Aesthetic Facial Surgery Center of New York

Patient Name: _____

Acknowledgment and Consent

I understand that Aesthetic Facial Surgery Center of New York (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I <u>have received</u> a copy of the Notice of Privacy Practices.

By:_____ Date:_____
(Patient)

-OR-

By:_____ Date:_____
(Patient representative)

Description of Representative's Authority_____

Aesthetic Facial Surgery Center of New York

MEDICAL HISTORY

Last name: _____ First name: _____ Middle initial: _____

Date of Birth: _____

ALLERGIES

List all Allergies:	Describe your Reaction:

CURRENT MEDICATIONS

Drug Name (brand/generic)	Dosage:	Schedule (frequency)

PAST MEDICAL HISTORY

Have you ever had any of the following? Please circle all that apply

Anemia	Depression	Heart Disease	Shortness of Breath
Ankle Swelling	Diabetes	Heart Attack	Stroke
Bleeding Tendency	Dizziness	Hearing Problems	Thrombophlebitis
Cancer	Emphysema	High Blood Pressure	Ulcer
Chest Pain	Endocrine Problem	HIV (AIDs)	Vision Problems
Coughing Blood	such as thyroid	Pneumonia	

Illnesses	Date	Hospitalizations	Date	Injuries	Date	List all surgeries	Date

FAMILY HISTORY

Relative	Current Health	Age if Living	Age of Death	Cause of Death	Known Illnesses
Mother					
Father					
Brother(s)					
Sister(s)					

HISTORY OF TOBACCO

Aesthetic Facial Surgery Center of New York

Have you ever smoked? Yes No If yes, when? _____

Are you currently smoking? Yes No

Cigarettes_____ How many a day?_____ How many years? _____

Cigars _____ How many a day?_____ How many years? _____

Smokeless tobacco _____ How many a day?_____ How many years? _____

HISTORY OF ALCOHOL

Do you drink alcohol? Yes No Recovery Alcoholic? Yes No Probably an Alcoholic? Yes No

Drink Alcohol____ How many times a week?_____ OR times a month? _____

Cigars _____ How many a day?_____ How many years? _____

Preferred beverage? _____

HISTORY OF RECREATIONAL DRUGS

Have you ever used illicit drugs? Yes No

Do you currently use illicit drugs? Yes No Drug(s) of choice _____

COSMETIC HISTORY

Have you had (Restylane, Collagen, etc.) injections? _____ Last injection? _____

Have you had Botox injections? _____ Last injection? _____

Have you ever been pregnant? YES NO How many times?_____ Live births?_____

Are you currently pregnant? YES NO Are you planning more children? YES NO

Have you used Accutane? _____ For how long? _____

Have you recently had facial surgery? _____ Type and date: _____

Have you ever had laser resurfacing? _____ Type and date: _____

Have you had a bad reaction to local or general anesthesia? YES NO If yes, explain _____

Have you had significant emotional problems? YES NO If yes, explain _____

Have you had psychiatric care? YES NO If yes, explain _____

Have you seen other plastic surgeons about this same problem? YES NO If yes, explain _____

Do you have high blood pressure? YES NO If yes, explain _____

Do you bleed easily from cuts or surgery? YES NO If yes, explain _____

Do you form large scars or keloids? YES NO If yes, explain _____

Do you have frequent infections or boils? YES NO If yes, explain _____

I hereby consent to be examined and treated by Oleh Slupchynskyj, MD and that the above information is correct.

_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

Aesthetic Facial Surgery Center of New York
44 East 65th Street, Suite 1A New York, NY 10021 212-628-6464

Aesthetic Facial Surgery Center of New York

Patient Name: _____

COSMETIC FINANCIAL POLICY

Consultation:
A $125 consultation fee will be charged. If you should decide to have surgery this fee will be applied to the surgeon fee.

Payment Options:
We accept Visa, MasterCard and cash. Outside financing options are available. We will be able to supply information at your appointment or you can visit our website to receive more information.

Scheduling
After your consultation, if you decide to go ahead with surgery you will work with our patient care coordinator to select a date for your surgery.

Pre-Payment
There is a deposit required before the date selected can be reserved exclusively for you. The deposit is $500.00 or 10% of surgery cost whichever is greater. This is a non-refundable deposit. This fee is used to cover the booking and scheduling expenses involved with your surgery. This amount will be deducted from your total cost.

Pre-Surgical Visit
Prior to surgery, preferably two (2) weeks, you will meet with the medical assistant. Our medical assistant will explain all pre-operative instructions, order lab tests required, review your surgical procedure and post-operative limitations with you, and give you your post-operative prescriptions with instructions for their use. Post-operative appointments are scheduled at this time. Any questions you may have will be answered at this consult.

Surgery Final Payment
Two (2) weeks prior to surgery, you will be expected to pay the remaining balance due on your account. We accept: Visa, Mastercard, Money Orders, Cashiers Checks. We are sorry but we are unable to accept personal checks for surgery payment.

Cancel Policy: If for any reason, medical or personal, you cancel two weeks or lees prior to your scheduled surgery date fees will be charged as follows:

- Two (2) weeks prior to surgery – 10% or $500 whichever is greater of your surgery fee for expenses incurred.
- One (1) week prior to surgery – 25% of surgical fee
- One (1) day (24 hours) prior to surgery – entire surgical fee.

If you have any questions, the staff will be happy to assist you. We look forward to caring for you.

Please sign and date.

Financial Guarantor Signature: _____ Date: _____