Derek Jones M.D.
FACIAL PLASTIC SURGERY℠

Medical Center / Clinic℠
HEALTHCARE CENTERED AROUND YOU

COSMETIC PATIENT INFORMATION

Your answers to the following questions will help us with your treatment. **Please answer each question as completely and accurately as you can.** If you are unsure about a question, please ask one of our medical staff to clarify it.

Your Name: _____

Address: _____

Home Ph.: _____ Work: _____ Mobile: _____

Email: _____

Please circle your contact preference: Home Work Mobile Email

Have you ever had plastic surgery? No ☐ Yes ☐ Please list the procedure(s) and date(s):

_____

_____

If you have a primary care physician, please provide us with:

Primary Care Physician's Name: _____

Address: _____

If you have any specific interests, please check all that may apply:

Surgical

- ☐ Rhinoplasty
- ☐ Lower-Face Lift
- ☐ Mid-Face Lift
- ☐ Forehead Lift
- ☐ Blepharoplasty (Eye Lid Lift)
- ☐ Mole Removal
- ☐ Scar revision
- ☐ Reconstructive surgery

Injectables

- ☐ Botox
- ☐ Dysport
- ☐ Restylane
- ☐ Juvederm
- ☐ Juvederm Voluma
- ☐ Sculptra
- ☐ Radiesse
- ☐ Perlane

Cosmetic

- ☐ Skin Resurfacing
- ☐ Latisse for eyelash growth
- ☐ Obagi Skin Care

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COSMETIC PATIENT INFORMATION (cont.)

Please circle what best describes you:

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.
Younger than Same as Older than

Each day, I look at myself in the mirror:
Once or twice Every now and then More than 10 times

I am looking for a procedure that can give me a:

- ☐ Small Improvement — Minimal down time
- ☐ Moderate Improvement — Some down time
- ☐ Significant Improvement — Longer down time

Emergency Contact Information

In case of an emergency, designate a local friend or relative to be notified.

Name: _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____

Assignment and Release

I hereby authorize my insurance and government benefits be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release any information required for this claim.

Signature: _____ Date: _____

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GENERAL QUESTIONNAIRE

How did you hear about us?

☐ Referred by another physician
Referring physician's name: _____

☐ Referred by a friend or family member
Referring person's name: _____
May we contact them to thank them? ☐ No ☐ Yes — contact info:

☐ Internet search (circle one): Google Yahoo Bing Facebook

☐ Bella Magazine ☐ Blab TV ☐ Other

How long did it take to get an appointment to see Dr. Jones?: _____

MEDICAL HISTORY

1. Have you **ever** had any of the following? (Please check all that apply.)

☐ High Blood Pressure	☐ Heart Attack	☐ Abnormal Heart Rhythm	☐ Stroke
☐ Heart Failure	☐ Heart Murmur	☐ Seizures	☐ Asthma
☐ Syncope/Fainting Spells	☐ Kidney Disease	☐ Liver Disease/Jaundice	
☐ Cancer Type(s): _____			
☐ Hepatitis	☐ Thyroid Problems	☐ Pneumonia	☐ Anemia
☐ Tuberculosis (TB)	☐ Arthritis	☐ Acid Reflux	☐ Latex Allergy
☐ Diabetes	☐ Blood Transfusion	☐ Bleeding Problems	☐ Depression
☐ Radiation Treatment	☐ Substance Abuse	☐ Deep Vein Thrombosis/Blood Clots	

Other conditions you have been treated for: _____

_____

_____

_____

_____

_____

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MEDICAL HISTORY (continued)

2. Have you ever had any of the following surgeries? (Place approximate date of surgery in blank.)

Tonsillectomy and/or Adenoidectomy_____
Tympanostomy (Ear tubes)_____
Nose or Sinus Surgery_____
Open Heart Surgery_____
Gall Bladder_____
Other ENT Surgery_____ (Please list) _____

