# ADLER • GILES PLASTIC AND COSMETIC SURGERY SPECIALISTS

**323 Osceola St.**
**Stuart, FL 34994**
**(772) 546-FACE (3223)**

**555 Biltmore Way, Ste. 103**
**Coral Gables, FL 33134**
**(786) 552-0027**

**Toll Free 1-877-220-1170**

## CONSULTATION AND MEDICAL HISTORY DATA

Name_____ SS#_____ Today's Date_____
Date of Birth_____
Age_____

Address: Home_____
street city state zip telephone #

Business_____
street city state zip telephone #

Marital Status: S, M, D, Sep., Widowed Spouse's Name_____

Your Occupation / Employer_____

Spouse's Occupation / Employer_____

How were you referred to us?_____

Names of family members who are our patients_____

Emergency Contact Person_____ Phone #_____

In which surgical procedure(s) are you interested?
Rhinoplasty (nose)_____ Chin_____ Face or Neck Lift_____ Eyelids_____ Skin Cancer_____
Chemical Peel_____ Dermabrasion_____ Laser_____ Scar Revision_____
Otoplasty (ears)_____ Removal of cysts, warts, moles, etc._____ Hair Transplantation_____
Suction Lipectomy_____ Other_____

What specifically do you wish to have corrected: (i.e. what don't you like about the above condition(s)?___
_____

Do you desire improvement in both appearance and function? YES NO

When did you begin to consider surgical correction?_____

Why have you decided to have it done at this time?_____

Have you consulted any other doctor about this? (When?)_____

Have you discussed this surgery with your family? YES NO
Are they agreeable? YES NO

Have you had any previous cosmetic, plastic or reconstructive surgery? YES NO
When and what if anything was done?_____

Who performed the surgery?_____ Where was it performed?_____

Were you satisfied with the results?_____ If not why?_____

Have you had any other surgery, or an injury, to the face, nose, or eyes?_____

Has anyone in your family or a close friend had cosmetic, plastic, or reconstructive surgery?_____

What was done?_____By Whom?_____

Have you had any other prior surgery?___What was done and when was it performed?_____
In the head and neck area_____On your skin_____
On your teeth and gums_____In your chest_____
Abdomen_____Reproductive system_____
On your back, arms, or legs_____Other_____

Were there any complications? YES NO Did you have a normal recovery? YES NO
Did the results meet your expectations? YES NO Please explain_____

NO YES Are you now taking any drugs or medications? (Strength and number of time per day)
Please list_____

NO YES Are you allergic to any medications, creams, tapes, makeup, etc._____

When was your last physical examination?_____
Who is your family doctor?_____City_____State____
Telephone number_____Please include area code if applicable.

NO YES Would you object to our contacting him/her for additional information pertaining to your health?

NO YES Have your ever received local anesthesia? (Novocaine, Lidocaine, etc.) by a dentist or doctor?

NO YES Did you have a reaction to any anesthetic? Explain_____

NO YES Are you considered a healthy person?_____

NO YES Do you take vitamins or herbal products? Please list all_____

Do you or any of your blood relatives have: (INDICATE WHO)
Heart trouble_____Excessive bleeding tendencies_____Psychiatric_____
High blood pressure_____Diabetes_____Thyroid problems_____
Excessive bruising_____Excessive scarring_____Delayed or poor healing_____

Do you have any history of bleeding (INDICATE WHICH)
From the nose_____In the urine_____Vomiting blood_____From the rectum_____Coughing up blood_____
Other_____

NO YES Do you have hay fever, nasal allergies, or asthma? Explain_____

NO YES Do you have or have you had any problems with your eyes or vision? Explain_____

NO YES Do you have frequent pains in the chest?_____

NO YES Has a doctor ever said you have or had "heart trouble"? Explain_____

NO YES Do you have or have you had "stomach trouble" or ulcers? Explain_____

NO YES Do you have or have you had chest or lung problems? Explain_____

NO YES Have you ever had liver, "gallbladder trouble" or "yellow jaundice"? (Circle which one)

NO YES Have you been bothered by kidney or bladder problems? Explain_____

NO YES Do you or any family members suffer from arthritis?_____

NO YES Do you experience poor circulation in your fingers or toes?_____

NO YES Do you have frequent skin infections, irritations, or rashes? (Circle which one)

NO YES Have you ever had fever blisters or cold sores or canker sores on your face, lips or in your mouth or genital herpes? (Circle which one)

NO YES Do you often have severe headaches or migraines or dizzy spells? (Circle which one)

NO YES Has any part of your body been paralyzed or numb? Explain_____

NO YES Did you ever have a convulsion or seizure? Explain_____

NO YES Have you ever received treatment for your genital area? Explain_____

NO YES Were you ever told you had a venereal disease or AIDS? Explain_____

NO YES Are you frequently sick or ill?_____

NO YES Do you worry about your health?_____

NO YES Were you ever treated for anemia or any problems with your blood? Explain_____

NO YES Have you ever taken hormones or thyroid medication? Explain_____

NO YES Do you smoke or have you ever smoked? Amount_____# of years____Quit_____

NO YES Do you drink more than six cups of coffee per day?_____

NO YES Do you usually take two or more alcoholic drinks a day?_____

NO YES Have you ever received treatment for abuse of alcohol or drugs? Explain_____

NO YES Do you often get depressed?_____

NO YES Do you usually feel unhappy or depressed?_____

NO YES Are you considered a nervous person?_____

NO YES Did you ever have a "nervous breakdown"? Explain_____

NO YES Have you ever received medical treatment for a "nervous breakdown"?_____

NO YES Are you easily upset or irritated?_____

NO YES Do you tend to hold a "grudge" when someone angers you?_____

NO YES Have you ever considered consulting a psychiatrist or psychologist? Explain_____

NO YES Have you ever been under the care of a psychiatrist or psychologist? Explain_____

Women only: When was your last menstrual period?_____

NO YES Are your periods often irregular?_____

NO YES Have you had "female" or GYN problems? Explain_____

NO YES Men only: Have you ever had prostate problems? Explain_____

NO YES Do you have any other medical problems that have not been covered? Explain_____

_____

_____

NO YES Do you accept the fact that every medical surgical treatment is associated with risks and other imponderables?

