

Patient Information: Please Print

Date: _____

First Name: _____ Middle: _____ Last: _____

Local Address: _____

Street Apt/Unit No City State Zip

Secondary Address: _____

Street Apt/Unit No City State Zip

Local Home Phone: _____ Can we leave a message for you at home? **Yes No**
 Secondary Home Phone: _____ Fax: _____
 Work Phone: _____ ext: _____ May we call you at work? **Yes No**
 Cell Phone: _____ Can we leave a message for you on your cell? **Yes No**
 E-Mail Address: _____ Can we email Special Offers/Promotions/Newsletters to you? **Yes No**
(Note: we never share your email with anyone else)

Date of Birth: _____ Age: _____ Sex: Male Female Marital Status: _____ Name of Spouse: _____

Social Security No: _____ Driver's License # (state): _____

Emergency Contact: Name: _____ Telephone #: _____ Relation: _____

Please answer all of the questions as accurately as possible. If you do not understand, please ask for assistance.

- * Describe the reason for your visit with us: _____
- * Have you seen another doctor for this condition? Yes No If yes, who have you seen? _____
- * Please list previous **Surgeries, Hospitalizations and/or Major Illnesses**, including plastic surgeries and dates: _____
- * List all current **Medications**, dosage, and frequency (including non-prescription drugs, vitamins, and herbals): _____
- * Drug Allergies: _____ Weight _____ Height _____

Social History: Education Level: Some High School College Graduate Medical Degree
 High School Master's Degree Law Degree
 Some College Doctorate

Employer: _____ Occupation: _____

Women Only:

Age period began _____ Number of pregnancies _____ Date of last mammogram _____
 Are you pregnant? _____ Number of children _____ Breast lump or discharge: _____
 Date of last menstrual period? _____ Did you breast feed? _____ Do you do breast self exams? _____
 When did you stop? _____

Habits: (Please Circle)

SMOKING

Do you currently smoke? Yes No
 How many a day? _____
 Have you smoked in the past? Yes No
 When did you quit? _____
 How many years did you smoke? _____

ALCOHOL / CAFFEINE

Do you drink alcoholic beverages? Yes No
 How many alcoholic drinks per week? _____
 Do you drink caffeinated beverages? Yes No
 How many caffeinated beverages per day? _____

RECREATIONAL DRUGS

Do you use any of these recreational drugs?
 (Please Check **All** that Apply)
 None Crystal Meth
 Marijuana LSD
 Cocaine-smoked Ecstasy
 Cocaine-sniffed Morphine
 Heroin Vicodin/Percocet

EXERCISE

Do you exercise? Yes No
 How many times a week do you exercise? _____

Patient Name: _____ Age: _____ Primary Care Doctor: _____

Family History: Has any **blood relative** ever had the following: *(Please Check **All** that Apply)*

- | | | |
|---|--|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> von Willebrand Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Abnormal clotting | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Endocrine Disease |
| <input type="checkbox"/> Anesthesia Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Malignant Hyperthermia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Autoimmune Disorders | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Deep Vein Thrombosis |

Past Medical History: Have **you** had the following: *(Please Check **All** that Apply)*

CHILDHOOD ILLNESS

(Asthma, Polio, Rheumatoid Fever, etc.)

GENERAL HX

- Recent Weight Gain
- Recent Weight Loss
- Poor Nutrition
- Chronic Fatigue

NEURO/PSYCH

- Depression
- Anxiety
- Fibromyalgia
- Seizures

HEAD & NECK

- Cleft Lip
- Cleft Palate
- Snoring / Apnea
- Hearing Loss
- Wears Glasses
- Wears Contacts
- Vision Loss
- Dry Eyes
- Blepharospasm

CARDIAC HISTORY

- High Blood Pressure
- High Cholesterol
- Congestive Heart Failure
- History of MI (Heart Attack)
- Arrhythmias
- Pacemaker
- Mitral Valve Prolapse

LUNG HISTORY

- Asthma
- History of Pneumothorax
- COPD
- Emphysema

ANESTHESIA HISTORY

- Difficult Intubation
- Difficult Extubation
- Postop Nausea / Vomiting
- Malignant Hyperthermia

INFECTIOUS DISEASE HX

- Genital Warts
- Genital Herpes
- Oral Herpes (Cold Sores)
- HIV

GASTROINTESTINAL HX

- Irritable Bowel Syndrome
- Reflux Disease (GERD)
- Constipation
- Diverticulosis
- Non-Bleeding Ulcers
- Bleeding Ulcers
- Hemorrhoids

