Campanile Plastic Surgery

425 S. Cherry Street #321
Denver, CO 80246
PH 303-345-7476

Patient Name _____ _____ _____
First Middle Last

Birthdate ___/___/___ Gender: M/F SSN _____ HT. _____ WT. _____

Address _____ _____ _____ _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail _____ ☐ **Please check if you would like to be removed from our mailing list**.

Any restrictions for contacting you? ☐ No ☐ Yes Contact Restrictions: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Partner ☐ Other_____

How did you hear about Campanile Plastic Surgery? (Mark all that apply)

☐ www.CampanilePlasticSurgery.com ☐ www.Google.com ☐ Web: www. _____

☐ Friend/Relative, Please name_____ ☐ Doctor, Please name_____

☐ Other _____ If you were referred by a specific person, may we thank them? ☐ Yes ☐ No

Personal Background Employer/ School:_____ Occupation: _____

Primary Care Physician: _____ Phone Number: _____

Responsible Party or Emergency Contact

Full Name _____ Relationship to Patient _____ Birthdate ___/___/___

Address ___/___/_____ _____ _____ _____
Street & Apt # City State

Home Phone _____ Work/Cell Phone _____

Insurance Information

Primary Ins Name _____ Name of Insured _____

Date of Birth of Insured ___/___/___ SSN of Insured _____ Relationship to Patient _____

Secondary Ins Name & Information _____

Pharmacy Information

Pharmacy Name _____ Pharmacy Location _____ Phone _____

I, _____, authorize payment of Medical Benefits to Campanile Plastic Surgery, LLC and agree to release information necessary for processing. I agree to be responsible for payment of services and resonable costs of collection.
(print name)

I, _____, authorize the release of my Medical Records to Campanile Plastic Surgery, LLC.
(print name)

Signature of Patient: _____ Date: _____

Medical History Record

Reason for visit (chief complaint) _____

If symptoms present, explain & state when they first appeared _____

Past History:

Previous surgeries & dates: _____

_____

Previous anesthetic/surgical problem: _____

General Medical History (please circle YES or NO):

Yes / No - high blood pressure
Yes / No - heart disease or attack
Yes / No - chest pain or shortness of breath
Yes / No - stroke
Yes / No - asthma
Yes / No - glaucoma, double vision, eye pain
Yes / No - history of deep venous thrombosis(blood clot)
Yes / No - depression, anxiety, mood swings, loss of appetite
Yes / No - back pain, joint pain/swelling, numbness of arms or legs
Yes / No - easy bruising, swollen lymph glands
Yes / No - herpes or cold sores
Yes / No - fainting or blackout episodes
Yes / No - ulcer disease or abdominal problems
Yes / No - hepatitis if so, please circle A B or C
Yes / No - HIV or AIDS
Yes / No - diabetes
Yes / No - other significant illness (kidney, thyroid, seizures) If so, describe_____
Yes / No - leg swelling
Yes / No - excessive thirst or hunger
Yes / No - seizures, loss of balance, slurred speech
Yes / No - Have you taken ibuprofen, aspirin, or blood thinning agents in the past two weeks? (Avoid for two weeks before and after surgery)
Yes / No - Do you have prolonged bleeding when cut? (e.g. Hemophilia) if yes, explain:_____
Yes / No - Have you formed excessive or unsatisfactory scars in the past? Keloids?
Yes / No - Have you ever received treatment for a mental condition, emotional problem or depression? If yes, explain:_____

Dominant Hand: Left or Right

Current Medications (list all including aspirin, birth control, vitamins and/or supplements):

Medications	Dose/Strength	Frequency taken

Allergies: (please list any and all) _____

Family History: (Circle YES or NO)

