PATIENT INFORMATION

PLEASE PRINT DATE________________________________

NAME____

ADDRESS____

CITY___________________________________STATE_____ZIP___________E-MAIL____

HOME#_______________________________CELL#________________________________WORK#___________________________

EMPLOYED BY____POSITION____________________________________

MARITAL STATUS________________GENDER__________________DATE OF BIRTH_____________________AGE__________

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. 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 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. 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. 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)

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:______________________________

GENERAL INFORMATION

Telemedicine is the distribution of health-related services and information via electronic and telecommunication technologies, such as computers and mobile devices, to access and manage health care services remotely. Telemedicine may include technologies you use from home or that your doctor uses to improve or support health care services. Telemedicine allows out-of-office patient and clinician contact, care, advice, reminders, education, intervention, monitoring, and remote admissions. Examples of telemedicine include videoconferencing, teleconferencing, transmission of images, and e-health, including patient portals and remote monitoring of vital signs.

ALTERNATIVE METHODS OF MEDICAL CARE BESIDES TELEMEDICINE

In-person care is an alternative method of medical care to telemedicine.

BENEFITS OF TELEMEDICINE

The benefits of telemedicine include:

- Makes health care accessible to people who live in rural or isolated communities
- Provides long distance clinical care
- Makes services more readily available or convenient for people with limited mobility, time, or transportation options
- Obtains expertise of specialists
- Improves communication and coordination of care among members of a health care team and patient
- Provides support for self-management of health care
- Offers quick and efficient medical evaluation and management

RISKS OF TELEMEDICINE

As with any medical care options, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to, the following:

- Lack of sufficient information transmitted (e.g., due to poor resolution of images or poor audio), which could hinder appropriate medical decision-making by the physician and assistant(s)
- Delays in medical evaluation and treatment, which could occur due to deficiencies or failures of the equipment
- Failure of security protocols, causing a potential breach of privacy and/or inadvertent disclosure of personal identifying information and/or protected health information
- Lack of access to complete medical records, which may result in adverse drug interactions, allergic reactions, or other judgment errors
- Overuse of medical care
- Unnecessary or overlapping care
- Lack of private space for vulnerable populations to have confidential and private conversations
- Difficulty sharing sensitive health information remotely by select individuals
- Unreliable internet connection resulting in disruptions in conversations

CONSENT FOR THE USE OF TELEMEDICINE

1. I understand that the purpose of telemedicine is to provide health care services.
2. I permit Dr. Cristina Keusch and her assistants to use telemedicine in my care.
3. I understand that telemedicine means using phone and/or video to communicate with my health care team instead of seeing my team in person (face-to-face).
4. I understand that reasonable efforts will be made to protect my privacy, though there may be risk of inadvertent disclosure of my personal identifying information and/or protected health information.
5. I understand that I can ask questions and discontinue the use of telemedicine at any time I choose.
6. I understand that telemedicine does not replace other types of medical assessment and care. If I am not improving and have serious health concerns, I will seek immediate medical attention at an emergency facility.
7. ALL OF MY QUESTIONS REGARDING TELEMEDICINE WERE ANSWERED, AND THE FOLLOWING WAS EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
   a. THE CONCEPT OF TELEMEDICINE
   b. RISKS AND BENEFITS OF THE USE OF TELEMEDICINE
   c. ALTERNATIVE METHODS OF MEDICAL CARE

I CONSENT TO THE USE OF TELEMEDICINE IN MY MEDICAL CARE AND THE ITEMS THAT ARE LISTED ABOVE (1–7).

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS.

Patient or Person Authorized to Sign for Patient ____

Date_____________________

Witness ___________________________________

Date______________________

I have been offered a copy of this consent form (patient's initials) ________

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida Law (Section 817.565655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at BOCA RATON PLASTIC SURGERY CENTER, it may be medically necessary to obtain a blood, urine, stool, tissue, or other type of biological specimen sample for analysis. This analysis will not involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning of disposal.

By signing this document you affirmatively state that it is your international decision to consent to the transfer of any and all biological specimens collected by or deposited with BOCA RATON PLASTIC SURGERY CENTER TO A THIRD PARTY AS SET FORTH ABOVE. This consent does not authorize the sale or transfer of biological specimen for the purpose of DNA analysis.

Patient Name (printed)____

Patient Name (signature) ____

Date ____

Patient Name ____________________________ Date ___________________________

Please list up to 3 people we may talk to regarding your treatments, healthcare, and post-care. (i.e. spouse, parent, guardian, friend)

Or write N/A if you do not want us to speak with anyone regarding your treatments, healthcare, and post-care.

You have the right to modify your choices at any time in writing.

Person 1

Name____

Relationship____

Contact #____

Person 2

Name____

Relationship____

Contact #____

Person 3

Name____

Relationship____

Contact #____

List Legal Guardians if the patient is a Minor.

____

Check yes or no to consent to unaccompanied minor post op visits. Y / N

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 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 noncredit card challenge agreement is irrevocable.

Phone/Text Consent

Initial ____ I consent to receive calls and/or text messages from Dr. Cristina Keusch and her office staff for my protected healthcare and other services at the telephone number(s) provided, including my wireless number provided. I understand that I may be charged for such calls/text by my wireless carrier and that such calls/texts may be generated by an automated system.

Signature of Patient or Legal Guardian____

Print Patient's name____Date____________________

CONSENT TO TREAT

This consent provides us with your permission for our physician and ARNP to perform reasonable medical examination, testing and treatments. You have the right to discuss your treatment plan, and we encourage you to ask questions.

APPOINTMENT POLICY RULES

1. Appointments must be cancelled 48 hours in advance to avoid a $100 rescheduling fee.
2. The surgical scheduling fee of $2500 is applied to the surgical cost and is non-refundable and non-transferable.
3. There is a *no refund policy* on all treatments including surgical services, injectables, non-surgical procedures, lasers, etc. regardless of cause, including packages.
4. Ultherapy & SofWave appointments must be cancelled *at least* 48 hours in advance or there will be a $500 cancelation fee. Ultherapy & SofWave charges are due in full at time of scheduling.
5. All Laser, Ultra, Exilis, SofWave, Diamond Glow, Botox and Vivace packages must be completed within 1 year or all remaining treatments will be forfeited.
6. Skin care products have a 30-day return policy with no exceptions.

I have read and understood the above information.

Patient Signature______________________________________

Date ___________________________________

NOTICE FOR PATIENTS REGARDING INSURANCE

Boca Raton Plastic Surgery Center does not accept public or private health insurance as a form of payment and Dr. Keusch has opted out of Medicare. This is a self-pay facility. All payments are due in full at the time of treatment or at an agreed upon date for surgical services, generally, a minimum of 21 days prior to surgery.

Acceptable Forms of Payment

Debit/Credit
Cash
Check
Care Credit
PatientFi
ALLE Points/Dollars/Coupons

The staff at Boca Raton Plastic Surgery Center cannot provide any assistance for insurance claims.

This includes: prior-authorizations, pre-certifications, claims, denials, appeals, CPT codes, ICD-10 codes, diagnosis codes. or anything relating to your insurance. Our system is not set up for insurance claims, nor is our staff trained to answer questions related to insurance coverage.

I have read and agree with this policy:

Patient Signature ____

Date ______________________________________