1 East Erie St., Ste. 242 ● Chicago, IL 60611 ● 312-440-3100

Today's Date________________________ Patient Number____________

Name: ❐Mr. ❐Mrs. ❐Miss ❐Ms. ❐Dr. ____
Last **First** **Middle**

How would you like to be addressed by our office staff? ______________________________ **Sex:** ❐Male ❐Female

*Please check the box below of the **phone number** you prefer us to use **FIRST** for contacting you.*

❐ **Home** ____________ ❐ **Work** ____________ ❐ **Cell** ____________

Email address: ______________________________ Have you been to our website? **(www.drpielet.com)** ❐ Yes ❐ No

Address: ____
Street Apt# City State Zip Code

Social Security#: ____________________ **Date of Birth** ________________ **Age** ____________

Marital Status: ❐ Single ❐ Married ❐ Divorced ❐ Widowed ❐ Partnered Spouse's Name____________________

Primary Care Physician____________________________**Phone Number**____________________

Employer ____________________________Occupation ____________________

How did you hear about our office? (Mark all that apply)

❐ Web ❐ TV Ad ❐ TV News ❐ Magazine ❐ Newsletter ❐ Seminar ❐ Salon ❐ Phonebook

❐ Friend/Relative: ____________________ ❐ Doctor: ____________________ ❐ Other: ____________

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

Emergency Contact____________________ **Relationship**____________ **Emergency Phone**____________

Areas of Interest: (mark all that apply)

Facial Procedures

- ❐ Blepharoplasty (Eyelid Lift)
- ❐ Botox
- ❐ Brow or Forehead Lift
- ❐ Earlobe Repair
- ❐ Facial Liposuction (Neck, Jowls)
- ❐ Face or Neck Lift
- ❐ Lip Enhancement
- ❐ Otoplasty (Ear Pinning)
- ❐ Portrait (Plasma Skin Regeneration)
- ❐ Rhinoplasty (Nose Reshaping)
- ❐ Skin Resurfacing (Laser, Peel, Etc.)
- ❐ Wrinkle Fillers (Injections)

Breast Procedures

- ❐ Breast Augmentation
- ❐ Breast Reconstruction
- ❐ Breast Reduction
- ❐ Mastopexy (Breast Lift)

Body Procedures

- ❐ Abdominoplasty (Tummy Tuck)
- ❐ Brachioplasty (Arm Lift)
- ❐ Buttock Augmentation
- ❐ Full Body Lift
- ❐ Liposuction (Thighs, Abdomen, Etc.)
- ❐ Thigh or Buttock Lift

Other Procedures

- ❐ Skin Care
- ❐ Telangectasia (spider veins)
- ❐ Laser Hair Removal
- ❐ Laser Tattoo Removal
- ❐ Leg Veins
- ❐ Lesions / Moles
- ❐ Other ____________________

____

____

Is there something specifically you would you like to discuss with the doctor?____________________

Would you like a complimentary skin evaluation while you are here today? ❐ Yes ❐ No

____Date______________________

What is your current weight? ____________________ **Ideal weight** _______________ **Height** ____________________ **Age** _____________

Do you have any health problems (arthritis, back problems, kidney stones, diabetes, seizure disorders, etc.)? ❒ Yes ❒ No

List:____

Please list *all* **medications** you have recently taken or are currently taking (including aspirin or ibuprofen products and vitamins/supplements)

____

Are you allergic to latex? ❒ Yes ❒ No

Do you have any medical allergies? (If so, please list them) ____

MEDICAL HISTORY

(Mark all that apply)

Do you have: ❒ heart murmur ❒ high blood pressure ❒ diabetes ❒ immune disorders ❒ Yes ❒ No

Do you have any problems with: ❒ bruising ❒ bleeding ❒ Yes ❒ No If yes, please explain. ____

Have you ever had a problem with: ❒ nerves ❒ muscles ❒ Yes ❒ No If yes, please explain. ______________________________________
(i.e. temporary paralysis, nerve injuries, strokes, etc).

