FARAHMAND
PLASTIC SURGERY

(239) 332-2388
Fax (239) 332-2382
12411 Brantley Commons Ct.
Fort Myers, FL 33907
www.farahmandplasticsurgery.com

Confidential Record: Information combined here will not be released except when you have authorized us to do so. Please answer all the questions to the best of your knowledge. Dr. Farahmand will use the information you provide in her decision regarding your care.

Patient's Name: _____ Today's Date: _____

HEALTH HISTORY

Have you ever had or Do you currently have?	YES	NO	Notes	Have you ever had or Do you currently have?	YES	NO	NOTES
High Blood Pressure				Shortness Of Breath			
Diabetes				Sleep Apnea			
Epilepsy				Bronchitis/ Chronic Cough			
Thyroid Disease				Swelling of Ankles			
Asthma				Dizzy Spells/Fainting			
Cancer				Jaundice			
Rheumatic Fever				Liver Failure			
Hepatitis				Difficulty Breathing			
HIV or AIDS				Arthritis			
Heart Disease				Rheumatoid Arthritis			
Damaged Heart Valve				Joint Pain			
Heart Murmur				Blood Disorders, Anemia			
Chest Pain, Angina				Stomach Ulcers			
Heart Attack				Chronic Fatigue			
Irregular Heart Beat				Chemotherapy			
Cardiac Pacemaker Or Defibrillator				Implants: Joints, Dental			
				Mental Health Problems			
Congestive Heart Failure				Kidney Trouble			
				Stroke			
When Climbing a flight of stairs, do you get short of breath?				Hay Fever			
				Sinus Problems			
				Blood Transfusions			

Past Surgical – Anesthesia History: *mark all that apply.* ***If none apply initial here:_____***

□ Family History of Unexpected Death(s) following General Anesthesia or Exercise
□ Family or Personal History of MH (Malignant Hyperthermia)
□ Muscle or Neuromuscular Disorder
□ High Temperature following Exercise
□ Personal History of Muscle Spasm, Dark or Chocolate Colored Urine
□ Unanticipated Fever Immediately Following Anesthesia or Serious Exercise
□ Personal or Family History of Bleeding Problems

Do you take:	YES	NO	Notes:
Vitamin E:			
Blood Thinners			
Heart Medications			
Diuretics(water Pills)			
Aspirin			
Adderall			
Ritalin			
High Blood Pressure Medication			
Any Kind of Stimulants:			

Patient's Name: _____ **Today's Date:** _____

HEALTH HISTORY CONTINUATION

DRUG OR LATEX ALLERGIES	YES	NO	NOTES (REACTION)
PENICILLIN			
NOVOCAINE			
SULFA			
LATEX			
OTHER DRUGS (List):			

Do you Smoke? □ NO □ YES,

How many packs per day?_____ How many years?_____

Are you exposed to smoke? _____ Are you using any Nicotine Products? (I.e. Patches) _____

Do you Vape?_____ Do you use recreational drugs? (I.e. CBD oil) _____

Do you use any Marijuana (CBD, THC, etc.) products for any purpose? □ NO □ YES, How often?_____

Do you drink alcohol? □ NO □ YES, How much daily?_____

Medications: *(include all Prescriptive, Over-The-Counter, Vitamins and Herbal Medications taken regularly)*

_____

_____

_____

_____

Do you Take or Have Taken Steroids? (List) _____

List Any Medical Problems not previously mentioned:

_____

_____

Previous Surgeries with Dates: (Cosmetic and non-cosmetic)

_____

_____

Height:_____ **Weight:** _____ **Date of Last Physical:**_____

Primary Physician: _____ Phone: _____
First and Last Name

Cardiologist: _____ Phone: _____
First and Last Name

Do you have a Living will?_____ A Health Care surrogate and/or power of attorney?_____

Are you currently under Psychiatric Care?_____ Do you have a Psychiatric Diagnosis?_____

Have you ever or are you currently taking medication for psychiatric diagnosis? (List)_____

By Signing Below, I agree that the above information is complete, and accurate to the best of my knowledge.

