Please print legibly with ballpoint pen — Thank-you!

THE MAAS CLINIC
For Facial Plastic and Aesthetic Surgery

◎ Corey S. Maas, M.D
◎ Shahin Javaheri, M.D.
◎ _____

Today's Date: _____

VISIT LOCATION
◎ The Maas Clinic-Tahoe ◎ The Maas Clinic-San Francisco ◎ Appearance Care Center ◎ Berkeley

Patient Information

Patient Name | Date of Birth | Age | M ◎ | F ◎

Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

Email Address | Social Security | Married ◎ | Divorced ◎ | Single ◎ | Other ◎

Are there restrictions for contacting you? Y ◎ N ◎ | If Yes, Please Explain:

Emergency Contact | Phone Number

Insurance Information

Primary Insurance | Policy/Group Number

Insured's Name | Relationship to Patient: Self ◎ Child ◎ Spouse ◎ Other ◎

Insurance Phone | Referral Required? Y ◎ N ◎ | If Yes, Referral Secured? Y ◎ N ◎ | Co-Pay (Amount)

Secondary Insurance | Policy/Group Number

Insured's Name | Relationship to Patient: Self ◎ Child ◎ Spouse ◎ Other ◎

Insurance Phone | Referral Required? Y ◎ N ◎ | If Yes, Referral Secured? Y ◎ N ◎ | Co-Pay (Amount)

Referring Physician & Other Information

Referring Physician | Phone

Primary Care Physician | Phone

How did you hear about us?
☐ TV ☐ Newspaper ☐ Journal ☐ Phone Book ☐ Web Search ☐ Seminar ☐ Salon
☐ Friend ☐ Family ☐ Spa Week ☐ Email ☐ Other

Primary Reason for Visit _____

I would like to learn more about:

☐ Skin Care and/or Products
☐ Other Cosmetic Procedures: _____
☐ Other Aesthetic Procedures: _____

Release

*AUTHORIZATION: I hereby authorize the physician to furnish information to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. I also agree to the terms of the cancellation policy stating that a $50 fee will be assessed for less than 48 hours notice on cancellations and/or missed appointments. A copy of this authorization shall be considered as valid as the original.

_____ _____

Patient Signature | Date

AGREEMENTS, UNDERSTANDINGS AND CONSENTS

THE MAAS CLINIC
For Facial Plastic and Aesthetic Surgery

◎ Corey S. Maas, M.D

◎ Shahin Javaheri, M.D.

◎ _____

Thank You For Choosing The Maas Clinic And/Or Its Affiliates

Patient Name: _____
(Please Print)

Patient & Physician Privacy

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner:	Detailed Info/Message/Mail		Message With Call Back Number Only	
Home Phone: _____	◎ Y	◎ N	◎ Y	◎ N
Cell: _____	◎ Y	◎ N	◎ Y	◎ N
Work Phone: _____	◎ Y	◎ N	◎ Y	◎ N
Email: _____	◎ Y	◎ N	◎ Y	◎ N

The Maas Clinic and Appearance Care Center (Dr. Corey S. Maas, Shahin Javaheri, and other 'Providers' at The Maas Clinic collectively labeled "Physicians") agree to provide treatment to _____ (Patient Name) . The Physicians take pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes in these laws. For example, physicians are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician believes this is improper and may not be in the patients' best interest. Accordingly, Physician agrees not to provide medical information for the purpose of marketing indirectly to Patient. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores for "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

The Physicians have invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about the Physicians, his practice, expertise, and/or treatment on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Physicians, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physicians for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be in force and enforceable for a period of five years from Physician's last date of service to Patient. As a matter of office policy, Physicians are requiring all patients in its practice to sign the Mutual Agreement so as to establish that any anonymous or pseudo-anonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship.

Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Physicians agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

_____ _____
Patient Signature Date

Photographic Consent/Release

Before and after photographs are important parts of your medical treatment, planning, and evaluation. The Maas Clinic (TMC) and the Appearance Care Center (ACC) use photographs as an integral part of your medical records and all patients must have photographs taken before treatment.

Many patients who are contemplating surgery or office procedures find looking at before and after photographs very useful for their education. TMC and ACC's providers may also use them for lectures and education on plastic surgery.

