6430 Rockledge Drive, #100
Bethesda, MD 20817
(p) 301-493-4334
www.cosmeticplastics.com

Cosmetic Surgery ASSOCIATES
A FOREFRONT PRACTICE

Patient Information Form

Patient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Cell Carrier: _____

DOB & Age: _____

Sex: _____ Email Address: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

How did you hear about us?

- ☐ Doctor Referral _____
- ☐ Patient Referral _____
- ☐ Washingtonian
- ☐ Angies List
- ☐ Realself.com
- ☐ Facebook
- ☐ Google
- ☐ Healthgrades.com
- ☐ Vitals.com
- ☐ RateMDs.com
- ☐ Bethesda Magazine
- ☐ Northern VA Magazine
- ☐ New Beauty Magazine
- ☐ Other _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

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Health History

Patient: _____ Date: _____ Doctor: _____

Thank you for answering the following questions. Your answers provide important information that will affect your care. They will be held in the strictest confidence.

Height: _____ Weight: _____

Current Medications (including herbals such as Ginseng, Ginkoba, etc.):

_____

_____

Are you allergic to any medications? ☐ Yes ☐ No If yes, what medication(s)?: _____

_____

Is there a possibility you may be pregnant?: ☐ Yes ☐ No Due Date: _____

Have you or do you currently have:	YES	NO
Latex allergy	☐	☐
High blood pressure	☐	☐
Heart Attack(s)	☐	☐
Heart Murmur	☐	☐
Irregular Heart Beat	☐	☐
Chest pain, angina	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Hepatitis or liver disease	☐	☐
Bleeding disorder	☐	☐
Epilepsy or convulsions	☐	☐
Stroke	☐	☐
Thyroid disease	☐	☐
Diabetes	☐	☐
Kidney disease	☐	☐
AIDS or HIV infection	☐	☐
Eye disease or glaucoma	☐	☐
Radiation therapy	☐	☐
Chemotherapy	☐	☐
Malignant hyperthermia	☐	☐
Sleep apnea	☐	☐
Blood clots, you or any family history	☐	☐

Please list all previous surgeries:

Do you smoke?: ☐ Yes ☐ No Packs per day?: _____

Have you ever smoked?: ☐ Yes ☐ No When did you quit?: _____

Are you under the care of a psychiatrist/psychologist?: ☐ Yes ☐ No

If so, for what are you being treated?: _____

Signature: _____ Date: _____

Cosmetic Surgery Associates
A Forefront Practice

Patient Name:_____ Date of Birth_____

Communication & Financial Policies

The following are policies of Forefront Dermatology, S.C. and its affiliated practices ("Forefront"). Signature is required before services can be provided.

Patient Communications: In Forefront's discretion, information of a confidential nature may be left on your voicemail or answering machine at the preferred number(s) you have provided to Forefront or with a friend or family member who answer the telephone at one of the preferred numbers or at your residence and who can verify your address and date of birth. Such message may include, without limitation, reminders of upcoming scheduled appointments or answers to medical questions you may have inquired about to our staff. Forefront may also communicate with you via e-mail, text message, or post card to your home address provided such method complies with applicable HIPAA communication standards.

Research: I authorize Forefront to contact me regarding any research study in which I may be eligible to participate relating to my care.

Financial Responsibility:

Scheduling and Payment For surgeries scheduled more than 14 days in advance, a $1000 deposit is required to hold the surgery date and the full amount is due 14 days prior to the scheduled surgery date. For any surgery scheduled less than 14 days in advance, amount will be due in full to hold the surgery date. **Failure to pay in full 14 days in advance will result in cancellation of your surgery and forfeiture of your deposit.**

The remaining amount can be paid by cash, check, ACH debit, credit/debit card, or applicable financing options (Prosper, Alphaeon or Care Credit).

Cancellation Policy **If surgery is cancelled within 14 days or less from the date of surgery, it will be subject to forfeiture of 50% of total fees.** A $500 rescheduling fee will be required if rescheduling within 4 weeks of the original surgical date.

