***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. All in-office credits expire 12 months from date of issue and all other in-house procedural payments expire 24 months from date of payment.

_____ _____

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.IndyFace.com.

**LATE OR CANCELLED APPOINTMENTS/REFUND POLICY**

By signing below, I hereby acknowledge that if I am more than ten (10) minutes late for a scheduled appointment, I will be asked to reschedule my appointment. I also agree that if I miss or cancel any scheduled appointment with less than 24 hours prior notice, I will pay WFPS a $75.00 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 the full amount of the returned check, a $35.00 a bad check fee, and any legal fees generated in recovering those funds.

**FINANCIAL AGREEMENT**

By signing below, I understand all payments and credits expire after 24 months unless otherwise indicated. I hereby agree to pay WFPS their charges for all services rendered during my treatment. 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 understand that WFPS does not accept nor bill insurance for any treatments. I understand that if I elect to request insurance reimbursement on my own that WFPS accepts no responsibility. **I also acknowledge and understand that WFPS will not accept responsibility or involvement in negotiating a settlement on any claim.**

_____ _____

Patient Signature Date

_____ _____

Witness Date

**Winslow**

*Facial Plastic Surgery*

**Patient Information Questionnaire**

Mr./Mrs./Ms./Dr.

Name _____Date of Birth_____ Age_____

Address_____ City_____

State _____Zip_____ Sex: M F Marital Status: M S D W Sep

Home Phone _____ Cell _____ Work Phone _____

School/Employer_____ Occupation _____

Height_____ Weight_____ Has your weight changed more than 5 pounds in the past 6 months? Y N

E-mail_____

**Emergency Contact**

Name:_____ Phone:_____

Address:_____

Relationship to Patient: _____

**Contact and Communications**

What is your preferred method of contact? **HOME PHONE** **CELL PHONE** **EMAIL**

May we contact you/confirm appointments via text? Y N

May we contact you/confirm appointments via email? Y N

May we leave a voicemail or message with a family member for appointment reminders? Y N

**This office routinely receives phone calls and other communications from a Patient's family member or friend to get information about an appointment or to make a payment for a procedure.**

Do you consent to communication between this office and a designated individual or individuals for scheduling and payment activities? Y N

**If yes, please provide the name(s) and relationship(s) of the individual(s):**

**Name:** _____ **Relationship:** _____

**Name:** _____ **Relationship:** _____

Would you like to be included in our standard e-mail list to receive news of our events and specials? This list is internal and is not shared with any outside parties without your specific prior authorization. Y N

**Patient Healthcare Providers**

Please provide a list of all current treating physicians, including your Primary Care Physician:

**Physician Name and Address**: _____

Phone: _____ Specialty or Type of Practice: _____

**Physician Name and Address**: _____

Phone: _____ Specialty or Type of Practice: _____

**Physician Name and Address**: _____

Phone: _____ Specialty or Type of Practice: _____

**Physician Name and Address**: _____

Phone: _____ Specialty or Type of Practice: _____

**Physician Name and Address**: _____

Phone: _____ Specialty or Type of Practice: _____

Who is your preferred pharmacy? _____

Address: _____ Phone: _____

**Briefly describe the reason for your consultation:**

_____

_____

_____

_____

**How did you hear about our office?**

_____WTHR TV _____Magazine

_____FOX 59 TV _____indyface.com

_____Realself.com _____Spa/Salon (specify)_____

_____Friend (name) _____

_____Doctor (name) _____

_____Other (specify) _____

**CONSENT FOR USE AND DISCLOSURE OF PROTECTED INFORMATION**

## SECTION A: PATIENT GIVING CONSENT

Name: _____ DOB: _____ Telephone: _____

E-Mail: _____

## SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

**Purpose of Consent:** By signing this form, you will consent to the use and disclosure of certain protected information to carry out treatment, payment activities, and healthcare operations. You will also be consenting to the use and disclosure of your image and contact information for other limited purposes listed below, unless you choose to restrict such use. Your Consent will expire upon the end of the treating physician's practice of facial reconstructive surgery or your written revocation. There is no expiration of your Consent for the use or disclosure is for the purposes of medical or scientific research of use in Specialty Board examination absent your specific written revocation.

**Notice of Privacy Practices:** You have been provided a copy of our Notice of Privacy Practices and should review it carefully before you decide whether to sign this Consent. This Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

**Right to Revoke:** You have the right to revoke this Consent at any time by giving WFPS written notice of your revocation submitted to:
WFPS
2000 E. 116th Street, Suite 200
Carmel, Indiana 46032
The revocation must be signed by you or your legal representative. Please understand that revocation of this Consent will not affect any action WFPS took in reliance on this Consent before it received your revocation.

