PREMIER IMAGE COSMETIC & LASER SURGERY, P.A.

WILLIAM E. SILVER, M.D.,F.A.C.S. MARC KLEIN, M.D. LOUIS M. DEJOSEPH, M.D.

4553 N. Shallowford Rd. Suite 20-B, Atlanta, GA 30338 Phone: 770-457-6303 Toll Free: 1-888-455-FACE

FAX 770-457-2823 Web Site: www.picosmeticsurgery.com

PATIENT INFORMATION

PHYSICIAN: circle one SILVER / KLEIN / DEJOSEPH DATE______________________

Full Legal Name____ **Nickname**___________________

Sex_____**Age**_____**D.O.B.**___________ **Race**___________ **Social Security #** ______-_____-_________

Address______________________________ **City** ________________**State**_____ **Zip code**___________

Would you like to receive promotional or informative correspondence via the US Postal Service? YES NO Home

Phone #_________________**Cell Phone #**_________________ **E-Mail**_____________________

Marital Status: Please Circle One **Single** (never been married) **Married Divorced Widowed Partnered**

Employer____________________________________Occupation__________________________________

Address____ City______________________________

State____________ Zipcode________________ **Work Phone#**______________________ **Ext.**________

Spouse's Name________________ Spouse's Employer__________________ Occupation____________

Children's names and ages____

Address_____________________________City______________State______ZipCode________________

Have you ever been treated here before?____ Have any family or friends been treated here before? ____

If yes, name/relationship/doctor/approx.date____

Emergency Contact (not living with you) ____

Address____ Phone #____________________

If patient is a minor, please complete this section:

Father's Name_________________________ Employer__________________ Phone# ________________

Mother's Name__________________________ Employer__________________ Phone # ________________

Person responsible for bill (if other than patient):

Name______________________ Relationship ____________ Address___________________________

City______________State_____ZipCode________Employer__________________Phone#_____________

REFERRAL SOURCE (please complete) YELLOW PAGES

(specify)____ FRIEND /

PATIENT **(specify)**____ TV OR

RADIO AD **(specify)**____

INTERNET **(specify)**____

SEMINAR

(specify)____ SIGN /

WALK-IN ____

PHYSICIAN (**Name & Specialty**)____

Address ____ **Phone #**____________________

OTHER____

*****OUT OF STATE AND INTERNATIONAL PATIENTS, PLEASE LET US KNOW IF WE CAN ASSIST WITH YOUR TRAVEL PLANS*****

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Premier Image Cosmetic and Laser Surgery, P.A. 770/457-6303 Northside Dunwoody Surgery Center 770/455-1983 4553 North Shallowford Rd. Suite 20 B Atlanta, GA 30338

www.allaboutcosmeticsurgery.com

Effective 4/1/2003

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 office/ surgery center is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of your Health Information for Treatment Purposes:

- A nurse obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.
- When calling to confirm your appointment, an employee may leave a voice message on a family machine.

Examples of Uses of your Health Information for Payment Purposes:

We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) request information from us regarding medical care given. We will provide information to them about you and the care given.

Examples of Uses for Your Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol, and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office/ surgery center. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office/ surgery center – we are not required to grant the request, but we will comply with any request granted.
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office/ surgery center.
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office/ surgery center.
- Appeal a denial of access to your protected health information, except in certain circumstances.
-
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office/ surgery center. We may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
  - Is not part of the health information kept by or for the office/ surgery center.
  - Is not part of the information that you would be permitted to inspect and copy.
  - Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records.

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office/ surgery center.
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office/ surgery center. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to a family member or friends relevant to that person's involvement in your care or in payment for such care; or uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office/ surgery center, except to the extent information or action has already been taken.

If you want to exercise any of the above rights, please contact Janet Davies, Practice Administrator at 770-457-6303, 4553 North Shallowford Rd suite 20 B, Atlanta, GA 30338, in person or in writing, during regular business hours (9:00 – 5:00 Monday – Friday). She will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities:

The office/ surgery center is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and

requesting a copy of our "Notice" or by visiting our office/ surgery center and picking up a copy.

To Request Information or File a Complaint:

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Janet Davies, Practice Administrator by calling 770/457-6303.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office/ surgery center by delivering the written complaint to Janet Davies. You may also file a complaint by mailing or e-mailing it to the Secretary of health and Human Services, whose street address and email address is: Office/ surgery center for Civil Rights – U.S. Department of Health and Human Services – 200 Independence Avenue SW – Room 509F, HHH Building – Washington, D.C. 20201.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office/ surgery center.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses:

Communication with Family:

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification:

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition or your death.

Research:

- We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief:

- We may use and disclose your protected health information to assist in disaster relief efforts.

Food and Drug Administration:

- We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation:

- If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health:

- As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contacting or spreading a disease or condition.

Abuse & Neglect:

- We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Law Enforcement:

- We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight:

- Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/ Administrative Proceedings:

- We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat:

- To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions:

- We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Other Uses:

- Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."