Thyroidectomy_____
Knee or Hand Surgery (Circle)_____
Neck or Back Surgery (Circle)_____
Wisdom Teeth Extracted_____
Hysterectomy_____

Please list all other surgeries:_____

Have you ever had problems with anesthesia? ☐ Yes ☐ No

3. Are you allergic to any medications? ☐ Yes (List below) ☐ No

4. Medications you are currently taking (Also include non-prescription medications, such as aspirin, herbal treatments, and vitamins that you take on a regular basis): ☐ No Medications

Medication Name	**Reason for Taking**

(For additional medications, please write on the back of this page or provide a complete list.)

5. Are your immunizations / vaccinations up to date? ☐ Yes ☐ No

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SOCIAL HISTORY

6. Your Occupation: _____

7. Your Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

8. Do you have a child/children? ☐ Yes ☐ No In Daycare? ☐ Yes ☐ No

9. Do you live alone? ☐ Yes ☐ No If no, who lives with you? _____

10. Do you smoke? ☐ No, I never smoked

☐ No, I quit _____ years ago. At that time, I was smoking pack(s) per day for _____ years

☐ Yes, I've smoked _____ packs of cigarettes per day for _____ years

☐ Yes, I smoke cigars or a pipe

Are you exposed to smoke from other members of your family on a daily basis? ☐ Yes ☐ No

11. Do you drink alcohol? ☐ No, never (or rarely) ☐ No, but I used to

☐ Yes, daily ☐ Yes, 1 or more times a week ☐ Yes, 1 or more times a month

Have you had a problem with alcoholism? ☐ Yes ☐ No

12. Are you at risk for AIDS / HIV / Hepatitis (E.g., sexual orientation, drug abuse, previous blood transfusions)? ☐ No ☐ Yes, please explain _____

_____

FAMILY HISTORY

13. Do you have any **blood relatives** who have any of the following conditions? (Check all that apply):

☐ Heart Disease ☐ Problems with Anesthesia ☐ Diabetes ☐ Allergies

☐ High Blood Pressure ☐ Bleeding Problems ☐ Asthma ☐ Stroke

☐ Hearing Loss ☐ Cancer Type(s) _____

_____

_____

_____

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CURRENT SYMPTOMS

14. Please check all symptoms that you now have:

General:	☐ Fatigue ☐ Chills ☐ Fever ☐ Night Sweats ☐ Weight Loss/Gain
Eyes:	☐ Change in Vision ☐ Double Vision ☐ Wear Glasses
Ears:	☐ Hearing Loss ☐ Ear Pain ☐ Ear Drainage ☐ Ringing ☐ Dizziness
Nose:	☐ Nasal Congestion ☐ Nasal Bleeding ☐ Nasal Drainage ☐ Sinus Pain
Throat:	☐ Difficulty Swallowing ☐ Change in Voice ☐ Feel a Lump in Throat/Throat Pain
Lungs:	☐ Shortness of Breath ☐ Frequent Cough ☐ Wheezing ☐ Coughing Blood
Cardiovascular:	☐ Chest Pain ☐ Irregular Heartbeat ☐ Ankle Swelling
Gastrointestinal:	☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Vomiting Blood ☐ Abdominal Pain
Genitourinary:	☐ Difficulty Urinating ☐ Blood In Urine
Neurological:	☐ Depression ☐ Memory Loss ☐ Weakness ☐ Numbness ☐ Tingling
Musculoskeletal:	☐ Back Pain ☐ Joint Pain ☐ Arm or Leg Pain ☐ Muscle Weakness
Skin:	☐ Skin Cancer ☐ Skin Disease
Endocrine:	☐ Increased Appetite ☐ Excessive Thirst ☐ Heat/Cold Intolerance
Allergy/Immunology:	☐ Sneezing ☐ Itchy/Watery Eyes ☐ Facial Swelling ☐ Hives

15. Age _____ Height _____ Weight _____

Approximate Blood Pressure _____

The above information is accurate to the best of my knowledge.

