PATIENT PROFILE

Date:_____

How did you hear about us: ☐ Physician ☐ Family/Friend ☐ Google ☐ Other

NAME AND CONTACT INFORMATION

Name: (Last, First, Middle) _____ DOB: _____ SSN: _____
Mobile Phone: _____ Other Phone: _____ Email: _____
Address: _____
Occupation: _____ Employer Name/Phone Number: _____
Street Address: _____

GUARANTOR – Person financially responsible for payment, if other than patient

Name _____ DOB: _____ Relationship to Patient_____
Address _____Phone # _____ Employer/Address: _____

INSURANCE/BILLING

Policy Holder Name (If Not Patient): _____ DOB/Relationship to Patient: _____
Primary Insurance: _____ Policy #: _____
Secondary Insurance: _____ Policy #: _____

MEDICAL

Referring Physician: _____ Phone: _____
Reason for Today's Visit: _____ How long has this been going on? _____
Known Medical Problems: _____
Allergies to Medications or Other Substances: _____
Pharmacy/Address: _____Phone: _____

DEMOGRAPHICS

MARITAL STATUS: __Single __Married __ Other _____ **GENDER**: __Male __Female __ Other_____
RACE: __American Indian or Alaska Native __Asian __Black or African American __Native Hawaiian or Other Pacific Islander __White __Other_____
ETHNICITY: (Check One) __Hispanic or Latino __Not Hispanic or Latino

EMERGENCY CONTACT – Who should be notified in case of an emergency? Please provide a number other than yours.

Name: _____ Phone: _____ Relationship: _____

I would like to hear more about:

Facial Rejuvenation:
- __Botox/Fillers
- __Eyelid lift
- __Facelift
- __HALO facial treatment
- __In Office Facial Rejuvenation
- __Laser Skin Resurfacing
- __Mole/Cyst Removal
- __Neck Lift

Skin Care Products to address:
- __Acne
- __Dark Spots/Hyperpigmentation
- __Dullness
- __Dryness
- __Facial Redness
- __Large Pores/Excess Oil
- __Rough Texture
- __Under Eye Wrinkles

Breast Procedures:
- __Breast Augmentation
- __Breast Lift with Augmentation
- __Breast Implant Removal
- __Breast Implant Exchange
- __Breast Reduction
- __Fat Transfer to Breast
- __Gynecomastia Reduction (men)
- __Nipple/Areola Reduction

Body Contouring:
- __Abdominoplasty (Tummy tuck)
- __Arm Lift
- __Brazilian Butt Lift
- __Labiaplasty/Mons Reduction
- __Liposuction – Laser
- __Lower Body Lift
- __Thigh Lift
- __Upper Body Lift

I understand that I am responsible for all charges for services unless arrangements are made prior to services being provided. Payment is expected at time of service. I guarantee that the above information is correct. I will notify this office if any changes occur.
Please allow front desk staff to copy your insurance card(s) if you would like to have our office file your insurance as a courtesy. Our filing will in no way relinquish you of your responsibility of payment of these services should they not be paid by your insurance carrier in a timely and reasonable manner.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: _____ **DATE:** _____

ENVISION
PLASTIC & RECONSTRUCTIVE SURGERY
1561 Lakefront Drive, Suite 202 | Sarasota, FL 34240
PHONE (941) 822-8955 | **FAX** (941) 259-0197 | ENVISIONPLASTICSURGERY.COM

HEALTH HISTORY

PATIENT NAME _____ **DOB** _____ **HEIGHT**____ ft ____in **WEIGHT** _____ lbs

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN FOR ANY CHRONIC MEDICAL PROBLEMS? **YES or NO**
IF YES PLEASE EXPLAIN? _____
_____

PAST MEDICAL HISTORY (Check if you have had any problems with or are presently experiencing any of the following)

__AIDS or HIV	__Blood transfusion	__Glaucoma	__Low blood pressure	__Stroke
__Anemia	__Bronchitis	__Hepatitis	__Measles	__Thyroid disease
__Arthritis	__Cancer	__Hernia	__Migraine headache	__Transfusions
__Asthma	__Chicken pox	__High blood pressure	__Mitral valve prolapse	__Tuberculosis
__Back trouble	__Diabetes	__Hives or eczema	__Mumps	__Ulcer
__Bladder infection	__Diphtheria	__Infectious mono	__Pneumonia	__Venereal disease
__Bleeding tendency	__Epilepsy	__Kidney disease	__Psychiatric disorders	__Whooping cough

