PHYSICIANS HAIR RESTORATION

HEALTH INFORMATION AS OF:

(Please Print Legibly & Fill In or Correct All Fields)

Patient Name: . M/F		Name You Prefer To Be Called:		
Home Address: City: , State: , Zip:				
Cell Phone # Home Phone #		E-Mail:	Marital Status:	
Emergency Contact:		Phone #	Relationship To Patient:	
Employer/Occupation:		Name Of Spouse:		
DOB:	Age:	Social Security #	Weight:	Height:

DO YOU NOW OR HAVE YOU EVER HAD..... (You must circle an answer for each individual item)

Heart Trouble	Yes	No	Glaucoma or Eye Problems	Yes	No
Heart Attack	Yes	No	Visual Disturbances	Yes	No
Heart Pain	Yes	No	Dry Eyes	Yes	No
Palpitation or Irregular Pulse	Yes	No	Other Eye Problems	Yes	No
Extra Heart Beats	Yes	No	Hepatitis	Yes	No
Stroke	Yes	No	Yellow Jaundice	Yes	No
Hypertension	Yes	No	Gallstones or Gallbladder Trouble	Yes	No
Blood Pressure Abnormalities	Yes	No	Cirrhosis of the Liver	Yes	No
Abnormal EKG	Yes	No	Alcoholism or Drug Dependency	Yes	No
Rheumatic Fever	Yes	No	Esophageal Varices	Yes	No
Heart Failure	Yes	No	Frequent Indigestion	Yes	No
MRSA infection	Yes	No	Ulcers	Yes	No
Shortness of Breath	Yes	No	Gastritis	Yes	No
Chest Pain	Yes	No	Colitis	Yes	No
Asthma	Yes	No	Problem Constipation	Yes	No
Sleep Apnea	Yes	No	Vomiting Blood	Yes	No
Deep vein thrombosis or blood clots	Yes	No	Diarrhea	Yes	No
Pneumonia	Yes	No	Tarry or Bloody Bowel Movements	Yes	No
Tuberculosis	Yes	No	Any family members with bleeding problems	Yes	No
Smokers Cough	Yes	No	Goiter or Thyroid Disorders	Yes	No
Emphysema	Yes	No	Diabetes	Yes	No
Coughing or Spitting of Blood	Yes	No	Skin Disorders	Yes	No
History of cortisone or other prednisone use	Yes	No	Arthritis	Yes	No
Tape or Adhesive allergy	Yes	No	Fracture of Neck or Spine	Yes	No
Bell's Palsy or Paralysis	Yes	No	Bleeding Tendency or Disorder	Yes	No
Nervous Breakdown	Yes	No	Abnormal Bleeding after Tooth Extraction	Yes	No
Nervous Disorder	Yes	No	Airway Obstruction (Nasal)	Yes	No
Family history of breast cancer	Yes	No	Breast Cysts, Tumors, Abscesses	Yes	No
Drug Habit	Yes	No	Nipple Discharge (Apart from Normal Lactation)	Yes	No
Self-Destructive Tendencies	Yes	No	Kidney Disorder	Yes	No
Psychiatric Hospitalization or Care	Yes	No	Blood Transfusion	Yes	No
Thyroid Problems	Yes	No	Seizures or convulsions or fainting spells	Yes	No
Kidney or Renal Disease	Yes	No	Heavy Menstrual Period	Yes	No
Heart murmur	Yes	No	Dentures, bridges, capped teeth or crowns	Yes	No
Piercing other than the ears	Yes	No	Loose teeth	Yes	No
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No	Cosmetic bonding to teeth	Yes	No

Please list all **PRESCRIPTION MEDS** (include dosages): _____

_____

_____

Please list all **OVER THE COUNTER MEDS/SUPPLEMENTS:** _____

_____

Using Hormones Presently? ☐No ☐Birth Control Pill ☐IUD ☐Nuva Ring ☐Bio-identical Hormone Replacement

Drug Allergies? ☐No ☐Yes _____

Latex Allergy? ☐No ☐Yes

Do You currently smoke? ☐No ☐Yes.....If so, how much?_____.....For how long?_____

Did you recently quit smoking? ☐No ☐Yes.....When?_____

Alcohol Consumption? ☐occasionally ☐often ☐never

How many times have you given birth? ☐0 ☐1 ☐2-4 ☐>4 **.....Have you had a C-Section?** ☐Yes ☐No

Exercise Tolerance (check all that apply):

- ☐I exercise regularly
- ☐I am able to easily climb a flight of stairs with a bag of groceries in each hand
- ☐I am able to do yard work or garden without any difficulty
- ☐I am able to vacuum, mop, and perform other household chores without difficulty
- ☐I get short of breath whenever I physically exert myself

List **ALL PRIOR SURGERIES** (non-cosmetic AND cosmetic, including approximate dates):

_____

_____

Have you had a **mammogram** in the last 12 months? ☐Yes ☐No

Who is your **primary care physician**? _____

Where is the practice located (city) _____

How did you initially hear about Physicians Hair Restoration?
☐**Internet** ☐**Television** ☐**Magazine** ☐**Physician** ☐**Friend**_____

Which of the following websits do you use, when reading and writing reviews?
☐**Angie's List** ☐**Yelp** ☐**Google** ☐**Healthgrades** ☐**Vitals** ☐**Facebook** ☐**I have never written a review**
☐**Other** _____

By signing below, I agree that the above information is complete and accurate to the best of my knowledge

Signature: _____ Date:_____

I acknowledge that I am in receipt of the Notice of Privacy Practices.