Only with your permission may they be used for marketing or advertising. We fully realize the sensitive nature of this matter and will keep your name protected at all times if you choose to allow TMC and/or ACC to use your image. Please INITIAL the appropriate option(s).

◎ I allow ◎ I do NOT allow my photographs to be used on The Maas Clinic or The Appearance Care Center web page.

◎ I allow ◎ I do NOT allow my photographs to be used for marketing, advertising, consumer education or other media.

I have read the above consent and release. I am the patient, parent or conservation (circle one) and am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution.

_____ _____
Patient Signature Date

Billing Agreement

For value received, the undersigned patient promises to pay for all charges incurred for services rendered to the Patient. The Patient understands that The Maas Clinic healthcare provider will process the paperwork to charges incurred for services rendered to the Patient. The Patient understands that the provider will process the paperwork to complete insurance claim(s) but only as a courtesy to the Patient. The Patient authorizes this provider to release any and all medical information necessary to complete insurance claim(s) and assigns any monies due and owing under the insurance contract to this provider. It is, however, understood and agreed that the Patient is responsible for all monies due and owed for services rendered by this provider in the event insurance does not pay for these services.

Your signature indicates that you have read the above and agree to the terms contained therein. These agreements are irrevocable.

_____ _____
Patient Signature Date

REVIEW OF BODY SYSTEMS

Patient Name: _____ Reason for Visit _____
Last First MI

Patient History & Physical Review

List all surgeries (hospitalizations and date of surgery)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Describe your overall health: ◯ Excellent ◯ Good ◯ Fair ◯ Poor If Poor, Explain: _____

List any medical treatment you are currently receiving (if not already explained above): _____

1. Are you currently taking aspirin or any medication containing aspirin or Vitamin E? ◯ Y ◯ N If Yes, Describe: _____
2. Are you taking non-prescription medications (including herbal supplements)? ◯ Y ◯ N If Yes, Describe: _____
4. Have you taken any steroid preparations over the last year? ◯ Y ◯ N If Yes, When and Why? _____
5. Please list all current medications taken during the last months, including topically used medications such as Retin A (Please include dosage):

_____ _____ _____
_____ _____ _____
_____ _____ _____

6. Do you smoke? ◯ Y ◯ N If Yes, How Much? _____ How Long? _____
7. If female, are you or could you be pregnant? ◯ Y ◯ N
8. Do you drink alcohol? ◯ Y ◯ N If Yes, How Much? _____ How Often? _____
9. Do you use recreational drugs? ◯ Y ◯ N If Yes, Describe: _____
10. Do you have bleeding or bruising problems? ◯ Y ◯ N
11. Do you have a history of problems with anesthesia? ◯ Y ◯ N If Yes, What Happened? _____

ALLERGIES Medication and/or Tape/Latex: _____

_____

H & P (Continued)

Do you have or have you had any of the following: (Please check for each and give dates)

AIDS/HIV ◯ Y ◯ N	Liver Disorders ◯ Y ◯ N	Hepatitis ◯ Y ◯ N
Arthritis ◯ Y ◯ N	Epilepsy/Seizures ◯ Y ◯ N	Kidney Problems ◯ Y ◯ N
Autoimmune Disease ◯ Y ◯ N	Diabetes ◯ Y ◯ N	Thyroid Disease ◯ Y ◯ N
Cancer ◯ Y ◯ N	Spinal/Back Disorders ◯ Y ◯ N	Tuberculosis ◯ Y ◯ N
Depression ◯ Y ◯ N	Headaches/Migraine ◯ Y ◯ N	Ulcers ◯ Y ◯ N
Dizziness/Vertigo ◯ Y ◯ N		
EYE Glasses/Contacts ◯ Y ◯ N	Blurred Vision ◯ Y ◯ N	Dry Eyes ◯ Y ◯ N
Itching/Irritation ◯ Y ◯ N	Visual Loss (One/Both) ◯ Y ◯ N	