GU/PREGNANCY HISTORY

- Vaginal Deliveries
- C-sections
- Urethral Stricture
- Recurrent UTIs
- Incontinence

EXREMITY HISTORY

- Difficulty Walking
- Varicose Veins
- Chronic Swelling (Edema)
- Leg / Ankle Ulcers

BREAST HISTORY

- Breast Mass (right)
- Breast Mass (left)
- Nipple Discharge (right)
- Nipple Discharge (left)
- Breasts too Small
- History of Breast Feeding
- Breast Drooping
- Excessively Large Breasts
- Difficulty Fitting in Clothes
- Rash under Breasts
- Neck Pain
- Shoulder Grooving
- Back Pain
- Embarrassed / Unwanted Attention
- Mammogram >1yr
- Mammogram >5 yr

ENDOCRINE HISTORY

- Diabetes (Diet Controlled)
- Diabetes (Oral Meds)
- Diabetes (Insulin Dependent)
- Hyperthyroid (Overactive)
- Hypothyroid (Underactive)

HEMATOLOGIC HISTORY

- Anticoagulation Meds
- Easy Bleeding
- von Willebrand Disease
- Hemophilia
- Excessive Clotting
- History of Vein Thrombosis (DVT)
- History of Pulmonary Embolus (PE)
- Anemia

LIVER HISTORY

- Hepatitis A
- Hepatitis B
- Hepatitis C
- Gallstones
- Jaundice
- Cirrhosis

UROLOGIC/KIDNEY HISTORY

- Kidney Stones
- Benign Prostatic Hypertrophy (BPH)
- Pyelonephritis (Kidney Infections)
- Renal Insufficiency
- Renal Failure

CANCER HISTORY

- Breast
- Lung
- Liver
- Colon
- Ovarian
- Skin (Basal / Squamous)
- Skin (Melanoma)
- Other Cancer: _____

OTHER HISTORY

- Other problems not asked?

Patient Name: _____

Review of Systems: (Please Check All that Apply)

Do you have:

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Nausea | <input type="checkbox"/> Muscle Aches / Pains |
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Joint Aches / Pains |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Recent Rashes |
| <input type="checkbox"/> Watery Eyes | <input type="checkbox"/> Constipation | <input type="checkbox"/> Dryness of Skin |
| <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Burning upon Urinating | <input type="checkbox"/> Recent Weight Gain |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Feelings of Depression |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Increased Frequency of Urination | <input type="checkbox"/> Decrease Energy Level |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Increased Thirst | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Increased Appetite | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Cold Intolerance | |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Heat Intolerance | |

I attest that this medical history is true, accurate and complete. Further, I understand that ANY omissions, falsifications, misrepresentations or otherwise incorrect information that I provide, regardless of the reason that it is incorrect, may directly affect my medical care and increase my risks of complications. I agree to hold harmless Kent V. Hasen, M.D. and his professional staff, for any actions taken based on false, misleading, incorrect or incomplete information that I have provided. In addition, I agree to accept full and complete responsibility to inform the office of any changes in my medical history that occur while I am under the care of Dr. Hasen.

Signature of Patient (or Parent if Minor)	Date
Physician Signature	Date

How did you learn about our office? (Please Check All that Apply)

Referral:

- Dr: _____
- Friend / Relative: _____
- Patient: _____
- Employee: _____
- Emergency Room

Seminar/Expo:

- Date of Seminar: _____
- Date / Name of Expo: _____

Charity/Fundraiser:

- Date / Name of Charity/Fundraiser: _____

Other:

- Please Explain: _____

Website:

- Our Website: DrHasen.com
- Search Engine: _____
- ASPS Plastic Surgery Website
- ASAPS Plastic Surgery Website
- 1-800-MySurgeon.com
- SmartPlasticSurgery.com
- PerfectYourself.com
- Looking Your Best.com
- Consumer Guide to Plastic Surgery.com
- Love Your Look.com
- Natrelle.com (Allergan Natrelle Implants)
- Implant Forum.com
- Justbreastimplants.com
- CareCredit Website
- Botox / Juvederm Website
- Restylane Website
- Radiesse Website
- Sculptra Website

Print Media:

- Magazine: Gulfshore Life
- Magazine: N-Magazine
- Magazine: Naples Illustrated
- Magazine: Bonita Living
- Magazine: Neapolitan Family
- Newspaper: Naples Daily News
- Newspaper: Bonita Banner
- Newspaper: Ft. Myers News Press
- Yellow Pages: Sprint Yellow Page
- Yellow Pages: Yellow Book
- Yellow Pages: Verizon
- School Directory: Village School
- School Directory: Temple Shalom

TV/Radio:

- Radio – WGUF 98.9
- Radio – WAVV 101.1
- Radio – Mix 104.7
- Television: _____

Other Cosmetic Interests or Concerns

To better allow us to help all of your surgical and non-surgical cosmetic concerns, please complete below:

Cosmetic Surgery: *(Please Check All that Apply)*

FACE

- Endoscopic Forehead / Brow Lift
- Eyelid Surgery (Blepharoplasty)
- Multiplanar Face Lift
- MACS Short Scar Face Lift
- Lower Face Lift
- Neck Lift
- Neck Liposuction
- Chin Augmentation
- Ear Reshaping (Otoplasty)
- Nose Reshaping (Rhinoplasty)

BREAST

- Breast Augmentation
- Breast Lift (Mastopexy)
- Breast Implant Exchange / Revision
- Breast Reduction
- "Scarless" Breast Reduction
- Male Breast Reduction (Gynecomastia)
- Silicone Breast Implants
- Saline Breast Implants

BODY

- Liposuction
- Tummy Tuck
- Arm Lift
- Buttock Lift
- Thigh Lift
- Lower Body Lift
- Massive Weight Loss

Non-Surgical Procedures: *(Please Check All that Apply)*

SKIN CARE

- Acne Treatments
- Facial Treatments
- Facial Peels (MicroPeel)
- Microdermabrasion
- TCA Pigment Peel
- Deep Phenol / Croton Oil Peel
- Skin Care Products
- Eyelash Growth Products
- Eyelash Tinting
- Eyebrow Tinting
- Eyebrow Waxing
- Permanent Eyeliner Makeup
- Permanent Eyebrow Makeup

FILLERS / BOTOX

- Botox Cosmetic
- Fat Injections
- Juvederm Injections
- Radiesse Injections
- Restylane Injections
- Perlane Injections
- Sculptra Injections

LASERS

- Fraxel Re:Store Laser
- Thermage Procedure
- Treatment of Wrinkles
- Treatment of Sun Spots
- Treatment of Acne Scarring
- Treatment of Facial Capillaries

- Would you like to improve the appearance of your facial skin? _____
 - If yes, Dr. Hasen would like to give you a complimentary skin care consultation with our skin therapist / aesthetician as a gift to you for completing these forms. Ask our staff for details.

Person Financially Responsible: *(if other than patient)* Employer Parent Spouse Other

Last Name: _____ First Name: _____

Social Security No: _____ Date of Birth: _____ Telephone # _____

Payment/Insurance (circle):

Self Pay Medicare Commercial Medicaid Workmen's Comp Auto/No-Fault

Insurance Information (only if applicable): *Please Print*

Name of insurance Company: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____ Insured Relation to you: _____

Insured Birth date: _____ Insured Social Security Number: _____

Insured Policy ID Number: _____ Insured Group Number: _____

Please provide your insurance cards for us so that we can make a photocopy of them. If this is a worker's compensation injury, please provide us with a Notice of Injury form from your employer, as well as your employer's name, address and telephone number.

We are pleased to assist you in the filing of your insurance. However, each patient is responsible for the payment of his/her own medical bills. Payment is due when services are rendered. We are not participating providers for any insurance company or plan including Medicare. Dr. Hasen is in an "opt out" status with Medicare. This means that all non emergent services provided by Dr. Hasen will not be covered by Medicare and cannot be billed to them. If you have secondary insurance, they may cover a portion of the fee.

I hereby authorize Dr. Kent Hasen to release any information regarding services rendered by him and allow a photocopy of my signature to be used to file insurance. I hereby authorize and direct payment check(s) for benefits due to me for the services rendered by Dr. Kent Hasen to be made directly to him. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees for services rendered. If my account is turned over to collection, I agree to pay any additional legal/collection fees incurred.

Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF PATIENT PHOTOGRAPH

Name _____

Address _____
(street address, city, state and zip code)

I consent to the taking of photographs by Dr. Hasen or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Hasen. I further authorize Dr. Hasen or one of his/her associates to release to the American Society of Plastic Surgeons (“ASPS”) and the American Society for Aesthetic Plastic Surgery, Inc. (“ASAPS”) such photographs.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of ASPS or ASAPS and may be retained by ASPS or ASAPS or released by ASPS or ASAPS for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs 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. Hasen.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. 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 affect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty years from the date written below.

I also understand and grant consent for my photographs to be used in advertisements for Dr. Hasen in any print, visual or electronic media including, but not limited to newspaper, magazine, brochures, television or internet.

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 further understand that, because ASPS and ASAPS are not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA.

