17300 North Outer 40 Road, Suite 300
Chesterfield, MO 63005
636.530.6161

Welcome To Our Office

(Please Print)

Name: _____
Last **First** **Middle**
Home Address: _____
City: _____ **State:** _____ **Zip:** _____
Home Telephone: ( ) _____ **Cell Telephone: ( )** _____
Work: ( ) _____ **Other: ( )** _____
At which number do you prefer to be contacted? _____
We make appointment reminders, would you like to be contacted by phone or e-mail? (Circle)
E-mail Address: _____
Would you like to receive our e-newsletter for current specials: Yes _____ **No** _____
Have you ever been to our medical spa? Yes _____ **No** _____
Birth date: ___/___/___ **May send information to my home? Yes** _____ **No** _____
SSN: _____ **Sex: Male Female** **Occupation:** _____
Employer: _____
Employer Address: _____
City: _____ **State:** _____ **Zip:** _____
Employer Phone Number: ( ) _____
Responsible Party: _____
Relationship to Patient: _____ **Insurer's birth date:** _____
Home Address: _____
City: _____ **State:** _____ **Zip:** _____

Which procedure(s) would you like to discuss today on your visit?

_____ _____ _____

How did you hear about us? _____ _____ _____
(If radio, please specify which station)

<u>Emergency Contact</u>
Name: _____ **Relationship:** _____
Home Phone.: ( ) _____ **Work: ( )** _____ **Cell: ( )** _____

Signature: _____ **Date:** _____
Parental signature (if under the age of 18): _____
Due the HIPAA (Health Insurance Portability and Accountability Act) all information must be completed on this form and the following forms. If you have any questions regarding this, anyone in our office will be glad to help you.

Thank you for choosing St. Louis Cosmetic Surgery!

HEALTH INFORMATION

NAME: _____ AGE: _____

PRIMARY PHYSICIAN: _____ GYNECOLOGIST: _____
Date of last physical exam: _____ Date of last mammogram: _____
Pants/Dress Size: _____ **Bra Size**: _____

Are you taking any medications on a regular basis or any within the past 12 months? (*Include Aspirin/Vitamins*) Yes_____ No_____
If yes, please list: _____ _____ _____
_____ _____ _____ _____

Are you taking Birth Control (oral) _____, or using Intrauterine Devices or on Hormones? (*circle*) Yes_____ No_____

Are you Allergic to or ever had any reaction to any medications, drugs or local anesthetic? Yes_____ No_____
(Including Novocaine, Xylocaine, Latex, soaps, lotions, tapes, etc.) Please list: _____
_____ _____ _____ _____

Have you ever had an operation or been hospitalized for any reason? Yes_____ No_____

Date	**Reason**	**Physician**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How many Pregnancies have you had? _____ Births? _____

Have you ever had rheumatic fever, heart trouble, heart murmurs, palpitations, irregular heartbeat, chest pains, high blood pressure, shortness of breath, swelling of the ankles? (*Please circle*) Yes_____ No_____

Have you ever had diabetes, hepatitis, cancer, thyroid disorder, kidney problems, asthma, chronic lung or bronchial disease, or any other serious illness? (*Please circle*) Yes_____ No_____

Have **you or anyone in your family** ever been diagnosed and/or treated for bleeding disorder, blood clots, excessive bleeding, Deep Venous Thrombosis (DVT), or Pulmonary Embolism? (*Please circle*) Yes_____ No_____

Have you ever had a fractured nose, difficulty breathing, nose bleeds, post nasal drip, hay fever, deviated septum, sinus pain? (*Please circle*) Yes_____ No_____

Have you ever had eye disease, trouble with dryness, soreness, burning, itching, excessive tearing of the eyes? (*Please circle*) Yes_____ No_____

Have you ever had any psychiatric problems, nervous breakdown, presently or have you ever been under the care of a psychiatrist? Yes_____ No_____

Do you have any problems with excessive scarring, or have you ever formed a keloid after being cut? Yes_____ No_____

Do any diseases run in your family? Yes_____ No_____
Please list: _____

Is there any additional health information you feel you may need to discuss with us? Yes_____ No_____
Explain: _____

Do you have a problem with alcohol or chemical dependency? Yes_____ No_____
Do you use any Nicotine containing products? (i.e.: patches, gum) Yes_____ No_____
Do you smoke ***Cigarettes*** or ***Vapor/electronic cigarettes*** (circle which one) How Much? _____ Yes_____ No_____

Doctor's Signature: _____ Date_____

ST. LOUIS
COSMETIC SURGERY INC.

