Renuance Cosmetic Surgery Center

Brian Eichenberg, MD | Zachary Filip, MD | Rachel Ford, MD
Plastic, Aesthetic, & Reconstructive Surgery
American Association for Accreditation of Ambulatory Surgery Facilities

Welcome

Please PRINT in blue or black ink.

Last Name: _____ First Name: _____ M.I. _____

Home Address: _____ City: _____

State: _____ Zip: _____ Phone Number: _____

Date of Birth: ____/____/____ Age: _____ Sex: F M Marital Status: S M D W

Email: _____

If patient is a minor, or unable to complete documents, please give parent or guardian information:

Last Name: _____ First Name: _____ M.I._____

Phone Number: _____ Relation: _____

How did you first hear of us (*circle one*)? Google search Yelp! Facebook RealSelf Billboard Internet Ad/Banner YourVilla Magazine Inland Empire Magazine Temecula Valley Hospital

Other: _____

Or a friend or family member? Who may we thank? _____

Reason for today's visit: _____

Are there any additional *areas* you would like to discuss (*circle any*)?

Breasts	Abdomen/waist	Arms	Thighs	Buttocks
Neck	Cheeks/jowls	Lips	Eyes	Forehead
Wrinkles	Sun Damage	Dark spots	Scars	Loose facial skin
Acne	Laser hair removal	Spider veins	Other: _____	

Are there any additional *products* you would like to know more about (*circle any*)?

Botox	Juvederm	Voluma	Latisse	Obagi	Kybella
VI Peel	TCA peel	CO2 Laser	Sublative	Sublime	Photofacial
TNS Serum	Lytera	Skinmedica	Fat grafting/transfer	New "Gummy Bear" Breast Implants	

Are you a Brilliant Distinctions® Loyalty Program Member (*circle one*)? YES NO

May we provide you with information on ways to save on products and treatments (*circle one*)? YES NO

_____ _____

Initials Date

MEDICAL HISTORY FORM

Patient Name _____ Date of Birth _____

Emergency Contact _____ Phone Number _____ Relation _____

Primary Care Physician _____ Phone Number _____ Date of Last Visit _____

Medical Insurance Carrier _____ Policy Number _____ Claims Phone Number _____

Employer _____ Occupation _____

Height _____ Weight _____ Do you use Tobacco? YES NO If yes, amount/day _____

Do you drink alcohol? YES NO If yes, amount/week _____

Do you exercise regularly? YES NO Are you able to comfortably climb 2 flights of stairs? YES NO

MEDICATIONS *(please list ALL prescriptions, vitamins, supplements, over-the-counter medications, and birth control)*

_____

_____

ALLERGIES *(please list with type of reaction)* _____

SURGICAL HISTORY *(please list ALL surgeries and approx. year)* _____

_____

Any complication (*circle any*)? infection bleeding blood clot severe vomiting other: _____

MEDICAL HISTORY *(please circle ANY of the following conditions past or present)*

Heart Disease Heart Valve Atrial fibrillation Cancer _____ Breast Mass

Stomach Ulcer Reflux/heartburn Hernia Kidney Disease Stroke/TIA Migraine Seizures Blood Clot Bleeding Disorder High Blood Pressure Anemia Hepatitis Tuberculosis AIDS/HIV+ MRSA

Diabetes Thyroid Disease Sinus Infection Asthma COPD Sleep Apnea Seasonal Allergies

Dry eyes Glaucoma Arthritis Anxiety Depression

Major Injury / hospitalization: _____

Other: _____

FAMILY HISTORY *(please circle ANY or list any diseases affecting family members)*

Breast Cancer Malignant Hyperthermia Blood clot Bleeding disorder High blood pressure Heart Disease Diabetes Cancer Unexpected death due to anesthesia Other: _____

REVIEW OF SYMPTOMS *(please circle ANY NEW symptoms you have had within the past year)*

Unexplained weight change Frequent fevers Frequent headache Memory difficulty Seizures

Dry Eye Vision change Swollen lymph nodes Chest pain Shortness of breath Palpitations

Wheezing Cough Abdominal pain Chronic Diarrhea Blood in stool Easy bleeding Jaundice

Easy bruising Joint pain Skin rash Feeling hopeless Feeling overly nervous Other: _____

_____ _____

Initials Date

FOR WOMEN CONSIDERING BREAST PROCEDURES (circle yes or no):

Have you ever had a mammogram?	YES	NO	If yes, date _____
Have you ever had an abnormal mammogram?	YES	NO	
Have you ever had a breast biopsy?	YES	NO	
Have you breast fed in the past 3 months?	YES	NO	
Do you anticipate becoming pregnant in the future?	YES	NO	

SPECIAL CONSIDERATIONS (circle yes or no):

Have you ever had an electrocardiogram (ECG)?	YES	NO
Have you or any family member had a severe reaction to general anesthesia?	YES	NO
Have you had a bad reaction to local anesthesia for a dental procedure?	YES	NO
Do you use a CPAP machine for Sleep Apnea?	YES	NO
Do you have any allergies to adhesive tape?	YES	NO
Are you sensitive to latex?	YES	NO
Are you a slow or poor healer?	YES	NO
Do you form large scars or keloids?	YES	NO
Have you ever taken any steroid medications such as prednisone?	YES	NO
Have you taken any oral retinol medications such as Accutane?	YES	NO
Do you have any back or joint pain or limitations in movement?	YES	NO
Do you have a medical condition or information not revealed elsewhere on this form?	YES	NO

If so please describe below:

_____

_____

_____

_____

_____

_____

I certify to the best of my knowledge that the above represents my current and complete condition without omission. I understand that failure to disclose any information releases my surgeon from any harm that may result from this lack of knowledge.

