ALBERT FOX
FACIAL PLASTIC SURGERY CENTER

Patient Information & Medical History Form
Albert Fox Facial Plastic Surgery Center

Name | Date of Birth | Age

Street Address | City | State | Zip Code

Home Phone | Cell Phone | E-mail Address

Social Security # | Marital Status | Primary Care Physician

Employer | Occupation | Work Phone

Street Address | City | State | Zip Code

Emergency Notification of Kin (Name & relationship) | Best Phone #

Pharmacy Name and Location | Pharmacy Phone # if known

Past Medical History Please Check "yes" or "no". If "yes", please explain.

	Yes	No	Please explain:
Cancer			
Diabetes			
High Blood Pressure			
Heart Disease			
Lung Disorders/Asthma			
Liver Disease			
Kidney Disease			
Neurological Disorders			
Stroke			
Thyroid Disorder			
Visual Disorder			
Glaucoma			
Dry Eyes			
Other			

Past Surgical History **Please list your previous surgeries including year performed below:**

Albert Fox Facial Surgery Center
299 Faunce Corner Rd. 1st Fl
North Dartmouth, MA 02747

508-207-4455
www.foxfacialsurgery.com

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Medications **Please list all, including herbal/homeopathic medications with doses below**:

Allergies **Please list medications and reactions (e.g. itching, hives)**

Do you smoke? __ Yes _____ No How much and for how many years? _____

If No, did you smoke previously _____ Yes _____ No How many years & year you quit? _____

How often do you drink alcohol and what amount? _____

Do you use drugs (including Marijuana)? _____ Yes _____ No

Family History **Do you have any family members with the following illnesses?**

	Yes	**No**	**Please explain:**
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
High Blood Pressure	_____	_____	_____
Heart Disease	_____	_____	_____
Lung disorder/ Asthma	_____	_____	_____
Liver Disease	_____	_____	_____
Kidney Disease	_____	_____	_____
Neurological Disorders	_____	_____	_____
Stroke	_____	_____	_____
Thyroid Disorder	_____	_____	_____
Visual Disorder	_____	_____	_____

Any history of bleeding disorder? _____ Yes _____ No

Any history of Anesthesia reactions? _____ Yes _____ No

Now Experiencing Please Circle Y or N:

Cough	Y	N	Headaches	Y	N
Chest Pain	Y	N	Double Visions	Y	N
Short of Breath	Y	N	Dry Eyes	Y	N
Asthma	Y	N	Eye Glasses	Y	N
Palpitations	Y	N	Contact Lenses	Y	N
Weight Loss	Y	N	Anemia	Y	N
Weight Gain	Y	N	Easy Bruising	Y	N
Fevers	Y	N	Rash	Y	N
Night sweats	Y	N	Heartburn/Reflux	Y	N

Other:

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How did you learn about Dr. Albert Fox? (Please Circle)

Yellow Pages SOCO Magazine NBSO Internet Other

Website Friend Family Seminar Physicians

If referred by a friend, family member, or physician, who? (Optional) _____

BY SIGNING THIS FORM, I ATTEST THAT THE ABOVE MEDICAL INFORMATION IS ACCURATE, AND I HAVE DISCLOSED ALL INFORMATION HONESTLEY AND TO THE BEST OF MY ABILITY.

Patient or Guardian's signature: _____ Date: _____

_____ _____

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Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your aesthetic treatment and care. Please understand that payment of your bill is part of this treatment and care. For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with our Patient Care Coordinator.

How may I pay?
We accept payment by cash, check, VISA, MasterCard, American Express, and Discover.

Do I need a referral from my Primary Care Physician?
If you are being seen for a cosmetic consultation with Dr. Albert Fox, you will not need a medical insurance referral. Insurances do not cover cosmetic treatments or surgeries.

How much is my consultation visit?
There is a $100 fee for a consultation with Dr. Fox. This fee is due upon visit, and is non-refundable if other services are not rendered. The consultation fee may be applied to a treatment or surgery should you be a candidate or go forth with such treatment or surgery.

