CONSTANTINE
COSMETIC SURGERY

Today's date: _____

Last Name: _____ First Name: _____ Middle Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Social Security Number: _____ Date of Birth: _____ Age: _____ Sex: _____

Mobile Phone: _____ Height: _____ Weight: _____

Other Phone: _____ Phone Type: Home

Email: _____ Email Type: Personal

Employer: _____ Type of Work: _____

Marital Status: Single Spouse/Significant Other's Name: _____

Emergency Contact: _____ Emergency Contact Phone: _____

DOCTOR AND PHARMACY

Primary Care Physician: _____ Preferred Pharmacy: _____

Practice Name: _____ Pharmacy Location: _____

HOW DID YOU HEAR ABOUT US? PLEASE CHOOSE ONE.

- (●) Website
- ( ) Google
- ( ) Radio
- ( ) Advertisement
- ( ) Yelp
- ( ) Facebook
- ( ) Instagram
- ( ) Driving by
- ( ) Friend or Family - Name: _____
- ( ) Other: _____

REASON FOR YOUR VISIT

It is the responsibility of our patients to accurately inform us of any and all medications, medical history, or information possibly relevant to your surgery. Any misrepresentations, purposeful or otherwise, may lead to improper treatment and potentially adverse reactions to proposed medications. Any purposeful misrepresentation related to the information presented in this record may result in termination of the doctor-patient relationship and any care with our organization.

LIST ALL MEDICATIONS - PRESCRIBED OR NON-PRESCRIBED

LIST ALL ALLERGIES INCLUDING LATEX - PLEASE LIST ALLERGEN, REACTION AND SEVERITY

LIST ALL PREVIOUS HOSPITALIZATIONS AND SURGERIES

HAVE YOU TAKEN/USED

Smoke or vape? No — How much per day:_____ For how many years_____

Use illicit or recreational drugs? No — How long ago:_____

Drink alcoholic drinks? No — How many per day:_____ How many days/week:_____

DO YOU HAVE A PERSONAL HISTORY USING ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY.

- ◯ Heart Disease
- ◯ Autoimmune Disorders
- ◯ Diabetes
- ◯ High Blood Pressure
- ◯ Low Blood Pressure
- ◯ Keloids
- ◯ Cold Sores/Fever Blisters
- ◯ Liver Disease/Hepatits
- ◯ Kidney Disease
- ◯ Seizures/Epilepsy
- ◯ Benign Breast Disease
- ◯ Malignant Breast Disease
- ◯ HIV/AIDS
- ◯ Genital or Oral Herpes
- ◯ Stomach Ulcers
- ◯ Bleeding Disorders/Easy Bruising
- ◯ Metal Implants/Pacemaker
- ◯ Family history of breast disease

HAVE YOU TAKEN OR USED ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY.

- ◯ Accutane
- ◯ Benzoyl Peroxide
- ◯ Retin-A
- ◯ Tretinoin
- ◯ Renova
- ◯ Retinols
- ◯ Glycolic Acid
- ◯ Salicylic Acid

When was the last time you used any of these?_____

FAMILY AND BREAST HEALTH

Are you pregnant? No — Number of pregnancies:_____ Last mammogram:_____

Are you breast feeding? No — Number of children:_____ Current bra size:_____

Planning more pregnancies? No — Children's ages: _____ Desired bra size:_____

FOR SURGERY USE ONLY - INFORMATION UPDATED AND REVIEWED

DR. SIGNATURE:_____ DATE: _____

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PATIENT RIGHTS & RESPONSIBILITIES

I. Patient Rights:

Constantine Cosmetic Surgery has adopted the following statement of patient rights and responsibilities. This list shall include, but not be limited to, the patient's right to:

A. Be informed of his or her rights as a patient in advance of, receiving care. The patient may appoint a representative to receive this information should he or she so desire.

B. Exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment for care.

C. Considerate, respectful and dignified care, provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.

D. Access protective and advocacy services or have these services accessed on the patient's behalf.

E. Appropriate assessment and management of pain.

F. Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see him/her. The patient has a right to change providers if other qualified providers are available.

G. Be advised the physician has a financial interest in the surgery center.

H. Receive complete information from his/her physician about his/her illness, course of treatment, alternative treatments, outcomes of care (including unanticipated outcomes), and his/her prospects for recovery in terms that he/she can understand.

I. Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.

J. Participate in the development and implementation of his or her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.

K. Be informed of the facility's policy and state regulations regarding advance directives and be provided advance directive forms if requested.

L. Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual involved in his or her healthcare.

M. Confidential treatment of all communications and records pertaining to his/her care and his/her stay at the facility. His/her written permission will be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.

N. Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communications specific to the vision, speech, hearing cognitive and language-impaired patient will be appropriate to the impairment.

O. Access information contained in his or her medical record within a reasonable time frame.

P. Be advised of the facility's grievance process, should he or she wish to communicate a concern regarding the quality of the care he or she receives. Notification of the grievance process includes: whom to contact to file a grievance, and that he or she will be provided with a written notice of the grievance determination that contains the name of the facility's contact person, the steps taken on his or her behalf to investigate the grievance, the results of the grievance and the grievance completion date.