Patient, Parent or Guardian Signature: _____

Please Print Name: _____ Date: _____

POLICIES & DISCLOSURES FORM

Although this form is no longer required for HIPPA compliance, you are being asked to sign this form because it IS REQUIRED for the State of California and/or other compliance.

Please read carefully

INSURANCE DISCLAIMER

Renuance Cosmetic Surgery Center is currently not billing any insurance companies. However, under special circumstance, we can provide you with all the necessary information to bill your insurance company yourself. Unless you know your insurance company will be billed for your services at Renuance Cosmetic Surgery Center, it will be up to the patient and/or guardian to provide insurance information. I assign directly to Renuance Cosmetic Surgery Center and all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctors to release all information necessary to secure the payment of benefits.

CONSENT

I consent to the use or disclosure of my protected health information by Renuance Cosmetic Surgery Center for the purpose of diagnosing me or providing treatment to me, for obtaining payment for my health care bills, or to conduct the health care operations of Renuance Cosmetic Surgery Center. I understand that diagnosis or treatment of me by Renuance Cosmetic Surgery Center associates and/or staff may be dependent upon my consent as evidenced by my signature on this document.

RESTRICTION ON THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION

I understand I have the right to request that Renuance Cosmetic Surgery Center restrict the way my protected health information is used or disclosed in order to treat me, to obtain payment, or for the other healthcare operations of this facility. Renuance Surgery Center is not required to agree to the restrictions that I may request, however, if Renuance Cosmetic Surgery Center associates and/or staff does agree to a restriction that I request, the restriction is binding on this facility and its staff.

REVOKE CONSENT

I have the right to revoke this consent, in writing, at any time, except to the extent that Renuance Surgery Center already has taken action based upon this consent.

DEFINITION OF PROTECTED HEALTH INFORMATION

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

DISPUTES

Should a dispute arise related to the cost of services and/or care provided by Renuance Cosmetic Surgery Center associates and/or staff, the patient agrees to pursue appropriate avenues of recourse and will not engage in comments against Renuance Cosmetic Surgery Center associates and/or staff on any Internet blog site and will not indemnify the practice for expenses resulting from such actions. In the event of a failed Small Claims action against Renuance Cosmetic Surgery Center, associates and/or staff, the patient will compensate Renuance Cosmetic Surgery Center for its time and expense in defending against such action. I also understand payment is due in full the same day the service or procedure is performed.

RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES

I understand I have a right to review Renuance Cosmetic Surgery Center's Notice of Privacy Practices prior to signing this document. Renuance Cosmetic Surgery Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Renuance Cosmetic Surgery Center. Renuance Cosmetic Surgery Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices to better protect your personal information. I understand that I can obtain a revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to me in the mail or by asking for a revised notice at the time of my next appointment.

_____ _____

Initials Date

POLICIES & DISCLOSURES FORM (continued)

Please read carefully

HEALTH INSURANCE

Most health insurance companies exclude coverage for cosmetic surgical operations or any resulting complications. Please carefully review your health insurance subscriber-information pamphlet. Most insurance plans exclude coverage for secondary or revisionary surgery due to complications of cosmetic surgery. It is unethical and fraudulent to bill insurance for cosmetic procedures. Insurance may however cover costs related to the diagnosis and treatment of medical conditions that can uncommonly follow surgery such as a fever or hospitalization. Thus, it is not advisable to undergo any type of elective (non-emergency) surgery without health insurance. The need for basic health insurance should outweigh your need for cosmetic surgery. If you do not have health insurance you should consider postponing elective surgery.

I agree that Renuance Cosmetic Surgery Center surgeons may order medically necessary care during an emergency that was not previously planned or discussed. I agree that I shall be financially responsible for the cost of that care and shall not seek reimbursement from Renuance Cosmetic Surgery Center surgeons and/or staff. I understand the Renuance Cosmetic Surgery Center facility and surgeons are not contracted with insurance companies and will be considered out-of-network. In the event your surgeon is contracted with an insurance company for a non-cosmetic procedure this will be clearly outlined.

CONSENT FOR USE OF PHOTOGRAPHS

I hereby give permission to the surgeons and Renuance Cosmetic Surgery Center staff to take photographs of parts of my body in connection with the surgical procedure(s) and/or treatments being discussed and to use my photographic likeness for the purpose of medical treatment and professional medical purposes, including but not limited to, medical education, accreditation, certification, research, medical professional seminars and lectures, and publication in medical journals and books.

I also give permission to use my photographic likeness in all forms and media for purposes of advertising, trade, editorial usage, lay publication, and any other lawful purposes, including but not limited to a website, social media site, office photograph book, brochures, other internet exposure, or other advertising items. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images. To decline this use initial here: ____

Your name and protected health information will never be associated with your photos for purposes other than medical treatment, however in some circumstances photographs may portray features that may make your identity recognizable. Renuance Cosmetic Surgery Center will take all reasonable precautions to ensure your privacy, but be aware that even secure electronic storage methods are susceptible to being hacked, and the files, although they do have your name attached, may contain internal codes that have not yet been “scrubbed” or deleted. We will notify you if there has been a violation and we will protect your privacy to the best of our ability.

FINANCIAL AND CANCELLATION POLICY

I understand payment is expected at time services are rendered. Renuance Cosmetic Surgery Center does **not** accept American Express or personal checks. Acceptable forms of payment include cash, cashier’s check, Visa, Discover, MasterCard and Care Credit. I understand that cancellations or requests to reschedule within twenty-four (24) hours of the appointment time will incur a $50 fee, which you will be responsible for prior to your next procedure. Cancelling or rescheduling surgery will incur additional fees outlined on the quote.

I have read and understand the above policies and disclosures.

Patient, Parent or Guardian Signature: _____

Please Print Name: _____ Date: _____