Patient Information

Date ___________________

Patient Name ____ Date of Birth ____________________

Address ____ Social Security # ___________________

City ____________________________________ State ________ Zip ___________ Gender [ ] Female [ ] Male [ ] MTF [ ] FTM

Marital Status [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Other

Name of Spouse ____ Consent to speak with spouse _________________

How did you hear about us? (*please be specific*) ____
(Internet search, newspaper ad/ flier, patient referral, etc.)

Your Occupation ____________________________________ **Employer** ____

Address ____ City ________________________________ State _____ Zip __________

Emergency Contact ____ **Relation** ______________________ **Phone** _____________________

Contact Information & Privacy Instructions:

		OK to phone	OK to leave messages
Cell Phone	(____) ____________________	[ ]	[ ]
Work Phone	(____) ____________________	[ ]	[ ]
Email	____		

Pharmacy: ______________________ Address: ________________________________ Phone: ______________________

[ ] Yes [ ] No Can a message be left with Ablavsky Plastic Surgery name and what the call is in reference to?

[ ] Yes [ ] No Is there anyone you would like to authorize to schedule, confirm or change appointments?

Name __________________________________ Relation ______________________

Reason for today's surgical consultation:

[ ] Arm Lift [ ] Botox/ Juvederm [ ] Breast Aug [ ] Breast Lift [ ] Breast Reduction, current bra size _________, desired bra size _________

[ ] Remove / Replace Implants[ ] Facelift [ ] Necklift [ ] Eyelid Lift [ ] Explant [ ] Lip Enhancement [ ] Rhinoplasty [ ] Otoplasty

[ ] Tummy Tuck [ ] Thigh Lift [ ] Gluteal Lift [ ] Other _____________________________

[ ] Liposuction (specify areas) ____

I, _____________________________, represent to the physician and staff that I am 18 years of age or older. If not, I am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor or accredited medical personnel Dr. Ablavsky may assign.
I have been provided a copy of Ablavsky Plastic Surgery's Notice of Privacy Practices. I understand my rights as a patient under the HIPAA Act. I understand my rights to access and control my health information. I understand that I may be contacted by employees of Ablavsky Plastic Surgery to remind me of appointments, healthcare treatment options, or other health service issues. I have selected and given permission for the contact options checked above.

Patient Signature ____ Date ______________________

Medical History

Patient Name ____ Date ________________________

Age ___________ Height _________ Weight ___________ lbs. Temp _________

Allergies ____

Have you ever had a problem or reaction with any of the following?
[ ] Local Anesthetics [ ] Adhesive Tape [ ] Antibiotics [ ] Pain Killers [ ] Iodine [ ] Latex

Medications Name of Medication Dosage Frequency
____
____
____

Have you taken any of the following in the last 6 months?
[ ] Steroids [ ] Aspirin/ Advil [ ] Blood Thinners [ ] High Blood Pressure

Tobacco History [ ] Cigarettes [ ] Cigar [ ] Pipe [ ] Chew [ ] Vape # of Years using ________ Packs/ day ________ Year Quit _______

Have you had any of the following medical conditions in the past 5 years? (Please check all that apply)

[ ] Diabetes [ ] Heart Trouble [ ] Chest Pain [ ] Rheumatic Fever [ ] Nervous Breakdown

[ ] Angina [ ] Stroke [ ] Asthma [ ] Hepatitis [ ] High Blood Pressure

[ ] Liver Disease [ ] Jaundice [ ] Kidney Disease [ ] Tuberculosis [ ] Blood Transfusion

[ ] Epilepsy [ ] AIDS/HIV [ ] Emphysema [ ] Black Stools [ ] Blood in Urine

[ ] Psychiatric Care [ ] Cancer (list type) ____

Medical History Are there any other medical conditions or medical history not listed above? (Please explain) ___________________
____
____

Have you or a family member had a reaction to anesthesia? [ ] Yes [ ] No
Have you or a family member had abnormal bleeding from surgery? [ ] Yes [ ] No

Surgical History: Year ____________ Type of Surgery ____
____
____

Hospitalizations: Year ___________ Reason for Hospitalization ____
____
____

Family Physician ____ **Date of last check up** ____________________

For Women Only **Date of your last period** __________________________ **Date of last mammogram** ____________________

Are you pregnant? [ ] Yes [ ] No # of Children __________ # of Births ____________

Family history of breast cancer? [ ] Yes [ ] No

Request for Medical Records

Patient Name: ____ DOB _________________

I, ______________________________________ (Patient or Legal Guardian) hereby authorize the following person/ office to release and disclose information to **Ablavsky Plastic Surgery**.

Company Name ____ Phone ______________________________

Attention: Medical Records Fax ________________________________

Address ____

City __________________________________ State ________ Zip _____________

Information to be Requested:

[ ] Entire Medical Record [ ] Progress Notes [ ] Laboratory Results [ ] Diagnostic Work

[ ] History / Physical Exam [ ] Medication List [ ] EKG [ ] List of Allergies

[ ] Insurance Information [ ] Photos [ ] Non- Surgical Procedures [ ] All Surgeries

[ ] Surgeries from ______________________ to __________________________

Send records to: **Ablavsky Plastic Surgery** 19222 Stone Hue, Ste. 104 San Antonio, TX 78258 Phone 210-942-6672 Fax 210-664-3966

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164-524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Facility Privacy Officer.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV) and Hepatitis B Virus. It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse. ______________ patient initials.

