

Welcome to our practice!

What is the reason for your upcoming consultation?

What additional services would you like to learn about? Please check all that apply.

<input type="checkbox"/> Acne <input type="checkbox"/> Skin care products <input type="checkbox"/> Facial fine lines/wrinkles <input type="checkbox"/> Thin lips <input type="checkbox"/> Eyelash Fullness or thickness <input type="checkbox"/> Chemical peel <input type="checkbox"/> Cellulite Reduction <input type="checkbox"/> Spider Veins <input type="checkbox"/> Facial redness <input type="checkbox"/> Brown spots/age spots/freckles <input type="checkbox"/> Laser Hair Removal	<input type="checkbox"/> Brow Lift <input type="checkbox"/> Drooping eyelids <input type="checkbox"/> Under eye bags <input type="checkbox"/> Nose size or shape <input type="checkbox"/> Facial fullness/drooping <input type="checkbox"/> Mole removal <input type="checkbox"/> Neck wrinkles <input type="checkbox"/> Ear size or shape	<input type="checkbox"/> Breast size <input type="checkbox"/> Breast shape <input type="checkbox"/> Breast Implant Correction <input type="checkbox"/> Breast Reconstruction <input type="checkbox"/> Tummy Tuck <input type="checkbox"/> Upper Arm lift <input type="checkbox"/> Thigh Lift <input type="checkbox"/> Butt Lift <input type="checkbox"/> Liposuction <input type="checkbox"/> Red or raised scars
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Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		True Age		Older Than
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

↓ For Staff Use Only ↓

Physician / provider:		
<i>Follow-up</i>	<i>Date</i>	<i>Completed by (name)</i>
<input type="checkbox"/> Initial Inquiry/Information Given		
<input type="checkbox"/> Contact in future – give date		
<input type="checkbox"/> Products		
<input type="checkbox"/> Free consultation		
<input type="checkbox"/> Procedure scheduled		
<input type="checkbox"/> Procedure completed		

1 PATIENT INFORMATION

Date _____

Patient: _____

Address: _____

City _____ State _____ Zip _____

Sex: F M Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient SSN _____

Occupation _____

Spouse's Name _____

Children's Names and Ages _____

Whom may we thank for referring you? _____

Primary Medical Doctor _____

Other treating physicians _____

2 CONTACT INFORMATION

Telephone Numbers: Home _____

Cell _____ Work _____

Email _____

May we add you to our email newsletter list: Yes No

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home Phone _____ Work/Cell _____

3 FAMILY HISTORY

FATHER	Alive <input type="checkbox"/> Deceased <input type="checkbox"/>	Present health or cause of death _____
MOTHER	Alive <input type="checkbox"/> Deceased <input type="checkbox"/>	Present health or cause of death _____

Check illnesses which have occurred in any of your blood relatives:
 Bleeding tendency Heart disease High blood pressure Diabetes Stroke

<input type="checkbox"/> BREAST CANCER	<input type="checkbox"/> OTHER CANCERS
List affected relatives:	Type Affected Relative
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Birthdate _____ SSN _____

Insurance Co. _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the company specified above and assign directly to Dr. Cassileth all insurance benefits, if any, otherwise payable to me for services rendered, and I understand that she is not a member of my health insurance company. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

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MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Cassileth for any services furnished me by Dr. Cassileth or her staff. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Responsible Party Signature

Relationship to Patient (if not "Self") Date

APPOINTMENT CANCELLATION POLICY

We require 24-hour cancellation notice for all consultation and treatment appointments with our office. Failure to notify our office of the need to cancel at least 24 hours prior to the scheduled appointment will result in cancellation fees as follows:

Dr. Cassileth: \$100

Cassileth Cosmetic Medicine: \$25

In order to reserve your future appointment, the following information will be kept on file until the day of your appointment.

Name:

Signature:

Date:

Credit Card #:

Exp:

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes: how we may use and disclose your Protected Health Information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law; and your rights to access and control your Protected Health Information. "Protected health information" ("PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your PHI will be used, as needed, to obtain payment for your health care services. For example, your health plan may require that your relevant PHI be disclosed to the health plan to obtain approval for treatment.

Healthcare Operations

We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other Permitted and Required Uses and Disclosures

Other uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights with Respect to Your PHI

- **You have the right to request a restriction of your PHI.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.
- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** **You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.
- **You have the right to have your physician amend your PHI.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.**

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

PRIVACY PRACTICE ACKNOWLEDGEMENT

This sheet is a supplement to the materials provided. Please refer to these handouts for more complete information. I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing the consent. I understand that this organization has the right to change its *Notice of Privacy Practices* and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this content.

Name:

Signature:

Relationship to patient, if applicable:

Date:

CONSENT FOR USE OF IMAGES

I hereby grant Dr. Cassileth and Cassileth Cosmetic Medicine permission to present my pre-procedure and post-procedure photos on their website(s), in their before and after books, for PR purposes and during consultation with patients. For surgery and procedures for the body, no photos of the face will be included.

I understand that every attempt will be made to represent myself accurately and with integrity and dignity in all media. I hereby certify that I have read the foregoing and fully understand its meaning and effect.

Name: _____

Signature: _____

Witness: _____

Date: _____