Have you ever been treated for any psychiatric illness? ❒ Yes ❒ No If yes, please explain. ____

Do you wear: ❒ dentures ❒ retainer of any kind? ❒ Yes ❒ No

Do you get fever blisters or other cold sores on your lips? ❒ Yes ❒ No If yes, how often? __________________________________

How often do you drink? ❒ Regularly ❒ Socially ❒ Never On average how many drinks do you consume in one sitting?_____________

Have you ever smoked or do you currently smoke? ❒ Yes ❒ No If yes, how much? ______________________________

Do you exercise on a regular basis? ❒ Yes ❒ No If yes, how often?____

List all diseases that run in your family ____

GYNECOLOGICAL HISTORY

(female patients)

Pregnancies_______________ Normal deliveries____________ C-sections_________________Miscarriages/Abortions________________

Date of last menstrual period_______________________ Do you take oral contraceptives or estrogen? ❒ Yes ❒ No

COSMETIC HISTORY

Please list *all* cosmetic procedures and the surgeons who preformed them including injections. (i.e. Botox, Restylane)

Procedure	Surgeon	Date of Procedure

SURGICAL HISTORY

Please list *all* non-cosmetic surgeries, other injuries and/or hospitalizations, reasons for treatment and dates.

I understand that office visit charges are payable on the day service is rendered.

Patients Signature____ **Date**______________________________

1 East Erie St., Ste. 242 ● Chicago, IL 60611 ● 312-440-3100

Patient Name___________________________

Thank you for choosing Rodger Wade Pielet, M.D. F.A.C.S. We hope you find your consultation informative and we want to answer all your questions to your satisfaction. Please feel free to discuss any further questions or concerns with the doctor or any member of our informative staff.

Consultation for cosmetic surgery includes a complete evaluation, recommendations from Dr. Pielet, and a thorough explanation of all procedures. As this surgery is completely elective your decision to undergo a cosmetic procedure should be based on a comprehensive understanding of the surgical procedure, including anticipated results, possible complications, risks and expenses involved. Sufficient time will be allowed for this evaluation and explanation. You should be comfortable with both your decisions as well as the recommendations of your surgeon. Any further return visits for additional clarification may be made at no additional charge.

Very infrequently, a touch-up or revision may be required. If this is related to the original procedure, there would be no further charge for this revision. You would, however, be responsible for any facility and/or anesthesia charges incurred.

Signature____**Date**__________________

Photographs will be taken during the course of your treatment for the purpose of recording your progress and for medical education. These photographs may be used for teaching or publication, as the physician deems appropriate. Your identity will remain strictly confidential. Please initial below if you consent to the statements above regarding he medical photographs.

Initials ___________

1 East Erie St., Ste. 242 ● Chicago, IL 60611 ● 312-440-3100

Patient Name________________________

ACKNOWLEDGEMENT FORM

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Rodger Wade Pielet, M.D.s' **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:
____
____
____
____
____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed:___________________________________ **Date:**_______________________

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship:_______________________ **Witnessed by:**_______________________

<u>If the patient refuses to sign, indicate your attempt to obtain a signature below.</u>

[ ] Patient refused to sign this Acknowledgement.

Date:_____________________

Time:_____________________

Employee Name:_________________________

ACKNOWLEDGE FORM

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Rodger Wade Pielet, M.D., we are committed to treating and using protected health information about you responsibly. This notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes our rights as they relate to your protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Rodger Wade Pielet, M.D., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- And a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how our health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why other may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Rodger Wade Pielet, M.D., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522,
- And, revoke your authorization to use disclose health information except to the extent that action has already been taken.

Our Responsibilities

Rodger Wade Pielet, M.D. is required to:

- Maintain the privacy of our health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction,
- And accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will e-mail the revised notice to you.

We will not disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer, Caryle, at 312-440-3100.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with your regional Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Examples of Disclosure for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician or other member of our health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your heath care team. Members of our health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular heath operations.

For example: We will share your relevant health information with other providers involved in your care, to assist in the coordination of your care. This may include specialist, hospitals, clinics and other individuals or organizations prior to or after us who have provided you with health care.

Billing and Collection: Additionally, should, for any reason a dispute as to your bill arise, or there should arise any legal proceeding, quasi-legal proceeding, administrative hearing or other matter which requires that the physician or his company provide information to such group, court, or admistrative body for purposes of collection of a bill or defending the physician’s practices under the standard of care, then patient consents to a waiver of HIPAA for such purposes.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department, radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose our health information to our business associates so that they can perform the job we have asked them to do and bill your or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the hospital, general condition and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative or another person responsible for your care, your location and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative (close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose 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 health information.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund Raising: We may contact you as a part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food,

supplements, product and product defect, or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required b law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.