Patient's Signature:_____ **Date:**_____

Reviewed By: _____ **Date:**_____

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Patient Registration Form

Today's Date:_____

Patient's Name:_____
First Middle Last

Date of Birth_____Age:_____SS#_____

Address_____
Street & Apt. # City State Zip

Phone: Home_____Cell Phone_____Other_____

Any restrictions for contacting you? ☐NO ☐YES Contact Restrictions:_____

Email _____

Marital Status: ☐Single ☐Married to:_____ ☐Divorced ☐ Widowed

Patient's Employer:_____Occupation:_____

Work Phone:_____is it okay to call you at work? ☐YES ☐NO

Work Address: _____
Street & Apt. # City State Zip

How did you hear about Farahmand Plastic Surgery?

☐ Email ☐ Internet/Google ☐Seminar ☐Friend/ Relative_____

☐Doctor_____ ☐Other_____

Type of Procedure(s) you are interested in?_____

_____

_____

Emergency Contact:

Name: _____Relationship to Patient:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Parent/Guardian's name and place of employment if patient is a minor_____

_____

PATIENT SIGNATURE: _____**DATE:**_____

Cosmetic Financial Policy

Patient's Name:_____ **Date of Birth:**_____

This document is designed to inform our patients and families of our expectations for payment. Patients who schedule cosmetic surgery will be required to pay a **non-refundable $1,000 deposit of surgery cost** due at the time surgery is scheduled. This deposit will not be refunded if the patient cancels surgery for any reason. **ALL surgeries** must be paid in full by the Pre Op appointment or two weeks before surgery date, whichever comes first. If a patient cancels surgery the week of scheduled surgery day, NONE of the Surgical Fee will be refunded.

*Methods of payment accepted for both the non-refundable deposit and the balance for surgeries are Visa, Master Card, American Express, Discover, Cash and Cashier's Checks made payable to "Farahmand Plastic Surgery"

**When paying the balance for a surgery with Cashier's Check it must be presented to us a minimum of two weeks before scheduled surgery.

***Care Credit may be used to pay for a procedure in it's entirety or for the balance due. We DO NOT accept Care Credit for any Surgery Non-Refundable Deposits.

For patients receiving in office procedures such as facial fillers, Botox, Dysport, Xeomin and/or Chemical Peels our office expects payment in full at the time of service. For "In Office Procedures" we accept Visa, Master Card, American Express, Discover and Cash or Cashier's Check.

****NO PERSONAL OR THIRD PARTY CHECKS ACCEPTED FOR ANY SERVICES**

****ALL SALES** ARE CONSIDERED **FINAL**, **NO REFUNDS**.

Patient Signature_____

Relationship to Patient (circle) SELF GUARDIAN REPRESENTATIVE OTHER:_____

Date_____

Employee Signature_____

Farahmand Plastic Surgery
12411 Brantley Commons Court
Fort Myers, Florida 33907
(239)332-2388 office (239)332-2382 fax

FARAHMAND PLASTIC SURGERY
CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient's Name:_____ **Date of Birth:**_____

Please CHECK ONE of the Following:

_____I GIVE my permission to the employees of Farahmand Plastic Surgery to disclose my protected health information to me AND the following family or friends:

NAME:_____ RELATION:_____
NAME:_____ RELATION:_____
NAME:_____ RELATION:_____
NAME:_____ RELATION:_____
NAME:_____ RELATION:_____

_____I request that all my Protected Health Information be disclosed ONLY to me and no other friends or family.

WHAT TYPE OF MESSAGE MAY WE LEAVE FOR YOU?

In an effort to serve you better Farahmand Plastic Surgery would like to know what type of message we may leave on your answering machine/voicemail when contacting you. It is the policy of Farahmand Plastic Surgery to call you at any phone number you provided to us. When we contact you by calling you at any phone number you have provided us:

→ MAY WE LEAVE A DETAILED MESSAGE ON YOUR ANSWERING MACHINE/VOICEMAIL? YES or NO

If no, we will leave a message with just enough information for you to call us back.

