**Colorado Plastic Surgery Center** **Nick Slenkovich, MD** **Surgery Center of Colorado**

**PATIENT INFORMATION** **DATE** _____

Name: (Last) _____(First) _____ (MI) ___ □ Male □ Female

Address:_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Email Address: _____

Marital status: □ Single □ Married □ Divorced □ Widowed Race _____

Employer: _____ Occupation: _____

How did you hear about us? _____

**EMERGENCY CONTACT INFORMATION:**

Name: _____ Relationship: _____

City/Location: _____ Phone Number: _____

**REASON FOR COSMETIC CONSULT:** Please indicate the nature of your visit and/or the procedure(s) you would like to discuss:

☐ Breast Enlargement ☐ Liposuction ☐ Botox/Fillers ☐ Body Lift ☐Resurfacing/Peels/Laser ☐ Facelift ☐ Eyelid lift

☐ Nose Reshaping ☐ Ear Reshaping

☐ Tummy Tuck ☐ Breast Lift ☐ Breast Reduction ☐ Lipolysis ☐ Other _____

**REASON FOR RECONSTRUCTIVE CONSULT:** Please indicate the nature of your visit and/or the procedure(s) you would like to

☐ Facial Reconstruction ☐ Other _____

**HEALTH AND MEDICAL INFORMATION:**

Age: _____ Height: _____ Weight: _____ Primary Care Physician and Location: _____

Have you ever smoked? □ yes □ no If yes, ____ packs/day for ___ Still smoke? □ yes □ no Date you quit: _____

How much alcohol do you drink? __ drinks per □ day □ week □ month How many cups of coffee/caffeine per day? _____

**Additional Health History** List the dates of your most recent:

Physical/Check-up _____ Normal? □ Yes □ No EKG (heart tracing) _____ Normal? □ Yes □ No

Chest X-Ray _____ Normal? □ Yes □ No Blood work _____ Normal? □ Yes □ No

**Women Only:** How many pregnancies have you had? _____ How many children born alive? _____ How many c-sections? _____

Is there any chance you could be pregnant? □ Yes □ No Date of most recent breast exam: _____

Are you having regular menstrual periods? ? □ Yes □ No Date of most recent mammogram: _____

Heavy bleeding with your periods? ? □ Yes □ No

| **MEDICATIONS:** Please list all the medications you are currently taking, prescription and nonprescription, supplements, vitamins, diet pills and those medications you may not take *every* day. Please also include the dose of the medication. | |
|---|---|
| Medication/Dose | Medication/Dose |
| | |
| | |
| | |
| | |
| **ALLERGIES:** Please list all allergies to medications, tape, latex, iodine, etc. and the reaction you have when exposed. | |
| | |
| | ☐ I have no known drug allergies |

**Colorado Plastic Surgery Center** **Nick Slenkovich, MD** **Surgery Center of Colorado**

Patient Name: _____

**SURGICAL HISTORY:**

Please list your surgical history and/or serious accidents or injuries. Please include the date of the surgery, accident or injury.

| **PROCEDURE** | **DATE** |
|---|---|
| | |
| | |
| | |
| | |

Have you and/or any of your family members had any anesthesia complications? ☐ Yes ☐ No

If yes, please describe: _____

**PAST MEDICAL HISTORY/REVIEW OF SYSTEMS:** Please check all that apply to *YOU*:

**NEUROLOGICAL**
- ☐ Migraines
- ☐ Stroke
- ☐ Seizures
- ☐ Head Injury
- ☐ Depression

**BLOOD**
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Blood clots/DVT
- ☐ AIDS/HIV+
- ☐ Nose Bleeds
- ☐ Prior Transfusion

**PULMONARY**
- ☐ Asthma
- ☐ Tuberculosis (TB)
- ☐ Emphysema
- ☐ Pulmonary Embolism

**CARDIOVASCULAR**
- ☐ Heart Disease
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Swollen legs/ankles
- ☐ Palpitations

**SKIN/IMMUNE**
- ☐ Arthritis/Joint Pain
- ☐ Back/Neck
- ☐ Skin disorder
- ☐ Autoimmune
- ☐ Lupus/Scleroderma
- ☐ Pigmentation