Patient's signature	Date	Physician's signature

PLACE LABEL HERE OR LEGIBLY PRINT
PATIENT"S FIRST AND LAST NAME AND MCC#

Print Patient First and Last Name

Print MCC#

Medical Center Clinic℠
HEALTHCARE CENTERED AROUND YOU

PATIENT INSURANCE ASSIGNMENT & RESPONSIBILITIES ACKNOWLEDGEMENT

Please read each section thoroughly and sign acknowledgement below:

Consent to Treatment: I consent to care, treatment, testing, and all other services performed by healthcare providers at Medical Center Clinic. I understand that I have the right to refuse any proposed care, treatment, testing, surgery, or other procedure. I understand that I have the right to ask questions and discuss my care with my healthcare provider.

Lifetime Insurance Assignment: I hereby instruct and direct my past and/or present insurance company to issue payment directly to:

West Florida Medical Center Clinic, P.A.
8333 North Davis Highway
Pensacola, FL 32514

for all medical, surgical and diagnostic expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to MCC and I agree to pay, within sixty (60) days of the date of the first monthly bill, any balance of said charges over and above this insurance payment, including applicable copayments, deductible, non-covered services and items, unauthorized services or any fees denied, except to the extent my liability for any such balance is limited by agreement or law applicable to MCC. A photocopy of this assignment shall be considered as effective and as valid as the original. Furthermore, I understand that 1) MCC accepts Medicare assignment and Medicare payments will be directed to MCC and 2) Medical Center Clinic does not accept responsibility for collecting insurance or negotiating the settlement of a disputed insurance claim and any account balance not paid in full within sixty (60) days of the date of the first monthly bill is considered delinquent. I agree to pay reasonable attorney's fees and collection expenses should my account be referred for collection procedures.

Patient Financial Responsibility Policy: Co-payments, deductibles, co-insurance, and all other appropriate payment will be due at time services are rendered. Insurance companies require physician offices to collect all applicable patient portions prior to services being rendered.

Tobacco-Free Campus: Use or sale of tobacco products (cigarettes, including electronic; cigars; pipes; and smokeless tobacco) is prohibited on all Medical Center Clinic premises, campuses, parking lots and grounds.

I acknowledge and understand all of the above notices and assignments and will comply with all specified responsibilities.

_____ _____

Signature of Patient or Legal Representative Date

Notice of Health Information Privacy Practices

Effective September 23, 2013

This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully.

Thank you for choosing the Medical Center Clinic for your healthcare needs. Each time you visit one of our providers, we create a record of the care and services you receive to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of your records of your care received by a provider at Medical Center Clinic and explains how we may use and disclose your health information as well as your rights regarding the health information we maintain about you.

We are required by law to make sure that health information that identifies you is kept private; give you this Notice of our legal duties and privacy practices with respect to your health information; and follow the terms of the Notice currently in effect. We reserve the right to change our privacy practices and this Notice at any time.

WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN PERMISSION IN THE FOLLOWING CIRCUMSTANCES:

Treatment: We will use and disclose your health information to provided medical treatment to you, and to coordinate or manage your health care related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example, we may use and disclose your health information when you need a prescription, lab work, an x-ray or other health care services. Also, we may use and disclose your health information when referring you to another health care provider.

Payment: We may use and disclose your health information to bill and receive payment. For example: A bill may be sent to you or your insurance company. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Operations: We may use and disclose health information about you for health care operations. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including compliance program activities and business planning.

Business Associates: We may disclose your health information to our Business Associates to carry out treatment, payment or health care operations. For example, we may disclose health information about you to a company who bills insurance companies on our behalf to enable that company to help us obtain payment for the services we provide.

