

Aesthetic Specialists of the Palm Beaches

A Subsidiary of Ob/Gyn Specialists of the Palm Beaches, P.A.

Sharon Ross, MD Kelly VanGilder, DO

Dermal Filler Patient History

Name: _____ Date: _____

Address: _____

Telephone: _____ Cell: _____

Date of Birth: _____

Consent signed: Yes No Date: _____

Previous Dermal Filler Yes: No Date: _____

Complications: Yes No Date: _____

Type Dermal Fillers: _____

History of Anaphylactic Shock: Yes No Date: _____

History of Allergies: Yes No Date: _____

MEDICATION

Asprin Yes No

Anti-Inflammatories Yes No

Anticoagulants Yes No

Steroids Yes No

Non-Steroidals Yes No

(i.e. Advil, Aleve, Celebrex)

SUPPLEMENTS

Ginko Biloba Yes No

Vitamin A Yes No

Vitamin E Yes No

Garlic Yes No

Flax Oil Yes No

1515 N. Flagler Drive Suite 700 West Palm Beach, FL 33401

345 Jupiter Lakes Blvd Suite 200 Jupiter, FL 33458

561-802-5352

www.AestheticSpecialists.net

Dermal Filler Patient History (Continued)

**DO YOU HAVE AT PRESENT, ANY HISTORY OF THE FOLLOWING MEDICAL CONDITIONS?
HAVE YOU HAD IN THE PAST, ANY HISTORY OF THE FOLLOWING MEDICAL CONDITIONS?**

- | | | |
|---------------------------------|-----|----|
| 1. Multiple Severe Allergies | Yes | No |
| 2. HX of Herpes around the Lips | Yes | No |
| 3. On Immunosuppressive Therapy | Yes | No |
| 4. Autoimmune Disease | Yes | No |
| 5. Medical History | Yes | No |

(if answered Yes to any one of the above please explain below)

Comments:

I have answered the above questions to the best of my knowledge.

Signature

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Dermal Filler Consent Form

Name: _____

Telephone: _____

Email Address: _____

Age: _____ Height: _____ Weight: _____

Address: _____

Medications: _____

Allergies: Women: Are you Pregnant or Lactating?: _____

Physician's Name: _____

Circle any of the following history you have or have had in the past:

History of Anaphylaxis	Multiple Severe Allergies	Facial Acne
Active Inflammatory process	Infection (at proposed injection site)	Hives
Immunosuppressive Therapy	Autoimmune Disease	Herpes
Facial Rashes	Any Other Medical Disease: _____	

EXPLAIN:

Previous Hospitalizations/Operations:

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of the form.

Patient Signature: _____ **Date:** _____

DERMAL FILLER ADMINISTRATION CONSENT

Dermal Filler is a gel of hyaluronic acid generated by streptococcus species of bacteria, chemically cross linked with BDDE, stabilized and suspended in physiologic buffer at PH=7 and concentration of 20 mg/ml. Areas most frequently treated are: nasolabial folds, oral commissures, lips, and Glabellar. Client may experience a slight burning sensation during injections. The procedure takes about 20-30 minutes. Results last approximately six months.

RISKS AND COMPLICATIONS

It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness, and bruising, 2) Post treatment bacterial, viral, and/or fungal infection requiring further treatment, 3) Allergic reaction

PHOTOGRAPHS

I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentation. I understand my identity will be protected.

PREGNANCY, ALLERGIES

I am not aware that I am pregnant, have any significant Medical diseases, or have any severe allergies.

PAYMENT

I understand that this procedure is cosmetic and that payment is my responsibility.

I hereby voluntarily consent to treatment with Dermal Filler injection for the condition known as: Facial Static Wrinkles. The procedure has been explained to me. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

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Dental Infiltrate Consent

I, _____ understand that a Dental Infiltrate will be performed to provide temporary relief of discomfort associated with the administration of dermal filler. I understand that Dental Infiltrates are not 100% effective, but should reduce pain in most cases.

The risks of a Dental Infiltrate include bleeding, infection, and adverse reaction to the anesthetic.

_____ (Initial) I do not have any hypersensitivity to any local anesthetic agents, nor do I have a history of malignant hyperthermia.

I have read and understand this consent and all of my questions have been addressed and answered to my satisfaction. I have no contraindicating factors, and thereby grant permission for a Dental Infiltrate. I certify that if any changes occur in my medical history/health or regime, that I will notify this office as soon as possible.

Client (Print Name)

Signature

Date

Witness (Print Name)

Signature

Date

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PATIENT PRE AND POST TREATMENT INSTRUCTIONS FOR DERMAL FILLERS

Recommendations for a few simple guidelines and both pre and post-procedure. These can make the difference between a good result and a fantastic one.

PRE-TREATMENT INSTRUCTIONS

One week before exclude: Aspirin (Advil, Aleve, etc.), Ginkgo Biloba, garlic, flax oil, cod liver oil vitamin A, vitamin E and any other essential fatty acids.

Avoid Chemical Peels and Laser 1 –2 weeks prior to Dermal filler treatment.

POST-TREATMENT INSTRUCTIONS

Immediately after your procedure and for 24 hours you should avoid the following:

Strenuous Exercise

Sun exposure/heat exposure/tanning beds

Alcoholic Beverages

Massaging/pressing areas treated

Extreme cold temperatures

48 hours after your procedure you may begin adding Ginkgo Biloba, garlic, flax oil, cod liver oil, vitamin A, vitamin E or any other essential fatty acids.

If Laser treatment, Chemical Peel or any other procedure is considered after Dermal filler treatment, the risk of eliciting an inflammatory process may be possible. Consider such treatments 1 week before an/or after Dermal filler.

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NOTICE OF PRIVACY PRACTICES

**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 & Accountability Act of 1996 ("HIPAA") 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. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, 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 health information.

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

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and client 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 use or disclose protected health information to carry out treatment, payment, or health care operations in the following circumstances:

- In emergency treatment situations.
- If we are required by law to treat you; or
- 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 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 actions relying on your 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 disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

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The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to receive an accounting of disclosures of 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 our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 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 formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Cathy Zalusky, COO
OB/GYN Specialists of the Palm Beaches
1515 North Flagler Dr., Suite 920
West Palm Beach, FL 33401
561-655-3331

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

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Patient Acknowledgement of Receipt of the Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (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

By signing this document, I acknowledge that you have provided me with a copy of your *Notice of Privacy Practices*. The *Notice of Privacy Practices* contains 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 address above to obtain a current copy 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 health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

Please **initial** each line and sign below to facilitate the processing of any necessary insurance forms and to acknowledge your understanding of our office payment procedures:

_____ I authorize the release of any medical information necessary to process my insurance claims.

_____ I authorize payment of medical benefits to Ob/Gyn Specialists of the Palm Beaches or Perinatal and Gynecologic Specialists of the Palm Beaches.

RELEASE OF INFORMATION:

I authorize Aesthetic Specialists of the Palm Beaches a subsidiary of Ob/Gyn Specialists of the Palm Beaches to release information regarding my medical condition to the following people. (Please provide us with their names, relationship and phone number.

1) _____

2) _____

3) _____

_____ I authorize the request for any medical records to other health care providers for records necessary to my care.

May we leave the results of testing on your answering machine? YES _____ NO _____

If yes, what telephone number? _____

Patient Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____