**GENERAL**
- ☐ Fever
- ☐ Weight loss/gain
- ☐ Night Sweats
- ☐ Loss of Appetite

**HEAD/NECK**
- ☐ Change in vision
- ☐ Nasal blockage
- ☐ Sore throat
- ☐ Sinusitis
- ☐ Wear contacts/glasses

**ENDOCRINE**
- ☐ Heat/Cold intolerance
- ☐ Diabetes
- ☐ Thyroid Problems

**GASTROINTESTINAL**
- ☐ Constipation
- ☐ Reflux disease
- ☐ Diarrhea
- ☐ Hepatitis/Jaundice
- ☐ Frequent Urinary Infection

**ALLERGY**
- ☐ Tape Allergy
- ☐ Environmental
- ☐ Iodine Allergy
- ☐ Latex Allergy

☐ **CANCER**, type: _____

☐ **OTHER:** _____

☐ **NONE OF THE ABOVE LISTED**

**Family History** Please check those that apply to your family members: ☐ **NONE OF THE FOLLOWING**

☐ Blood clots/DVT ☐ Bleeding disorder ☐ Asthma ☐ Breast Cancer ☐ Stroke

☐ High Blood Pressure ☐ Heart Disease ☐ Diabetes ☐ Other

**PHYSICIAN NOTES:**

_____

_____

_____

# NON-MEDICAL PATIENT INFORMATION

**Patient Name** _____ **DOB**_____ **Age**_____ **Date**_____

What area(s) is your concern? _____

What surgery(s) are you interested in? _____

What improvement/change do you hope to make? _____

How long have you thought about a procedure? _____

Why is now the right time for a procedure? _____

Have you had any other consultations? _____

What do you still need that you didn't get in your previous consult? _____

Is your significant other/family supportive of your desire for a procedure? _____

Have you ever had surgery(s)? _____What type? _____

_____

Who will your care provider be? _____

How much time will you have off work/down time? _____

Do you understand that cosmetic surgery aims to improve appearance, not perfect? _____

Any fears/concerns that you have about surgery? _____

_____

Have you educated yourself on this procedure?____What ?s do you have?_____

_____

Do you take a multivitamin? ___ Aspirin ____ Ibuprofen? ___ Herbs? ____ Fish Oil?___

**IF INTERESTED IN BREAST SURGERY:**

Do you have a family history of breast cancer? _____

Have you ever had a mammogram or breast biopsy? _____

Have you had children _____ Did you breastfeed? _____ How long? _____

What size bra do you wear?_____What size do you hope to be?_____

Are you interested in saline or silicone gel implants?_____

**IF INTERESTED IN BODY SURGERY:**

Is your procedure related to weight gain?_____Weight loss?_____

Have you gained or lost more than 10 pounds in the last year?_____

What type of foods do you eat?_____Are you on a special diet?_____

**IF INTERESTED IN NASAL/FACIAL SURGERY:**

Have you ever had any injury/surgery to the face?_____

Are you having any problems with breathing?_____

Do you understand that facial surgery can result in extended bruising/swelling? _____

**OTHER:** _____

_____Staff Initials_____

# PRIVACY FORM

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. You will be given a copy of this notice.

**Patient Health Information:** Under federal law, your patient health information is protected and confidential. This information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information includes payment, billing, and insurance information.

**How we use your Health Information**: We use health information about you for treatment, to obtain payment, and for healthcare operations including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances we may be required to use or disclose the information without your permission.

**Examples of Care, Payment, and Healthcare Operations: Treatment—**We will use and disclose your health information to provide your medical treatment. For example, nurses, physicians, and other members of your treatment team will record and use it to determine your care. We may also disclose information to other healthcare providers who are helping in your treatment, to pharmacists filling your prescriptions, and to family members helping with your care. **Payment—**We will disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain your records of payment. **Health Care Operations—**We will use and disclose your health information to conduct our standard internal operations, including the administration of records, the evaluation of the quality of treatment, and the assessment of outcomes. **Quality Assurance-**We will also use your health information in the performance of physician's peer reviews, as required by law.

**Special use:** We may use your information to contact you with appointment reminders. We may also contact you to provide information about different treatment options.

