Dr. Constance Barone
PLASTIC SURGERY

Survey Form

Patient Name: _____

DOB (MM/DD/YYYY):_____

Date: _____

Dr. Barone and staff would like to know how you heard about us.

Please check one

	Specify
Internet: _____	**_____**
Friend: _____	**_____**
Radio (which station): _____	**_____**
Employee: _____	**_____**
Email: _____	**_____**
Television: _____	**_____**

Other: _____

Thank You

Dr. Constance Barone
PLASTIC SURGERY

New Patients

Today you will meet Dr. Barone.

Please understand that this is a free consultation.

Dr. Barone will review your medical history perform a brief interview and examination.

Dr. Barone will then determine if you are a good candidate for surgery and what procedures will be appropriate for you.

You will then meet with Jessica, surgery coordinator, and receive a quote as well as a discussion of payment options, and the opportunity to schedule an operative date.

If you feel more time is needed with Dr. Barone then please feel free to make an appointment through Jessica or the Front desk.

You will be charged **$150.00 non-refundable fee* subject to increase.**

Payable by: Cash or Credit Card for secondary consult.

Thank you for your cooperation and understanding.

Name (print) _____

Name Signature_____

DOB (MM/DD/YYYY) _____

Date _____

Dr. Constance Barone
PLASTIC SURGERY

Patient Information Form

Patient's Full Name: _____ Date of Birth: _____
Last First MI (MM/DD/YY)

Home Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

E-Mail Address:_____

Sex: { } F { } M Marital Status: { } Single { } Married { } Widow { } Divorced

Driver's License #:_____ Social Security #_____

Patient's Employer: _____ Work Phone #_____

Employer's Address: _____

Spouse/Guardian: _____ Phone #:_____

In Case of Emergency Contact: _____

Relationship: _____ Phone #:_____

Authorization {check appropriate boxes}

{ } I understand that I am ultimately responsible for all services rendered by Dr. Barone and her staff, whether covered by my insurance or not.
{ } I also authorize Dr. Barone and her staff to access my chart for management review.
{ } I authorize use of my email, text and voicemail for communication.
{ } I would like to be placed on your mailing list.
{ } I understand that Dr. Barone and her staff are not held responsible for, and personal belongings.

_____ _____
Patient's Signature Date

Dr. Constance Barone
PLASTIC SURGERY

Patient History Form

Date: _____

Date of Birth: _____ Age: _____

Name: _____
Last First MI

How did you learn about Dr. Barone?
_____

Primary Care Physician
Name: _____
Address: _____
Office Telephone: _____ Fax:_____

Pharmacy
Name: _____ Telephone: _____
Address: _____

Social History
Do you smoke? YES NO
If yes, _____ # packs per day _____ # of years
If you currently do not smoke when did you stop?
_____
Do you drink Alcohol? YES NO
If yes, how much?
_____
Do you use Recreational Drugs? YES NO
Describe: _____

_____ _____
Dr. Barone's Signature Date

Dr. Constance Barone
PLASTIC SURGERY

List ALL Medications you are taking or have taken within the last month (include aspirin, Motrin, and herbal drugs):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List ALL Drug Allergies including Latex, if none write "NKDA:"

_____

_____

_____

List ALL Surgical Operations and Hospitalizations you have ever had and ALL Medical Problems:

_____ _____

Dr. Barone's Signature **Date**

Name (Print) _____

DOB (MM/DD/YYYY) _____

Dr. Constance Barone
PLASTIC SURGERY

Review of Systems

Check Yes or No by the current ailment as it applies to YOU.
If unsure, place a question mark (?)

