James E Hardy MD Plastic Surgery LLC

11512 Lake Mead Ave Suite 605 P#904-996-0600 F#904-996-0650

PATIENT DEMOGRAPHIC AND HISTORY QUESTIONNAIRE

Please present your insurance cards and photo ID to the receptionist so copies may be made

LAST_____ FIRST_____M.I._____

STREET ADDRESS _____

CITY_____ STATE_____ ZIP_____ HOME PHONE_____

CELL #_____ WORK PHONE_____SEX_____ MARITAL STATUS_____
(Cell phone carrier)

SSN#_____DATE OF BIRTH_____OCCUPATION_____

E-MAIL ADDRESS _____

How did You Hear about Us_____

EMERGENCY CONTACT PERSON & TEL. NO._____

PRIMARY DOCTOR'S & TEL NO._____

PHARMACY NAME & TEL NO._____

If Student: ☐ Full Time ☐ Part Time Name of School _____

Spouse: _____ Spouse Date Of Birth: _____

In order to establish optimal relations with the patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of the office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVIENCE.Your Signature below indicates that you understand and accept this policy. Further, your signature authorizes the doctor to release such medical information if necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the doctor when assigned claim is filed.

_____ _____
Signature Date

Insured Party (If Different):_____DOB:____/ ____/____ SS#_____
Employed By:_____ Patient relationship to insured: ☐ Child ☐ Other: _____
_____
Address

Do we have permission to?

- ☐ Send an email for appointment reminders, additional information, and promotional messages?
- ☐ Send text message for appointment reminders and promotional messages?
- ☐ Leave a message on your answering machine at home?
- ☐ Leave a message at your place of employment?
- ☐ Discuss your medical conditions with any member of your household?

If yes, whom: _____ Relationship: _____

Staff Signature_____ Date _____

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Personal History Questionnaire

Date: _____-_____-_____

Name_____ DOB _____-_____-_____ Age _____
Last First MI

Height: _____ Ft: _____ In:_____ Sex: M F Marital Status: □ Single □ Married □ Widowed □ Divorced
Weight:_____

Date of last physical exam: _____-_____-_____ Doctor _____ Referring Doctor _____

Phone:_____-_____ Purpose of consultation: _____

How did you hear about Dr. James Hardy? _____

Past Medical History: Do you have or have had? (I**f yes, give date occurrence.)**

AIDS or HIV	**N Y** _____	Bleeding Tendencies	**N Y** _____	Asthma	**N Y** _____
Thyroid	**N Y** _____	Blood pressure	**N Y** _____	Lupus	**N Y** _____
Heart	**N Y** _____	Lungs	**N Y** _____	Cancer	**N Y** _____
Kidneys	**N Y** _____	Nervous problems	**N Y** _____	Fibromyalgia	**N Y** _____
Gallbladder	**N Y** _____	Bleeding problems	**N Y** _____	Arthritis	**N Y** _____
Stomach	**N Y** _____	Diabetes	**N Y** _____	Scleroderma	**N Y** _____
Hepatitis	**N Y** _____				

Other Serious illness you have had_____
Do you regularly smoke? **N Y** _____ How much per day-_____ Do you regularly drink over 3 cups of coffee per day? **N Y** _____
Do you regularly drink alcohol or beer? **N Y** _____ How much per week? _____

Medications: Are you presently taking any of the following? (Circle)

Asprin/Anacin	Cough medicine	Antibiotics	Phenobarbital	Dilantin	Bufferin	Thyroid pills	Blood pressure pills
Blood thinners	Iron	Motrin	Hormones	Insulin/diabetic pills		Digitalis	Sleeping pills
Ibuprofen	Birth Control pills	Arthritis medication		Cortisone		Water pills	

Please list specific medicines_____
Do you take herbal supplements? **N Y** How much per day?_____

Aspirin and aspirin type products can cause excessive bleeding during surgery.
DRUGS OR SUBSTANCE TO WHICH YOU ARE ALLERGIC? _____