Have you ever had: (circle all that apply)
Heart problems
Lung problems
Blood problems
Endocrine problems
Other_____

Other conditions not listed: _____

Primary Physician: _____ Do you have a specialist? **Yes / No** Specialty: _____

PREVIOUS HOSPITALIZATIONS/SERIOUS ILLNESSES/SURGERIES	WHEN?	HOSPITAL, CITY, STATE
_____	_____	_____
_____	_____	_____
_____.	_____.	_____

CURRENT MEDICATIONS (List all prescription and OTC or herbal supplements)

Medication Name	Dose/mg.	How Often?	Medication Name	Dose/mg.	How Often?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____.	_____	_____.	_____.	_____

SOCIAL HISTORY (check all that apply)

ALCOHOL USE:
__ Never
__Sometimes
__Weekly # of drinks_____
__Monthly # of drinks_____

TOBACCO USE: (circle)
Do you smoke / vape? YES NO
How much?_____
Former smoker? YES NO
Quit Date: _____

DRUGS:
__ Never
__ Yes (list type/frequency)
_____
_____

EXCESSIVE EXPOSURE TO:
__Fumes
__Dust
__Solvents
__Airborne particles

FAMILY MEDICAL HISTORY

Please indicate which family members have any of the following conditions (Mother, Father, Sibling, Grandparent):

Diabetes	☐	Abnormal Bleeding Tendencies	☐
Cancer Type:	☐	Rheumatoid Arthritis	☐
Heart Disease	☐	History of Anesthetic Complications	☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient or Legal Representative _____ **Date** _____

OFFICE POLICIES

OFFICE HOURS

Monday – Thursday | 8:30am – 5:00pm
Friday | 8:00am – 4:00pm

COVERAGE

The patient is responsible for making sure their insurance is in-network for our doctor(s).

CO-PAY

Co-pay is due at the time of service. Cash, check, American Express, Discover, Visa and Mastercard are accepted. If you are not prepared to pay the co-pay, we will gladly reschedule your appointment.

PRESCRIPTIONS

No medications will be called in after hours or on the weekend. You must call during business hours. **THERE ARE NO EXCEPTIONS.**

INSURANCE/FMLA/DISABILITY FORMS

There is a $20.00 charge for all disability, FMLA, Aflac and insurance forms.

RETURNED CHECKS

A $30.00 charge will be billed for all returned checks.

_____
Signature of Patient or Legal Representative

_____ _____
Printed name (of signed) Date

If signed by legal representative:

_____ _____
Relationship to Patient/Authority to Sign Reason Patient Unable to Sign

_____ _____
Legal Representative Address Legal Representative Phone Number

HIPAA Authorization For the Use and Disclosure of Protected Health Information

Name (Last, First, MI) _____ Gender☐ M☐ F☐ Other

SSN: XXXX-XX-_____ DOB: _____Phone (cell): _____Phone (other):_____

Address:_____

Pursuant to the HIPAA Standards for Privacy of Individually Identifiable Health Information (45 C.F.R. §164.508), I hereby authorize Envision Plastic and Reconstructive Surgery (**"Facility"**) to use or disclose my protected health information (**"PHI"**) as described below to:

RECIPIENT NAME AND ADDRESS: _____

I further authorize Recipient to receive such PHI. The purpose of the requested use or disclosure is (SELECT ALL THAT APPLY):

- ☐ Training and Education
  - ☐ Within Facility ☐ Outside Facility
- ☐ To inform the public about clinical, educational, scientific, and charitable activities or services of Facility via:
  - ☐ Live or taped television, radio, internet broadcasts, social media and live streaming broadcasts
  - ☐ Publications, including articles in a medical journal, newspaper, magazine, newsletter, website and print/online
- ☐ Marketing/advertising, for which payment may be received by Facility
- ☐ Sale, for which payment will be received by Facility
- ☐ For purposes of investigation and litigation
- ☐ For use in trial exhibits
- ☐ At the request of the patient
- ☐ Other (please specify): _____

The PHI to be used or disclosed includes the following information (**CHOOSE ONE**):

