Jandali Plastic Surgery

PATIENT INFORMATION FORM

Name: First_____Middle_____Last_____

Address:_____

City_____ State _____ Zip Code _____

Home Phone #(____)_____-_____ Work #(____)_____-_____ Cell #(____)_____-_____

Emergency # (____)_____-_____ Emergency Contact Name _____ Relationship _____

Social Security Number_____-_____-_____ Date of Birth_____/_____/_____ Age: _____ □ Male □ Female

E-mail Address _____@_____

Who is your primary care physician? _____ Phone: (____) _____-_____
(If you go to a group please specify the name of the physician you see most often.)

Your privacy is of the utmost importance to us. Please indicate below if there are any restrictions in contacting you:
_____

PHARMACY INFORMATION

As of January 1, 2018 the State of Connecticut uses an e-prescribe system for all prescriptions.

Preferred Pharmacy Name: _____ Address: _____ Phone: _____

POLICY HOLDER INFORMATION (If Other Than Patient)

Name: _____Relationship to Patient _____ Date of Birth: ____/____/_____

Social Security Number: _____-_____-_____ Address: (if different from patient)_____

Employer Name, Address, & Phone _____(____) _____-_____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

____A Physician Name: _____ Phone: _____
____Family Member/Friend Name:_____
____Internet Website:_____
____Other Please explain_____

Authorization to Release Information: I authorize Dr. Shareef Jandali and Jandali Plastic Surgery to release any information necessary, acquired in the course of my treatment, to process insurance claims.
Authorization to Pay Benefits Directly: I authorize my insurance company to pay Dr. Shareef Jandali and Jandali Plastic Surgery directly for medical service rendered. I understand that I will be responsible for non-covered charges, balances after insurance company benefits, deductibles and copayments.
Insurance: I understand that Dr. Shareef Jandali participates with Medicare, Medicaid, and Connecticare. For all other private insurances, Dr. Jandali does not participate and is an out-of-network provider. I affirm that I elect to receive services from Dr. Jandali.
Physician Assistant (PA): I understand that Dr. Jandali operates with a Physician Assistant and bills for his/her services accordingly. Dr. Jandali also operates with hospital staff PAs for which the various hospitals bill separately. I understand my office visit can be scheduled with a Physician Assistant and services will be billed accordingly.

_____ _____
Signature Date

Name_____

Patient History Form

Do you have any medical problems:_____
_____
_____

What surgeries have you had and when:_____
_____
_____

Medications: (please list dosage and # of times taken daily; include over the counter and herbals remedies)
_____
_____
_____
_____

Allergies: (which medications and what happens)_____
_____

Personal Social History: (please circle or fill in)
What kind of work do you do:_____
Do you smoke? Yes No How much and for how long?_____
If you used to smoke but quit, how much, for how long, and when did you quit?_____
Do you drink alcohol? Yes No How much and how often?_____
Do you take aspirin daily? Yes No

Family Medical History: (please circle all that apply)

Heart Disease High Blood Pressure Respiratory Disease Diabetes

Neurological Disease Cancer None Other:_____

SYSTEM REVIEW: (circle Y for "yes" and N for "no")

Constitutional

Recent weight gain_____lb; loss_____lb		
Poor appetite	Y	N
Fatigue	Y	N
Fever	Y	N
Chills or sweats	Y	N

Eyes

Eye pain	Y	N
Blurry vision	Y	N
Double vision	Y	N

Ear, Nose, Mouth, and Throat

Frequent nose bleeds	Y	N
Ear pain	Y	N
Ringing in ears	Y	N
Sore throat	Y	N
Trouble swallowing	Y	N

Cardiovascular

Chest pain	Y	N
Palpitations	Y	N
Shortness of breath	Y	N
Swelling of feet or ankles	Y	N
Leg pain	Y	N
High blood pressure	Y	N