I am also interested in learning more about:
(Please circle)

Facelift

Forehead Lift

Eyelid Surgery

Nose Surgery

Laser Resurfacing

Lip Augmentation

Chin Liposuction

Microdermabrasion

Mini Facelift

Breast Augmentation

Breast Lift

Cosmetic Breast Reduction

Tummy Tuck

Liposuction

Post-weight loss skin tightening

Ear Pinning

Botox/fillers

IPL Photofacial- *for sun damage, dark spots, rosacea and fine lines*

CoolSculpting

Skin Care Products
Sold only by Physicians

Thermage

Permanent Makeup

Facials

PAYMENT POLICY

We strive to provide all of our patients with prompt and excellent medical care and to assist you in the handling of your bill. In order to maintain your account in good standing, our requirements for payment of your account are as follows:

A. PAYMENT IS EXPECTED FOR ALL OFFICE VISITS, SERVICES, TREATMENTS, AND PRODUCTS AT THE TIME OF EACH VISIT.
B. ALL CHARGES ARE DUE AND PAYABLE THE DATE THEY ARE INCURRED
C. We do not accept the theory that legal cases should be settled before payment of the fee is due. ALL CHARGES ARE DUE AND PAYABLE THE DATE THEY ARE INCURRED.

Because our services are rendered to YOU, you are responsible directly to us for settlement of your account within the time limit set. Please feel free to discuss your bill or charges at an early date, to avoid misunderstandings.

It is understood that failure to comply with this agreement would leave St. Louis Cosmetic Surgery, Inc. no alternative but to seek collection action.

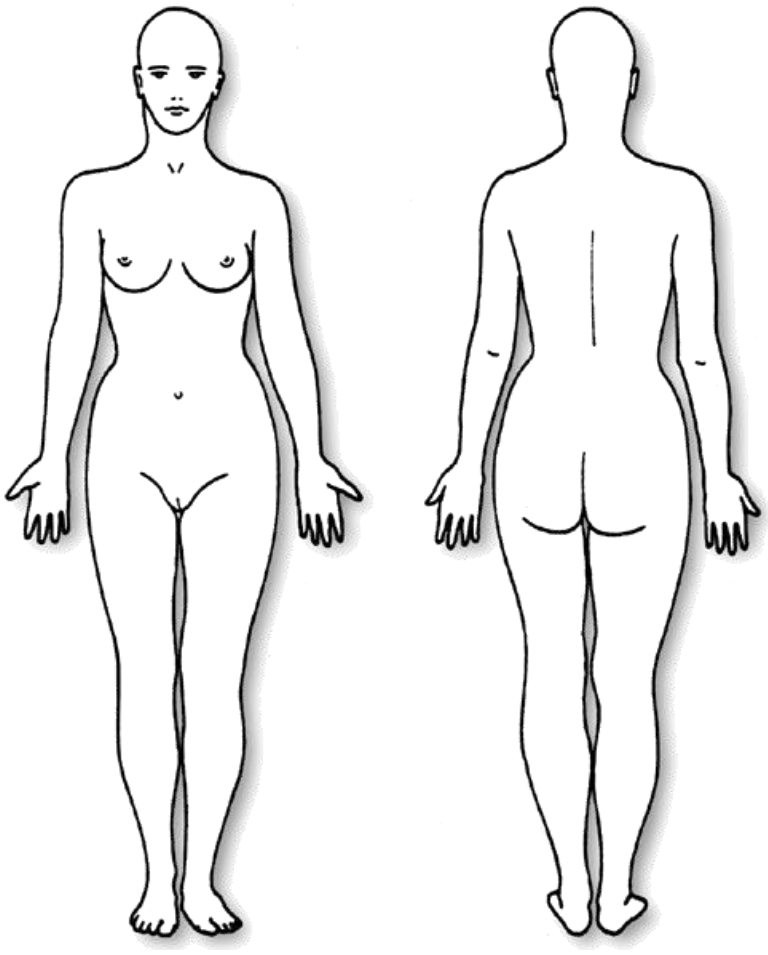
The quote that you receive at your consult will include the doctor's fee, plus OR and anesthesia. Payment of these fees will be due prior to surgery.

We do not accept or file insurance claims. Our services are not covered by insurance.

Signature **Date**

If any areas of your face bother you, please circle those areas.

If any areas of your body bother you, please circle those areas.



St. Louis Cosmetic Surgery
17300 N. Outer 40 Road, Suite 300 Chesterfield, MO 63005

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA" we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

- **Treatment** means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Healthcare Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on you authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communication of protected health information from us by alternative locations.
- The right to inspect a copy of your protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of legal duties and privacy with respect to protected health information.

This notice is effective as of April 1, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post, and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our Privacy Officer, or upon request we will supply you with the address of the Department of Health & Human Services, Office of Civil Rights to file a written complaint. We will not retaliate against your filing a complaint.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

St. Louis Cosmetic Surgery, Inc.
17300 North Outer Forty Road, Suite 300 **Phone: 636-530-6161**
Saint Louis, MO 63005 **Fax: 636-777-7500**

I understand that, under the Health Insurance Portability & Accountability Act of 1966 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the above address to obtain a current comp of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

CONFIDENTIAL COMMUNICATIONS

I request that all communications to me (by telephone, mail or otherwise) by St. Louis Cosmetic Surgery, Inc., and/or its staff be handled in the following manner:

For written communications, send to: For oral communications, call:

_____ _____
Telephone Number

_____

_____

If you are unavailable at this number, may we leave an answering machine or voice mail message?
__Yes __No

Do we have permission to disclose your health information with another person other than yourself?
__Yes __No
If yes, Name: _____
Relationship

Patient Signature: _____

Date of birth: _____Date: _____