PATIENT HEALTH HISTORY

PLEASE PRINT: Please answer all of the questions as accurately as possible.

General Patient Information

Date: _____

Patient Name: Last _____ **First** _____ **MI**_____

SS# _____ **Birthdate** _____/_____/_____ **Age:** _____ **Gender:** □ **M** □ **F**

Address: _____

City/State/Zip: _____

Home Phone: _____ **Day Phone:** _____ **Cell Phone:** _____

HEIGHT _____ **feet** _____ **inches** **WEIGHT:** _____**lbs/ kg**

May We Leave Messages on Answering Machine: YES OR NO

Marital Status: M/D/S/W Spouse's Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Family Doctor: _____ Phone: _____

Referring Doctor: _____ Phone: _____

Occupation: _____ Place of Employment: _____

How did you hear about us? _____

Email: _____ **May we e-mail you about promotions & events:** YES □ NO □

Preferred Pharmacy: _____ Pharmacy Number: _____

INSURANCE INFORMATION

Name of Insurance Company: _____
Policy# or ID: _____ **GROUP #** _____
Policy Holder (if different from abovementioned patient):
_____ **DOB** _____

Current Medications
(Check all that apply provide product name)

- **Non-steroidal anti-inflammatory or Pain Medication:** _____
- **Aspirin:** _____
- **Blood Pressure:** _____
- **Topical Steroids:** _____
- **Steroids:** _____
- **Insulin:** _____
- **Weight Reduction Meds:** _____
- **Have you ever taken weight reduction meds?** _____
- **Blood Thinners:** _____
- **Anti- seizure Meds:** _____

- Hormones: _____

Medications Continued…

- Arthritis Meds: _____
- Herbals: _____
- Tranquilizers/Sedatives: _____
- Vitamins: _____
- Sleeping Pills: _____
- Minerals: _____
- Iron: _____
- Antibiotics: _____
- Barbiturates: _____
- Birth Control Pills: _____
- Asthma Med/Inhaler: _____
- Allergy Meds: _____
- Decongestants: _____
- Laxatives: _____
- Antidepressants: _____
- Others: _____

Allergies Reactions
(provide reactions)

- Medication: _____

_____

- Latex: _____
- Other: _____

Past Surgeries/Tests

Date of Last Mammography: _____ Results: _____

Date of Last Physical: _____ Results: _____

Past Surgeries: _____

_____

Conditions/Illnesses
Check all that apply.

- Anemia
- Anxiety/Stress
- Anesthesia problems
- Arthritis
- Asthma
- Bleeding tendency
- Cancer
- Chest pains
- Depression
- Diabetes
- Dizziness
- Easy bruising/bleeding
- Epilepsy
- Fainting
- Gastrointestinal
- Goiter
- Heart attack
- Heart disease
- Heart palpitation or pain
- Hepatitis
- Herpes
- High blood pressure
- High Cholesterol
- HIV
- Keloids/thick scars
- Kidney problems
- Latex allergy
- Migraine
- Mitral valve prolapse
- Palpitations
- Physical defect or deformity
- Rash/new or change in mole
- Rheumatic fever
- Rosacea
- Stomach ulcer
- Stroke
- Thyroid trouble
- Tuberculosis
- Ulcers
- Unexplained weight loss/gain

Family History (Which blood relative?)	
Maternal	**Paternal**
o **Breast Cancer:** _____ o **Melanoma:** _____	o **Breast Cancer:** _____ o **Melanoma:** _____

Social History

Cigarette Use:

- o **I currently smoke cigarettes. Packs/Day:** _____

Alcohol Use:

Do you drink alcohol? Yes or No #of drinks/week: _____ **Is your alcohol a concern for you or others? Yes or No**

Please describe your concerns:

_____

_____

_____

How long this has been a concern?

_____

_____

What have you done to address this concern?

_____

_____

_____ _____

SIGNATURE **DATE**

PHOTOGRAPHIC RELEASE

Patient Name _____

Part of Body _____

I give Dr. Learn and LL Plastic Surgery and her/its representatives the absolute and irrevocable right and permission to photograph me and to use photographs that are taken of me:

1. Copyright same in the name of Dr. Learn or LL Plastic Surgery
2. Use, re-use, publish and re-publish the same in whole or in part, individually or in conjunction with other photographs, in any medium and for any purpose including the following:

	Yes	No
	___	___
• Education and training	___	___
• Paper and electronic health publications	___	___
• Advertising purposes (Marketing, Magazines, etc.)	___	___
• Internet or websites	___	___
• Social media (Facebook, Instagram, Twitter, etc.)		
• Display in office	____	____
• Show to other patients	____	____

I agree to release Dr. Learn and LL Plastic Surgery from any valuable consideration in exchange for this release including, but not limited to, financial remuneration, services or products.
I release and discharge Dr. Learn and LL Plastic Surgery and personnel from any and all claims and demands arising from, or in conjunction with, the use of photographs, including any and all claims for libel.
This authorization and release shall also insure the legal representative, licenses and assigns of Dr. Learn and LL Plastic Surgery as well as the person or persons who took the photographs.
I am over the age of 18, or the parent of a subject under the age of 18 and am myself the legal age to execute agreements.
I have read the foregoing and fully understand and agree to the contents thereof. I confirm that I understand this consent form.