☐ MY ENTIRE MEDICAL RECORD, including illustrations, photographs, or other imaging or video records created in my case, from _____ to_____. I understand that the information in my medical record may include information relating to my identity, diagnosis, prognosis, and/or treatment, which may also include information relating to sexually transmitted disease, acquired immunodeficiency virus (HIV), behavioral health or mental health services, and/or treatment for alcohol and/or drug abuse. I authorize the release of such information, with the following exceptions:

- ☐ Only illustrations, photographs, or other imaging or video records created in my case
- ☐ Other (please specify): _____

In addition to the above authorized disclosure,

☐ I hereby grant permission for the use of my medical records or other records, including illustrations, photographs, or other imaging records created in my case, for use in my examination, testing, credentialing, and/or certifying purposes by the American Board of Plastic Surgery, Inc.

Federal and state laws protect PHI. However, I understand that PHI disclosed pursuant to this Authorization may be subject to redisclosure by Recipient and may no longer be protected. I further understand that Facility has no control over how Recipient uses the information disclosed.

This authorization will expire (**CHOOSE ONE**):

- ☐ On the _____day of _____, 20_____, or
- ☐ Upon the occurrence of the following event or condition: _____; provided, however, that if no event or condition is listed, it will expire ten (10) years from the date I sign below.

I understand that I have the right to revoke this Authorization at any time, and in order to do so, I must present a written revocation to Facility at 1561 Lakefront Drive., Ste 202, Sarasota, FL 34240. I understand that any such revocation will not apply to information that has already been released in response to or in reliance upon this Authorization.

I understand that I may refuse to sign this Authorization and that my refusal will not affect my health care treatment, payment, health plan enrollment, or eligibility for benefits.

I understand that I will be given a copy of this Authorization form after signing it and that I should retain that copy for my records.

Signature of Patient or Legal Representative_____ Today's Date: _____

Signature of Witness: _____ Today's Date: _____

IF SIGNED BY LEGAL REPRESENTATIVE

Relationship to Patient/Authority to Sign: _____ Reason Patient Unable to Sign: _____

Address, City, State, Zip and Phone Number_____

Verbal Consent Received from Capable Patient if Unable to Sign: Yes ☐

FORM INVALID IF NOT SIGNED

PATIENT COMMUNICATION PREFERENCE FORM, DESIGNATION OF INDIVIDUALS INVOLVED IN CARE/TREATMENT AND INDICATION OF PERSONAL REPRESENTATIVE

PATIENT – FULL LEGAL NAME (FIRST M.I. LAST) _____ DOB (MM/DD/YYYY) _____

PATIENT COMMUNICATION(S) PREFERENCE REQUEST

I request and authorize Envision Plastic and Reconstructive Surgery to communicate with me regarding my health care treatment and payment (including, but not limited to information such as appointment reminders, billing information, and lab/X-ray results) as indicated below:

- ☐ Fax
- ☐ Message on answering machine/voicemail
- ☐ Pick-up forms on my behalf
- ☐ Secure encrypted email
- ☐ Secure encrypted text message
- ☐ Standard US Postal Mail

Please provide the following information for the manner(s) selected below:

PHONE (HOME) _____ PHONE (CELL) _____

ADDRESS, CITY, STATE, ZIP _____

EMAIL _____

DESIGNATION OF INDIVUDUAL(S) INVOLVED IN YOUR CARE/TREATMENT

As a patient, you may designate one or more individuals with whom we may share Protected Health Information/Personal Identifying Information (PHI/PII) about you related to their involvement in your care/treatment or payment for your care/treatment. PHI/PII includes information about your current medical condition and diagnosis, treatment and prognosis, and billing and payments. Such individual(s) might be a spouse, relative, domestic partner, or friend. You can remove or add individuals at any time, including during treatment.