Family History: Have blood relatives? (Please circle and give reason)

High Blood Pressure _____	Arthritis _____	Asthma_____
Diabetes_____	Stroke_____	Golter_____
Bleeding Disorder_____	Breast Cancer_____	Other cancer_____

Serious Illness or injuries; please list any serious illness, injuries or hospitalizations.
Illness/Injury_____Year _____
Illness/Injury_____Year_____
Operations: Please list operations and year
Operation_____Year_____Operation_____Year_____
___

Women Only
Chance you may be pregnant? **N Y** Regular Menstrual? **N Y** Date of last menstrual period? _____
How many pregnancies?_____ How many Children? _____ Did you breast feed?_____ How many/_____
Any complications with pregnancies?_____
Date of last mammogram: _____ □ Normal □ Abnormal Specify Abnormalities: _____
Bra Size _____ Breast Cancer: **L R** Date:_____ Mastectomy_____
Date_____
Breast biopsy **L R** Date _____ Surgeon for breast biopsy _____ Address
_____
Oncologist: _____ Address _____

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Cosmetic Questionnaire

***Patient Name*_____ *Date*___-___-_____**

What areas of your body would you like to improve or enhance?

- ☐ ***Breast (Enlargement, reduction, lift)***
- ☐ ***Face** (Forehead, jowls, eyelids, nose, ears)*
- ☐ ***Neck***
- ☐ ***Torso** (Abdomen, love handles, back)*
- ☐ ***Thighs/ Legs***
- ☐ ***Arms***
- ☐ ***Skin Management*** (wrinkles, brown/red spots)
- ☐ ***Hair** (Balding)*

Are you interested in any of the following procedures? (Please check all that apply)

- ☐ ***Breast Augmentation***
- ☐ ***Breast Lift (Mastopexy)***
- ☐ ***Breast Reduction***
- ☐ **Face *Lift***
- ☐ ***Brow Lift (Endoscopic)***
- ☐ ***Neck Lift***
- ☐ ***Eyelid Surgery (Blepharolplasty)***
- ☐ ***Nose Reshaping (Rhinoplasty)***
- ☐ ***Tummy Tuck (Abdominoplasty)***
- ☐ ***Thigh Lift***
- ☐ ***Vaser Liposelection (Liposuction)***
- ☐ ***Arm Lift (Brachioplasty)***
- ☐ ***Lip Lift***
- ☐ ***Lip Augmentation***
- ☐ ***Hair Transplant***
- ☐ ***Ear Tuck (Otoplasty)***
- ☐ ***Cheek Augmentation** (Malar Augmentation)*
- ☐ ***Calf Augmentation***
- ☐ ***Gluteal Augmentation** (Buttocks Lift)*
- ☐ ***Fraxel Laser Treatment***
- ☐ ***CO2 Laser Treatment***
- ☐ ***Chin Augmentation***
- ☐ ***Botox Treatments***
- ☐ ***Juvederm Treatments***
- ☐ ***Restylane Treatments***
- ☐ ***Perlane Treatments***
- ☐ ***Sculptra Treatments***
- ☐ ***Male Chest Enhancement***
- ☐ ***Please inquire about other services not listed***

Would you like information on medical spa or to talk to one of aestheticians about a skin care consult, massage and/or facial today? ☐ ***yes*** ☐ ***no***

May we contact you with information regarding updates in cosmetic procedures or skin care products?

☐ ***yes*** ☐ ***no***

If yes please list: Phone# _____ ***and/or Email Address***_____

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Patient: _____ _ UR#_____ DOB: _____ Procedure Date: _____

PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I,_____, authorize James Hardy MD Plastic Surgery Center and Medical Spa, and/or his representative(s), to take photographs, slide, or videotapes of me or parts of my body for the following procedure(s): _____, and for medical purposes to be used for my care, medical presentations and/or articles.