Yes / No - Any anesthetic problems _____
Yes / No - High Blood Pressure _____
Yes / No - Diabetes _____
Yes / No - Any bleeding problems _____
Yes / No - Hepatitis _____
Yes / No - Heart Attack _____
Yes / No - Cancer (skin) _____
Yes / No - Other cancers (type) _____
Yes / No - Psychiatric disorders _____
Other:_____

Social History: (Circle YES or NO)

Yes / No - Do you smoke? If yes, _____packs per day
Yes / No - Did you ever smoke? If yes, _____years ago
Yes / No - Do you drink alcohol? If yes, _____drinks per day, or ☐ Occasional
Have you taken steroids within the past year? ☐ Yes ☐ No

Do you, or have you, ever used any drugs for recreational purposes? (may interact with some anesthetics) ☐ YES ☐ NO
If yes, Which ones:_____

Any Additional information not listed on this form:_____

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. Campanile and/or any member of his staff.

Signature of Patient: _____ **Date:** _____

Cosmetic Concerns

I have the following concerns/interests:

Aging appearance of my:
☐ Skin
☐ Face
☐ Eyes
☐ Lips and mouth
☐ Facial folds and creases
☐ Fine lines and wrinkles
☐ Sun damage
☐ Skin tone

Breast:
☐ Size
☐ Shape
☐ Position
☐ Sagging
☐ Lack symmetry between my breasts

Body:
☐ Arms
☐ Back
☐ Breast
☐ Upper Abdomen
☐ Lower Abdomen
☐ Buttocks
☐ Hips
☐ Inner Thighs
☐ Outer Thighs
☐ Legs
☐ Excess Fat Deposits
☐ Exaggerated curves
☐ Lack of defined curves

Facial appearance/proportion of my:
☐ Eyes
☐ Chin
☐ Ears
☐ Cheeks
☐ Lips
☐ Jaw

Other:
☐ Facial/Body spider Veins
☐ Irregular Scars
☐ Moles, lesions or other growths
☐ _____

I am here today because I:_____

My goals are to improve my appearance by :_____

I would describe the present condition(s) I wish to improve as:_____

Have you ever had any of the following treatments?

☐ Botox ☐ Filler Injections(Radiesse, Restylane, Juvederm) ☐ IPL ☐ Laser resurfacing ☐ Thermage ☐ Vein Treatments

☐ Microdermabrasion ☐ Lip Enhancement ☐ Laser Hair removal ☐ Peels ☐ Acne Treatments ☐ Other:_____

I use the following daily skincare (prescriptive, physician-based or over the counter):_____

Have you ever had a consultation with a plastic surgeon? ☐ Yes ☐ No If yes, please explain

_____

_____

Is there anything you wish to tell Dr. Campanile that you do not wish to include on this form? ☐ Yes ☐ No

Cosmetic Patient Financial Policy

We consider it a privilege that you have chosen to come to Campanile Plastic Surgery for your cosmetic needs. We completely believe that an informed patient is a good patient. We strive to inform you of all the medical aspects of your needs and also would like to advise you of our financial policy.

To secure a surgery date, a non-refundable 10% surgical booking fee is necessary.

If a surgery is cancelled within 14 days of the procedure, 25% of the total surgical fee is retained, unless an agreement is mutually achieved.

If a surgery is cancelled within 7 days of the procedure, 100% of the total surgical fee is retained, unless an agreement is mutually achieved.

All balances for surgery are collected at the pre-operative appointment; generally pre-operative appointments are scheduled 2 weeks prior to surgery.

Every effort is made to maintain the predicted operating room and anesthesia hours. However results are NEVER compromised for time. In the rare occasions that the surgery outruns the predicted time, you may be billed for additional anesthesia and/or surgical facility expenses.

Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 48 hours prior to the appointment. We reserve the right to charge for missed or late-cancelled appointments. Excessive abuse of scheduled appointments may result in mandatory and non-refundable prepayment to schedule a visit or we may choose to discharge you from this practice. Three consecutive missed appointments are considered excessive abuse.

