Bellissimo
PLASTIC SURGERY & MEDI SPA

SPA Registration Form

PATIENT NAME (Last, First, Middle Initial):				Maiden Name	DATE:
Marital Status S - M - W - DIV - SEP	Date of Birth:	Age:	Sex:	Race: [ ] Caucasian [ ] Asian [ ] Hispanic [ ] Indian [ ] African American	
Street Address: [ ] Permanent [ ] Temporary		City State Zip		Home Phone:	
Cell Phone Number		Referral Source:		May we thank your referral source: Y/N	
Patient's Employer:		Occupation: (Student []Part-time []Full-time)		Business Phone:	
Emergency Contact:		Relationship:		Telephone Number:	
**Email will be used for most all communication from our office. It may also be used to keep you informed of all promotions, discounts, education, etc This information will NOT be shared.* Email Address:					

What are your skin concerns and challenges?

_____

_____

What are you currently using on your skin?

Daytime _____Evening _____

Please circle the appropriate response:

Do you wear contact lenses? Y / N Do you have heart trouble? Y / N

Do you have asthma? Y / N Do you have diabetes? Y / N

Are you pregnant? Y / N Do you ever experience burning or itching on your skin? Y / N

Are you using Renova, Accutane, Retin-A or any glycolic acids for your skin? Y / N

Please list any allergies you have:

_____

Please list any medications you are now taking:

_____

Please list any cosmetics you are now using:

_____

Please check any of the treatments or services below that you have received before:

_____ Microdermabrasion (Date of last treatment: _____) _____Neurotoxins (Botox or Dysport, etc)

_____ Dermaplaning (Date of last treatment: _____) (Date of last treatment: _____)

_____ Facial (Date of last treatment: _____) _____Fillers-(Juvéderm, Voluma etc.)

_____ Chemical Peel (Date of last treatment: _____) (Date of last treatment: _____)

_____ _____

Signature **Date**

Bellissimo Plastic Surgery & Medi Spa
Medical History - SPA

Patient Name:_____ D.O.B:_____ Age: _____

Social History:

1. Occupation: _____

2. Single/ Married/Separated/Divorced/Widowed (circle one)

3. Have you ever used tobacco?: Yes No
If yes, # of packs per day?:_____ for # of years?:_____
If you quit using tobacco, when?:_____

4. Do you drink alcohol?: Yes No
How much:_____ How often?:_____

5. Do you use recreational drugs?: Yes No
Type:_____

Review of Systems: (*Please circle yes or no for **recurrent symptoms within the last 6 months***.)

General:

Changes in weight	Yes	No
Progressive/Prolonged Fatigue	Yes	No

Pulmonary:

Cough	Yes	No
Shortness of breath	Yes	No
Wheeze	Yes	No
Snoring	Yes	No

Cardiac

Do you ever wake up short of breath	Yes	No
Leg/ Ankle swelling	Yes	No
Do you sleep okay	Yes	No
Palpitations / Heart flutters	Yes	No
Abnormal sensation with exertion/ (in chest, arms, neck, back)	Yes	No

Infectious Disease:

Fever	Yes	No
Night Sweats	Yes	No
Recent Infection	Yes	No

Gynecologic/Urologic:

Incontinence	Yes	No
Difficulty / Painful urination	Yes	No
Blood in urine	Yes	No

Psychiatric:

Suicidal thoughts	Yes	No
Hallucinations	Yes	No
Memory loss	Yes	No
Felling depressed/anxious	Yes	No

Blood/Lymph:

Easy bruising	Yes	No
Frequent nose bleeds	Yes	No
Swollen glands	Yes	No

Head and Neck:

Decrease in hearing	Yes	No
Ringing in the ears	Yes	No
New Headaches	Yes	No
Sinus Problems	Yes	No
Sore Throat	Yes	No
Changes in voice	Yes	No
Dry Mouth	Yes	No

Eyes:

Blurred vision	Yes	No
Eye pain	Yes	No
Redness	Yes	No
Watering	Yes	No
Light sensitive	Yes	No
Dry feeling	Yes	No

Gastrointestinal:

Frequent Nausea / Vomiting	Yes	No
Abdominal pain	Yes	No

Skin:

Changing moles	Yes	No
New rash	Yes	No
Tendency to form Keloid scars	Yes	No
Develop cold sores	Yes	No

Neurological:

Dizziness	Yes	No
Difficulty walking	Yes	No
Sensory changes	Yes	No

Musculoskeletal:

Weakness / Numbness	Yes	No
Neck / Back Pain	Yes	No
TMJ / Jaw Pain	Yes	No

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Medical History - SPA

Past Surgical History: (Please list name of procedure and date.)

1._____ 2._____

3._____ 4._____

5._____ 6._____

ACKNOWLEDGEMENT:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Bellissimo Plastic Surgery of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Patient Signature:_____ **Date:**_____

Revised: 12-18-18

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I,_____, understand that as part of my health care, Bellissimo Plastic Surgery & Medi Spa originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the many health professionals who contribute to my care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided; and
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Policies that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Bellissimo Plastic Surgery & Medi Spa is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me a permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Bellissimo Plastic Surgery & Medi Spa reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Bellissimo Plastic Surgery & Medi Spa change their notice, they will give a revised notice to the patient upon the next office visit.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

Bellissimo
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Due to changes in healthcare and technology, Bellissimo Plastic Surgery & Medi Spa has the ability to provide certain information via email and/or text messaging. If you wish to receive messages from us in this way, please fill out the information below. Bellissimo Plastic Surgery & Medi Spa does not share the names, email addresses, or telephone numbers of our patients with any other company.