***Please Note: We will ALWAYS leave a detailed message on your answering machine, voicemail or with anyone who answer your phone when we are contacting you to remind you of an appointment at our office.

I understand that I may revoke or change this authorization at any time by filling out another "consent to Disclose Medical Information" form. I understand that I will not be denied or refused treatment if I refuse to sign this authorization. I understand that the information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by Federal and State Privacy Laws. I understand that I have a right to receive a copy of this authorization if I request one. I also understand that this information will not expire.

_____ _____
Signature of Patient or Personal Representative **Date**

_____ _____
***Printed name if not signed by Patient** ***Relationship/authority to Act on behalf of Patient**

*if not signed by the patient you must provide FPS with a copy of the document of authority that makes you the patient's personal representative (i.e Health Care Power of Attorney, Health Care Surrogate, Health Care Proxy, Guardian, etc). We also need a copy of your driver license.

_____
FPS Use Only: Please post the above information in the patient's coded/sticky notes.
Posted by : _____

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PROTECTED HEALTH INFORMATION CONSENT

Audrey E. Farahmand MD

Patient's Name:_____ Date of Birth:_____

I consent to the use or disclosure of my protected health information by **Farahmand Plastic Surgery** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Farahmand Plastic Surgery**'s practice.

I understand that diagnosis or treatment of me by **Farahmand Plastic Surgery** may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have a right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations. Dr. Farahmand is not required to agree to the restrictions that I may request. However, if Dr. Farahmand agrees to a restriction that I request, the restriction is binding on Dr. Farahmand's practice and on Dr. Farahmand.

I have the right to revoke the Consent, in writing, at any time, except to the extent that Dr. Farahmand's practice has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Farahmand Plastic Surgery's** Notice of Privacy Practices prior to signing this document.

Farahmand Plastic Surgery's Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices for the **Farahmand Plastic Surgery** practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performances of Dr. Farahmand health care operations.

A summary of the Notice of Privacy Practices for **Farahmand Plastic Surgery** is also posted in the waiting room.

This Notice of Privacy Practices also describes my rights and the duties of the **Farahmand Plastic Surgery** practice with respect to my protected health information.

Farahmand Plastic Surgery reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by contacting Dr. Farahmand's office at 12411 Brantley Commons Ct, Fort Myers , Florida 33907 or call (239) 332-2388.

_____ _____

Signature of Patient or Representative **Date**

_____ _____

Employee Signature Date

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AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Patient's Name:_____ **Date of Birth:**_____

I authorize Audrey Farahmand M.D. to disclose complete medical information concerning her findings, starting with the initial office visit until the date of the conclusion of her treatment (s).

I authorize Audrey Farahmand M.D. to disclose this information to those individuals who (in her sole determination) are required to receive such information; for purpose of medical treatment, medical quality assurance and peer review.

Date	**Patient's Signature**
Date	Employee Signature

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Patient Privacy Notice

Patient's Name:_____ **Date of Birth:**_____

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We may require your written consent before we use or disclose to others your medical information for purposes of providing or arranging your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting you treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice form time to time. The effective date at the top of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns, or complaints about the Notice or your medical information, please contact our office Privacy Officer at (239) 332-2388

Patient Initial Here:_____

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HIPAA email and text message consent

Patient's Name:_____ Date of Birth:_____

VERY IMPORTANT! PLEASE READ!

- HIPPA stands for *Health Insurance Portability and Accountability Act*
- HIPPA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers **is** encrypted
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email
- Most popular cell phone services do not utilize encrypted text messages.
- **When we send you an email and/or text message, or you send us an email and/or text message, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since the information is transmitted over the Internet for emails and over satellite for text messages. In addition, once the email and/or text message is received by you, someone may be able to access your email account and/or cell phone account and read the message(s)**.
- Email and texting is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPPA act, the federal government provided guidance on email, texting and HIPPA
- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website – http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01075.pdf
- The guidelines state that if a patient has been made aware of the risks of unencrypted email and/or text messaging, and that same patient provides consent to receive health information via email and/or text, then a health entity may send that patient personal medical information via unencrypted email and/or unencrypted text message.