Signature:(Must be parent or guardian for children 17 and under)_____ Date:_____

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in this office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goals of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to personals other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications information you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to confirm to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

Patient Name: Date of Birth:

FINANCIAL POLICY

RESPONSIBILITY
As a recipient of our services you are responsible for the charges associated with the services you receive. We will assist you in applying for financing if this is a need. This is a service we offer our patients. It is YOUR responsibility to fully understand the financing options before you apply. You remain legally and fully responsible for your entire bill.

TREATMENT COMPLICATIONS AND REFUNDS
The practice of medicine and surgery is not an exact science. Although good results are anticipated, there can be no guarantee or warranty, expressed or implied, by anyone as to the actual results that you may get. Surgical revisions and/or other medical treatment or management of problems and/or complications may be required. These will result in additional charges for which you will be responsible. Refunds will not be issued under any circumstances. For cases involving liposuction, patients will be eligible for revision only if they have not exceeded their goal weight post-procedure.

REVIEW POLICY
We strive to provide you with exceptional care and results. We appreciate your referrals and review of our practice. In the rare instance that you are dissatisfied we will address your concerns in a private and personal manner that will always protect your private information, In addition, you understand the reputation of our business is important & that negative reviews online can be viewed as slanderous and detrimental to our business. As our patient, you agree not to post negative reviews online

SCHEDULING YOUR PROCEDURE
In order to schedule your office procedure/surgery with The Refine Institute, we require that you pay 50% of your procedure fee as a deposit. The remaining balance will be due in-full three weeks prior to your procedure at your pre-op appointment. Because there are processing fees that are incurred when scheduling a surgery, $750 of this 50% deposit will be non-refundable if a surgery is cancelled *and not re-booked* 21 business days or more prior to your scheduled surgery date. Surgeries that are re-scheduled will incur a fee as listed below:

RESCHEDULING SURGERY
It is important that when you schedule your surgery at The Refine Institute you have thoroughly reviewed your personal calendar to make sure that your scheduled surgery date is ideal for you. Costs incurred by our office to re-schedule your procedure will be assessed according to the schedule below, if another patient cannot be moved into your surgical appointment time. If your time can be filled with another patient, the fee will be waived.
*If surgery is re-scheduled 14 business days or more prior to your surgery you will be charged a $100 re-schedule fee. Payment will be collected prior to your procedure.
*If surgery is re-scheduled 2-13 business days prior to your surgery you will be charged a $500 re-schedule fee.
*If surgery is re-scheduled 48 hours or less prior to your surgery, you will be charged a $1,000 re-schedule fee.

CANCELLING SURGERY
It is important to understand that surgical times are in high demand. By cancelling your appointment with less than 30 days notice, The Refine Institute may incur the cost of an empty OR suite, staffing, supplies and anesthesia costs as stated above. In addition to this, there are billable services that occur as we prepare for your surgery and are included in your surgery fee. If you choose to cancel your procedure, as a patient you are still financially responsible for these services. An itemized bill of these services will be provided to you within 14 days of receiving your cancellation request.

***All cancellation requests are required in writing to the office. Either email to admin@refineinstitute.com or fax to (704) 909-4801**

*If surgery is cancelled and not re-scheduled 30 business days or more prior to surgery, your 50% surgery deposit will be refunded, with the exception of the $750 non-refundable fee.
*If surgery is cancelled and not re-scheduled within 15 - 20 business days prior to surgery then you will be charged 25% of your surgery, operating room, and anesthesia fees.
*If surgery is cancelled and not re-scheduled within 2 –14 business days prior to surgery then you will be charged 50% of your surgery, operating room, and anesthesia fees.
*If surgery is cancelled and not re-scheduled in less than 48 hours prior to your surgery, you will be charged 75% of your surgery, operating room, and anesthesia fees.
** Any refund from cancellations will be subject to our financial review process. Once reviewed, your refund will be processed and will be received within 60 business days.

PROCESSING FEES

if you request FMLA, disability or any other paperwork be completed bring all documents with you to your pre op appointment or send to our office at least 3 weeks prior to your procedure. Please complete all line items requiring information pertaining to the employee. Failure to do so may delay completion of your paperwork. Be aware that the office will complete your paperwork with in 15 business days and there is a $50.00 processing fee due when you submit your paperwork.

Signature _____ **Date** _____

Patient Name: .

PHYSICIANS HAIR RESTORATION

HAIR EVALUATION FORM

At what age did your hair loss begin?

15-20 21-25 26-30 31-35 36-40 40+

How fast are you losing hair at this time?

SLOW FAST MODERATE VERY FAST

Who has the worst hair loss in your family?

FATHER MOTHER BROTHERS SISTERS GRANDPARENTS

Do you resemble this family member's pattern of hair loss? YES NO

Have you ever taken in the past either of the following?

Propecia (finasteride) YES NO

Rogaine (minoxidil) YES NO

On the following Norwood or Ludwig Scale of Hair Loss, please:

Circle the diagram closest to your current hair loss pattern