NO YES Do you give consent and authorize the recommended diagnostic, medical, surgical, anesthetic and other diagnostic services that the clinic deems beneficial while you are under their care?

*****I HAVE DISCLOSED ALL OF MY MEDICAL INFORMATION.*****

**ASSIGNMENT AND RELEASE**

I, the undersigned, certify that I (or my dependent) have coverage with _____ (name of insurance company) and assign directly to Adler•Giles Plastic and Cosmetic Surgery Specialists all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Adler•Giles Plastic and Cosmetic Surgery Specialists to release all information necessary to secure payment of benefits. We will gladly discuss your proposed treatment and answer any questions, to the best of our ability. You must realize, however, that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. Furthermore, not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We will file your insurance only once. If we do not receive a response in 45 days you will be responsible for payment and follow up with your carrier. We realize that temporary financial problems may affect timely payment on your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. I also understand that requests to bill attorneys will be denied. I authorize the use of this signature on all insurance submissions.

Signed:_____Date_____

Signed:_____Date_____
Stephen C. Adler, M.D. / P. Dudley Giles, M.D.

Revised: 11/22/04

# ADLER • GILES PLASTIC AND COSMETIC SURGERY SPECIALISTS
# AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION

Patient Name:_____

Date of Birth:_____ Medical Record #:_____

1. I authorize Adler • Giles Plastic and Cosmetic Surgery Specialists to disclose my health information specific to the following date or time period:_____
2. Individual or entity authorized to receive my health information:_____
   _____
   _____
3. Purpose for which disclosure is to be made:
   _____
4. Information to be disclosed:

| | | |
|---|---|---|
| ___ Practitioner Summary | ___ Emergency Room Report | ___ X-ray Records |
| ___ History & Physical Exam | ___ Laboratory Report | ___ Consultation |
| ___ Office Chart Notes | ___ Radiology Report | ___ Rx |
| | ___ Medical Clearance Report | |

   I understand that this will include health information relating to (check if applicable):

| | |
|---|---|
| ___ HIV (Human Immunodeficiency Virus) infection | ___ Mental Health |
| ___ Treatment for alcohol and/or drug abuse | ___ Genetic Testing |

5. Referring physicians will receive information on care provided following your visits or any other physician you designate. Designated Physician:_____
6. Our current policy is to call your home for appointment remainders and for follow up medical care. If you do not want us to call your home, please provide us with an alternate plan to contact you. Alternate plan:_____
   _____
7. I understand that if the person(s) or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations. Therefore, I release Adler • Giles Plastic and Cosmetic Surgery Specialists, its employees, and my physician(s) from all liability arising from this disclosure of my health information.
8. I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire in 90 days from the date signed below. I understand that I may revoke this authorization by notifying, in writing, the Medical Records Department, knowing that previously disclosed information would not be subject to my revocation request.
9. I understanding that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

_____ _____

Signature: Patient or Legal Representative Date Signature of Witness Date

---

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of this facility's health care operations. The Notice of Privacy Practices also describes my rights and the facility's duties with respect to my protected health information. The Notice of Privacy Practices is posted in the office of Adler • Giles Plastic and Cosmetic Surgery Specialists located at 323 Osceola St., Stuart, Florida, 34994.

_____ _____

Signature of Patient or Personal Representative Name of Patient or Personal Representative

_____ _____

Date Description of Personal Representative's Authority

Rev. 5/8/04

# ADLER•GILES PLASTIC AND COSMETIC SURGERY SPECIALISTS

## EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS

We will use your health information for treatment. For example: Information obtained by a practitioner or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. We may provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment. For example: A bill may be sent to your or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Business associates. There are some services provided in our organization through contacts with business associates. Examples include our billing service and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family. Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research. We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors. We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations. Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donations and transplant.

Marketing. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fundraising. We may contact you as part of fundraising efforts.

Food and Drug Administration (FDA). We may disclose to the FDA health information relative to adverse 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 Workers' Compensation or other similar programs established by law.

Public health. As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution. Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and safety of other individuals.

Law enforcement. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

**THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON APRIL 14, 2003.**

5/8/04

**ADLER FACIAL PLASTIC SURGERY, P.A.**
**323 Osceola Street**
**Stuart, Florida 34994**
**(772) 546-FACE (3223)**

# PLEASE READ CAREFULLY
# AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean: _____.
"Physician" shall be understood to mean: **Dr. Stephen C. Adler, M.D., and Adler Facial Plastic Surgery, P.A.**

I understand that I am entering into a contractual relationship with the physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly any meritless or frivolous claims of medical malpractice against the Physician.

Should I, initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS).

I agree the expert will be obligated to adhere to the guidelines or code of conduct defined by the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS).

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

_____ _____
Physician Patient/Guardian

_____ _____
Effective from Date of Treatment Date of Signature