Respiratory

Difficulty breathing	Y	N
Chronic/frequent cough	Y	N
Spitting up phlegm/blood	Y	N

Gastrointestinal

Nausea or vomiting	Y	N
Diarrhea	Y	N
Constipation	Y	N
Blood in stool	Y	N
Abdominal pain	Y	N
Heartburn	Y	N

Musculoskeletal

Joint stiffness/pain/swelling	Y	N
Pain in bones	Y	N
Back pain	Y	N

Endocrine

Hormonal problems	Y	N
Diabetes	Y	N
Heat or cold intolerance	Y	N

Genitourinary

Trouble urinating	Y	N
Prostate/testicle/penis trouble	Y	N
Gynecological trouble	Y	N
Irregular periods	Y	N

Skin

Rashes	Y	N
Itching	Y	N
Eczema	Y	N

Hematological

Bleeding/bruising tendencies	Y	N
Anemia	Y	N
Prior blood transfusion	Y	N
Phlebitis	Y	N
Clots in legs (DVTs)	Y	N

Neurological

Frequent headaches	Y	N
Memory loss or confusion	Y	N
Convulsions or seizures	Y	N
Numbness or tingling	Y	N
Tremors	Y	N

Psychiatric

Depression	Y	N
Anxiety/nervousness	Y	N
Insomnia	Y	N

Immunology

Frequent infections	Y	N
Swollen glands	Y	N

Allergies

Latex	Y	N
Iodine or x-ray dye	Y	N
Anesthesia	Y	N

Height_____ Weight_____

Have you or anyone in your family ever had blood clots?	Yes	No
Have you or anyone in your family ever had a pulmonary embolism (clot in lungs)?	Yes	No
Have you or anyone in your family ever been diagnosed with a clotting disorder?	Yes	No
Have you or anyone in your family ever had a stroke?	Yes	No
Have you or anyone in your family ever been on blood thinners?	Yes	No
Have you ever been diagnosed with lupus or any autoimmune disease?	Yes	No
For female patients: have you ever had a miscarriage? How many?	Yes	No _____

Female Patients for Breast Surgery Only:

What is your bra and cup size? _____

Are you pregnant or lactating?	Yes	No
Did you breastfeed in the past?	Yes	No
Are you planning on breastfeeding again?	Yes	No
Do you have children? How many?	Yes	No _____

When was your last mammogram? _____ Was it normal? Yes No

What were the findings? _____

(Dr. Jandali will need a copy of your recent mammogram for any cosmetic breast surgery)

Have you ever had a breast biopsy? _____

*****Do YOU want to learn how to take care of your skin?*** YES NO

JANDALI PLASTIC SURGERY

PHOTOGRAPHY, AUDIO RECORDINGS, &VIDEO FOOTAGE CONSENT

Name _____

I consent to the taking of photos or video footage by Dr. Shareef Jandali or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Shareef Jandali or his designee.

I provide this authorization as a voluntary contribution for the limited purpose of including them in any print, visual or electronic media, social media, specifically including, but not limited to, websites, magazines, newspapers, media reports, medical journals, Facebook, Instagram, and textbooks, for the purpose of advertising or informing the medical profession or the general public about plastic surgery procedures and methods. I allow staff at Jandali Plastic Surgery to repost and share photos/videos on their personal social media accounts. I understand that third party reposting or sharing of social media content from Jandali Plastic Surgery is out of the practice's control.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the images may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Shareef Jandali.

I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation and I do hereby release Dr. Shareef Jandali, his agents and employees from all liability in connection with said actions.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I release and discharge Dr. Shareef Jandali and all parties acting under his license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____

Signature Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of _____ _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

_____ _____

Signature Date

Jandali Plastic Surgery

CONSENT FOR COMMUNICATION via E-MAIL or TEXT

I hereby consent to have Dr. Shareef Jandali communicate, where appropriate, with me or members of his staff, other physicians, nurse practitioners, physician assistants, billing services, and insurance carriers, via e-mailing or text messaging regarding aspects of my medical care and treatment. I understand that e-mail and text are not a completely confidential method of communication. I further understand that there is a risk that e-mail or text communications between my physician and others (listed above) regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. Our practice will take utmost care in protecting personal health information, but this form of communication is often necessary to maintain close patient care. I understand that in an urgent or emergent situation, I should call my provider or go to the Emergency Room and not rely on email and/or text messaging.

