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:** _____

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

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

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

ENVISION
PLASTIC & RECONSTRUCTIVE SURGERY

HIPAA/Disclosure/Authorization

The Health Insurance Portability and Accountability Act (HIPAA) is a U.S. law designed to protect your private health information.

Please provide the following information to assist Envision Plastic & Reconstructive Surgery in ensuring your personal health details are shared only with those you authorize.

Patient Name (please print) : _____
(First Name) **(Last Name)** **(Date of Birth)**

I give permission for Envision Plastic & Reconstructive Surgery to share ***information*** with the following person(s) listed below				Check all that apply		
Name	**Contact Number**	**Relationship**		**Appointment**	**Billing**	**Medical**

Please read and initial the following:

_____ **I understand Envision Plastic & Reconstructive Surgery will only share information with**
_____ **person(s) listed above.**
_____ **I understand it is my responsibility to notify Envision Plastic & Reconstructive Surgery of any changes.**
_____ **I understand this form expires and will no longer be honored by Envision Plastic & Reconstructive Surgery one (1) year from the date signed.**

Pediatric patients only:

_____ **I understand pediatric patients will be seen only when accompanied by parent or legal guardian unless a valid *Designation of Health Care Surrogacy Form* is completed and on file with First Physicians Group.**

Printed Name: _____ **Signature:** _____

Relationship to Patient: _____ **Date:** ____/____/_____

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

Patient Photograph and Video Release Form

I, _____, permit Dr. James Kotick ("**my surgeon**") or his/her designee to take photos and/or videos before, during, and after my surgery. These may be of me or parts of my body ("**my images**"). I agree that my surgeon can share them with staff, other health professionals, and the public. This may be done for educational or marketing purposes.

I understand that once my de-identified images are published, I lose control over their use. I have no control over where they are published. I agree to give up certain rights to my image. I release any claim I may have to the publication of such images. This includes any payment for their distribution.

I understand that images posted online may be saved. They may be available forever. They may be found in online searches. I realize that people may repost my images without my surgeon's consent. This may be used in social media. Neither I nor my surgeon have any control over this. I agree that my surgeon is not responsible for third-party use. I release my surgeon from any claim that might arise from this use.

I agree that my surgeon can use my de-identified images in the following context:

Please initial <u>ONLY ONE</u> of the following

_____ALL MEDIA: My de-identified images and medical details may be used in print and broadcast media. This includes newspapers, pamphlets, educational films, the Internet (including social media and applications), and television.

_____ ALBUM ONLY: My de-identified images and medical details may be used in printed and/or digital photograph albums. The albums will only be used to show other patients my surgeon's methods.

I agree to the educational use of my images. I have fully read and understand the above terms. I have made my decision carefully and understand the risks.

PATIENT SIGNATURE: _____ Date: _____

Printed Name: _____

WITNESS SIGNATURE: _____ Date: _____

Printed Name: _____

For patients under the age of 18:

I, the parent or guardian of _____, a minor, am authorized to sign this release on his or her behalf. I agree to the educational use of his or her images.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

Printed Name: _____