PATIENT REGISTRATION

PATIENT NAME:		❒ Female ❒ Male	DATE:	
DATE OF BIRTH:	/ /19____	AGE:		
ADDRESS:		CITY :	STATE:	ZIP:

HOME TELEPHONE:	( )	MAY CONTACT ME	❒ YES ❒ NO	MAY LEAVE A MESSAGE	❒ YES ❒ NO
CELL PHONE:	( )	MAY CONTACT ME	❒ YES ❒ NO	MAY LEAVE A MESSAGE	❒ YES ❒ NO

EMPLOYER/ SCHOOL/OCCUPATION		E-MAIL	

MARITAL STATUS:	❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Partnered for _____

PERSONAL GOALS

My goals are to improve my appearance by: **(ie. Increase breast size)**	
I would describe the present condition(s) I wish to improve as: **(ie. Small breasts)**	

I HAVE THE FOLLOWING CONCERNS/INTERESTS

AGING APPEARANCE OF MY:	FACIAL APPEARANCE / PROPORTION OF MY:	BODY	BREAST:
❒ SKIN	❒ EYES	❒ ARMS	❒ SIZE
❒ FACE	❒ NOSE	❒ BACK	❒ SHAPE
❒ EYES	❒ EARS	❒ BREAST	❒ POSITION, SAGGING
❒ LIPS AND MOUTH	❒ CHEEKS	❒ UPPER / LOWER ABDOMEN	❒ SYMMETRY BETWEEN BREASTS
❒ NECK	❒ LIPS	❒ BUTTOCKS	❒ OTHER:
❒ FURROWED BROW	❒ JAW	❒ HIPS	
❒ SAD, BAGGY, PUFFY EYELIDS	❒ CHIN	❒ INNER/OUTER THIGHS	OTHER:
❒ THIN LIPS	❒ OTHER:	❒ LEGS	❒ FACIAL / LEG VEINS
❒ HEAVY JOWLS		❒ EXCESS FAT DEPOSIT	❒ IRREGULAR SCAR(S)
❒ DOUBLE CHIN		❒ EXAGGERATED CURVES	❒ MOLES, LESIONS OR OTHER GROWTHS
❒ FACIAL FOLDS & CREASES		❒ LACK OF DEFINED CURVES	❒ EXCESS BODY HAIR
❒ FINE LINES & WRINKLES		❒ OTHER	❒ HAIR LOSS
❒ SUN DAMAGE			❒ OTHER:
❒ SKIN TONE			
❒ LOSS OF FACIAL FULLNESS			

I HAVE HAD THE FOLLOWING TREATMENTS (PLEASE LIST THE EXACT TYPE & YEAR OF THE LAST TREATMENT OR SERIES OF TREATMENTS):

❒ Cosmetic Surgery (list type and year) ____

____

❒ Botox®*Cosmetic*, Dysport, Xeomin____

❒ Injected or implanted filler(s) ____

❒ Skin Resurfacing ____
(chemical peel, dermabrasion, laser resurfacing)

❒ Light/Energy-based Treatments ____
(i.e. IPL, Thermage, Laser

GENERAL HEALTH HISTORY

HEIGHT: ____'_____"	WEIGHT: ____lbs	ALLERGIES: ❒ DRUGS What DRUG(S)? ______ ❒ FOOD What FOOD? ______ ❒ LATEX ❒ ENVIRONMENTAL ______
I have had the following SURGERIES: (i.e. C-section, hysterectomy, appendix)		
Problems with ANESTHESIA		
I am presently under a DOCTOR'S CARE for the following medical conditions:		
I would describe my PRESENT STATE OF HEALTH as:	❒ Fair ❒ Good ❒ Excellent	
Current MEDICATIONS:	1. ______ 4. ______ 2. ______ 5. ______ 3. ______ 6. ______	

