Patient Demographics

Please complete this form in its entirety.

Patient Name:____

Address: ____

City:_______________________________________ State:_____________ Zip:___________

Home Phone # (_________)________________________ Cell # (_________)______________________

Date of Birth _______ /______ /_______ Age: _______ [ ] Male [ ] Female [ ] Other _____________

Social Security #: ________-_______-_________ Email:_____________________________________

Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced/Separated

Primary Language: ________________________ Full Time Student [ ] No [ ] Yes - at _______________

Employer: ____ Occupation:__________________________

Who referred you to our facility?

[ ] Friend / Relative/ Previous Patient: ____

[ ] Physician / Hospital ____

[ ] www.BreslowMD.com

[ ] www.injxcellence.com

[ ] Social Media: _________________________________

Medical Doctor's Name/ Primary Care Physician: ____

Address: ____ Phone #(________)______________________

Pharmacy Name: ________________________________ Pharmacy Phone #(_______)__________________

Pharmacy Address: ____

- INSURANCE INFORMATION -

Primary Insurance Company Name: ____

Phone Number #(____)____________________ ID # ____

Policyholder Name:____________________________ DOB_____/_____/_____ Relationship _______________

Guarantor's Employer: ____Work #(_____)____________________

By signing, I confirm that the information that I have provided is accurate to the best of my knowledge.

Patient Signature____ Date _____/_____/______

PATIENT DISCLOSURE CONSENT

HIPAA privacy rules give individuals the right to request a restriction of uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that communications be made via alternative means such as sending information to the individuals' place of employment instead of their home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER ***(check & complete all that apply)***

- ☐ Home telephone # ____________________
  - ☐ OK to leave a detailed message.
  - ☐ Leave a message with a callback number ONLY.
- ☐ Work telephone # ____________________
  - ☐ OK to leave a detailed message.
  - ☐ Leave a message with a callback number ONLY.
- ☐ Cell Phone #____________________
  - ☐ OK to leave a detailed message.
  - ☐ Leave a message with a callback number ONLY.
- ☐ **Emergency Contact Person:** ____________________

  Relationship ____________________

  Phone # ____________________
  - ☐ **OK to leave a message with detailed information.**
  - ☐ **Leave a message with a callback number ONLY.**
- ☐ Alternate telephone # ____________________

PRIVACY RULES REQUIRE US TO TAKE REASONABLE STEPS TO LIMIT THE USE OR DISCLOSURE OF YOUR INFORMATION TO THE MINIMUM NECESSARY. TO ACCOMPLISH THE INTENDED PURPOSE, USES AND DISCLOSURES ARE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY SITUATION.

____

Signature | Print Name | Date

Summary of Notice of Privacy Practices

This summary is provided to assist you in understanding the Notice of Privacy Practices

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your right as a patient and our common practices in dealing with patient health information.

Uses and Disclosures of Health Information
We will use and disclose information in order to treat or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for services or to allow insurance companies to process insurance claims for services rendered to you by us or health care providers. Finally, we will disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of staff.

Uses and Disclosures based on Your Authorization
Except as states in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without you written authorization.

Uses and Authorizations Not Requiring Your Authorization
In the following circumstances, we may disclose your health information without written authorization:

- To family members or close friends who are involved in your health care
- To certain limited research purposes for purposes of public health safety
- To government agencies for purposes of their audits, investigations, and other oversight activities
- To government authorities to prevent child abuse or domestic violence
- To the FDA to report product defects or incidents
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights
As our patients, you have the following rights:

- To have access to/and or a copy of your health information
- To receive an accounting of certain disclosures we have made regarding your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence
- To request that we amend your health information
- To request notice of our privacy practices

If you have a question, concern or complaint regarding our privacy practices, please refer to the Notice of Privacy Practices for the person or persons whom you may contact.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Privacy Practices and that I have read (or have had the opportunity to read if I so choose) and understand the notice.

_______________________________	_______________________________
Patient Name (Please Print)	*Parent OR Authorized Representative (If Applicable)*
_______________________________	_______________________________
Signature	*Date*

TREATMENT CONSENT AND RESPONSIBILITY AGREEMENT

Patient Name: ______________________________ **Date:** ______________

I, the undersigned, do hereby request and consent to an evaluation and treatment by Dr. Gary D. Breslow /Dr. Patrick Greaney, Jr. and/or The Breslow Center for Plastic Surgery. I wish to rely on Dr. Gary Breslow/Dr. Patrick Greaney, Jr to exercise judgment for my best interest to me or that of my dependent, the above-named patient, during the course of treatment. I will inform those involved in treating me or my dependent of any sensitive areas or adverse conditions that I or my dependent may have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment.

I clearly understand and agree that all services rendered to me or to my dependent, the above-named patient, may be charged directly to me and that I am personally responsible for full payment. I understand that even if I suspend or terminate treatment, any fees for professional services rendered to me or to my dependent up to the point of termination will be immediately due and payable.