General

Yes No

____ ____Weight loss greater than 10lbs in the last year
If Yes, how much? _____
____ ____ Fever
____ ____ Trouble Sleeping
____ ____ Poor Appetite

Eyes

____ ____ Glasses/ Contacts
____ ____ Loss or change of Vision
____ ____ Glaucoma or Cateracts
____ ____ Eye Surgery such as Lasix
____ ____ Dry Eyes
____ ____ Frequent use of Eyedrops

Ear, Nose and Throat

____ ____ Trouble breathing out of nose
____ ____ Nose bleeds
____ ____ Hearing Aids/ Hearing Loss
____ ____ Recurrent Ear Infections
____ ____Sore throat/Strep throat

Cardiovascular

____ ____High Blood Pressure
____ ____Heart Murmur
____ ____Mitral Valve Prolapse
____ ____Irregular heartbeat
____ ____Previous Heart Attack
____ ____Chest Pain
____ ____Deep Vein Thrombosis (DVT)
____ ____History of blood clots

Respiratory

____ ____ Shortness of Breath
____ ____ Asthma
If Yes, #times as week use an inhaler? _____
____ ____ History of Tuberculosis
____ ____ Chronic Cough
____ ____ Emphysema
____ ____ COPD (chronic obstructive pulmonary disease)
____ ____ History of Apnea
____ ____ Pulmonary Embolism (PE)

Gastrointestinal

____ ____ Ulcers
____ ____ History of Jaundice (Yellow Skin)
____ ____ History Cirrhosis
____ ____ History Gallstones

Females ONLY

Yes No

____ ____Prior Breast Biopsy
____ ____Breast Lumps
____ ____Bloody Nipple Discharge
____ ____Abnormal Mammogram
Date of Last Mammogram_____
____ ____Birth Control?
Method_____
____ ____Family History Breast Cancer
____ ____Are you pregnant?
____ ____Will you have any more children?

Genitourinary

____ ____Problems Urinating
____ ____Difficulty starting stream
___ ___Painful/Burning/Frequent Urination

Skin

____ ____Skin Cancer
Where_____
____ ____Problems with Scarring
Describe_____
____ ___Ever use Accutane?
If Yes, When_____
____ ___Bruise easily?

Neuro

____ ___Blackouts/Fainting/Confusion
____ ___Seizures

Psychiatric

____ ___Severe Depression History
____ ____Prior Counseling

Endocrine

____ ____Diabetes
____ ____Thyroid Problems
____ ____Lupus

Allergy/Immunologic

____ ____Latex Allergy
____ ____HIV / AIDS
____ ____Hepatitis __A __B__C
____ ____Food Allergies
____ ___Use Recreational Drugs?

Hematologic/Lymphatic

____ ____Bleeding Disorders
____ ____Enlarged Lymph Nodes

Name (Print) _____
DOB (MM/DD/YYYY) _____

Dr. Barone Signature _____
Date _____

Dr. Constance Barone
PLASTIC SURGERY

Patient Photographic Authorization and Release

I,_____, authorize Dr. Constance M. Barone and/or Constance M. Barone, M.D., F.A.C.S. and her representative(s), to take photographs, slides and/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 presentation and/or articles.

I also 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)

Yes	No	Medium
		In office *Photo Album* for prospective patients
		In office *Seminars* for prospective patients
		On Dr. Barone's *Website* for prospective patients
		In print Advertisements
		On *Television*
		Publication in *Books and Journals*

I further understand that:

1. These photographs, slides or videotapes may be published By Dr. Constance M. Barone and/or Constance M. Barone, M.D., F.A.C.S. 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 plastic surgery methods. I understand that such uses may also include marketing on behalf of Dr. Constance M. Barone, for which Dr. Barone 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 l decide to do so, I must present my written revocation to Constance M. Barone, M.D., F.A.C.S.; 9502 Huebner Road building 2/ unit 202 San Antonio, TX 78240. A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization.

Patients Name (Print) _____ DOB (MM/DD/YYYY) _____

Patient's Signature _____ Date _____

_____ _____

Dr. Barone's Signature Date

Patient Photograph Authorization and Release (Continued)

4. **The information disclosed under this Authorization, or some portion thereof, is protect by**

   State law and /or federal Health Insurance Portability and Accountability Act of 1996 ("HIPPA").