Patient Name: _____

Patient's Signature_____ Date_____

AUTHORIZATION FORM FOR PATIENT RECORDS RELEASE

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that my patient information may be subject to re-disclosure by the authorized recipients of the information listed below and that my information may no longer be protected by federal privacy regulations once it is disclosed.

Patient Name: _____

Patient's Signature_____ Date_____

Persons/entities authorized to receive my patient information:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

Specific description of the information to be used or disclosed (including date(s) if applicable):

_____

_____

_____

Jandali Plastic Surgery

ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/ LIMITED SPECIAL POWER OF ATTORNEY

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to **Shareef Jandali Plastic Surgery LLC** and **Shareef Jandali, MD,** (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of one or more of the Providers, or their attorney (or other representative) to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals)
for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against any person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account.

In the event the insurance carrier responsible for making medical payments to **Shareef Jandali Plastic Surgery LLC** and **Shareef Jandali, MD,** for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider including attorney fees and costs. To this end, Provider has exclusive settlement authority.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers (including Cohen Howard, LLP) or any other person or business that provides healthcare activity services as a "business associate' under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.
2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.
3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.
4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.
5. The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third-party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name: _____ Date:_____

Patient Signature: _____

Jandali Plastic Surgery

Late Cancellation & No-Show Policy
AUTHORIZATION FORM FOR CREDIT CARD CHARGE

At Jandali Plastic Surgery, we desire to offer the best service at all times and we value each patient's time in our office. When we make your appointment, we are reserving a room and staff for your particular needs. We understand that plans change. For this reason, we keep a wait list of patients who would like to be seen in the event of a cancellation.

We kindly request that you give us at least ***24 hours advance notice*** if you cannot make a scheduled appointment time or date. For a Monday appointment, you must cancel by Friday no later than 2 p.m. If no advance notice is given and an appointment is missed, there will be a **Late Cancellation/No-Show fee of $50**. All cancellations are to be made with the office, not with our answering service. For a late cancellation or no-show, your credit card will be charged ***$50*** on the day of the missed appointment.

PLEASE NOTE: Insurances do not cover No-Show or Late Cancellation Fees so you will be responsible for payment.

Courtesy calls to remind patients of appointments do not substitute for a No-Show or Late Cancellation.

If a Cosmetic Consult is missed or not cancelled 24 hours prior to the appointment, you will forfeit your $150 consultation payment.

Your credit card information will be kept in our secure files and will only be charged if there is a no-show or late cancellation for a scheduled appointment. A receipt will be sent to your address on file. If your credit card is declined, you will not be able to reschedule any future appointments until payment is remitted.

Credit Card (please circle): Visa Mastercard American Express Discover

Credit Card Number:_____ Security Code: _____

Expiration:_____ Zip Code for Billing Address: _____

I understand that the Late Cancellation & No-Show charge can be avoided if I give the office advance notice of at least 24 hours if I am unable to attend my scheduled appointment. I understand that this charge is nonrefundable.

I hereby authorize my credit card to be charged by Jandali Plastic Surgery in the event of a missed appointment or late cancellation.

Patient Name: _____

Patient's Signature_____ Date_____

Jandali Plastic Surgery

COSMETIC PROCEDURE DOWN PAYMENT AND FINANCIAL POLICY

At Jandali Plastic Surgery, the down payment fee to schedule and book the date of any cosmetic procedure, treatment, or surgery, is 10% of the total cost of the procedure.

- If the procedure or surgery is cancelled over 2 weeks before the surgery date, 50% of the down payment will be refunded.
- If the procedure or surgery is cancelled within 2 weeks of surgery, the full **DOWN PAYMENT IS NON-REFUNDABLE**, except in extenuating circumstances (proof may be requested).