Q. Be advised of contact information for the state agency to whom complaints can be reported, as well as contact information for the Office of the Medicare Beneficiary Ombudsman.

R. Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment or services.

S. Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trials. This includes the patient's right to a full informed consent process as it relates to the research, investigation and/or clinical trial. All information provided to subjects will be contained in the medical record or research file, along with the consent form(s).

T. Be informed by his/her physician or a delegate of his/her physician of the continuing healthcare requirements following his/her discharge from the facility.

U. Examine and receive an explanation of his/her bill regardless of source of payment.

V. Know which facility rules and policies apply to his/her conduct while a patient.

W. Have all patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

All facility personnel, medical staff members and contracted agency personnel performing patient care activities shall observe these patients' rights.

II. Patient Responsibilities:

The care a patient receives depends partially on the patient himself. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities should be presented to the patient in the spirit of mutual trust and respect:

A. The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications (including over the counter products and dietary supplements), allergies and sensitivities and other matters relating to his/her health.

B. The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.

C. The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.

D. The patient is responsible for keeping appointments and for notifying the facility or physician when he/she is unable to do so.

E. Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours unless exempted from that requirement by the attending physician.

F. In the case of pediatric patients, a parent or guardian is to remain in the facility for the duration of the patient's stay in the facility.

G. The patient is responsible for his/her actions should he/she refuses treatment or not follow his/her physician's orders.

H. The patient is responsible for assuring that the financial obligations of his/her care are fulfilled as promptly as possible.

I. The patient is responsible for following facility policies and procedures.

J. The patient is responsible to inform the facility about the patient's advance directives.

K. The patient is responsible for being considerate of the rights of other patients and facility personnel.

L. The patient is responsible for being respectful of his/her personal property and that of other persons in the facility.

GRIEVANCES:

We want your experience at Constantine Cosmetic Surgery to be a positive one. We strive to provide the best in patient care. Should you have a concern regarding the care you receive at Constantine Cosmetic Surgery, please bring it to our attention right away and we will strive to resolve it promptly. If at any time you feel your concerns are not being resolved accordingly, please direct them to the Administrator at:

Constantine Cosmetic Surgery
Attn: Administrator
5929 Fashion Boulevard
Murray, UT 84107
801.261.3637

Medicare beneficiaries can get information and help to understand their Medicare options (and to apply their rights and protections) at www.cms.hhs.gov/center/ombudsman.asp. Patients may also submit concerns directly to the Utah Health Facility Licensing, Certification and Resident Assessment at:

HFLCRA
Attn: Complaint Manager
PO Box 144103
Salt Lake City, Utah 84114
1-800-662-4157

ADVANCE DIRECTIVES:

The Utah Department of Human Services strongly recommends that individuals have a document that carefully sets out what their wishes are for end of life medical care and/or who should make medical decisions if the individual is unable to decide for themselves. This document is called an Advance Directive. It helps others give you the care you would want when you cannot make health care decisions. The State of Utah website (http://www.hsdaas.utah.gov/advance_directives.htm) provides the tools, instructions and forms you need to create an advance directive. Official State advance directive forms are also available at our surgery center.

Unlike in an acute care hospital setting, the surgery center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Therefore, it is our policy, regardless of the contents of any advance directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at this facility we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital further treatment, or withdrawal of treatment measures already begun, will be ordered in accordance with your wishes, advance directive or health care power of attorney.

Constantine Cosmetic Surgery is owned and operated by the Facility Director, Dr. Steven T. Constantine.

Patient Signature _____ Date_____

By signing above, I acknowledge my rights and responsibilities as a patient of Constantine Cosmetic Surgery.

CONSTANTINE
COSMETIC SURGERY

HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office taff and thers outside of our office t t are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the Law, we must make disclosures to you and when required by the Secretary and the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500.

Other Permitted and Required Uses and Disclosures: Will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at anytime, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notific tion purposes as described in this Notice of Privacy Practices. Your request must state the specific re triction requested and whom you want the restriction to apply.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e.: electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a tatement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a omplaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA compliance Offic in person or by phone at our main phone number.

Signature below is only acknowledgment that you received this Notice of our Privacy Practices.

Patient Signature: _____ Date: _____

CONSTANTINE
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CONSENT FOR VIRTUAL OR TELEPHONE CONSULTATION

I, _____, understand Constantine Cosmetic Surgery are located in the State of Utah. Dr. Constantine is a licensed physician in the State of Utah. The virtual or telephone consultation is not a prescribed treatment, but rather a discussion of elective surgical procedures and/or treatments.

The virtual or telephone consultation is a means for me to get detailed information about a procedure. Any tentative surgical plans need to be confirmed by an in-person consultation with an appropriate examination and do not constitute medical treatment.

Patient Signature: _____ Date: _____

SUBMIT FORMS

Once signed below, your documents will be ready to submit. We look forward to connecting with you soon.

DIGITAL SIGNATURE: _____ DATE: _____

Submit Forms