Signature: _____ Date: _____
Legal Guardian (if under 18): _____
Witnessed: _____

CONSENT TO TREATMENT- FINANCIAL RESPONSIBILITY

CONSENT TO TREATMENT

The undersigned patient/responsible party consents to the medical/surgical procedure(s) and treatment(s), including but not limited to anesthesia, laboratory procedures, x-rays, and examinations to be rendered pursuant to the general and special instructions of my physician. This extends to the anesthesiologists, emergency physicians, pathologists, and radiologists, all of whom are independent contractors and not employees of Lisa J. Learn, DO, FACOS.

FINANCIAL RESPONSIBILITY

By accepting any medical services or treatment, including but not limited to consultations, examinations, x-rays, and surgery, the undersigned patient/responsible party agrees to pay Lisa J. Learn, DO, FACOS all charges for such service or treatment.

Fees and interest charges may be added on to the account if payment for services is delinquent and an outside collections agency is required. The amount of the fees and interest charges will vary and is dependent on what Lisa J. Learn, DO, FACOS deems necessary to collect funds.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I am aware that as a courtesy my primary insurance will be billed. It is my responsibility to follow up on any delinquent claims.

I hereby authorize Lisa J. Learn, DO, FACOS to furnish information to insurance carriers concerning myself or my dependents' illness of treatments. I assign the insurance benefits to Lisa J. Learn, DO, FACOS and authorize and direct my insurance carrier to pay those benefits directly to Lisa J. Learn, DO, FACOS to release medical information to other physicians when deemed necessary for my medical treatment. I understand that if my medical insurance does not pay for any reason it will be my responsibility to pay the bill in full, unless prohibited by law.

If TRICARE, Medicare, Medicaid, Workman's' Compensation, or similar government programs should determine that I am *not eligible* for coverage or that the service or treatment is not covered, I will be responsible for payment unless prohibited by law.

AUTHORIZATION TO RELEASE INFORMATION

The undersigned patient/ responsible party authorizes Lisa J. Learn, DO, FACOS to disclose financial and medical information and records to: my employer and third-party payers, who are or may be responsible for payment of all or a portion of the charge; to other health care and/or to the referring physician to ensure continuity of medical care; and for purposes of accreditations, audits, certification, and peer or utilization reviews.

NOT RESPONSIBLE FOR PERSONAL PROPERTY

Patients should not bring valuables to this facility. Lisa J. Learn, DO, FACOS is not responsible for any personal property brought into or left in the facility.

PRESCRIPTION PATIENT ALERT

Effective July 4th 2018, **All** doctors are required to review a patients prescription history before prescribing medications.

BY SIGNING THE PATIENT INFORMATION FORM PATIENT/ RESPONSIBLE PARTY ACKNOWLEDGES THAT THEY HAVE HAD THE OPPORTUNITY TO READ THIS FORM, AND AGREES TO THE TERMS SET FORTH IN THIS FORM.

_____

PATIENT NAME (PRINT) PATIENT SIGNATURE

DATE

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGMENT

A Notice of Privacy Practices (NPP) is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosure of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

NOTE: A current copy of the Notice of Privacy Practice is available upon request.

_____

PATIENT SIGNATURE DATE

If applicable, reason patient's written acknowledgement could not be obtained:

□ **Patient was unable to sign**

□ **Patient refused to sign**

□ **Other** _____

OFFICE WITNESS SIGNATURE_____

DATE: _____

TELEMEDICINE PATIENT CONSENT/REFUSAL FORM

PATIENT NAME: _____

DATE OF BIRTH: _____

1. PURPOSE: The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the following procedure(s) and/or service(s)

   _____
   _____

2. NATURE OF TELEMEDICINE CONSULT: During the telemedicine consultation:
   a. Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
   b. A physical examination of you may take place.
   c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
   d. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s)
3. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.
4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and **Florida** state law apply to information disclosed during this telemedicine consultation.
5. RIGHTS: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. DISPUTES: You agree that any dispute arriving from the telemedicine consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.
7. RISKS, CONSEQUENCES & BENEFITS: You have been advised of all the potential risks, consequences and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telemedicine consultations for the procedure(s) described above.
Signature: _____

If signed by someone other than the patient, indicate relationship: _____

I **refuse** to participate in a telemedicine consultation for the procedure(s) described above.
Signature: _____

If signed by someone other than the patient, indicate relationship: _____

DATE: _____ TIME: _____

WITNESS: _____

DATE: _____ TIME: _____

APPOINTMENT: Office visits are by appointment only please call (**954-380-8411**). The receptionist may ask about the reason for your visit. This helps us schedule the doctors time more efficiently. Please arrive 15 minutes early for your appointment. Patients who are late may be asked to reschedule at the physicians discretion.

***CANCELLATIONS*:** We value all our patients and strive to provide the best care possible in the most comfortable setting. Please understand that when we schedule your appointment, we are reserving time for your particular needs. We kindly ask that if you must change your appointment, please give us 24 hours' notice. This courtesy makes it possible to give your reserved time to another patient. We know that your time is valuable.

MISSED APPOINTMENTS (NON-CANCELLED): We understand that occasionally missed appointments can occur for a variety of reasons. A **no show/late cancellation** is defined as missing an appointment without cancelling at least 24 hrs. before your scheduled time**.** There will be a charge of **$50** for missed/ non cancelled appointments. No refunds will be given. Repeated missed appointments may result in your physician sending a letter discharging you from the practice. We will then offer 30 days of emergent care only and transfer your medical records to your new physician.

PAYMENT: Payment is due in full at the time of service no exceptions.

I have read, understand and accept the above polices.

_____ _____ _____

PATIENTS NAME **SIGNATURE** **DATE**