Machine

From time to time it is necessary for our office to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to go over insurance benefits, to notify the patient that we would like to discuss lab or procedure results, or to ask a patient to call us regarding an issue or concern. At no time will our office discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

DIGITAL IMAGING DISCLAIMER AND CONSENT FORM

Dr. Karen will show me proposed surgical alterations of my face/neck on an electronic imaging system.

I understand that the alteration of these images is purely for the purpose of illustration and discussion. I understand that the outcome of the surgical procedure and appearance of any scars is directly related to my individual healing characteristics.

I understand that because of the significant differences in how living tissues heal, there may be little similarity, if any, to the electronic images and my final surgical result. I understand that these images only represent a simulation of my possible surgical results and are a tool for discussion which do not guarantee any final result.

My signature certifies my understanding that there is no warranty expressed or implied as to my final appearance by the use of these electronically altered images.

______________________________ ______________

Patient Date

______________________________ ______________

Witness Date

______________________________ ______________

Physician Date

CONSENT FOR USE AND RELEASE OF PHOTOGRAPHS, VIDEO TAPES AND DIGITAL IMAGES

Patient grants Dr. Matthew Karen permission to utilize the images captured by digital or standard photography throughout the course of treatment by said doctor. This permission gives the doctor and/or Exclusively Faces Cosmetic Surgery and Medispa unrestricted rights to use the images for general information, education, scientific, medical and public relations. He/She further grants permission to publish photographs in scientific journals, and utilize them for display purposes at presentations, meetings and through the use of electromechanical means, including the Internet.

Patient further acknowledges that he/she relinquishes all right, title and interest in these images, or any right to profit or gain directly or indirectly realized through the use of the images.

This consent may only be revoked in writing by the undersigned and delivered to Exclusively Faces Cosmetic Surgery and Medispa.

______________________________ ________________

Patient Date

______________________________ ________________

Witness Date

CONSENT BY PARENT OR GUARDIAN

I am the parent or guardian of ____________________, a minor. I authorize to sign this consent on his/her behalf and agree to the terms stated above.

__________________________ __________________________

Parent/Guardian Date

Exclusively Faces Cosmetic Surgery and Medispa Return/Cancellation Policies

Clarity, Ultra, Morpheus, Vanquish ME:
In order to reserve your appointment a 1/3 deposit is required upon scheduling of the appointment. The remaining balance minus your 1/3 deposit is due no later than 2 weeks before your scheduled procedure. The reason for the deposit and full payment ahead of time is due to the high cost of materials and our inability to return them to the providing company. A full money refund is permitted within **48 hours of SCHEDULING** the procedure, otherwise no money will be exchanged. If a refund is requested up to **6 months** after the initial 48 hours of scheduling the non received procedure, a refund will be granted **MINUS cost of materials and 20% office service charge.** A **credit on your account** may be applied after 6 months on the remaining unused procedure(s) from the initial scheduling date to be used for other cosmetic products and/or services for up to 6 months. After 6 months from initial date of account credit, all account credits will be forfeited.
A non received procedure or package is **not transferable** to another individual. Each recommended treatment or package you purchase is individually designed to your specific needs. It is recommended that in order to see desired results a minimum of 3-5 treatments be received. Our office sells the treatment individually and in package form. We offer discounts if you purchase the treatment package. All procedures **exceeding $300.00** cannot be paid by check on the same day of receiving the treatment. Cash or major credit card is acceptable in this case. Care Credit cannot be used for payment of IPL, BTL Vanquish ME, or Clear + Brilliant packages. If a return is requested on a received treatment for the remaining unused package treatments then the below example applies: Patient received (1) treatment and decided they want to return the (3) unused remaining package treatments. Exclusively Faces Cosmetic Surgery and Medispa will charge full price of the (1) received treatment and provide an office credit for the non received (3) remaining treatments at the promotional discounted package price.

Botox, Dysport, Restylane, Juvederm, Voluma, Radiesse and Chemical Peel:
A credit card is required upon initial scheduling to reserve your appointment with Dr. Karen. You may also stop by our office and place a deposit in the form of cash or check to secure your appointment. No appointment will be made with Dr. Karen unless a credit card on file and/or check is placed on hold. Your credit card and/or check placed on file will **not** be charged/cashed, unless you do not show for your scheduled appointment, in which case, you may be subject to a fee of $150.00 for failing your scheduled appointment time. If you reschedule another appointment with our office after the missed appointment and make it to your next appointment, then the charged amount will be credited to the product or service you are wishing to purchase.
A full money refund is permitted within **48 hours of SCHEDULING** the non received procedure. **No money refund from non received procedure after 6 months** from the initial appointment scheduling is permitted. A **credit on your account** may be applied after 6 months from initial scheduling of the non received procedure will be applied as an account credit to be used for other cosmetic products and/or services for up to 6 months. After 6 months from initial date of account credit, all account credits will be forfeited. **No money refunds and/or account credits will be granted for received procedure(s).**
All procedures or products **exceeding $300.00** cannot be paid by check on the same day of receiving the treatment and/or product. Cash or major credit card is acceptable in this case. Care Credit cannot be used for payment unless receiving individual procedure that day. Care credit **cannot** be used for **packages. If you prepay for a procedure you have up to two weeks to come in for your procedure otherwise that prepayment will be forfeited.**

Skin Care:
No exchanges or refunds. In the RARE event of a significant ALLERGIC reaction SEEN and CONFIRMED by our trained staff, Exclusively Faces Cosmetic Surgery and Medispa will appeal to the manufacturer on your behalf. **If** and **when** the skin care company replaces the product to our office, an account credit will be granted and can be used for other cosmetic products and/or services for up to 6 months. After 6 months from initial date of account credit, all account credits will be forfeited.