5. **I release and discharge Dr. Constance Barone and /or Constance M Barone, M.D., PLLC from all liability including liability for negligence, that in any way arises out of any and all rights that I may have or may have had in regards to the photographs, slides or videotapes of me including any claim for payment in connection with any publication of them in any medium. I release and hold harmless Dr. Constance M. Barone and Constance M. Barone, M.D., PLLC and her staff and her employees from any and all claims or causes of action that I may have of any nature whatsoever, which in any manner result from the use of the photographs or other images.**

6. **I understand that Constance M. Barone M.D., PLLC and her staff will take all reasonable precautions to ensure my privacy, but I am aware that even secure sites are susceptible to being hacked, and the files, although they will not have my name attached, may contain internal codes that may compromise my privacy. I understand that any disclosure of information carries with it the potential for unauthorized disclosure and will not hold liable Constance M. Barone M.D., PLLC and her staff.**

7. **This Authorization is make as a voluntary contribution in the interest of the public education and I certify that I have read the Authorization and Release carefully and fully understand its terms and that Dr. Barone and or her staff has answered all of my questions to my satisfaction.**

Patient's Name (Print) _____ DOB (MM/DD/YYY_____

Patient's Signature_____ Date _____

_____ _____

Dr. Barone's Signature Date

Dr. Constance Barone
PLASTIC SURGERY

Patient Consent for Use of Credit Cards, Debit Card, and Financing- Disclosure of Protected Health Information

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested to facilitate your payment.

Services that are performed and paid with a credit card, debit card, or financing third party are not eligible for payment challenges after services are provided. By signing this form, I irrevocably consent to allow Dr. Barone to use and disclose my protected health information to any credit card entity, bank, or financing company when they request information to process an account and assist with payment.

_____A $500.00 deposit is required when scheduling your surgery. This deposit will be deducted from your total surgery cost. This deposit is non- refundable if your surgery is cancelled for any reason including medical reasons or rescheduled.

_____ I will not challenge such credit card, debit, or financing card payments once services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.

_____ I agree that this no credit challenge agreement is irrevocable.

Patient Print Name: _____
Patient Signature: _____
DOB (MM/DD/YYYY): _____
Date: _____

Witness: _____
Date: _____

Dr. Constance Barone
PLASTIC SURGERY

Patient Acknowledgement

Receipt of Privacy Notice

I, _____ hereby affirm that I have received a copy of the *Notice of Privacy Practices* from Constance M. Barone, M.D., PLLC. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

_____ _____

Patient Name (Print) DOB (MM/DD/YYYY)

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority (if applicable)

Important Contract Information

Constance M. Barone, MD is excluded from Medicare under §§1128, 1156 or 1892 of the Social Security Act;

You, the patient or your legal representative accepts full responsibility for payment of Constance M. Barone, MD, PLLC's charge for all services furnished by Constance M. Barone, MD, PLLC and her associates;

You, the patient or your legal representative must understand that Medicare limits do not apply to what Constance M. Barone, MD may charge for items or services furnished by Constance M. Barone, MD, PLLC or her associates;

You, the patient or your legal representative agrees not to submit a claim to Medicare or to ask Constance M. Barone, MD, PLLC to submit a claim to Medicare;

Understand that Medicare payment will not be made for any items or services furnished by Constance M. Barone, MD, PLLC or her associates that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted;

You, the patient or your legal representative have the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out;

This is in effect today and will remain in effect indefinitely Constance M. Barone, MD, PLLC will be indefinitely opted out of Medicare and all insurance coverage.

Date _____

DOB (MM/DD/YYYY) _____

Patient Name (Print) _____

Patient or Legal Representative_____

Constance M. Barone, MD_____

You, the patient or your legal representative understands that Medigap plans do not, and that other supplemental plans may elect not to, make payment for items and services not paid for by Medicare;

Not be entered into by the beneficiary or by the beneficiary's legal representative during a time when the beneficiary requires emergency care services or urgent care services;

Be provided (a photocopy is permissible) to the beneficiary or to his/her legal representative before items or services are furnished to the beneficiary under the term of the contract;

Be made available to the Centers for Medicare and Medicaid Services (CMS) upon request; and

Be entered into for each opt-out period.

Date_____

DOB (MM/DD/YYYY) _____

Patient Name (Print) _____

Patient or Legal Representative_____

Constance M. Barone, MD_____

Dr. Constance Barone
PLASTIC SURGERY

Skin Typing Matrix

Name (print): _____ DOB: _____

Please answer the following questions by circling the number which best describes you. Your Clinician total your score during the consultation.