I authorize Bellissimo Plastic Surgery & Medi Spa to contact me via email at:

_____

I consent to receiving text messages/appointment reminders from Bellissimo Plastic Surgery & Medi Spa at:

(_____)_____

I understand that text messages are transmitted over a public network onto a personal telephone and as such may not be secure. For this reason, the practice will not transmit PHI via text message. Please call the office directly to discuss issues related to your care.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

_____ _____

Patient Signature (or personal representative) Date

FOR OFFICE USE ONLY

[ ] Consent received by_____on_____ [ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____

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PATIENT CONSENT AND RELEASE OF MEDICAL PHOTOGRAPHY

I have consented to the taking of photography, audio/visual recordings or other images of me by Bellissimo Plastic Surgery & Medi Spa, which will become part of my medical record. I understand that my photographs, video, digital and other images may be recorded to document and assist with my care. I acknowledge that the Practice will own these images, but that I will be allowed access to view them or obtain copies of them as part of my medical record. I also understand that the images that identify me can be released and/or used outside the Practice only upon written authorization from me.

I hereby authorize Bellissimo Plastic Surgery, LLC ("Bellissimo") to use pre-operative, intra-operative and post-operative photography for publication, or republication, in any print, visual or broadcast media, including, but not limited to, showing these images on public or commercial television, electronic digital networks, the Internet, and web sites or web pages, for purposes of medical education, patient education, viewing by perspective patients, lay publications, publications for marketing and/or advertising, newspaper and magazine articles, or during lectures to medical or lay groups.

Neither I, nor any member of my family, will be identified by name in any publication. Although measures will be taken to reduce or eliminate identifying features, the possibility remains that someone may recognize me.

I discharge all rights that I may have in the photographs and I release and discharge, Bellissimo, its assigns and licenses, from any claim that I may have relating to such use and publication, including any claim for payment in connection with distribution or publication of the photographs.

I understand that if I allow my images be used in publications, I have the right to revoke this consent up until the time the images are accepted for publication. Once the images have been published, I may not revoke my consent. Anonymity cannot be guaranteed in publications.

I have been provided the opportunity to ask questions concerning medical photography and understand that refusal to consent will not affect my medical care. If the patient is under 18 years of age, I verify that I am the parent or guardian of patient and that I will sign for the patient.

I certify that I have read the above authorization and release and fully understand its terms, intending to be legally bound hereby.

Initials

_____I agree and authorize the use of my photos.

_____ I **DO NOT** authorize the use of my photos.

Patient Name Printed: _____

Signature of Patient (Parent/Guardian): _____

Date: _____

Witness: _____ Date: _____

Notice of Privacy

Practices Summary

Our practice has a long- standing commitment to confidentiality and protecting the privacy of patient information, which includes any information related to your health, treatment or payment for your treatment that can identify you. Our privacy practices are in accordance with applicable federal and state laws.

New federal legislation requires that we have a "Notice of Privacy Practices". A copy of the notice for our practice is available at our front office. This notice explains how we protect your privacy, as well as your legal rights regarding your medical information. This is a brief summary of the content of the "Notice of Privacy Practices." It is not a complete listing of how we use and share your health information.

We may use and disclose your information without your consent:

- To provide treatment to you
- To coordinate your care with other providers
- To conduct standard health care operations business functions
- To bill and receive payment for the services we provide to you, including billing your insurance company or other party responsible for your bills
- To comply with pertinent government agency reporting requirements
- To meet other special reporting requirements as described in the Notice

(Note that information related to behavioral health, drug and alcohol services and AIDS/ HIV are protected by additional state laws.)

We can share your health information with family and /or friends who you agree can have this information. You can give verbal permission for these disclosures.

All other use of your health information will be made only with your specific written permission, or authorization.

You have the following legal rights regarding your health information:

- Right to see your medical record
- Right to have a copy of your medical record (there may be a charge for this)
- Right to ask for a list of who has seen your health information for any reason other than treatment, payment or other health care operations
- Right to ask for more restrictions on the use of your health information. (We are not required to agree to your request.)
- Right to ask for special confidential communication from our practice. (We are not required to agree to unreasonable requests.)
- Right to ask for a change to be made to your medical record
- Right to a copy of our "Notice of Privacy Practices"
- Right to file a complaint if you feel your privacy was violated

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Acknowledgement of Receipt of Notice of Privacy Practices

Bellissimo Plastic Surgery & Medi Spa has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information. You may review our current notice prior to signing this acknowledgement.

I acknowledged that I have received the Notice of Privacy Practice for Bellissimo Plastic Surgery & Medi Spa.

_____ _____

Name of Patient (Printed or Typed) DOB

_____ _____

Signature of patient (or personal representative) Date

(Personal Representative is required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Personal Representative to Patient

Please specify to whom other than yourself, we may release your protected health information (PHI) including lab or test results and diagnosis:

Name: _____

Name: _____

I,_____authorize Bellissimo Plastic Surgery & Medi Spa

Signature of patient (or personal representative)

to contact me and/or named authorized person(s) and to convey PHI and assume responsibility to notify Bellissimo Plastic Surgery & Medi Spa whenever this information changes.

FOR OFFICE USE ONLY

I have provided the above-named patient or patient representative with the Notice of Privacy Practices for Bellissimo Plastic Surgery & Medi Spa.

_____ _____

Employee Signature Date