MEDICAL CONDITIONS

	YES	NO
High Blood Pressure	❒	❒
Mitral Valve Prolapse	❒	❒
Heart irregularity/palpitations	❒	❒
Easily Bruise	❒	❒
Pacemaker	❒	❒
Asthma	❒	❒
Reflux or GERD	❒	❒
Diabetes	❒	❒
Sleep Apnea	❒	❒
CPAP Used	❒	❒
Skin Cancer	❒	❒
History of HIV	❒	❒

	YES	NO
Cancer	❒	❒
Type: ______		
Transplant	❒	❒
Type: ______		
Have you ever seen a cardiologist?	❒	❒
If yes, explain: ______		
Testing done? Explain: ______		
Have you ever used an inhaler?	❒	❒
If yes, explain: ______		
When was last use and why? ______		
Have you ever been to the ER due to breathing difficulty, chest pain or palpitations?	❒	❒
If yes, explain: ______		

Do you SMOKE? ❒ Yes ❒ No How many cigarettes ____/day? # of years _____
Do you take BLOOD THINNERS? ❒ Yes ❒ No
Do you take ASPIRIN daily? ❒ Yes ❒ No
Do you use ALCOHOL? ❒ Never ❒ Daily ❒ Socially If so, how much/how often? ______

Number of Children________

WHOM MAY WE CONTACT IN AN EMERGENCY?

NAME:		RELATIONSHIP:	
TELEPHONE:		MOBILE:	
ADDRESS:			

I was REFERRED to Dr. Castor by (name and relationship): ______ ______

I saw/learned about Dr. Castor in (choose all that apply):

❑ArtisanPlasticSurgeryCenter.com ❑RealSelf.com ❑lookingyourbest.com ❑DrCastor.com
❑Google ❑Clipper Magazine ❑Neighborhood News ❑Sophisticated Buyer ❑Osprey Observer

I attest the above history is completed to the best of my knowledge and understand and accept that my failure to disclose any of the above information can adversely affect a prescribed course of treatment to meet my goals, my safety, or the outcome of any treatment I elect to undergo with Dr. Castor or any member of his staff.

Patient Signature X ______ Date ______

HIPPA POLICY: Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

You can complain if you feel we have violated your rights by contacting the U.S. Department of Health and Human Services Office for Civil Rights, 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.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care, share information in a disaster relief situation, include your information in a hospital directory. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

We never share your information for marketing purposes, sale of your information or sharing of psychotherapy notes.

In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

We may use and share your information as we treat you. We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.* We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services. We can share health information about you for certain situations such as: Preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety. We can use or share your information for health research. We can use or share your information for health research. We can share health information about you with organ procurement organizations. We can share health information with a coroner, medical examiner, or funeral director when an individual dies. We can use or share health information about you for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Privacy Notice will be effective Oct 1, 2005 and will remain in effect until amended by us or replaced. You may contact our Privacy officer, Colleen Castor at colleen@drcastor.com or 813-971-2000 for questions, records or to change who we share your information with.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alterative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner regarding my Protected Health Information:
(Check all that apply)

___Cell Phone______________
__OK to leave a message with information
__Leave message with call back number only

___Written communication
__ OK to mail to my home address
__ Please use office address_____________________
____

___Home Phone_____________
__OK to leave a message with information
__Leave message with call back number only

___Other____
____

May discuss information or leave a message regarding my Protected Health Information with:

____________________________ ____________________________ _________________
Name Relationship Phone Number

____________________________ ____________________________ _________________
Name Relationship Phone Number

Notice to Patient: We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.
I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____________________________ _____________________________ ___________
Print name *Signature* *Date*

PRACTICE FINANCIAL POLICY

We wish to provide you with our practice financial policy so that if you decide to schedule a treatment all of our policies would be understood clearly beforehand. By signing the financial policy, I understand that I am under no obligation to schedule an appointment or book a procedure. I have read and understand the financial policy of the practice and I understand and agree.