Website:

- This Notice will be on the company website.

Premier Image Cosmetic and Laser Surgery, P.A.
Northside Dunwoody Surgery Center

ACKNOWLEDGEMENT OF ACCEPTANCE OF PRIVACY PRACTICES

I, (print name) ____________________________________, accept and understand this office's Notice of Privacy Practices.

Signature of patient or patient representative Date

You may refuse to sign the above acknowledgement.

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgment of acceptance of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

___ Individual refused to sign

___ Communication barriers prohibited obtaining acknowledgement

___ Other (please specify)

____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PACTICES

I, (print name) ____________________________________, have received or have been offered a copy of this office's Notice of Privacy Practices.

Signature of patient or patient representative Date

THE REQUESTED PERSONAL INFORMATION IS A NECESSARY PART OF OUR EVALUATION. ALL INFORMATION GIVEN TO US IS CONFIDENTIAL.

PERSONAL HISTORY

Please list any medical problems or previous hospitalizations______________________________

Have you had any serious past illnesses?____

Please list any accidents or injuries____

Please list any past surgeries (including minor surgery or surgery as a child)_________________

YES NO

___ ___ Do you have any allergies to medication? List medications ____________________
____ ___ ___ Do you have any food, environmental, or latex allergies? List reactions__________
____ ___ ___ Are you currently taking any drug or medications? How often? List (Include over the counter)____ ____ ___ Do you take vitamins or herbal products? List________________________________ ____ ___ Do you drink more than 6 cups of coffee per day? ____ ___ Do you drink alcohol? How much? How often?______________________________ ____ ___ Do you smoke? How much per day?____ ____ ___ Do you ever get cold sores or fever blisters?_________________________________ ____ ___ Do you have skin sensitivities, frequent rashes, or eczema? ____ ___ Have you ever taken Accutane? ____ ___ Do you have a skincare regimen you follow? Describe________________________

____ ____ ___
Have you ever received local anesthesia? (Novacaine) ____ ___ Did you have a reaction to anesthesia? ____ ___ Are you a past/present carrier of a contagious disease? Please specify____________

____ ____ ___
Are you or could you be pregnant? ____ ___ Have you taken medicine such as Cortisone or steroid during the past year? ____ ___ Do you have a personal or family history of any bleeding or clotting abnormalities? ____ ___ Do you bleed for more than a half hour after a needle stick? ____ ___ Do you bleed a day or more after surgery or a tooth extraction? ____ ___ Do you bruise easily? ____ ___ Do you bruise without cause? ____ ___ Do you bruise larger than a half dollar? ____ ___ Do you bruise from injections?

DATE OF YOUR LAST PHYSICAL?____________DATE OF MOST RECENT BLOODWORK_____________
DATE OF YOUR LAST CHEST X-RAY____________________HAVE YOU HAD AN ABNORMAL CHEST XRAY?_______DATE OF LAST EKG________________HAVE YOU HAD AN ABNORMAL EKG_______

FAMILY PHYSICIAN____PHONE#_____________________
SPECIALTY____

DO YOU HAVE OR HAVE YOU EVER HAD:

YES NO

_____ _____ Heart disease or heart trouble _____
_____ High blood pressure _____ _____ Lung disease
_____ _____ Hay fever _____ _____ Kidney disease
_____ _____ Liver disease _____ _____
Epilepsy/seizures/neurological problems _____ _____
Thyroid or goiter problems _____ _____ Chest pain _____
_____ Chronic cough _____ _____ Recent respiratory
infection _____ _____ Skin
trouble/infections/rashes/irritations _____ _____ Keloid or
ugly scars _____ _____ Glaucoma _____ _____
Phlebitis _____ _____ Problems lying flat _____ _____
Nosebleeds _____ _____ Fainting _____ _____ Asthma
_____ _____ Have you considered seeing a psychologist/

YESNO

____ Mitral valve prolapse
____Diabetes ____Muscle weakness
____Difficulty urinating
____Jaundice ____ Headache or
dizzy spells ____ Bowel/colon
disease or problems ____Shortness of
breath ____Back or neck trouble
____Ulcers/stomach trouble ____ Do
you use eye drops? ____ Treatment of
genital area ____ Are you easily
depressed ____ Hiatal hernia ____ Blood
transfusion _____ Ankle swelling _____
Facial fractures _____ Anemia _____
Drug or alcohol dependency

therapist _____ _____ Are you seeing a therapist
now? _____ _____ Are you on a special diet? _____
_____ Recent weight loss (amount)_________

____________Height

____________Weight

_____ _____ Any exposure to a communicable disease in the last 3 weeks? Explain_______________

DO YOU HAVE ANY OF THE FOLLOWING: Dentures______Partial plate_____Bridgework_______

ARE YOU WEARING ANY OF THE FOLLOWING: Contacts___False eyelashes___Hearing aid____
Wig/hairpece_____ Permanent eyeliner or other Permanent cosmetics ____________________