There is a $50 fee for any moneys returned or disputed by the bank. We do not accept personal checks for any services rendered at Campanile Plastic Surgery.

You understand that payment for procedures that are aesthetic or cosmetic in nature are my sole responsibility and will not be billed to any third party. You understand that payment for such procedures may be requested in advance of any treatment. You understand there are no warrantees, implied or otherwise, to the outcomes of any treatments or procedure.

You understand that if this account is submitted to a collection agency or attorney, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

At Campanile Plastic Surgery we accept:

Cash
Cashier Checks
MasterCard
Visa
American Express
Care Credit

Patient Signature:_____

Patient Print:_____

Date: _____

Campanile Plastic Surgery
425 South Cherry St, Suite 321 Denver, CO 80246
P: (303) 345-7476 F: (303) 536-3324

NOTICE OF PRIVACY PRACTICES

Effective September 20th, 2013

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. If you have any questions about this Notice please contact our Privacy Officer who is Erin Casey.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health 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 protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by writing a letter to our Privacy Officer with the desired restriction outlined.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices.

It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer at (303) 345-7476 or info@campanileplasticsurgery.com for further information about the complaint process.

This notice was published and becomes effective on September 20, 2013.

CAMPANILE PLASTIC SURGERY

PATIENT PRIVACY and CONSENT
FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby consent to the use or disclosure of my protected health information by the practice of Frank E. Campanile M.D., hereinafter referred to as Campanile Plastic Surgery, for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by the Practice may be conditioned upon my consent as evidenced by my signature on this document.

I have been offered, read and/or understand the Practice's *Notice of Privacy Practices*, which has been offered to me by the practice, prior to signing this document. I understand that patient privacy rights and disclosure varies state by state.

I understand that the *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations. This *Notice of Privacy Practices* also describes my rights and the practice's duties with respect to my protected health information. The *Notice of Privacy Practices* for the Practice is available at the office of Campanile Plastic Surgery.

I understand that if I request my medical records to be transmitted via e-mail, fax, or any other unsecure transmission form, these methods have low transmission security. Upon request of medical records to be sent via these methods, I accept all risks associated with the unsecure form of transmission, and I do not hold Campanile Plastic Surgery responsible for lost, missing, or unprotected information.

Terms of the *Notice of Privacy Practices* may change. If changes are made, I may obtain a revised *Notice of Privacy Practices* by: calling the offices of the practice requesting a revised copy to be sent in the mail, or by requesting one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative if the Patient is a Minor Date

_____

Printed Name of Patient or Personal Representative

_____

Relationship of Personal Representative to the Patient

_____

Signature of Practice Representative and Witness

CAMPANILE PLASTIC SURGERY

E-mail Consent Form

Campanile Plastic Surgery will use all reasonable means to protect the privacy of patient's health information. However, you may desire that we communicate with you via e-mail or other non-protected forms of communication. In order for Campanile Plastic Surgery to e-mail any patient information, you must consent to this form of communication.

Communications over the Internet or using traditional e-mail systems are not encrypted and are inherently insecure. Confidentiality of information transmitted this way cannot be assured. If you wish to communicate with our office using a non-secure web messaging system, you must read and sign this form.

Consent for Health Information To Be Communicated By Electronic Mail:

I understand that e-mail is not intended to be used to communicate information that is considered urgent or emergent.

I understand and acknowledge that communication via e-mail is inherently insecure. I understand that there is no assurance of confidentiality of information when communicating in this way.

I will not hold Campanile Plastic Surgery liable in the event that I or anyone else inappropriately uses or accesses the e-mail correspondence between myself and Campanile Plastic Surgery.

By signing below, I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communications of e-mail between Campanile Plastic Surgery and me, and consent to the conditions outlined herein, as well as any other instructions that Campanile Plastic Surgery may impose to communicate with me by e-mail. I understand that this consent is valid until such time as I revoke this consent in writing.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Email address