If medication information is being released directly to myself (patient), I understand that it may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Ablavsky Plastic Surgery or my physician, staff or agents of Ablavsky Plastic Surgery liable for any misinterpretation in my medical record as a result of not consulting my physician for the correct interpretation. ___________ patient initials.

I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patient is prohibited. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the organization or individual releasing the information on behalf of the facility. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under a policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _______________________________. If I fail to specify, this authorization will expire in one (1) year. __________ patient initials

Patient Signature ____ Date _____________________

Witness Signature ____ Date _____________________

Surgery Cancellation Policy

Patient Name ____ DOB ______________________

As cosmetic procedures are elective, it is important for patients to make financial arrangements prior to scheduling surgery. Full payment is required in advance, or your surgery will be canceled. If I choose to review my experience or there is a financial dispute, I waive my right to privacy under the HIPAA Act of 1996.

If you are electing to finance your procedure through an independent finance company such as a personal loan with your bank or Alphaeon Credit. Please be aware that the relation is directly with you. Although payments are to be paid directly to our office, balances must still be paid in full by your finance company prior to your surgery. You have a responsibility to ensure that all required paperwork requested by your finance company is completed in a timely way, and to ensure that payments have been made to our office on time.

We require a $500.00 deposit when your surgery is scheduled.

This payment is **non-refundable** and covers the administrative costs of scheduling. It is, however, considered a part of your overall fee and is not an additional expense. The $500.00 deposit is good for seven (7) months from the day it is paid or is forfeited and must be repaid if surgery is rescheduled.

The balance of your total surgery fee is due two (2) weeks prior to surgery.
Balance is payable by cash, cashier's checks, or credit card ONLY (cardholder must be present with a valid ID). We DO NOT accept personal checks or credit card checks.

If you should cancel your surgery after payments have been made: ________ patient initials

After deposit has been paid	you forfeit the $500 deposit
After paid in FULL and Pre-Op completed	you forfeit the $500 deposit PLUS 50% of the total surgical fee
Within 48 hours of your surgery	you forfeit the FULL AMOUNT

The fees for rescheduling your surgery are as follows: _________ patient initials

1 week prior	20% of the total surgical fee
72 hours prior	30% of the total surgical fee

NO REFUND of Surgical Fees will be given. Only **RESCHEDULING** the procedure is permitted

This agreement does not obligate me to schedule a surgery but does certify that I understand and accept the above pricing and cancellation policy for procedures at Ablavsky Plastic Surgery.

Patient Signature ____ Date ___________________

Witness Signature ____

**AUTHORIZATION FOR USE OF PHOTOGRAPHS
ON THE INTERNET AND/ OR PHOTO ALBUM**

The use of photographs is essential to the planning and evaluation of cosmetic or reconstructive surgery. Your surgery has been photographically documented before, possibly during and now after the procedure. These photographs are a permanent part of your medical record and will never be shown to anyone else without your consent. For various reasons, Michael Ablavsky, M.D., is often asked to show before and after photos of patients. Many patients, happy with their results, have given permission to use their photos anonymously. We now ask that you do so as well. Please consider the following circumstances and either authorize or deny use of your photos for each situation.

Name: ____

Procedures that you have had (will have) done:

1. ____
2. ____

"I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/ or certifying purposes by the American Board of Plastic Surgery, Inc" I recognize that prospective patients, such as myself, will ask to look at before and after photographs (slides) in the process of a surgeon and evaluating specific procedures. I authorize the anonymous use of photographs (slides) for this purpose by Michael Ablavsky, M.D.

Procedure 1: Yes No Procedure 2: Yes No

I authorize the anonymous use of my photographs (slides) by Michael Ablavsky, M.D. in seminars, health fairs and conferences for interested and prospective patients.

Procedure 1: Yes No Procedure 2: Yes No

I authorize the anonymous use of my photographs in articles written by Michael Ablavsky, M.D. for publication in medical journals so long as I am notified in writing of such use prior to the publication.

Procedure 1: Yes No Procedure 2: Yes No

I authorize the anonymous use of my photographs in articles written by Michael Ablavsky, M.D. for publication in magazines and newspapers so long as I am notified in writing of such use prior to publication.

Procedure 1: Yes No Procedure 2: Yes No

I authorize the anonymous use of my photographs (slides) in television of Michael Ablavsky, M.D. or programs produced for cable TV so long as I am notified in writing of such use prior to production.

Procedure 1: Yes No Procedure 2: Yes No

I authorize the anonymous use of my photographs by Michael Ablavsky, M.D. on the internet so long as I am notified in writing of such use prior to production.

Procedure 1: Yes No Procedure 2: Yes No

I understand that every attempt will be made to represent me and Michael Ablavsky, M.D. accurately and with integrity and dignity in all media. I hereby certify that I have read the foregoing and fully understand its meaning and effect.

Patient Signature ____ Date ___________________________