Treatment Packages:

A credit card is required upon initial scheduling to reserve your appointment. You may also stop by our office and place a deposit in the form of cash or check to secure your appointment. Your credit card and/or check placed on file will **not** be charged/cashed, unless you do not show for your scheduled appointment. In which case, you may be subject to a fee of $150.00 for failing your scheduled appointment time. If you reschedule another appointment with our office after the missed appointment and make it to your next appointment, then the charged amount may be credited to the product or service you are wishing to purchase by our discretion.

No money refunds will be granted for treatments. A **credit may be applied to your account** for non received package and can be used for other medispa services for up to 6 months. After 6 months from initial date of account credit, all account credits will be forfeited. **No money refunds and/or account credits will be granted for received procedure(s).**

No non received treatment or package is transferable to another individual. Each recommended treatment or package you purchase is individually designed to your specific needs. Care Credit **cannot** be used for payment packages.

Latisse:

No exchanges or refunds. In the RARE event of a significant ALLERGIC reaction SEEN and CONFIRMED by our trained staff, Exclusively Faces Cosmetic Surgery and Medispa will appeal to the manufacturer on your behalf. **If** and **when** Alergan replaces product to our office, an account credit will be granted and can be used for other cosmetic products and/or services for up to 6 months. After 6 months from initial date of account credit, all account credits will be forfeited.

Surgical Scheduling and/or Cancellation/Rescheduling:

A credit card is required upon initial scheduling to reserve your appointment with Dr. Karen. You may also stop by our office and place a deposit in the form of cash or check to secure your appointment. No appointment will be made with Dr. Karen unless a credit card on file and/or check is placed on hold. Your credit card and/or check placed on file will **not** be charged/cashed, unless you do not show for your scheduled appointment. In which case, you may be subject to a fee of $150.00 for failing your scheduled appointment time. If you reschedule another appointment with our office after the missed appointment and make it to your next appointment, then the charged amount will be credited to the product or service you are wishing to purchase. In order to reserve a surgery date for a surgical procedure a 1/3 deposit of the total procedure is required. The deposit is nonrefundable. The deposit can be made in the form of cash, check or major credit card. We will **not accept Care Credit** for deposit on surgery. This deposit allows us to reserve Dr. Karen's time, the OR, purchase necessary supplies, and arrange anesthesia if necessary, on the date you have selected. **Full payment** must be provided at your **pre-op appointment,** approximately 2 weeks prior to your surgery. We accept cash, check or major credit card.

Cancellations after 48 hours of scheduling the surgery will result in a 20% (total cost of surgery + anesthesia) penalty + cost of supplies purchased by Exclusively Faces for your procedure. Should you decide to reschedule your date, less than 2 weeks before surgery; a 3% administrative fee will be charged to you. If surgery is cancelled less than 2 weeks prior then 50% of the total cost is forfeited. If surgery is cancelled with less than 72 hours notice then the total cost is completely forfeited. In the event surgery is postponed by our office due to patient medical condition or weather related unforeseen circumstances every effort will be made to reschedule and accommodate the patient.

Cosmetic Consultation Appointment:

Exclusively Faces Cosmetic Surgery and Medispa offer complimentary consultations with our coordinators. There is a fee to be seen by Dr. Karen. In order to reserve an appointment, a credit card guarantee needs to be given to our staff. A maximum $150.00 penalty fee will be charged to the card ONLY in the event that the appointment is MISSED without rescheduling or canceling within a 24 Hour Notice period. If the appointment is rescheduled the maximum $150.00 fee will be credited at the time of your arrival to your rescheduled appointment. This policy helps us to be available for patients who want to be seen in a timely fashion.

<u>Cancellation of Appointment Policy:</u>

Cancellation of an Appointment

In order to be respectful of the wishes of other patients please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who would like treatment. This is how we can best serve the needs of all. If it is necessary to cancel your scheduled appointment we require that you give 24 Hour Notice. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to our facility.

How to Cancel Your Appointment

To cancel appointments please call 540-667-3223.

Late Cancellations

Late cancellations will be considered as a "broken appointment/ no show".

Broken Appointments/ No Show Policy

A "broken appointment/ no show" is someone who misses an appointment without canceling within 24 Hours.
Broken Appointments/No shows inconvenience those individuals who would like treatment in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in the patients' chart as a "broken appointment/ no show". There will be a fee of $150.00 for any and all appointments types.

<u>Financial Agreement:</u>

In the event that a portion or all of the cosmetic surgical procedure falls under my health insurance plan, I understand I am responsible for all health insurance deductibles and coinsurance. I understand that in my insurance company has a pre-certification requirement that it is my responsibility to obtain this pre-certification. I understand that I remain financially responsible for any and all charges not met by the proceeds of the assignment, and for all charges if payment is not received within a reasonable time after charges are filed or if payment is deemed retroactively. I accept responsibility for payment in full, or agreed upon payment arrangements, for services provided within thirty (30) days of receiving a statement. A 1.5% interest fee will be applied to all accounts not paid in full within thirty (30) days of receiving a statement. In the event I do not meet my financial responsibility, I agree to pay costs for collection including the collection agencies fees 35% interest, court costs, physician fee relating to court up to $350.00 an hour and attorney fees up to the maximum of the Commonwealth of Virginia Statue. I understand there is a $25.00 fee for all bank returned checks.
I have read all (3) pages of this form, or have had it read to me, and it had been explained to my satisfaction.

________________________ ________________________ __________
Patient Name (Print) Patient or Responsible Party Signature Date

____
Responsible Party's Relationship to Patient

I witnessed the signature: ________________________ ____________ __________
Employee Signature Title Date