Full payment for the procedure/surgery, implant (if applicable), facility fee, and anesthesia fee needs to be received within 2 weeks of scheduled surgery date, or the surgery will be cancelled or delayed, with loss of the down payment.

We also offer a layaway program to help patients who are not approved for financing and wish to make payments at regular intervals ***before*** surgery. This allows weekly or monthly payments with the full payment being paid 2 weeks before surgery.

The cosmetic procedure surgeon's fee quote will be good for six (6) months from the date of the consultation. This does not pertain to the implant cost or facility (operating room) and anesthesia fees, which are set by the hospital or surgery center, are subject to possible change, and are out of the control of Jandali Plastic Surgery.

From time to time, as an executive and discretionary measure, the surgeon's fees may be waived to assist patients in achieving their goals. This in no way indicates an admission of negligence or sub-standard care. This may include revisions/corrections within one year of surgery on a case-to-case basis. This does not include operating room charges, anesthesia charges, or cost of implants. Consideration of waived fees for revisions requires that you keep all postoperative appointments and that you demonstrate that postoperative instructions were followed.

At times, extenuating circumstances arise leading to a change in your reserved procedure or operating room date. In the event that this occurs, the surgical scheduler will notify you and work with you to accommodate the next most convenient date. Rescheduling of your surgery or procedure by our office does not entitle you to any discount of deposit paid or the overall cost of the procedure. If you cannot or desire not to proceed with surgery at another scheduled date, we will honor a full refund of your deposit.

Services that are performed that are paid with credit card, debit card, or with financing, are not eligible for post-care payment challenges. The practice encourages a complete postoperative care and follow-up interaction to address any issues that might arise.

Fees may be paid by cash, money order, Visa, MasterCard, Discover, American Express, CareCredit financing, or Alphaeon financing. Personal checks are NOT accepted.

I understand the Cosmetic Procedure Down Payment and Financial Policy.

Patient Name: _____

Patient's Signature_____ Date_____

Jandali Plastic Surgery

Notice of Privacy Practices and HIPAA Compliance

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, please contact our office at (203)374-0310.

Who will follow this notice?
Jandali Plastic Surgery provides health care to our patients in partnership with other professionals and health care organizations. The information privacy practices in this notice will be followed by:

- Any healthcare professional who treats you at our office.
- All departments and units of any of the hospitals or surgery centers to which Dr. Shareef Jandali has staff privileges.
- All employees, trainees, students, physician assistants, or volunteers at our office.
- Third party billing companies that work as independent contractors for billing purposes for Jandali Plastic Surgery

Our pledge to you:
We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by our office and any of the separate facilities and providers described above. We are required by law to:

- Keep medical information about you private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

How we may use and disclose medical information about you:
We may use and disclose medical information about you without your prior authorization for treatment (such as sending medical information about you to a specialist as part of a referral) (this includes psychiatric or HIV information if needed for purposes of your diagnosis and treatment); to obtain payment for treatment (such as sending billing information to your insurance company); and to support our healthcare operations (such as comparing patient data to improve treatment methods or for professional education purposes) (Note: only limited psychiatric or HIV information may be disclosed for billing purposes **without your authorization**). If you are treated in a specialized substance abuse program, your special authorization will be needed for most disclosures other than emergencies.)
Other examples of such uses and disclosures include contacting you for **appointment reminders** and telling you about or recommending **possible treatment options**, **alternatives**, **health-related benefits or services** that may be of interest to you. We may also contact you to support our **fundraising efforts.**
We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give our medical information about you, without prior authorization **for public health purposes, abuse or neglect reporting, health oversight audits or inspections, medical examiners, funeral arrangements and organ donation, workers' compensation purposes, emergencies, national security and other specialized government functions, and for members of the Armed Forces as required by Military Command authorities.** We also disclose medical information when required by law, such as in response to a request from **law enforcement** in specific circumstances, or in response to valid judicial or administrative orders or other **legal process**.
Under certain circumstances, we may use and disclose health information about you for **research purposes**, subject to a special approval process. We may also allow potential researchers to review information that may help them prepare for research, so long as the health information they review does not leave our facility, and so long as they agree to specific privacy protections.
We may disclose medical information about you to a friend or family member whom you designate or in appropriate circumstances, unless you request a restriction. We may also disclose information to disaster relief authorities so that your family can be notified of your location and condition.