**Other Uses and Disclosures:** We may use or disclose health information about you for other purposes. Subject to certain **HIPAA** requirements, we are permitted disclosure for the following purposes: **Required by Law—**We may be required by law to report gunshot wounds, suspected abuse, suspected neglect, or similar events. **Research—**We may use or disclose information for approved medical research. **Public Health Activities—**As required by law, we may disclose vital statistics, disease, information related to recalls of products, and similar information to health authorities. **Health Oversight—**We may disclose information to assist in investigation and audits, and eligibility for government programs. **Judicial Proceedings—**We will disclose information in response to subpoena or court order. **Law Enforcement Purposes—**We may disclose information subject to certain restrictions. **Workers' Compensation—**We may release information about your workers' compensation or other programs providing benefits for work-related injuries or illness. **Military or Special Government Functions—**If a member of the armed forces, we will release information as military authorities or correctional facilities command, or for national security. **Death—** We must report information regarding deaths to the coroner, medical examiner, funeral directors, and organ donation programs. **Serious Threat to Health and Safety—**We may share information when needed to prevent a serious threat to your health, safety, and/or to the public.

**Individual Rights:** You have the following rights with your health information. **Request Restrictions—**You may request restrictions on some uses of this information, although we are not required to agree with this request. **Confidential Communications—**You may request that we communicate with only you. You may request a special address or phone number. **Inspect and Obtain Copies—**In most cases you have the right to look and receive a copy of your information. **Amend Information—**If you believe there are errors in your information, or information is missing, you may request that it be modified. **Accounting of Disclosure—**You may request a history of the disclosure of the information about you for reasons OTHER than treatment, payment, or operations.

**Our Legal Requirement:** We are required to provide you with this notice, to protect your information, and to abide by the terms of this notice.

**Changes in a Privacy Practice:** We may change these terms at any time. We will change our notice to reflect the terms that we change. We will also post the terms changes in our waiting room. You may request a copy of this notice and/or the changes at any time. You may contact the Center Director below to answer any questions.

**Complaints:** If you have a complaint that may reveal we have violated this privacy statement, or do not agree with a decision that we made in regard to your information, please contact the Center Director below. You may also contact the US Department of Health and Human Services. The person below may provide you with the correct address upon request.

**Services**. The person below may provide you with the correct address upon request.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Patient Name:_____ Sex:_____ Physician Name:_____
MR Number:_____ DOB:_____ Admission Date: _____

# AGREEMENT FOR EMAIL AND/OR TEXT COMMUNICATION

Under specific circumstances, email communication or text communication containing protected health information (PHI) may take place between Colorado Plastic Surgery Center and myself, the patient. Secure electronic messaging is always preferred to insecure email or text communication for more sensitive PHI. This email or text communication may be used if both parties agree on this communication method and this form is completed and signed by both the provider and the patient or the patient's personal representative (if appropriate).

A copy of this form and all email or text communications, including photos, will be filed in the patient's Medical Record and a hard copy of this for will be provided to you upon request. This agreement is limited to email or text communications provided to Colorado Plastic Surgery Center by the patient and from Colorado Plastic Surgery Center to the patient.

Provider Awareness:

Standard email or text is not a secure means of communication. As the provider, Colorado Plastic Surgery Center will use the minimum necessary amount of protected health information when responding to your questions or communicating information to you.

Patient Awareness:

Please note that most standard email and text communication does not provide a secure means of communication. There is some risk that any protected health information contained in email or text may be disclosed to, or intercepted by, unauthorized third parties. Use of more secure communications, such as phone or fax is always an alternative that is available to you.

- ☐ I wish to communicate via email.
- ☐ I wish to communicate via text message.

By completing this form the provider and I understand and are willing to accept the risks involved with insecure email or text communication of my protected health information.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Withdrawal of Consent for Email Communications

I decline communicating with Colorado Plastic Surgery Center as my provider in the following methods:

- ☐ I do not wish to communicate via email.
- ☐ I do not wish to communicate via text message.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

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| | | | | | |
|---|---|---|---|---|---|
| Patient Name: | | Sex: | | Physician Name: | |
| MR Number: | | DOB: | | Admission Date: | |

# FINANCIAL INFORMATION

You may receive bills from several different providers for the care rendered to you today: the physician performing the procedure, the Ambulatory Surgery Center (ASC), and a laboratory if specimens are obtained during your procedure.