Previous Eye/Eyelid Surgery: _____ **NOSE** Sinus Condition ◯ Y ◯ N

Difficulty Nose Breathing ◯ Y ◯ N Nasal Allergies ◯ Y ◯ N Nose Bleeds ◯ Y ◯ N

Previous Nasal/Sinus Surgery: (_____) _____
Date

FACE Pain ◯ Y ◯ N Facial Skin Problems ◯ Y ◯ N Facial Paralysis/Weakness ◯ Y ◯ N

SKIN Acne ◯ Y ◯ N Unusual Scarring/Keloid ◯ Y ◯ N Face Scars ◯ Y ◯ N
Body Scars ◯ Y ◯ N Rash ◯ Y ◯ N Fever Blisters/Herpes ◯ Y ◯ N

Irradiation to Face/Neck ◯ Y ◯ N Previous Facial Surgery: (_____) _____
Date

CARDIOVASCULAR

Palpitations/Irregular Beat ◯ Y ◯ N	Coronary or Heart Attack ◯ Y ◯ N	
High Blood Pressure ◯ Y ◯ N	Heart Murmur ◯ Y ◯ N	Stroke ◯ Y ◯ N
Congenital Heart Disease ◯ Y ◯ N	Heart Trouble ◯ Y ◯ N	Previous Blood Clots ◯ Y ◯ N
CHEST Chronic Cough ◯ Y ◯ N	Pneumonia ◯ Y ◯ N	Bronchitis ◯ Y ◯ N
Asthma ◯ Y ◯ N	Previous Breast or Body Plastic Surgery: (_____) _____ Date	

PSYCHIATRIC Have you received psychiatric treatment? ◯ Y ◯ N If Yes, Were You Hospitalized? ◯ Y ◯ N
Have you ever been diagnosed with an eating disorder? ◯ Y ◯ N

The above information is accurate and complete to the best of my knowledge.

_____ _____
Patient Signature Date

APPEARANCE CARE QUESTIONNAIRE AND/OR FOR CLINIC APPOINTMENT

Patient Name: _____ ☐ Spa ☐ Skin Care ☐ Laser Hair Removal ☐ Other: _____
Last First MI

General Information

1. Do you get 8 hours of sleep a night? ◯ Y ◯ N
2. Are you pregnant? ◯ Y ◯ N
3. Are you breast feeding? ◯ Y ◯ N
4. Are you post-menopausal? ◯ Y ◯ N
5. How many glasses of water do you drink a day? _____
6. How many cups of caffeine do you drink daily? _____

Hair Color: ◯ Blonde ◯ Red ◯ Light Brown ◯ Brown ◯ Black ◯ Gray

Skin Tone: ◯ Pink ◯ Olive ◯ Native American ◯ Hispanic ◯ Asian ◯ Black

Eye Color: ◯ Blue ◯ Green ◯ Hazel ◯ Brown ◯ Black

Indicate your stress level: (1-10; 10 being the highest) ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Skin Care Products

Product List: What's It For?

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do Current Products Include?

Glycolic Acid ◯ Y ◯ N Retinol ◯ Y ◯ N

Retin A ◯ Y ◯ N Other: _____

Have you discussed our skin care line? ◯ Y ◯ N

Other services of interest not listed previously: _____

Waxing:

Legs ◯ Y ◯ N Lip Area ◯ Y ◯ N Bikini Area ◯ Y ◯ N

Brows ◯ Y ◯ N Other: _____

Sun Exposure

1. How much sun exposure do you receive? ◯ Minimal ◯ Average ◯ A LOT

   a. Skin Reaction: When exposed to the sun without protection for about 1 hour, I

   ◯ always burn, never tan ◯ sometimes burn, sometimes tan

   ◯ always burn, sometimes tan ◯ always tan

2. When were you last exposed to the sun? Outdoors: _____ Indoor Tanning: _____
3. Do you use sunless tanning lotions? ◯ Y ◯ N
4. Are you planning a holiday in the sun? ◯ Y ◯ N If Yes, When? _____

Email

YES, I want to receive a FREE Visia Computerized Complexion Analysis that measures six different aspects of skin types. Please add me to your email address!

Email: _____ (I will call to schedule my appointment soon).

I understand that I will receive all the latest promotions and new product information (not to exceed more than 2 emails/month).

Please list any conditions or concerns: _____

_____ _____
Patient Signature Date