SURGICAL PROCEDURES

We are dedicated to providing you with the best possible care and service. We regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

If you decide to book a procedure, you must pay a **nonrefundable scheduling and booking fee of $500.00** for all surgical procedures. This fee is deducted from the cost of the procedure. **No surgery date can be held until the scheduling and booking fee is received.**

Dr. Stan Castor may find it necessary for you, the patient, to purchase antibiotics, pain medication, scar creams, or other supplies such as liposuction garments deemed necessary and if so, it is the responsibility of the patient.

When a procedure is booked in our office surgical suite, the nurses, surgical assistants and anesthesia personnel are notified and their schedule is reserved as many of our employees work part-time at other locations. We require that you notify us of any rescheduling of surgery within 30 days of your procedure to avoid being charged for your change of appointment. This will allow us time to fill that time slot. Patients who change their surgery date within 30 days of their scheduled procedure date, will incur a **change fee of $200** unless there are extenuating circumstances. **Any cancellation of surgery will cause loss of the $500 scheduling deposit with no exceptions. Cancellation of surgery on the day of surgery will result in a loss of deposit and surgical fees – this is due to the reservation of the operating room, staff, supplies, anesthetist and other fees incurred due to your surgery.**

There will be a $30.00 fee for any returned checks as well as any processing fees incurred for the use of any financing institutions, which charge a fee.

All general anesthesia cases are to be paid in full **7 calendar days** prior to the date of your procedure unless other arrangements have been made and written on this policy. All local anesthesia cases may be paid up to the day of surgery. **All procedures are to be paid in full prior to the procedure date.** You may not make payments after the surgery date, unless you have arranged to make payments through one of the financing companies that we work with (Care Credit and Advance Care). There are no refunds for any procedures, treatments, or products.

OFFICE PROCEDURES *(Laser Resurfacing, Laser Hair Removal, Botox®, Dermal Fillers, Office Visits, Microdermabrasion, SkinRejuvenation & all similar procedures)*
If you fail to show for your appointment or do not give 24hour notice, you will be charged a $50.00 missed appointment fee. This fee amount is non refundable and will not be applied to your overall procedure/treatment cost. There are no refunds for any procedures, treatments, or products.

MINOR PATIENTS
For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

We offer multiple payment options for our patient's convenience. We accept credit cards; checks, cash or we can assist you in arranging patient financing for cosmetic surgery.

PATIENT FINANCING PROGRAMS

Patient financing offers more patients the opportunity to have the cosmetic procedures they desire through convenient low monthly payments, no interest plans and low fixed interest rates.

www.carecredit.com and www.advancecarecard.com

Our office provides you with a copy of our financial policy at the time of your consultation, booking of your procedure/treatment and it is posted in our waiting room so that you are aware of our policy prior to scheduling any appointments and/or procedures. We thank you for your understanding.

_______________	X_______________	_______________	_______________
Patient Name (Print Name) (responsible party if patient is a minor)	Patient Signature	Date	Staff

ARTISAN AESTHETICS
PLASTIC SURGERY & LASER CENTER

REFERRAL/MARKETING CONSENT

Part I. We need to know who we can thank for bringing you to us. Please check one and be specific.

❑Doctor or Hospital:________________________________(Please Provide a name.)
❑Patient/ Friend or Family:___________________________(Please Provide a name)
❑Internet Search:___________________________(Which site?)
❑Magazine/Flyer: (please check one) **❑Neighborhood News ❑Osprey Observer**
❑Clipper Magazine ❑Tampa Bay Parenting Magazine ❑South Tampa Magazine
❑Inside Polk Magazine
❑Phonebook:_______________________________

Part II. Can we send you information on specials/events? Choose either the YES or NO option, fill out and sign. Thank You!

YES – Email or mail me information on discounts, specials and events. * Please note your information will be used by this office only.

PRINT NAME:____

PRINT E-MAIL:____

____________________________________ ____________________________
Signature **Date**

NO- Do not send me information on discounts or any other information.

PRINT NAME:____

____________________________________ ____________________________
Signature **Date**

FOR OFFICE USE ONLY –
CONTACT INFO ADDED TO LIST ON : ___________________________BY:_______________________