ALLOW UNENCRYPTED EMAIL -or- DO NOT ALLOW UNENCRYPTED EMAIL

******************** Check the appropriate box below, sign and date********************

☐ I understand the risks of unencrypted email and do hereby give permission to Farahmand Plastic Surgery to send me personal health information, **Monthly specials** via unencrypted email.

☐ I do not wish to receive personal health information or Monthly Specials via email.

_____ _____

Signature **Date** Employee signature/Date

_____

E-mail Address

ALLOW UNENCRYPTED TEXT MESSAGING -or- DO NOT ALLOW UNENCRYPTED TEXT MESSAGING

******************** Check the appropriate box below, sign and date********************

☐ I understand the risks of unencrypted text messages and do hereby give permission to Farahmand Plastic Surgery to send me personal health information via unencrypted **text messages**

☐ I do not wish to receive personal health information via text messages .

_____ _____

Signature **Date** Employee Signature /Date

_____

Cell Phone Number

FARAHMAND
PLASTIC SURGERY

AUTHORIZATION TO DISCLOSE PROTEDTED HEALTH INFORMATION SPECIFICALLY PHOTOGRAPHS/FILMS/VIDEOS

Patient's Name:_____ **Date of Birth:**_____

Farahmand Plastic Surgery may disclose protected health information in the form of photographs, films, and/or videos from the records of the above named patient.

The reason(s) for this authorization (check all that apply):
□ Education of other patients or physicians
□ The physician requests the information for marketing purposes
□ Other (specific each purpose) _____

Initial One:

_____ I AGREE and authorize the above-mentioned physician to place my photo, film, or video on his/her professional Web Site.

_____ I DO NOT authorize the use of these photos, film or Video on any Web site.

Initial All: (If Authorized)

_____ I understand that the images will not be identified by name but that such photographs, videotapes, computer images, and/or internet images may reveal my identity. I accept this loss of anonymity.

_____ I understand that I have the right to revoke this authorization, ***in writing***, at any time by sending such written notification to the practice at *12411 Brantley Commons Ct. Fort Myers, FL 33907*.

_____ I understand that a revocation is not effective to the extent that my physician has already disclosed the health information.

_____ I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment)

_____ I understand that information released by this authorization in order to be disclosed by the recipient and may no longer be protected by federal and state law.

_____ I further understand that photographs placed on the Internet become part of the public domain and may be modified or used for unintended or unanticipated purposes including for commercial gain.

_____ I understand this authorization ends:

☐ On (Date): no expiration date

_____ _____

Patient Signature Date/Time **Witness Signature Date/Time**

_____

Physician Signature Date/Time

_____ Copy given to patient/legal representative _____ Original Placed in chart

TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

Patient's Name:_____

Initials

_____ I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

_____ I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of FLORIDA at the time of this service.

_____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

_____ I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

_____ I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____ I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

For electronic communication between **DR. Audrey Farahmand** and staff and_____ .

(Healthcare provider's name) *(Patient's name)*

_____ _____

Patient or Legal Representative Signature/Date/Time Relationship to Patient

_____ _____

Print Patient or Legal Representative Name Witness Signature/Date/Time

I certify that I have explained the nature of this agreement to the patient/patient's legal representative. I have answered all questions fully, and I believe that the *patient/legal representative (circle one)* fully understands what I have explained.

_____

Healthcare Provider Signature/Date/Time

_____ copy given to patient _____ original placed in chart

initial initial

Optional National Emergency Crisis Language

I understand that due to the state of the current national emergency crisis, telehealth is offered by Dr. Audrey Farahmand to appropriate patients in an effort to comply with federal and state mandates of isolation and social distancing as an effort to provide protection to everyone.

The purpose of this form is to obtain your consent for a telehealth visit with one of our healthcare providers at the office of FARAHMAND PLASTIC SURGERY.

The purpose of this visit is for the care of_____ during the national emergency.

Condition/Treatment

J12355 3/20

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS, and accreditation requirements, if any, and legal requirements of your individual state(s).