Revisional Surgery If touch-up, redo, emergency, or revisional surgery is necessary or desired, facility charges (including but not limited to operating room, anesthesia, and/or supply charges, i.e., implants) will be the patient's responsibility whether revisional surgery is performed in our office operating room, another surgical center or the hospital. The Surgeon's fee for revisional, emergency, or touch-up surgery will be determined on an individual basis. Determination of fees may also be dependent upon patient compliance with follow-up visits and instructions.

Insurance Cosmetic Surgery Associates, a Forefront Dermatology Practice, does not participate in or accept any insurance payments for procedures or services provided. **Each patient is personally responsible for their account regardless of insurance coverage and/or prior authorization.**

Consultation/Post Operation Appointment All consultation visits and post-op appointment are complimentary.

Reminder, please review to the accepted forms of payment for payments as referenced above. Please note that personal checks or business checks are not accepted at this time.

_____ _____

Patient Signature **Date**

The undersigned hereby provides consent as the parent or guardian of the above referenced minor patient.

_____ _____

Parent or Guardian Signature/Date **Relationship to Patient**

FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

Patient Name (PLEASE PRINT) _____ Date of Birth _____

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" (the "Notice") of Forefront Dermatology, S.C. and its affiliated practices ("Forefront"). Our Notice provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by contacting our practice at 855-535-7175.

Please note that Forefront may communicate with you in the following ways, unless you instruct us otherwise:

- In Forefront's discretion, information of a confidential nature may be left on your voicemail or answering machine at the preferred number(s) indicated below or with a friend or family member who answers the telephone at one of the preferred numbers or at your residence and who can verify your address and date of birth. Such message may include, without limitation, reminders of upcoming scheduled appointments, information regarding your pathology or laboratory tests, billing information or answers to medical questions you may have inquired about to our staff. If you are signing this form via an electronic method which does not allow you to provide your preferred phone number and email address above, these communication policies shall apply to the phone numbers and email addresses you provide to Forefront staff for the above stated purpose.

Preferred Number _____	☐ Mobile (cell) ☐ Work ☐ Home
Preferred Number _____	☐ Mobile (cell) ☐ Work ☐ Home
Preferred Email Address _____	

- Forefront may also communicate with you via e-mail, text message, or post card to your home address provided such method complies with applicable HIPAA communication standards.
- You specifically authorize and give your express consent to receive autodialed and/or pre-recorded calls—including, voice and short message service (SMS) text messages and other electronic messages—from or on behalf of Forefront and its representatives at the number(s) provided above or an appropriate e-mail address to communicate appointment reminders, notifications regarding the availability of pathology or laboratory results, billing and collection information and marketing or advertising messages offering products or services that may be of interest to you. Forefront may receive direct or indirect payment for these marketing messages. You understand that by providing your telephone number and/or e-mail address to Forefront, you consent to being contacted using the above-described methods. If you receive communications from Forefront, you will be given the opportunity to opt-out of future communications by responding "STOP" or through another easily used mechanism, should you make that choice. You understand that you are not required to sign this agreement in order to receive treatment and that your consent is not a condition of purchasing or using any services offered by Forefront.
- If you have any questions about our Notice, please contact our compliance department – Phone: 920-663-0505, e-mail: compliance@forefrontderm.com

I acknowledge receipt of Forefront's Notice of Privacy Practices. I understand and agree to how Forefront may communicate with me, as stated above.

X _____ _____
(Signature of Patient or Legal Representative) Date

Parents may not sign for children over the age of 18 (or 19 years of age in Alabama).

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

Print name _____
(Legal representative)

For Office Use Only
Complete this section if this form is not signed and dated by the patient or patient's representative.
Reasons why the acknowledgement was not obtained:

- ☐ Patient refused to sign this Acknowledgement even though the patient was asked to do so and the Notice of Privacy Practices were made available to the patient.
- ☐ Other _____

_____ _____
Employee Name Date

Updated 5/22/19