PATIENT INFORMATION

PLEASE PRINT DATE_____

NAME_____

ADDRESS_____

CITY_____STATE____ZIP_____E-MAIL_____

OUT OF STATE ADDRESS_____

HOME#_____CELL#_____WORK#_____

EMPLOYED BY_____POSITION_____

MARITAL STATUS_____GENDER_____DATE OF BIRTH_____AGE_____

DRIVER LICENSE, WE WILL PHOTOCOPY YOUR LICENSE

SPOUSE OR PARENT/GUARDIAN INFORMATION:

NAME_____RELATION TO PATIENT_____

PHONE#_____

RESPONSIBILITY FOR PAYMENT:

NAME_____RELATION TO PATIENT_____PHONE#_____

GENERAL INFORMATION:

REFERRED BY_____

REASON FOR SEEING DOCTOR/LIST PROCEDURE_____

IF ACCIDENT –DATE OF INJURY_____DO YOU HAVE AN ATTORNEY FOR THIS PROBLEM? _____

ARE YOU **ALLERGIC** TO ANY MEDICATION?_____PLEASE LIST_____

_____

AUTHORIZATION FOR DISCLOSURE OF INFORMATION: I authorize Dr. Cristina F Keusch to disclose complete information concerning her medical findings and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who in Dr. Keusch's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

RELEASE OF INFORMATION/MEDICAL RECORDS: I hereby authorize Dr. Cristina F Keusch to release any information acquired in the course of my examination or treatment to my attorney's, physicians and /or insurance companies. I hereby authorize photocopies of this form to be valid as the original. This statement will remain in effect until revoked by me in writing.

DATE_____**SIGNATURE**_____

PHOTOGRAPHS: Pre and post-operative photographs are essential in plastic surgery, both for planning and for the analysis of post-operative results. It is the policy of this office that patients scheduled for surgery will have photographs taken before and after surgery. These photographs are intended solely for the use in this office. They cannot be shown to prospective patients nor can they be used in any talks or demonstrations without the expressed permission from you, the patient. I have read the above and fully understand the implications. I hereby give my consent to allow Dr. Keusch to take pre-operative, intra-operative and post-operative photographs of me.

DATE_____**SIGNATURE**_____

PRIVACY ACT: I authorize Dr. Keusch and her staff to call me, leave messages and confirm appointments, etc., in connection with my care. Please check the following:

HOME#_____**CELL#**_____**WORK**_____ **DATE**_____ **SIGNATURE**_____

HOSPITAL PRIVLEGES: I acknowledge that Dr. Cristina Keusch has privileges at Boca Raton Regional Hospital. 800 Meadows Rd, Boca Raton 33431

DATE_____**SIGNATURE**_____

MEDICAL INFORMATION

LIST ALL PREVIOUS SURGERY HOSPITALIZATIONS INCLUDING REASON

Surgery-Hospitalization/reason	Hospital	Type of Anesthesia	Year

ANESTHESIA COMPLICATIONS _____

LIST ALL MEDICATIONS YOU ARE TAKING, INCLUDING:EYE DROPS,OINTMENTS,VITAMINS/HERBS

Medication	Dosage amount	How Often Each Day

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD:

( )Emphysema,Asthma,Broncitis,Tuberculosis
( )Diabetes
( )Thyroid Disorders: Hypo or Hyper etc
( )Pancreas Disorders
( )Stomach Problems Ulcer
( )Liver Disease,Hepatitis, Jaundice
( )Kidney Disorders,Bladder Infections,Urinary
( )Pre-Menstral Syndrome
( )Pre/Peri/Post Menopausal CIRCLE ONE
( )Stroke
( )Cancer
( )High or Low Blood Pressure
( )Heart murmur
( )Irregular/ Fast heartbeat
( )Angina
( )Seizure Disorder/Epilepsy
( )Rheumatic Fever
( )Circulatory Problems
( )Blood Transfusion Reaction
( )Excessive Bleeding
( )Headaches
( )Fainting Spells/Syncope
( )Glaucoma
( )Cataracts
( )Dry Eye Syndrome
( )Radiation Treatment
( )Arthritis
( )Use Of Acutane
( )Psychiatric Treatment
( )Prostate Problems

YES	NO	
( )	( )	Do you have any skin problems? If yes describe_____
( )	( )	Prone to cold sores_____
( )	( )	Do you smoke? E-cigarettes or Vaping? If so how much per day?_____
( )	( )	Are you a former smoker? If so when did you stop?_____
( )	( )	Do you drink alcoholic beverages? If yes how much per day?_____
( )	( )	Do you have vision problems? If yes explain_____
( )	( )	Do you wear eyeglasses?_____Do you wear contact lenses_____
( )	( )	Do you wear removable dental appliances/dentures?_____
( )	( )	Do you have dental caps or crowns?_____
( )	( )	Do you now or have you ever used "street drugs"?_____
( )	( )	Are you pregnant?_____
( )	( )	Do you have any allergies to foods , medications or environment? If yes explain?_____
( )	( )	DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK THE DOCTOR SHOULD KNOW ABOUT? IF YES EXPLAIN _____

