Dr. Castor, Artisan Aesthetics

ARTISAN AESTHETICS
PLASTIC SURGERY & LASER CENTER

Form Name: Patient Demographics

Last Name _____ First Name _____ ○ Female ○ Male Date _____

Date of Birth _____ Age _____ E-Mail _____

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 _____ Marital Status ○ Single ○ Married ○ Divorced ○ Widowed ○ Other

Personal Goals

My goals are to improve my appearance by: (i.e. Increase breast size) _____

I would describe the present condition(s) I wish to improve as: (i.e. Small breasts) _____

I HAVE THE FOLLOWING CONCERNS/INTERESTS

AGING APPEARANCE OF MY:

☐ Skin ☐ Face ☐ Eyes ☐ Lips and Mouth ☐ Neck ☐ Furrowed Brow ☐ Sad, Baggy, Puffy Eyelids ☐ Thin Lips
☐ Heavy Jowels ☐ Double Chin ☐ Facial Folds & Creases ☐ Fine Lines & Wrinkles ☐ Sun Damage ☐ Skin Tone
☐ Loss of Facial Fullness

FACIAL APPEARANCE / PROPORTION OF MY:

☐ Eyes ☐ Nose ☐ Ears ☐ Cheeks ☐ Lips ☐ Jaw ☐ Chin ☐ Other

BODY

☐ Arms ☐ Back ☐ Breast ☐ Upper / Lower Abdomin ☐ Buttocks ☐ Hips ☐ Inner / Outer Thighs ☐ Legs
☐ Excess Fat Deposit ☐ Exaggerated Curves ☐ Lack of Defined Curves ☐ Other

BREAST

☐ Size ☐ Shape ☐ Position, Sagging ☐ Symmetry Between Breasts ☐ Other

Other

☐ Facial / Leg Veins ☐ Irregular Scar(s) ☐ Moles, Lesions, or Other Growths ☐ Excess Body Hair ☐ Hair Loss

I HAVE HAD THE FOLLOWING TREATMENTS (Please list the exact type & year of the last treatment or series of treatments):

○ Cosmetic Surgery	List Type _____	List Year _____
○ Botox®Cosmetic, Dysport, Xeomin	List Type _____	List Year _____
○ Injected or implanted filler(s)	List Type _____	List Year _____
○ Skin Resurfacing (chemical peel, dermabrasion, laser resurfacing)	List Type _____	List Year _____
○ Light/Energy-based Treatments (i.e. IPL, Thermage, Laser)	List Type _____	List Year _____

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Form Name: General Health History 2 2022

General Health History

Height

Weight

Number of Children

Allergies

☐ Drugs ☐ Food ☐ Latex ☐ Environmental

What Drugs?

What Food?

Environmental Allergies?

I have had the following SURGERIES: (i.e. C-section, hysterectomy, appendix, gastric bypass, gastric sleeve, etc)

Problems with ANESTHESIA

I am presently under a DOCTOR'S CARE for the following medical conditions:

Current Medications

I would describe my PRESENT STATE OF HEALTH as

○ Fair ○ Good ○ Excellent

MEDICAL CONDITIONS

High Blood Pressure

○ Yes ○ No

Mitral Valve Prolapse

○ Yes ○ No

Heart Irregularity/palpitations

○ Yes ○ No

Easily Bruise

○ Yes ○ No

Pacemaker

○ Yes ○ No

Asthma

○ Yes ○ No

Reflux or GERD

○ Yes ○ No

Diabetes

○ Yes ○ No

Sleep Apnea

○ Yes ○ No

CPAP Used

○ Yes ○ No

Skin Cancer

○ Yes ○ No

History of HIV

○ Yes ○ No

Cancer

○ Yes ○ No

Cancer Type

Transplant

○ Yes ○ No

Transplant Type

Have you ever seen a cardiologist?

If yes, explain:

Testing done? Explain:

○ Yes ○ No

Have you ever used an inhaler

If yes, explain:

When was last use and why?

○ Yes ○ No

Have you ever been to the ER due to breathing difficulty, chest pain, or palpitations?

If yes, explain:

○ Yes ○ No

Do you use ANY NICOTINE PRODUCTS? This includes Vapor, Nicotine gum or lozenges, cigars, cigarettes?

○ Yes ○ No

Frequency of nicotine use:

Number of years

Do you take BLOOD THINNERS

○ Yes ○ No

Do you take ASPIRIN daily?

○ Yes ○ No

Do you take DIET PILLS? Either over-the-the counter or prescribed:

○ Yes ○ No

If yes, name of pills?

Do you use ALCOHOL?

○ Never ○ Daily ○ Socially

If so, how much?

WHOM MAY WE CONTACT IN AN EMERGENCY?

Name

Relationship

Telephone

Mobile

Address

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.

Print your full name and sign:

X

Ip Address

Dr. Castor, Artisan Aesthetics

Form Name: HIPAA FORM 1

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.