Other uses of Medical Information:
In any other situations not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Right to Access and or Amend Your Records:
In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information is not maintained by us; or if we determine that your record is accurate. You may submit a written statement of disagreement with a decision by us not to amend a record.

Right to an Accounting:
You have the right to request a list of accounting for any disclosures of your health information we have made, except for uses and disclosures of treatment, payment, and healthcare operations, circumstances in which you have specifically authorized such disclosure and certain other exceptions.
To request this list of disclosures, indicate the relevant period which must be after July 1, 2011, but in no event for more than the last six years. You must submit your request in writing to our office as appropriate.

Right to Request Restrictions:
You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request and work to accommodate it when possible, but we are not legally required to accept it. We will inform you of our decision on your request. All written requests should be submitted to our office.

Requests for Confidential Communications:
You have the right to request that medical information about you be communicated to you in a confidential manner such as sending mail to an address other than you home, by notifying us in writing of the specific way or location for us to use to communicate with you.

Right to request a paper copy of this Notice:
You may receive a paper copy of this Notice from us upon request, even if you have agreed to receive this notice electronically.

Changes to this Notice:
We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in waiting areas and on our website at www.jandaliplasticsurgery.com. You can receive a copy of the current notice at any time. Copies of the current notice will be available each time you come to our office for treatment. You will be asked to acknowledge in writing your receipt of this notice.

Complaints:
If you are concerned that your privacy rights may have been violated, or you disagree with a decision made about access to your records, you may contact out office at (203)374-0310.
If you are not satisfied with our response, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our office can provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been offered a copy of this Notice of Privacy Practices.

Patient Name: _____

Patient's Signature_____ Date_____

JANDALI PLASTIC SURGERY
COVID-19 Coronavirus Risk - Consent Form

I understand that I am opting for an elective consult/office visit/treatment/procedure/surgery that is not urgent and may not be medically necessary. I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that Dr. Shareef Jandali, all the staff at Jandali Plastic Surgery, and all local hospitals are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective consult/office visit/treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective consult/office visit/treatment/ procedure/surgery, and I give my express permission for Dr. Shareef Jandali and all the staff at Jandali Plastic Surgery and to proceed with the consult/office visit/treatment/procedure/surgery.

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective consult/office visit/treatment/procedure/surgery can lead to a higher chance of complication and death. I understand that possible exposure to COVID-19 before/during/after my consult/office visit/treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective consult/office visit/treatment/procedure/ surgery, I may need additional care that may require me to go to an emergency room or a hospital. I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the consult/office visit/treatment/procedure/surgery itself.

I understand that there are certain patient risk factors that are thought to exacerbate a COVID-19 infection. I understand that I may have one or multiple of these risk factors and accept the increased risk.

- Increasing Age (esp. age>65)
- Male sex
- Obesity (BMI>35)
- Diabetes Mellitus
- Autoimmune Disease
- Cardiovascular Disease (Hypertension, Coronary Artery Disease, CHF)
- Hypercoagulable conditions
- Immunosuppressive medications (steroid use / disease modify anti-rheumatic drugs & biologics / transplant medications)
- Kidney Disease (Glomerulonephritis / Renal Impairment, etc.)
- Extended length of surgery
- Lung Diseases (e.g. COPD, interstitial lung diseases, pulmonary fibrosis, pulmonary hypertension)
- Obstructive Sleep Apnea
- Smoking and vaping

I have been given the option to defer my consult/office visit/treatment/procedure/surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired consult/office visit/treatment/procedure/surgery.

I attest that I have been offered a copy of this consent form.
I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

Patient or Person Authorized to Sign for Patient

_____ Date/Time_____