I authorize Envision Plastic and Reconstructive Surgery to share PHI/PII about me with the individuals below related to their involvement in my care/treatment or payment for my care/treatment (attach additional pages if needed):

NAME (FIRST M.I. LAST) _____

RELATIONSHIP TO PATIENT _____

ADDRESS, CITY, STATE, ZIP _____

EMAIL _____

PHONE NUMBER _____

NAME (FIRST M.I. LAST) _____

RELATIONSHIP TO PATIENT _____

ADDRESS, CITY, STATE, ZIP _____

EMAIL _____

PHONE NUMBER _____

NAME (FIRST M.I. LAST) _____

RELATIONSHIP TO PATIENT _____

ADDRESS, CITY, STATE, ZIP _____

_____

EMAIL

_____

PHONE NUMBER

INDICATION OF LEGAL REPRESENTATIVE:

You may also indicate your Legal Representative below. A Legal Representative is a person who has authority under applicable law to act on your behalf in making decisions related to health care if you become incapacitated or unable to make decisions on your own, for example, a "health care agent" or "attorney in fact" under a Durable Power of Attorney for Health Care. We will treat such person the same as we would treat you with respect to PHI/PII relevant to such personal representation. We may ask for documentation to verify that a Legal Representative has appropriate legal authority to act for you before disclosing PHI/PII about you.

Please initial one:

____ I **do not wish** to indicate my Legal Representative. I understand that the Envision health care team may identify a Legal Representative for me in certain circumstances in accordance with applicable law, for example if I become incapacitated or am unable to make decisions on my own and designating a Legal Representative will expediate or enhance my care as a patient.

____ I **do wish** to indicate my Legal Representative as the following person for purpose of making decisions related to health care:

Legal Representative – Full Legal Name (FIRST M.I. LAST)

Signature:

By signing this form, I authorize Envision to disclose information about me as indicated above. I understand that I may change the information provided in this form at any time by submitting changes in writing to Envision. I understand that changes will not be effective related to information previously disclosed, but will be effective going forward.

This authorization will expire **(SELECT ONE):**

- ☐ On the _____ day of _____, 20____, or
- ☐ Upon the occurrence of the following event or condition: _____;
  provided, however, that if on event or condition is listed. It will expire ten (10) years from the date I sign below.

I understand that I have the right to revoke this Authorization at any time, and in order to do so, I must present a written revocation to Envision at 1561Lakefront Drive Suite 202 Sarasota FL, 34240.

I understand that any such revocation will not apply to information that has already been released in response to or in reliance upon this Authorization.

I understand that I may refuse to sign this Authorization and that my refusal will not affect my health care treatment, payment, health plan enrollment, or eligibility for benefits.

I understand that I will be given a copy of this Authorization form after signing it and that I should retain that copy for my own records.

_____ _____

Signature of patient or legal representative **Today's date (MM/DD-YYYY)**

If signed by a legal representative:

_____ _____

Relationship to patient/Authority to sign Reason patient unable to sign

_____ _____

Legal representative's address Legal representative's phone number

Verbal consent received from capable patient if unable to sign: ☐ Yes

FORM INVALID IF NOT SIGNED AND DATED

REQUEST FOR RELEASE OF MEDICAL RECORDS FOR TREATMENT PURPOSES

To Whom It May Concern:
The individual identified below is a patient of Envision Plastic and Reconstructive Surgery and has consented to your release of his/her medical records to our practice for purposes of treatment. Accordingly, please provide the information as indicated below. Contact us with any questions: 941-822-8955.
Thank You
Envision Plastic and Reconstructive Surgery

PATIENT – FULL LEGAL NAME (FIRST M.I. LAST) _____ DOB _____

OBTAIN FROM:

PHYSICIAN/ORGANIZATION _____

ATTENTION _____

ADDRESS _____

CITY, STATE, ZIP _____

PHONE _____

FAX _____

SEND OR FAX TO:

PHYSICIAN/ORGANIZATION _____

ATTENTION _____

ADDRESS _____

CITY, STATE, ZIP _____

PHONE _____

FAX _____

INFORMATION TO BE RELEASED:

I hereby consent to the release of the following information from/to the individual(s)/organization(s) as indicated above:

- ☐ All dates
- ☐ All records
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Specific Dates
- ☐ Imaging/X-Rays
- ☐ Laboratory Reports
- ☐ Medication Records
- ☐ Operative Notes
- ☐ Progress Notes
- ☐ Other:

Signature of patient or legal representative _____ Today's date (MM/DD-YYYY) _____

If signed by a legal representative:

Relationship to patient/Authority to sign _____ Reason patient unable to sign _____

Legal representative's address _____ Legal representative's phone number _____

Verbal consent received from capable patient if unable to sign: ☐ Yes