Private /Personal Physician_____Date of last exam_____

Address_____Telephone_____

Last known blood pressure_____Date of last EKG_____Chest x-ray_____Mammogram_____

Height_____Current Weight_____

In the event of a significant exposure to blood or body fluids to medical personnel, I give permission for my blood and /or saliva to be tested for HIV, Hepatitis C antibodies and antigens at any time during my care in this facility. I understand that I have the right to decline testing by not signing this form. _____Date _____

I HAVE READ(or have had read to me)THE ABOVE MEDICAL INFORMATION LISTED AND I HEARBY CERTIFY THE INFORMATION I HAVE PROVIDED IS CORRECT TO THE BEST OF MY KNOLWEDGE

Signed _____Date _____

(Parent/Guardian if patient is a minor)

CRISTINA F. KEUSCH, M.D., P.A., TELEPHONE NUMBER: 561-368-9455

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The notice contains a patient rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict your protected health information regarding treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The practice has a Notice of Privacy practice and that the patient has the opportunity to review this notice
- The practice reserves the right to change the Notice of Privacy practices
- The patient has the right to restrict the uses of their information but the practice does not have
- to agree with those restrictions
- The patient may revoke this consent in writing at any time and all future disclosures will then cease
- The practice may condition receipt of treatment upon the execution of this consent
- For the patient's convenience, the patient may choose to allow the practice permission to leave protected health information on certain answering machines, emails, voicemail, as selected and approved by the patient below

PATIENT NAME:_____DATE:_____
SIGNATURE:_____RELATIONSHIP TO PATIENT:_____

Appointment reminders may be left on my ____**Cell Phone** ____**Home Phone**
____ **Check here if you do NOT want messages left**

Biopsy results may be left on my ____**Cell Phone** ____ **Home Phone**
____**Check here if you do NOT want messages left**

Medical information (prescription refills, etc.) may be left on my ____**Cell Phone** ____ **Home Phone**
____**Check here if you do NOT want messages left**

I allow the release of my health information to the following person(s): (*please print names clearly*)
Name:_____Relationship to Patient:_____
Name:_____Relationship to Patient:_____

By signing, I acknowledge that I will disclose all of my health information known to me at this time and that all of my other personal information is accurate.

Signature:_____Date:_____

Cristina F. Keusch M.D., P.A., F.A.C.S.
DIPLOMATE AMERICAN BOARD OF PLASTIC SURGERY
DIPLOMATE AMERICAN BOARD OF SURGERY
FELLOW AMERICAN COLLEGE OF SURGEONS

TELEPHONE/TEXT MESSAGE CONSENT

I CONSENT TO RECEIVE CALLS AND/OR TEXT MESSAGES FROM DR. CRISTINA KEUSCH AND HER OFFICE FOR MY PROTECTED HEALTHCARE AND OTHER SERVICES AT THE TELEPHONE NUMBER(S) PROVIDED, INCLUDING MY WIRELESS NUMBER PROVIDED. I UNDERSTAND I MAY BE CHARGED FOR SUCH CALLS/TEXTS BY MY WIRELESS CARRIER AND THAT SUCH CALLS/TEXTS MAY BE GENERATED BY AN AUTOMATED DIALING SYSTEM.

PATIENT'S NAME_____

SIGNATURE _____

DATE SIGNED_____

Cristina F. Keusch M.D., P.A., F.A.C.S.
DIPLOMATE AMERICAN BOARD OF PLASTIC SURGERY
DIPLOMATE AMERICAN BOARD OF SURGERY
FELLOW AMERICAN COLLEGE OF SURGEONS

DATE_____

People with whom we can discuss your healthcare:

Name _____

Relationship_____

Contact No._____

Name _____

Relationship_____

Contact No._____

Name _____

Relationship_____

Contact No._____

_____ _____
Patient name (print) Patient signature

BOCA RATON PLASTIC SURGERY CENTER/CRISTINA F. KEUSCH, M.D.

Patient Consent for Use of Credit Cards, Debit Cards and Financing
Disclosure of Protected Health Information

By signing this consent, I am in agreement that the services and products received and paid for at the Boca Raton Plastic Surgery Center by credit card or Care Credit will not be disputed or reversed. If I attempt to do so, we at the Boca Raton Plastic Surgery Center or Cristina F. Keusch M.D. have the right to share information from your chart and file with your credit, debit or financing third part company to verify that you have indeed received the treatment or product. In the unlikely event that occurs, you agree that this will waive your right to privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you decline signing this form, you must pay for services or products to the practice by cash or check on the day of the appointment.

Initial ____I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op and follow-up interaction to address any issues that might arise, which are further addressed in the revision policy.

Initial ____I agree that this non credit card challenge agreement is irrevocable.

_____

Signature of Patient or Legal Guardian

_____

Print Patient's Name Date