My Ethnic origin is closed to:	Very Fair (Celtic and Scandinavian)	1
	Fair-Skinned Caucasians with light hair and light eyes	2
	Pale-Skinned Caucasians with dark hair and dark eyes	3
	Olive-Skinned (Mediterranean, some Asian, some Hispanic)	4
	Dark-Skinned (Middle Eastern, Hispanic, Asians, some Africans)	5
	Very dark-Skinned (African)	6
My eye Color is:	Light Blue	0
	Blue / Green	1
	Green / Gray / Golden	2
	Hazel / Light brown	3
	Brown	4
My natural hair color at age 18 was:	Red	0
	Blonde	1
	Light Brown	2
	Dark brown	3
	Black	4
The Color of my skin that is not Normally exposed to sun is:	Pink to reddish	0
	Very Pale	1
	Pale with beige tone	2
	Light brown	3
	Medium to dark brown	4
	Dark brown – black	6
If I go out into the sun for an hour or so Without sunscreen and have not been out In the sun for weeks, my skin will:	Burn, blister and peel	0
	Burn, then when burn resolves there is little or no color change	1
	Burn, but then turns to tan in a few days	2
	Get pink but then turns to tan quickly	3
	Just tan	4
	Just gets darker	5
	My skin color is so dark I can't tell	6
When was the last time the area to be treated was exposed to natural sunlight, tanning booths or artificial tanning cream?	Longer than one month age	0
	Within the past month	1
	Within the past two weeks	3
	Within the past week	4

Total Score: _____

If your score is:	Your Skin type is:
0 – 3	1
4 -7	2
8 -11	3
12 – 15	4
16 – 19	5
20 - 24	6

Videotape and Photographs Release and Authorization

I hereby irrevocably consent to and authorize the use and reproduction by Constance M. Barone, MD, PLLC; Elegante Surgery Center, LLC and its affiliates, or anyone authorized by any of them, of any and all photographs, electronic images or video footage of me taken by Constance M. Barone, MD, PLLC; and/or Elegante Surgery Center, LLC., Constance M. Barone, MD, PLLC and Elegante Surgery Center, LLC has in its possession, provided either by me or by a third party (collectively, Images) for the purpose of informing the medical profession and the general public about plastic surgery and plastic surgery procedures and techniques without compensation to me. Such use shall include, but not be limited to, distributing the images via print, visual and electronic media, specifically including websites and social media sites such as YouTube, Facebook, Twitter, Instagram, and Snapchat. The images (including any photographic negatives) shall be the sole property of the respective sites and Constance M. Barone, MD, PLLC and Elegante Surgery Center, LLC., Constance M. Barone, MD, PLLC and Elegante Surgery Center, LLC also shall have the right to use my name in connection therewith if it so chooses. It is clearly understood that these images and video may be tagged which could identify patients name.

I hereby waive any right to inspect or approve the finished product, photograph, video, DVD, CD-ROM or matter that may be used in conjunction therewith or to the eventual use that it might be applied.

I hereby release, discharge and agree to hold harmless Constance M. Barone, PLLC and Elegante Surgery Center, LLC and its affiliates and their respective representatives, assign, and employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and name and the reproduction thereof as stated above, including any claim for payment in connection with distribution or publication of and/or photographs. I am also fully aware that these photographs, videos and or images may **NOT** be removed at any time. I also fully understand that the photographs and/or videos contain nudity of my body which will be able to identify my face and identity. This also includes body tattoos, piercing and or birthmarks which clearly may be visible and fully reveal my identity.

I hereby warrant that I am over twenty-one years of age, and competent in my own name insofar as the above is concerned.

I have read and understand the foregoing release, authorization and agreement, before signing my name below, and enter into it knowing and voluntarily.

Date: _____ Printed Name: _____

Signature: _____

I have read the above Release and Authorization. I am the parent, guardian, or conservator of _____, a minor. I am authorized to sign this authorization on his/her behalf.

Date: _____ Printed Name: _____

Signature: _____

_____ Patient Initials and Date of Birth: _____

Date: _____ Witness Print Name: _____

Signature: _____