In addition, I authorize the use of these images, without compensation to me, for the following specific purposes: (Please **initial** in the boxes marked **Yes** or **No** for each item)

		MEDIUM
		in the office **photo album** for prospective patients.
		in office **seminars** for prospective patients.
		on our **website** for prospective patients.
		in print **advertisements**.
		on **television**.
Additional Comments:		

I understand that:

1. Such photographs, slides, or videotapes may be published by James Hardy MD Plastic Surgery Center and Medical Spa, in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and internet web sites, for the purpose of informing the medical profession or the general public about dermatology methods. I understand that such uses may also include marketing on behalf of Dr. Hardy, for which Dr. Hardy may receive direct or indirect remuneration.
2. I will not be identified by name in any of the media described above: however, I also understand that in some circumstances the photographs, slides, or videotapes may display features that identify me.
3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to Current office Administrator at 11512 Lake Mead Avenue, Suite 605. A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization. If I do not revoke this authorization, it shall expire on the following date, event, or condition: 5 years from date of surgery/close of practice/death of patient.
4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr Hardy.

Signature:_____ Date:_____

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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.

If you have any questions about this notice, please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations 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.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at the time. Upon your request, we will provide you with any revised Notice of Privacy Practices by www.bodycontourinstitute.com or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

I. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

Once you have reviewed and signed this notice, your physician will use or disclose your protected health information as described in this Section I. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment of the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's care.

Following are examples of the types of uses and disclosures of your protected health information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

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 that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. 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.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. 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, marketing and fundraising activities, 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 there 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 appointments.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.
We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact your for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to indentify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by the appropriate military command authorities; (2) for the purpose of determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose protected health information to authorized federal officials for conduction national security and intelligence activities, including for the provision of protective services to the President or other legally authorized.

Worker's Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Used and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

Research (ONLY IF APPLICABLE): We may disclose your protected health 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 protected health information.

II. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

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. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

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 for the purposes of treatment, payment of healthcare options. You may also request that and part of your protected health information not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you and the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you with to request with your physician. You may request a restriction by contacting the privacy officer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking your for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. The right applies to disclosures for purposed other than treatment, payment, or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members of friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain expectations, restrictions and limitations.

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 electronically.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with you written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that you physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to you health care will be disclosed.

Others involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly related to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relieve efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclose under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements by the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized). In certain conditions in response to subpoena, discovery request or other lawful process.

Law Enforcement: We may disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not the Practice's premises) and it is likely that a crime had occurred.

III. Complaints

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

You may contact our Privacy Officer at (904) 247-8522 or for further information about the complaint process.

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

Acknowledgement

I acknowledge that I have read and understand James E Hardy MD plastic Surgery LLC Notice of Privacy Practices and consent to the use or disclosure of my protected health information by James E Hardy MD plastic Surgery LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, to conduct health care operations of James E Hardy MD plastic Surgery LLC, and as required by law.

I have received information regarding the providers of care in this organization, information on receiving a copy of the Patients Bill of Rights and Responsibilities, and information regarding the grievance process.

I also acknowledge that I understand my rights as a patient of this practice concerning my Protected Health Information, as it is outlined in this notice. I am aware James E Hardy MD plastic Surgery LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Name of Patient of Personal Representative	
Signature of Patient or Personal Representative	
Date	
Description of Person Representative's Authority	

James E Hardy MD Plastic Surgery LLC
11512 Lake Mead Ave Suite 605 Phone# 904-996-0600 Fax # 904-996-0650

PATIENT WORKSHEET

Today's Date: _____

Name: _____

Address: _____
Street City State Zip

Birth: _____Age: _____Sex (M) (F)

Height: _____Weight:_____

Home_____Business_____Cell_____

Email: _____Fax:_____

SSN#:_____Next of Kin: _____

Insurance Carrier _____Number_____

Insured's Name_____

Person Responsible for Bill_____

Operative Procedures

For Office Use Only

Pre-consultation: Information, Questions, and Instructions
By: _____Comments:_____
_____

CONSULTATION
Date: _____Examination, History &
Questionnaire, Book, Photo, Procedure & Recommendations

Operative Procedures