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Form Name: HIPAA 2

HIPAA Policies (Continued)

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

☐ Cell Phone	Cell Number	○ OK to leave a message with information ○ Leave message with call back number only
☐ Home Phone	Home Number	○ OK to leave a message with information ○ Leave message with call back number only
☐ Written Communication	Office Address	○ OK to mail to my home address ○ Please use office address
☐ Other		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 your full name and sign:

X _____ Ip Address

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Form Name: MARKETING CONSENT 2022

REFERRAL MARKETING CONSENT

Whom may we thank for bringing you to us? Please check all that apply and be specific.

Previous Patient: Friend or Family? Name:

Doctor or Hospital? Name:

Internet Search? Site Name:

PERMISSION TO CONTACT FOR SPECIALS OR EVENTS

Can we contact you about discounts, special offers, or events? Your information will not be shared with any other entity and is for our marketing use only.

- ○ YES! Let's stay in touch! Contact me for discounts, promotions, offers, and special events.
- ○ NO. I do not wish to be contacted for discounts, promotions, offers, or events.

If you answered YES, please print email address. If you answered NO, please just complete signature line.

Print your full name and sign:

X _____ Ip Address

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ARTISAN AESTHETICS
PLASTIC SURGERY & LASER CENTER

Form Name: PRACTICE FINANCIAL POLICY 2022

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. We are dedicated to providing you with the best possible care and service. We regard your understanding of our financial policy 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.

Please sign below acknowledging you have read, understand, and agree to the financial policies set forth.

SURGICAL PROCEDURES

***If you decide to book a surgical procedure, either local or general anesthesia, you must pay a *non-refundable* scheduling and booking fee of $500.00. This fee is deducted from the cost of the procedure. No surgery date can be held until the scheduling and booking fee is received.

***All surgeries must be paid in full *14 calendar days* prior to the date of your scheduled procedure unless you have made other arrangements with our staff. You may not make payments after the surgery date, unless you have made payment arrangements through one of the financing companies we participate with (CareCredit and Alphaeon.)

***Antibiotics, pain medications, scar creams, extra liposuction garments, extra bandages, or other supplies may be deemed necessary. If so, these are the financial responsibility of the patient.

***If needed, surgical touch-up procedures will be considered up to one year after surgery. This is at the discretion of the doctor. All "Touch-Ups" are subject to surgical, operating room, and anesthesia fees and are the responsibility of the patient.

***There are no refunds for any procedures, treatments, or products.

SURGICAL RESCHEDULING/CANCELLATION POLICY

*** Changing your surgery date within 30 days of the scheduled surgery date will incur a $500 Change Fee. Surgery cannot be rescheduled until that fee is received.

***Surgeries rescheduled more than one time will be subject to a $500 Change Fee.

***Change fees are non-refundable and do not go toward surgical fees. This is due to the "hard costs" of practice fees: time taken to reschedule multiple appointments, changes to other patient's surgeries to accomodate your change, and filling surgical spots where surgical staff, operating room and anesthesia have been reserved for your time.

***Booking and scheduling deposits are held for no longer than one year. Should you need to change your surgery, the deposit will remain in effect for one year from the date it was originally scheduled. If a surgery is pushed out beyond one year of the originally scheduled date, the fee for the surgery is subject to increase.

***Any cancellation of surgery will cause loss of the $500 scheduling and booking fee, as well as any Change Fees paid, *with no exceptions.* The scheduling and booking fee covers the following services rendered by the doctor and staff and the "hard costs" already incurred in booking the procedure: consultation fees, financial counseling, implant sizing, and pre-booked anesthesia and OR staff fees. The Change fees covers the "hard costs" mentioned above.

***Cancellation within 24 prior to surgery will result in a loss of all fees paid due to the reservation of the operating room, staff, supplies, anesthetist, and other fees incurred.

AESTHETIC PROCEDURES

***If you fail to show for your appointment or do not give 24 hours notice, you will be charged a $50.00 missed appointment fee. This fee is non-refundable and will not be applied to your overall procedure/ treatment cost.

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

PAYMENT OPTIONS

We offer multiple payment options for our patient's convenience. We accept all major credit cards; checks or cash.

PATIENT FINANCING: We can assist you in arranging patient financing through one of our approved credit services, www.carecredit.com or www.alphaeon.com for any surgical or aesthetic procedures. These plans offer convenient low monthly payment plans.

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

BY SIGNING THE FINANCIAL POLICY, I UNDERSTAND THAT I AM UNDER NO OBLIGATION TO SCHEDULE AN APPOINTMENT OR BOOK A PROCEDURE. I HAVE READ, UNDERSTAND, AND AGREE TO THE FINANCIAL POLICY OF THE PRACTICE.

Print your full name and sign:

X _____ Ip Address

Staff Signature_____