BEN LEE MD

Denver Aesthetic Surgery LLC
8101 East Belleview Avenue, Suite J / Denver, Colorado 80237
T 303 770 1379 / F 720 616 7932 / info@benleemd.com / www.benleemd.com

HIPAA CONSENT

(Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations)

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I may ask for a copy of the *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____
_____
_____

HIPPA consent acknowledged by signing below:

Signature:_____

Date:_____/_____/____

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PATIENT INFORMATION

Name:_____ _____/_____/_____ _____
Last First Middle Initial Date of Birth Age

Email:_____ Primary Phone:_____
(By providing us with your email you are giving us permission to send you email communication. Emails are used to send out special offers and promotions and will not be sold.)

Address:_____ City:_____ State:_____ Zip Code:_____

Gender at Birth: M / F Gender Identity: M / F / Other: _____ Single_____Married_____Widow_____Divorced_____

Employer/School:_____ Occupation:_____

Emergency Contact:_____ Phone:_____

Relation to Patient:_____

Whom may we thank for the referral?_____

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Patient Photograph Release Form

Patient's Name: _____ **Date of Birth**: _____

Photograph Consent and Release

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the members of Denver Aesthetic, Surgery LLC medical staff. I hereby give my consent for Denver Aesthetic Surgery, LLC to use the photographs under one of the following circumstances.

Please initial at least ONE of the following:

_____ **Internet:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Denver Aesthetic Surgery, LLC, can be used on the company's website to inform the public about plastic surgery methods. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name or any other identifying marks at any time during any use or publication of these materials by any party.

_____ **All Media:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Denver Aesthetic Surgery, LLC, can be used in any print, digital, or broadcast media, including but not limited to pamphlets, educational films, Internet, Facebook, Instagram, and television to inform the public about plastic surgery methods. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name or any other identifying marks at any time during any use of publication of these materials by any party.

_____ **Medical Care Only:** Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Denver Aesthetic Surgery, LLC. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Denver Aesthetic Surgery, LLC.

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other phot consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

Signature (Patient or Parent/Guardian if Patient is under 18) Date

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Medical History
(Please Print)

Age (at time of consult): _____ Height:_____ Weight:_____

Please list prior surgeries and approximate dates:
Date of Surgery: *Surgery:* *Surgeon:*

Did you experience any complications with any surgeries? Yes No
If so, please explain_____
Do you bruise easily? Yes No
Do you use aspirin, ibuprofen, or other anti-inflammatory products frequently? Yes No
When did you last use this type of product? _____
Do you use diet pills, either over the counter products or prescription products? Yes No

Please list any allergies that you have:
Medication: **Reaction:**

Are you allergic or sensitive to soy bean based or PABA products? Yes No
Are you presently under a physician's care? Yes No
Physician: _____ If yes, what for:_____
Do you have a primary care physician: Yes No Physician's name?
_____
Do you have any chronic nose or sinus complaints? Yes No
Please describe:
_____
Do you have frequent headaches: Yes No Please describe:_____
Do you wear contacts? Yes No

Please list all medications that you are currently on and the reason for taking them: (Including hormone therapy, birth control and supplements:

Have you ever experienced any of the following problems?
Eye Pain Yes No
Blurred vision Yes No
Loss of vision Yes No
Dryness of the eyes Yes No
Any other eye problems? _____
Do you have any health problems related to your teeth or gums? Yes No
If yes, please describe: _____
Do your gums bleed when you brush your teeth? Yes No
Do you wear dentures? Yes No Uppers _____ Lowers _____
Do you have any skin problems? Yes No
If yes, please describe: _____
Have you ever had X-Ray treatment for a skin condition? Yes No
If yes, please describe: _____
Have you ever been treated for skin cancer? Yes No
If yes, please describe: _____
Do you use sunscreens on a regular basis? Yes No If yes, what SPF? _____
Do you smoke? Yes No If yes, amount per day: _____
Have you ever coughed up blood? Yes No If yes, please describe: _____

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Do you drink alcoholic beverages? Yes No If yes, amount per day: _____

Have you ever had any of the following? (Please check all that apply):

___Chest pain	___Scleroderma	___Rectal Bleeding	___Mitral Valve Prolapse
___Lupus	___Chronic Diarrhea	___Heart Murmur	___Arthritis
___Hepatitis	___Heart Attack	___Back Pain	___Jaundice
___Stroke	___Chronic Stomach Pain	___Kidney Infection	___Dizzy Spells
___Stomach ulcer	___Bladder Infection	___Swollen Feet/ankles	___Vomited blood
___Cold Sores	___High Blood pressure	___Black stools	___Palsy
___HIV	___Eczema	___Psoriasis	___Rosacea
___Skin Cancer	___Thyroid Disease	___Epilepsy	___Metal Implants

Have you ever been under the care of a psychologist or psychiatrist? Yes No
Do you ever experience feelings of claustrophobia? Yes No
Do you have difficulty sleeping on your back? Yes No
Do you have sleep apnea or any other sleep related disorder? Yes No

Does anyone directly related to you, or do you have any of the following?:

Cancer	Yes	No	Relation _____
Diabetes	Yes	No	Relation _____
High Blood Pressure	Yes	No	Relation _____
Heart Attack or Stroke	Yes	No	Relation _____

Was the Heart Attack or Stroke Early in life? (late 40's, early 50's) Yes No

This section if for female patients only

Date of last menstrual period: _____/_____/_____ Do you use birth control pills? Yes No
Have you ever been pregnant? Yes No Any complications? _____
Did you breast feed your children? Yes No If yes, how long? _____
Are you currently breastfeeding? Yes No

Do you use RetinA or any other topical prescription? Yes No Product: _____
Have you ever used or are currently using Accutane? Yes No

Please describe your skincare routine: _____

What are the top 3 concerns with your skin? _____

What is your nationality? _____

Does your skin: ___Always burn, never tans ___Sometimes burns, turns to tan ___Always tans, never burns

Have you ever had any of the following treatments? ___Chemical peel ___Microdermabrasion ___Microneedle ___Dermaplane
___Filler ___Botox ___Laser treatments
___Plastic surgery ___Other:

Have you ever had any other cosmetic or plastic surgery procedures before? Yes No
If yes, what procedure(s) have you had?
_____
_____
_____

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Financial Policy

We value our relationship with you and want to assure its ongoing success through a mutual understanding of our financial policies. Please read the Financial Policy in full. By signing at the bottom, you are acknowledging that you have read the policy and understand it.

1. To reserve a surgery date, a **30% NON-REFUNDABLE** deposit is due upon scheduling surgery.

2. Payment in full is due ***at the time of Pre-Operative Appointment*** **OR 14** days prior to surgery. If payment is not received **at time of pre-operative appointment**, surgery may be cancelled. ***Should you reschedule your procedure to a later date, the balance remains due in full on the original due date.** Please make payments to Denver Aesthetic Surgery.

3. Surgery cancellations and changes create serious scheduling problems. The surgical facility, anesthesiologist, surgeon, and other staff are reserved and prescheduled in advance. Therefore, please understand the importance of respecting our **two- week** cancellation policy.

4. Unless the doctor or surgery center cancels the appointment, patient is expected to show up, even in inclement weather.

5. **Fifty percent of the surgeon's fees are NON-REFUNDABLE if your surgery or any portion of your surgery is cancelled LESS than 14 days before your surgery date. One hundred percent of the surgeon's fees are NON-REFUNDABLE if your surgery or any portion of your surgery is cancelled less than 7 days before your surgery date**. If surgery is scheduled less than 14 days prior to procedure, all fees are due AT THE TIME OF the scheduling and all penalties apply.

6. All Fees are Non-Refundable in accordance to the above guidelines ***with the exception of proven medical issues that would deem said surgery as dangerous to patients' health condition.*** Surgeries cancelled within above guidelines may be refunded ***with the exception of the deposit as stated above in number 1.***

7. If a refund is due to the patient for any reason, we require a minimum of 14 business days to process the refund check. The surgical center may take 3-6 weeks for full refund.

8. Should you need to reschedule your procedure, **you must give 14 days' notice in order to apply any prepaid fees or deposits to a new surgery date.** If your surgery is cancelled and rescheduled more than once, or rescheduled less than a week in advance, a **$250.00** rescheduling fee will apply. All prepaid fees and deposits are **forfeited** if not rescheduled within 6 months of the original surgery date.

9. Last minute device orders after the consent forms are signed are subject to a $50 expedite fee.

10. **Surgical facility, anesthesia services and surgical assistant services are charged on an hourly basis. Your quote is based on the specific time the physician has quoted the surgery.**

11. I understand that I am responsible for all pre-operative lab tests required to clear me for surgery (i.e., CBC blood test, Mammogram, EKG, Chest X-Ray). I also understand that I am financially responsible for all prescriptions pre-and post-operatively. These charges are not included in the surgical quote.

12. Centrum Operating Room (OR) fees MUST be paid directly to the Centrum Surgical Center. Their business office will call to collect payment 3-5 days prior to your surgery.

13. The surgeon's fees include one year of normal post-operative care and ***some*** minor revisions under local anesthetic, if needed, within a year from the date of surgery. All post-operative visits must be attended for revisions to be financially covered by office. Should complications arise as a result of your surgery, you may incur additional costs; however, surgeon's fees will be waived.
    a. If surgical revisions are necessary and are completed in office, you will be responsible for a **surgical facility fee ($500) and Surgical Supplies/Devices of at least $350.**
    b. If your surgical revision require to be completed at Centrum Surgical Center**,** you will be responsible for the **Centrum Surgical Center OR fee, anesthesia services, and Surgical Supplies/Devices of at least $350.**

14. **We do not accept personal checks** – we accept the following form of payments: ***Cash, Cashier's Check, Credit/Debit Card, and select Medical Financing. (*****See our Surgical Coordinator for more information)**

15. We do not accept health insurance. Patients are expected to pay out-of-pocket for appointments and procedures.

I certify that I have read and fully understand Ben Lee M.D. Plastic Surgery financial policies. I agree to be personally responsible for all payments.

Patient/Responsible Party's Signature: _____ Date: _____/_____/_____