

THE
REFINE
INSTITUTE

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 # | E-Mail: | | Marital Status: | |
| Home Phone # | | | | |
| Emergency Contact: | | Phone # | Relationship To Patient: | |
| Employer/Occupation: | | Name of Spouse: | | |
| DOB: | Age: | Social Security # | Weight: | Height: |
| What surgery are you considering? | | | | |

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

| | | |
|---|-----|----|
| Heart Trouble | Yes | No |
| Heart Attack | Yes | No |
| Heart Pain | Yes | No |
| Palpitation or Irregular Pulse | Yes | No |
| Extra Heart Beats | Yes | No |
| Stroke | Yes | No |
| Hypertension | Yes | No |
| Blood Pressure Abnormalities | Yes | No |
| Abnormal EKG | Yes | No |
| Rheumatic Fever | Yes | No |
| Heart Failure | Yes | No |
| MRSA infection | Yes | No |
| Shortness of Breath | Yes | No |
| Chest Pain | Yes | No |
| Asthma | Yes | No |
| Sleep Apnea | Yes | No |
| Deep vein thrombosis or blood clots | Yes | No |
| Pneumonia | Yes | No |
| Tuberculosis | Yes | No |
| Smokers Cough | Yes | No |
| Emphysema | Yes | No |
| Coughing or Spitting of Blood | Yes | No |
| History of cortisone or other prednisone use | Yes | No |
| Tape or Adhesive allergy | Yes | No |
| Bell's Palsy or Paralysis | Yes | No |
| Nervous Breakdown | Yes | No |
| Nervous Disorder | Yes | No |
| Family history of breast cancer | Yes | No |
| Drug Habit | Yes | No |
| Self-Destructive Tendencies | Yes | No |
| Psychiatric Hospitalization or Care | Yes | No |
| Thyroid Problems | Yes | No |
| Kidney or Renal Disease | Yes | No |
| Heart murmur | Yes | No |
| Piercing other than the ears | Yes | No |
| Positive blood test for: HIV, AIDS, Hepatitis | Yes | No |

| | | |
|--|-----|----|
| Glaucoma or Eye Problems | Yes | No |
| Visual Disturbances | Yes | No |
| Dry Eyes | Yes | No |
| Other Eye Problems | Yes | No |
| Hepatitis | Yes | No |
| Yellow Jaundice | Yes | No |
| Gallstones or Gallbladder Trouble | Yes | No |
| Cirrhosis of the Liver | Yes | No |
| Alcoholism or Drug Dependency | Yes | No |
| Esophageal Varices | Yes | No |
| Frequent Indigestion | Yes | No |
| Ulcers | Yes | No |
| Gastritis | Yes | No |
| Colitis | Yes | No |
| Problem Constipation | Yes | No |
| Vomiting Blood | Yes | No |
| Diarrhea | Yes | No |
| Tarry or Bloody Bowel Movements | Yes | No |
| Any family members with bleeding problems | Yes | No |
| Goiter or Thyroid Disorders | Yes | No |
| Diabetes | Yes | No |
| Skin Disorders | Yes | No |
| Arthritis | Yes | No |
| Fracture of Neck or Spine | Yes | No |
| Bleeding Tendency or Disorder | Yes | No |
| Abnormal Bleeding after Tooth Extraction | Yes | No |
| Airway Obstruction (Nasal) | Yes | No |
| Breast Cysts, Tumors, Abscesses | Yes | No |
| Nipple Discharge (Apart from Normal Lactation) | Yes | No |
| Kidney Disorder | Yes | No |
| Blood Transfusion | Yes | No |
| Seizures or convulsions or fainting spells | Yes | No |
| Heavy Menstrual Period | Yes | No |
| Dentures, bridges, capped teeth or crowns | Yes | No |
| Loose teeth | Yes | No |
| Cosmetic bonding to teeth | Yes | No |

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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 >4Have 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 Dr. Pratt or Dr. Augenstein and The Refine Institute?

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:(Parent or guardian for children 17 and under) _____ Date: _____



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

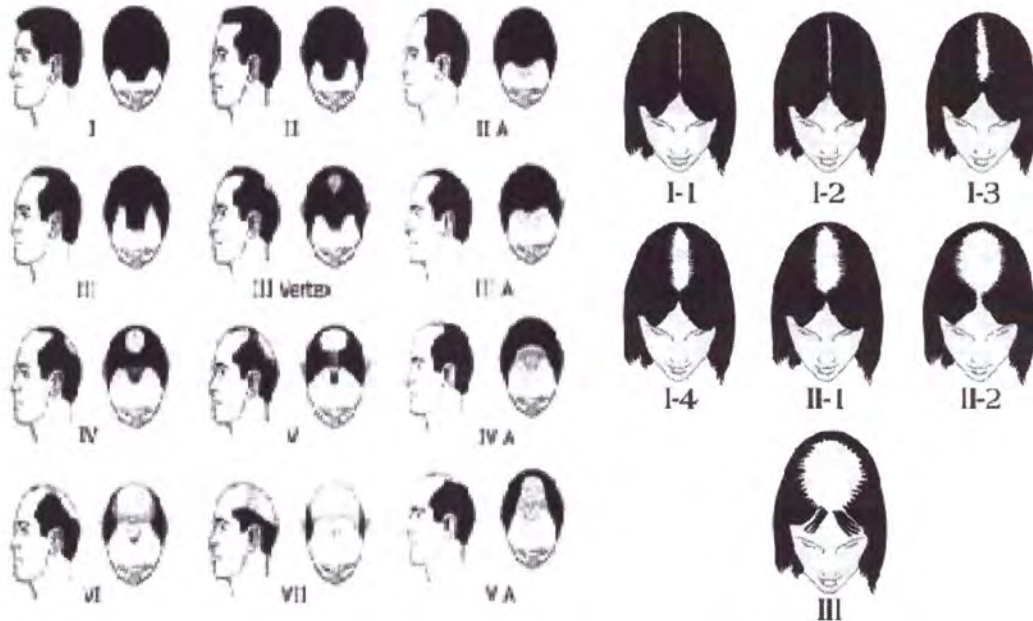
Have you ever taken in the past either of the following?

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





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 persons 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.

INSURANCE AND COSMETIC SURGERY

Hair Restoration procedures are **NOT** covered under health insurance. Any attempt to obtain insurance payment for these services is fraudulent. Our office will not assist anyone attempting to defraud an insurance company, this office, or any other entity. Attempting to defraud an insurance company, this office, or any other entity may result in civil and/or criminal penalties.

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.

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.

SURGERY RE-SCHEDULE & CANCELLATION POLICIES

SCHEDULING AN IN-OFFICE PROCEDURE

In order to schedule your office procedure with Physicians Hair Restoration, we require that you pay 50% of your procedure fee in advance. The remaining balance will be due in full three weeks prior to your procedure. Because of processing fees that are incurred when scheduling and coordinating an office procedure, \$750 of your payment will be non-refundable if you do not complete your commitment for any reason.

RESCHEDULING SURGERY

It is important that when you schedule your surgery at Physicians Hair Restoration that 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 not easy for us to fill at the last minute. By cancelling your appointment with less than 21 days notice, The Refine Institute may incur the cost of an empty OR suite and The Refine Institute's time that cannot be utilized by another patient as well as anesthesia fees. If you have paid your deposit by credit card, the refund will be applied back to the same account, however, you will be charged a 5% credit card processing fee.

*Any cancellations are required in writing. You can either email to admin@refineinstitute.com or fax to (704) 909-4801.

*If surgery is cancelled and not re-scheduled 21 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 money owed 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.

Patient Signature: _____ Date: _____