

# Aesthetic Specialists of the Palm Beaches

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

Sharon Ross, MD Kelly VanGilder, DO Jennifer Schindel, RN CJ Eaton, RN Kany Torres, FS

## Confidential Skin Health Survey

Please Print:

Today's Date \_\_\_\_\_  
First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone H (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_  
Dermatologist/Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Your Occupation \_\_\_\_\_ Email \_\_\_\_\_  
Referred By  Friend  Mailer  Newspaper  Magazine Ad  other  
Esthetician Name \_\_\_\_\_

1. Is this your first facial?  Yes  No  
2. What is the reason for your visit today?  
\_\_\_\_\_  
\_\_\_\_\_  
3. What special areas of concern do you have?  
\_\_\_\_\_  
\_\_\_\_\_  
4. Are you presently under a physician's care for any current skin condition or other problem?  Yes  No  
What? \_\_\_\_\_  
5. Are you pregnant?  Yes  No  
6. Are you taking birth control pills?  Yes  No  
If so, what type? \_\_\_\_\_  
7. Hormone replacement?  Yes  No  
If so, what? \_\_\_\_\_  
8. Do you wear contact lenses?  Yes  No  
9. Do you smoke?  Yes  No  
10. Do you often experience stress?  Yes  No  
11. Have you had skin cancer?  Yes  No  
12. Are you now using (or used in the past):  Azelex  
 Differin  Renova  Retin-A  
 Tazarac  Glycolic or alphahydroxy acids  
If so, when and for how long? \_\_\_\_\_  
13. Are you now using or have you ever used Accutane?  
 Yes  No  
If so, when and for how long? \_\_\_\_\_  
14. Do you have acne?  Yes  No  
Experience frequent blemishes?  Yes  No  
If so, how frequently? \_\_\_\_\_  
15. Do you have any allergies to cosmetics, foods, or drugs?  
 Yes  No  
Please list \_\_\_\_\_  
16. Are you presently taking medications –oral or topical?  
 Yes  No If so, please list  
\_\_\_\_\_  
\_\_\_\_\_  
17. What products do you use presently?  Soap  
 Cleansing milk  Toner  Scrub  Mask  
 Creams  Sunscreen  Other  
\_\_\_\_\_

Please circle if you are affected by or have any of the following:

Asthma	Hepatitis	Metal bone, pins, or plates
Cardiac problems	Herpes	Pacemaker
Eczema	High blood pressure	Psychological problems
Epilepsy	Hysterectomy	Sinus problems
Fever blisters	Immune disorders	Skin diseases –other
Headaches-chronic	Lupus	Urinary or kidney problems

Please explain above problems or list any significant others: \_\_\_\_\_

I understand that the services offered are not a substitute for medical care, and any information provided by the therapist is for educational purpose only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the therapist in giving better service and is completely confidential.

Policies:

1. Professional consultation is required before initial dispensing of products.
2. We do not give cash refunds
3. We require a 24-hour cancellation notice.

I fully understand and agree to the above policies.

Client's signature \_\_\_\_\_

Date \_\_\_\_\_

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## FACIAL PEEL CONSENT

Facial peels (hereinafter “clinical procedures”) can provide marked improvement in the appearance of one’s skin for certain conditions. It is not, however, a “cure all” procedure. Therefore, it is very important that you have a thorough understanding of what these clinical procedures can and cannot do for your particular skin condition. In addition, it is imperative that you acknowledge the potential risks associated with clinical procedures.

Before subjecting yourself to any clinical procedures, read carefully the following statements. After you have read each statement, please initial each respective statement in the space that has been provided.

\_\_\_\_\_ The clinical procedure has been explained to me in detail by the physician and/or members of the physician’s staff.

\_\_\_\_\_ I understand that the clinical procedure is a skin rejuvenation treatment and that I may need several administrations of clinical procedures in order to receive my best results.

\_\_\_\_\_ I understand that for optimum results, a home treatment program is needed to enhance The results of clinical procedures.

**Discomfort:** This is usually minimal and of short duration.

**Swelling:** This is very unusual, but if it occurs it will be minimal and subsides in a few hours to a few days.

**Reddening:** A red discoloration may persist anywhere from a few days to several weeks.

**Demarcation:** Refers to the difference in color, texture or pigmentation that may occur at the junction between the treated and non-treated skin areas.

**Existing Blemishes:** Moles, blood vessels (telangiectasias), freckles and sunspots may become more obvious and darker since the superficial layers of dead skin have been removed.

**Eye Injury:** If chemicals get into the eye, scarring and vision disturbances may occur. Protective safety glasses should be worn while chemicals are being used during the clinical procedure.

**Scarring:** Is very unusual, but may occur.

**Pigmentation:** Although extremely rare, temporary and possibly permanent changes in the color of the skin may occur.

**Milia:** May occur, but will disappear quickly.

**Infection:** Is extremely unlikely, but may occur. An outbreak of Herpes may occur in affected individuals (ask your doctor about an antiviral medication if you are prone to cold sores).

**Hair Growth:** If the dermaplaning phase of the peel is administered, hair is expected to grow back blunt ended. New hair will not appear darker or denser. However, I do understand that any hormonal imbalance that may be present within my anatomical system can alter the normal hair growth pattern and cause a darker and denser restoration process.

**General:** Any and all risks and complications can result in additional surgery, hospitalization, time off from work and expenses to you.

- **Should one or more of the foregoing complications arise, please notify the office immediately.**
- **Early detection and treatment may minimize the extent of a complication and future problems.**
- **The foregoing list is not intended to be a complete or exhaustive list of all possible complications which may arise as a result of clinical procedures.**

**The physician will be glad to detail less likely complications or problems.**

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\_\_\_\_\_ I understand that clinical procedures need not be administered by a physician. It is also my Understanding that, in addition to receiving formal training, any non-physician medical Assistants (i.e., RN, LPN, physician assistant, ARNP, cosmetologist or aesthetician) who administers clinical procedures has had his/her skills reviewed and endorsed by the supervising physician.

\_\_\_\_\_ I understand that is extremely important to strictly follow all homecare instructions when striving for optimal results.

I understand that if I experience any adverse side effects that appear to be attributable to my use of homecare products, I would discontinue use of the products immediately and notify the office.

The reason(s) for me to seek clinical procedures are:

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I certify that I have read and understand ALL of the above. I have also been offered an opportunity to discuss same with a physician.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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## **PATIENT ACKNOWLEDGEMENT OF POSTED INSURANCE NOTICE**

I, (print full name) \_\_\_\_\_ acknowledge that I have seen the notice posted in the waiting room of Ob/Gyn Specialists of the Palm Beaches, P.A. and Perinatal/Gynecologic Specialists of the Palm Beaches, Inc. regarding malpractice insurance. The notice reads as follows:

*“Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.”*

### **YOUR DOCTOR HAS DECIDED NOT TO CARRY MALPRACTICE INSURANCE**

*This is permitted under Florida Law subject to certain conditions. Florida Law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice.”*

*“This notice is provided pursuant to Florida Law.”*

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**MR#:** \_\_\_\_\_

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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: \_\_\_\_\_