I acknowledge that Dr. Gary D. Breslow/ Dr. Patrick Greaney, Jr and The Breslow Center for Plastic Surgery do not participate directly with any insurance company or managed care plans (except Medicare) and that I am responsible for any outstanding fees for services provided to me or to my dependent, the above-named patient, by The Breslow Center for Plastic Surgery that are not reimbursed through insurance or other third-party payers. I understand that a potentially refundable deposit to cover fees for uncovered services may be required at the time of service or follow-up. I acknowledge that a 1.5% per month interest charge may be added to any balance unpaid after 90 days of aging. I further acknowledge that I will be held responsible for any and all collection expenses incurred by Dr. Gary D. Breslow /Dr. Patrick Greaney, Jr. and/or The Breslow Center for Plastic Surgery including a 30% attorney fee on any balance referred to an attorney for collection as a result from my delay in payment for services rendered by Dr. Gary D. Breslow /Dr. Patrick Greaney, Jr. and/or The Breslow Center for Plastic Surgery.

I understand that I will be responsible for all facility and anesthesia fees incurred for subsequent revision and/or emergency procedures performed on me or my dependent, the above-named patient, as well as necessary supplies including but not limited to implants, unless otherwise specified by Dr. Gary D. Breslow /Dr. Patrick Greaney, Jr. and/or The Breslow Center for Plastic Surgery. Any surgeon's fee that may be incurred for subsequent revision and/or emergency procedures will be addressed on a case by case basis.

I authorize The Breslow Center for Plastic Surgery to submit all precertification requests and claims directly to the insurers on my behalf. I hereby authorize the release of my medical records and other information necessary to process insurance claims. I understand and agree that any and all monies received from insurance companies and/or other third-party payers as reimbursement for services rendered to me or to my dependent, the above-named patient, by Dr. Gary D. Breslow /Dr. Patrick Greaney, Jr. and/or The Breslow Center for Plastic Surgery shall be forfeited in full to Dr. Breslow/ Dr. Greaney and The Breslow Center for Plastic Surgery. Any other arrangements that may involve insurance billing, reimbursement, payment plan, or payment deferral, must be made in writing with the office manager and/or Dr. Breslow. Verbal agreements are not acceptable.

______________________________ ______________________

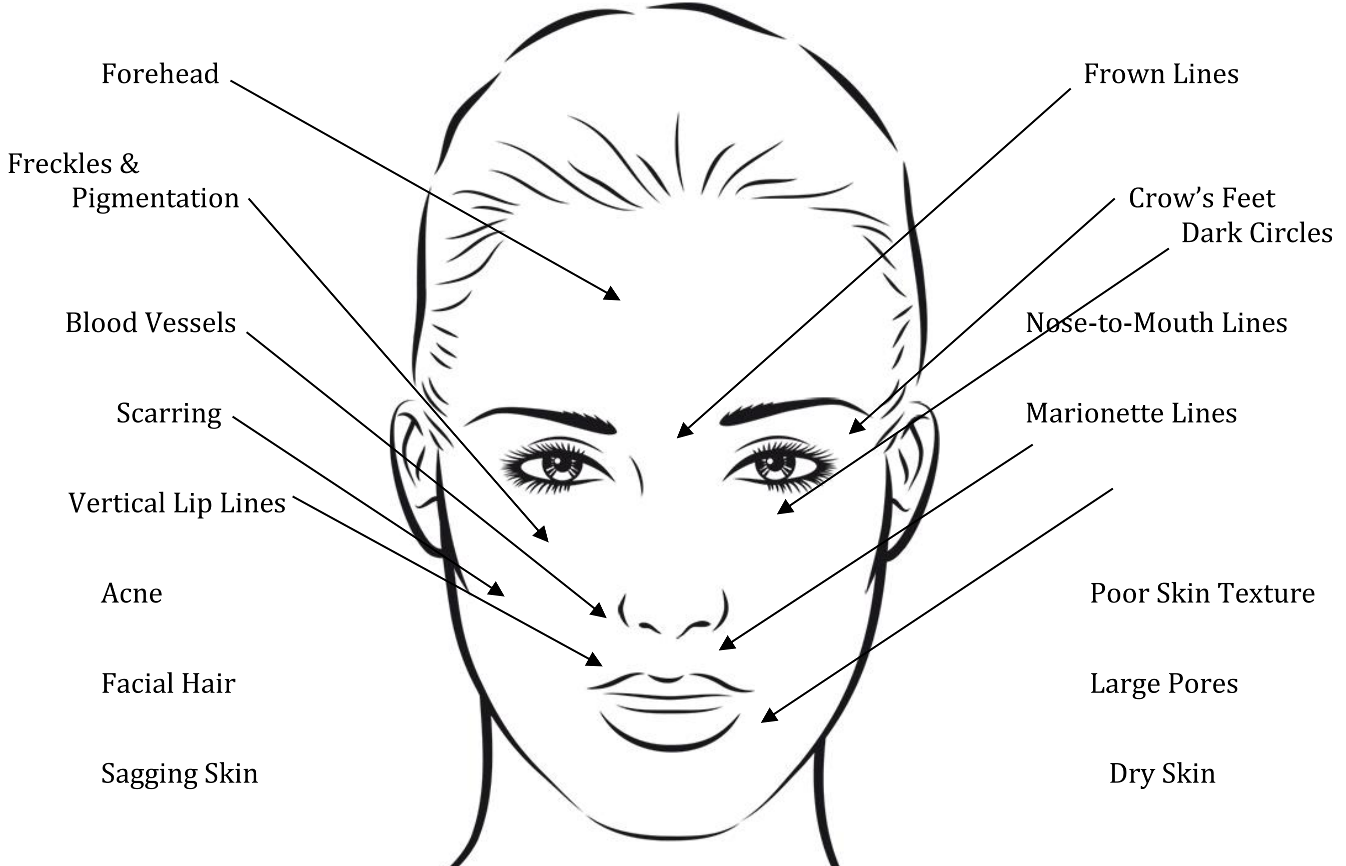
Patient Signature OR Authorized Representative (If Applicable) *Relationship to Patient*