FAMILY HISTORY: Diabetes____Bleeding____Heart disease____Anesthesia problems_____________
Other____

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW?_________________________

Signed____
(Patient or Guardian)

IN WHICH PROCEDURES ARE YOU INTERESTED IN:

____RHINOPLASTY _____REMOVAL OF FACIAL LESIONS _____SEPTOPLASTY (correct breathing problems) _____SCAR REVISION _____FACE OR NECK LIFT _____LASER SKIN RESURFACING _____MID FACELIFT _____CHEMICAL PEEL _____EYELID SURGERY _____LIP ENLARGEMENT _____FOREHEAD / BROW LIFT _____LIP REDUCTION _____ENDOSCOPIC / MINIMAL INCISION SURGERY _____REMOVAL OF PROMINENT _____BREAST SURGERY (AUGMENTATION) VEINS ON FACE

_____BREAST UPLIFT _____CORRECTION OF PROTRUDING _____BREAST REDUCTION EARS _____NIPPLE SURGERY _____DERMABRASION

_____ABDOMINOPLASTY (TUMMY TUCK) _____COLLAGEN INJECTIONS _____LIPOSUCTION: _____BOTOX _____STOMACH _____ADVANTA _____THIGHS _____ALLODERM _____HIPS _____FAT TRANSFER _____BACK / LOVE HANDLES _____RESTYLANE _____ANKLES _____LINES AROUND LIPS _____KNEES _____LINES AROUND EYES

_____THIGH LIFT _____COSMETIC DENTISTRY _____ARM LIFT _____SKIN CARE PRODUCTS _____CHEEK AUGMENTATION _____LASER FACIALS _____CHIN ENLARGEMENT _____MICRODERMABRASION _____CHIN REDUCTION _____LASER HAIR REMOVAL _____FACIAL / NECK LIPOSUCTION _____HAIR REPLACEMENT SURGERY _____DEEP SMILE LINES

WHAT SPECIFICALLY DO YOU WISH TO HAVE CHANGED?______________________________

WHEN DID YOU BEGIN TO CONSIDER SURGICAL CORRECTION?_________________________

HAVE YOU CONSULTED WITH ANY OTHER DOCTORS ABOUT THIS?(WHEN)_____________

HAVE YOU DISCUSSED THIS SURGERY WITH YOUR FAMILY? ____YES ____NO ARE THEY AGREEABLE? ____ YES ____NO HAVE YOU HAD PREVIOUS COSMETIC SURGERY? ____YES ____NO WHEN AND WHAT WAS DONE?____

WHERE WAS THE SURGERY PERFORMED?____
BY WHOM?____
WERE YOU SATISFIED WITH THE RESULTS?____IF NOT,WHY?__________________________

HAVE YOU HAD ANY OTHER SURGERY OR INJURY TO THE AREA?_____DESCRIBE WHAT AND WHEN____
HAS ANYONE IN YOUR FAMILY OR A CLOSE FRIEND HAD COSMETIC OR RECONSTRUCTIVE SURGERY?______WHAT WAS DONE?________________________________
WHEN?______________________BY WHOM?__________________________

INSURANCE INFORMATION

Do you have insurance coverage?_____________ Name of insurance

company____ Name of Policy

Holder_____________________________ Date Of Birth________________

ID#________________________________Group#__________________________ Address for

claims____ Phone

#____________________________

(Please have your insurance card ready to present to the receptionist.) AUTHORIZATION AND

ASSIGNMENT OF BENEFITS (Please sign both) I authorize William E. Silver, M.D., Marc Klein, M.D.,

and Louis M. DeJoseph, M.D. to furnish
information to insurance carriers only concerning my illnesses and treatments.

Date___________Signature____ I assign to William E.

Silver, M.D., Marc Klein, M.D., and Louis M. DeJoseph, M.D. all payments
for medical services rendered to me or my dependent. I understand that I am responsible for any amount not

covered by assigned insurance.

Date___________Signature____

A photocopy of this authorization and assignment shall be considered as valid as the original. It is customary to pay for professional services when rendered. Itemized receipts will be furnished on request. Patients are asked to file for routine office visits with their respective insurance companies. In the event of surgery, it is the patient's responsibility to furnish us with appropriate insurance forms on which to file surgery charges. The patient is responsible for all fees, regardless of insurance coverage.

PHOTOGRAPHY CONSENT

I hereby give my permission to William E. Silver, M.D., Marc Klein, M.D., and Louis M. DeJoseph, M.D. or any assistant he may designate, to take photographs for diagnostic purposes, to enhance the medical report, during surgery, and postoperatively for evaluation purposes. I agree that these photographs will remain his property.

Date___________Signature____

I further authorize him to use such photographs for teaching purposes or to illustrate scientific papers, books, or lectures if, in his judgment, medical research, education, public education, or science will be benefited by their use. It is specifically understood that in any such publication or use, I shall not be identified by name.

Date__________Signature____