## SECTION C: OTHER USES AND DISCLOSURES

In addition to the use and disclosure of protected health information for treatment, payment, and business operations, WFPS may wish to conduct surveys for purposes of patient satisfaction and quality assurance, seek testimonials from patients for use in public relations and advertising activities and use patient images for promotional purposes. Please initial your consent or refusal to the following:

| Consent | Refuse | Use or Disclosure |
|---|---|---|
| | | Photographic or video images for promotional and patient information/education in the office |
| | | Photographic or video images for promotional and patient information/education outside of the office, to include social media |
| | | Photographic or video images for medical Specialty Board in formulating its examination of applicant physicians. |
| | | Photographic or video images in professional presentations or journal publications by Dr. Winslow |
| | | Contact information for purposes of obtaining patient feedback, including testimonials for use in advertising and publication on various social media and other internet sites.***** |

***The organization that receives patient contact information has entered into a Business Associate Agreement with WFPS and is required to comply with all HIPAA privacy and security requirements under that Agreement.**

## SECTION D. SIGNATURE AND ACKNOWLEDGEMENT

I have had a full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that by signing this Consent form, I am agreeing to the use and disclosure of my protected health information as set forth above.

Signature: _____ Date: _____

Relationship to Patient: _____

## 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 & hormones):

_____

_____

Previous Surgeries & Dates

_____

Current Active Illnesses

_____

**Are you currently being treated by a psychiatrist?** **Yes** **No** Name_____Phone_____)

Have you been diagnosed with:

____Borderline Personality Disorder ____Major Depressive Disorder _____Schizophrenia
____Body Dismorphic Disorder ____General Anxiety Disorder

**Nicotine/Smoker:** **Yes** **No** **Type/Packs per day**_____

**Alcoholic Drinks per week:** _____

**Do you have a personal history of?**

| | | | |
|---|---|---|---|
| _____Heart Disease | _____Alcoholism | _____Heart Attack (date) | _____Diabetes |
| _____Tuberculosis | _____Stroke | _____Asthma | _____Heart Murmur |
| _____Breathing Problems | _____Chest Pain | _____Hepatitis/HIV | _____Nose Bleeds |
| _____Glaucoma/Eye Disorder | _____Dry Eyes | _____Skin Cancer | _____Arthritis |
| _____Stomach Problems/Reflux | _____Other Cancer | _____Headaches | _____Latex Allergy |
| _____Pulmonary Edema | _____Thyroid Prob. | _____Blood Disorders | _____Seizures/Epilepsy |
| _____MRSA | _____Cold Sores | _____High Blood Pressure | _____Varicose Veins |
| _____Bad Scarring/Keloid | _____Facial Paralysis | _____Bronchitis/Emphysema / Abnormal Lung Function | |
| _____Mitral Valve Prolapse | | _____Irritable Bowel Disease | |
| _____Immunosuppression | | _____Blood Clots Pulmonary Edema | |
| _____Easy Bruising or Prolonged Bleeding | | _____Previous Post Operative Complications | |

_____Autoimmune Disease_____

_____Accutane Use(Past or Present) Date Discontinued _____

_____Other _____

**Please specify if you checked any medical history:**

_____

**Family history of?**

| | | |
|---|---|---|
| _____Heart Disease | _____Diabetes | ____Tuberculosis |
| _____Stroke | _____Asthma | |
| _____Hepatitis/HIV | _____Glaucoma/Eye Disorder | _____Skin Cancer |
| _____Arthritis | _____Other Cancer | _____MRSA |
| _____Bad Scarring/Keloid | _____Depression | _____Mental Illness |
| _____High Blood Pressure | _____Seizures | _____Blood Disorder |
| _____Easy Bruising or Prolonged Bleeding | _____Bronchitis/Emphysema | _____Blood Clots |

_____Previous Post Operative Complications

_____Autoimmune Disease_____

_____Other _____

**Please specify if you checked any medical history:**

_____

10/31/2018

***Winslow***

*Facial Plastic Surgery*

**Authorization for Disclosure of Information**

*Because we offer an in-house surgical suite it is required that we undergo peer review for accreditation purposes. A licensed medical professional will randomly pull charts for evaluation to ensure all standards are met and exceeded. We must obtain authorization for this practice please be assured your information remains protected and is never releases without additional consent.*

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_____