Do you offer any payment plans?
We require that all surgery fees must be paid in full 2 weeks prior to the scheduled procedure. All non-surgical treatment fees must be paid in full on the day of your desired treatment. For our patient's convenience we do accept the Care Credit financing plans (ask our Patient Care Coordinator for details).

Does my medical healthy insurance cover any of my visits and/ or surgery?
If your problems or concerns are reconstructive in nature then insurance may likely cover your visits and/or surgery. Insurance do not cover any cosmetic procedures.

We hope that this helps answer any questions that you may have. If you should have any further question regarding our financial policies, please see our Patient Care Coordinator.

Patient/Guardian Signature _____ Date _____

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HIPAA Information and Consent Form

Patient Name: Date:

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. This form is a "friendly" version; a more complete text is posted in the office, and additional information can be found at the U.S. Department of Health and Human Services website. www.hhs.gov

HIPAA provides certain rights and protections to you as the patient. Specifically, there are rules and restrictions regarding your Protected Health Information (PHI): who may have access to it and how we treat it. A certain amount of access is required to provide you with professional service and care, but in the course of providing these services, HIPAA ensures that your information is treated with respect and attention to privacy.

In complying with HIPAA regulations, we have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. Albert Fox Facial Plastic Surgery Center, LLC utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the Office Manager or Dr. Fox.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both Albert Fox Facial Plastic Surgery Center, LLC and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

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PHOTOGRAPHIC RELEASE

Patient Name: _____
Procedure: _____
Date: _____

In the course of treatment - and with the permission of the patient granted here - Photographs, video, and/or slides ("imagery") may be made by the Albert Fox Facial Surgery Center. Imagery may include the actual surgical treatment procedure, and all imagery will become the property of Albert Fox Facial Plastic Surgery Center, LLC.

While the purpose of creating such imagery is to help track patient progress and document procedures, we do from time to time wish to use our own patient results in medical presentations and in the promotion of the facility. Any use of patient imagery will not include name, address and other information of non-medical nature.

Please Complete and sign this form.

Approval for Use Please initial beside each use as indication of your consent. Leave blank any use for which you do not consent.

_____ May use imagery for my personal medical records ONLY
_____ May use imagery for Seminar Presentations/ Newsletters
_____ May use imagery for Promotional Websites, example: Real Self
_____ May use imagery for the Albert Fox Facial Plastic Surgery Website
_____ May use imagery for Medical Presentations/ Medical Teaching & Education

I authorize imagery of me to be made by Albert Fox Facial Plastic Surgery Center, LLC (AFFPSC) and to be used in the capacity I have indicated above.

_____ _____
Patient/Responsible Party Date

_____ _____
Witness Date

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Request to Remove Restrictions for Uses and Disclosure of Protected Health Information

PATIENT NAME _____ DATE OF BIRTH _____

The Health Information Portability and Accessibility Act (HIPAA) places restrictions on who may access your Private Health Information (PHI). This means that your friends, family, and even your spouse cannot have access to your files or information without your express consent.

To allow your information to be accessible to a specific individual(s), please complete this form. The HIPAA Privacy Rule permits you to make this request for the removal of restrictions; however, we are not obligated to honor the request.

To assist us in responding promptly and accurately to your request, please complete this form in its entirety.

Remove Restrictions

Please list those you would like to have access your Personal Health Information:

NAME **RELATIONSHIP**

_____

_____

_____

_____

_____

Albert Fox Facial Plastic Surgery Center, LLC may leave medical information on my home and/or cell phone provided to the office. ❑ YES ❑ NO

Please contact our Practice Privacy Officer, Sherry Pereira, at (508)207-4455 if you have any questions.

Authorization

I authorize the removal of HIPAA restrictions regarding PHI for the persons I have stated above in the capacity I have noted.

PATIENT/GUARDIAN'S SIGNATURE _____ DATE _____

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