## FINANCIAL AGREEMENT

If you have insurance, we will help you receive maximum benefits by filing for you; however, we will expect payment of co-pays, co-insurance, and deductibles at the time of service. The undersigned individual guarantees prompt payment of all charges if the insurance carrier rejects the claim of any charges related to this account. If charges remain unpaid, it may become necessary to turn the account over to a collection agency.

## ASSIGNMENT OF INSURANCE BENEFITS

Medicare/Medicare/Other Insurance

I hereby assign benefits to be paid, on my behalf, to the ASC that renders service to me. I understand and agree to be financially responsible for charges not paid within a reasonable time by insurance or other third party payer. I certify the information given with regard to insurance coverage is correct.

## RELEASE OF INFORMATION

I authorize the ASC to release all or part of my medical records when required for the submission of any insurance claims for payment to the Centers for Medicare and Medicaid Services and their agents, my insurance company(s), or to my employer (if this is a workers compensation claim).

I also authorize reports of my evaluation, treatments, and any follow up evaluations to be sent to or discussed with my referring Doctor, the Doctor requesting the consultation, my family Physician(s), as well as any other healthcare providers, hospitals, or outpatient facilities that I have or will identify to you. I permit a copy/fax of this form to serve as an original signature of authorization.

## DISCLOSURE OF OWNERSHIP

I have been advised of the following:

A physician performing the procedure may have an ownership interest in this facility.

A schedule of typical fees for services provided by this facility is available upon my request. These procedures are performed at hospitals and other outpatient facilities in this community. I have the right to choose where to receive services, including a facility where my physician does or does not have an ownership interest. I have chosen to be treated at this facility.

## CERTIFICATION

**I have read and fully understand the information in this form.**

| | |
|---|---|
| _____ | _____ |
| **Patient Signature** | **Date** |
| _____ | _____ |
| **Witness Signature** | **Date** |

Patient Name: _____ Sex: _____ Physician Name: _____

MR Number: _____ DOB: _____ Admission Date: _____

# PHOTOGRAPHY AND OUR PRACTICE

The use of photographs is essential to the planning and evaluation of aesthetic or reconstructive surgery. Dr. Slenkovich plans to take photos of your case before, possibly during, and after planned surgeries or treatments. These photos become part of your medical record and will not be shown to anyone without your consent.

For various reasons, Dr. Slenkovich is often asked to show before and after photos of patients. Many patients have given permission to use their photos anonymously, and we now ask that you do so as well.

## AUTHORIZATION FOR THE USE OF PHOTOGRAPHS

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire thirty years from the date written below. I understand that I may refuse to sign this authorization and that such refusal will have no effect on the medical treatment I receive from Dr. Slenkovich.

I understand that the information disclosed may be protected by state law and/or the federal Health Insurance Portability and Accountability act of 1996 (HIPAA). I further understand that any third-party receiving this information may not be protected by HIPAA and that this information may be re-disclosed (for example if the third party is not a health care provider or health plan).

**PERMISSIONS:**

I hereby grant permission for the use of any of my medical records, illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc. Additionally, I grant permission for the use of such information in conjunction with coordinating my medical and surgical care.

**Please review the following circumstances for the anonymous use of your photos, and <u>clearly</u> <u>strike-through any use to which you object</u>:**

- Prospective patients, such as myself, in the process of evaluating procedures during consultation.
- In consultation or review with other physicians during seminars, professional conferences or teaching courses for the purpose of informing the medical profession or general public about plastic surgery methods.
- Health insurance company authorizations, if required.

**For any of the following uses, Dr. Slenkovich will ask for your permission in advance:**

- Articles written by Dr. Slenkovich for publication in magazines, newspapers or professional journals, *so long as I am notified in writing of such use prior to publication.*
- Television interviews of Dr. Slenkovich or programs produced for television, *so long as I am notified in writing of such use prior to production.*
- Internet or website use by Dr. Slenkovich, *so long as I am notified in writing of such use prior to production.*
- Patient education brochures, *so long as I am notified in writing of such use prior to production.*

_____ _____

**Patient Signature** **Date**

_____ _____

**Witness Signature** **Date**

Patient Name: _____ Sex: _____ Physician Name: _____

MR Number: _____ DOB: _____ Admission Date: _____