Injxcellence Medical Spa
The Breslow Center for Plastic Surgery
Love the way you look!

Name:____

Date: ____________________

What are your areas of concern? Please circle all that apply.



When looking at my face in the mirror, I believe I look younger than, the same as, or older than my true age.

Younger Than	True Age	Older Than
1 2	3	4 5

When looking at my face in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned	Somewhat Concerned	Very Concerned
1 2	3	4 5

Are you interested in learning more about?

- ☐ BOTOX Cosmetic
- ☐ Facials
- ☐ Chemical Peels
- ☐ Sun Protection
- ☐ Acne Topical Treatments and Creams
- ☐ RADIESSE injectable gel/wrinkle filler
- ☐ JUVEDERM
- ☐ Alpha Hydroxy acid and glycolic peels
- ☐ Other skincare products
- ☐ Skin Rejuvenation
- ☐ Age Spots/liver spots
- ☐ Facial vein removal

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PATIENT PHOTOGRAPHIC AUTHORIZATION

The Breslow Center does not use your photographs unless we have your permission.

I consent to the taking of photographs by Gary D. Breslow, M.D. / Patrick J. Greaney, Jr. M.D. AND/ OR the staff of me and/or parts of my body in connection with the surgical procedure(s) which I am considering having performed by Gary D. Breslow, M.D. / Patrick J. Greaney, Jr. M.D.

Digital Morphing: I consent to permit Gary D. Breslow, M.D. / Patrick J. Greaney, Jr. M.D. AND/OR the other staff members of The Breslow Center for Plastic Surgery, P.A. to perform computerized changes of these images (described as "image morphing") in order to help me better understand various possible cosmetic results following surgery. It has been explained to me and I fully understand that demonstration of these morphed images in no way constitutes a guarantee of my appearance following surgery, and is being used solely as an instrument of demonstration and discussion of the surgery for which I am seeking consultation.

Internal Office Use: I hereby give The Breslow Center for Plastic Surgery P.A. and those acting pursuant to its authority permission to use my photograph, video, testimonial or interview for internal office use only. It will be used for an indefinite period of time and all personal identifiers will be removed.

____ ____________________________

Patient Signature OR Authorized Representative *(If Applicable)* Date

CONSENT FOR RELEASE OF PHOTOGRAPHS

The Breslow Center does not use your photographs unless we have your permission.

I authorize The Breslow Center for Plastic Surgery and those acting pursuant to its authority, permission to publish my photograph(s), video(s), testimonial(s) or interview(s).

I hereby authorize The Breslow Center for Plastic Surgery to:

- ❖ Use my interview photograph & testimonial in connection to any press, media release news article, collateral material, video, or video testimonial.
- ❖ Publish or distribute the testimonial through print, video, multi-media, Breslow Center website, or any other advertising mediums in whole or in part without restrictions or limitations for any educational and promotional purpose for an indefinite period of time.
- ❖ Utilize my photographs for educational purposes to include in-office photo albums; lectures to audiences comprised of medical professionals and/or lay persons.
- ❖ Present my photograph(s), video(s), testimonial(s) or interview(s) to other patients of the Practice who are contemplating surgery and/or procedures for their education.

I hereby consent to the release of said photograph(s), video(s), testimonial(s) or interview(s) for the above purposes. I agree that The Breslow Center for Plastic Surgery is the sole owner of said material.

I waive any right to inspect and/or approve the finished product and understand that I will not be entitled to monetary payment or any other considerations as a result of any of these images.

______________________________ ______________________________

Patient Name (Please Print) *Parent OR Authorized Representative (If Applicable)*

______________________________ ______________________________

Signature *Date*