Appointment Reminders, Treatment Alternatives or Health-Related Services: We may contact you to provide appointment reminders, tell you about health-related services, to recommend possible treatment options or alternatives that may be of interest to you.

Research: We may use and disclose information to researchers or to collect information in databases used for research. Research projects are reviewed and approved by a Review Board to protect the privacy of your health information.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to ad-verse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Military and Veterans: If you are a member of the armed forces, or separated or discharged from the military services, we may disclose your health information as required by national military command authorities or the Department of Veterans Affairs.

Public Health: We may disclose your health information to a public health authority that is permitted by law to collect or receive the information for the purpose of preventing or controlling disease, injury, or disability.

Correctional Institution: If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information necessary to provide you with healthcare; to protect your health and

safety or the health and safety of other individuals; or for the safety and security of the correctional institution.

Law Enforcement: We may disclose health information in response to a valid subpoena, warrant, summons or similar process. We may also release information for purposes of locating a suspect, a fugitive, a material witness, or missing person.

Health Oversight Activities: Federal law makes provisions for your health information to be released to an appropriate health oversight agency for activities such as audits, investigations, and inspections. This includes government agencies that oversee the healthcare system, government benefit programs, other government regulatory pro-grams, and the civil rights laws.

SPECIAL CIRCUMSTANCES

Florida Privacy Laws: Health information related to substance abuse, mental health, or sexually transmissible diseases have special privacy protections in Florida. We will not disclose health information relating to substance abuse, mental health, or sexually transmissible disease unless: 1) the patient consents in writing, or 2) a court order requires disclosure of the information, or 3) medical personnel need information to meet a medical emergency, or 4) qualified personnel use the information for the purpose of conducting scientific research, management audits, financial audits or program evaluation, or 5) it is necessary to report a crime or a threat to commit a crime, or 6) to report abuse or neglect as required by law.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or law that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your revocation. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights with respect to your health information:

Right to Inspect and Copy Your Health Information: You have the right to see and obtain copies of health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

Right to Amend: If you think that health information we have about you is incorrect or incomplete, you may ask us to correct or add to the information, but we are not required to agree to the requested amendments.

Right to an Accounting of Disclosures: You have the right to request an "accounting" of certain disclosures of your protected health information.

Right to Request Restrictions: You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment or health care operations, but we are not required to agree to the requested restrictions.

We will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to your health plan for purposes of carrying out payment or your health plan's operations; and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

Right to Request Confidential Communications: You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

Right to Breach Notification: You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to Obtain a Copy of This Notice: You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

QUESTIONS OR COMPLAINTS

If you have questions about this Notice, or believe that your privacy rights have been violated, please contact Sharon Hoyle, CHC, CHPC, CPC, Corporate Compliance and Privacy Officer toll free at 1-866-822-3571, by e-mail at privacy.officer@medicalcenterclinic.com, or by U.S. Mail at:

Medical Center Clinic
Attn: Sharon Hoyle, Corporate Compliance and Privacy Officer
8333 N. Davis Hwy
Pensacola, FL 32514

You have the right to file a written complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

PLACE LABEL HERE OR LEGIBLY PRINT
PATIENT"S FIRST AND LAST NAME AND MCC#

Print Patient First and Last Name

Print MCC#

Medical Center Clinic℠
HEALTHCARE CENTERED AROUND YOU

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

Thank you for choosing Medical Center Clinic for your health care needs.

We are required by law to provide you with a copy of our Notice of Privacy Practices ("Notice"). To ensure that our records are accurate, please sign below to acknowledge that you have been provided with a copy of our Notice.

Patient Signature _____ Date of Signature _____

If a personal representative signs on behalf of the patient, please complete the below additional information:

Personal Representative's Name (Print) _____ Relationship to Patient _____

OFFICE USE ONLY

A good faith attempt was made to obtain the patient's written acknowledgement of receipt of MCC's Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual declined to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please describe below)

_____

_____

Employee Name (please print) _____ Date _____