I release and discharge Dr. Hasen, ASPS, ASAPS and all parties acting under their 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

If you have medical insurance, we are eager to help you received your maximum allowable benefits. We must emphasize that as providers, **our relationship is with you, not your insurance company.** While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date that services are rendered. **We are not participating providers for any insurance company or plan.**

Medicare

This office is no longer a participating provider for Medicare. We have “opted out” of Medicare. This means that we cannot bill Medicare for services provided to any Medicare beneficiary. Medicare requires us to create a contract verbal or written with the patient for any services provided. You should check for yourself if your secondary insurance cover the procedure since Medicare will not. Surgical procedures performed on Medicare patients by Dr. Hasen will require a private contract between our office and the patient with the full understanding that this cannot be billed at any point to Medicare by our office or by the patient directly.

Medicaid

We are not participating providers for Medicaid.

Private Health Insurance

Each patient is responsible for his/her medical bills. You are aware that your health insurance policy is a contract between you and the insurance carrier. Your coverage, the requirements for pre-authorization, pre-certification, second surgical opinions, deductibles and co-payments are all defined in your policy. *You are solely responsible for reading, understanding and following the procedures outlined in your policy handbook.* As a courtesy to you, we will file your insurance claim with all of the appropriate codes, but we do not have billing experts on staff and follow up is your responsibility. We will be pleased to assist you in appealing to your insurance carrier if there is a large discrepancy between your bill and your benefits. This will maximize your benefits. However, it should be clearly understood that many insurance carriers reimburse below the “usual and customary” fee schedules. For this reason, we have found it necessary to **no longer participate in the fee schedule of any insurance company.** We are “**out-of-network**” providers and you should consult with your insurance company to figure out the amount you may owe in addition to what they pay. **All deductibles, co-payments, and differences between your insurance carrier’s reimbursement and our fee schedule are the responsibility of the patient.** We expect payment at the time of service is provided. We reserve the right to collect 1.5% interest per month on all delayed payments unless you have made specific arrangements with the office manager.

Managed Care Networks

Dr. Hasen is not a participating provider with Community Health Partners. We will file claims to insurers and organizations with which Community Health Partners is contracted. All fees including office visit fees for out-of-network providers, co-pays, co-insurance and/or deductibles will be due at the time of service.

Worker’s Compensation and No Fault

Worker’s compensation patients are required to present a notice of injury before they can be seen. Dr. Hasen is not a participating provider with Workman Comp insurance companies. We do NOT accept letters of protection as a form of payment in litigation disputes. In such cases, patients are completely responsible for payment at the time service is rendered.

Aesthetic Surgery

The customary fee for the initial consultation is **\$150.00.** This includes digital imaging and a follow-up consultation with the doctor. The consult fee can be applied to the surgeon’s fee of your cosmetic surgery quote if surgery is booked within 30 days. Fees for aesthetic surgery are due at least 14 days prior to surgery. Your scheduled time cannot be guaranteed if payment is not received, and all deposits will be forfeited. There is a **\$75 credit card** scheduling deposit that is required to hold a date for a consultation. This will be charged if the consultation is not cancelled with over 48 hours prior notice.

Ancillary Medical Services

When your medical care requires pathology, laboratory studies, or radiological examinations, you will receive a separate bill from the facility rendering service. This office refers to the ancillary service facilities that we believe provide the best in medical care for you. Our practice has no financial interest in these facilities, and payment is the individual responsibility of each patient. The doctor maintains privileges at the Naples Community Hospital, North Collier Hospital, Physician’s Regional Medical Center and Collier Surgery Center, where surgical care is available.

Package Pricing/ Payment Plans

In case of financial hardship, this office will work diligently to assist you. Credit Cards represent the best payment plan as we do accept Debit, Visa, MasterCard, Care Credit, Discover and AMEX. A payment plan for non-cosmetic surgery can be worked out through our office but wholly administered by MAF Collections at a standard fee of 8% of the total amount financed. Package pricing, at significantly discounted fees, is available. Patients requesting reduced fees or waiver of fees altogether are expected to accept referral to Social Services of Collier County. This government office is expert in determining financial hardship and assists payment for those truly in need (see below). When patients do not qualify for social services but demonstrate need for reduced fees, global fees to cover visits, surgery, anesthesia, and follow-up will be offered commensurate with the patient's financial abilities.

Experience demonstrates that financial matters are best understood and accepted in advance of surgical care, unless a true emergency exists. We take most seriously our responsibility to care for each and every patient regardless of his or her ability to pay, when seen through the emergency room. In return, we expect good faith on the part of patients requesting discounted fees to work with the office manager to settle all financial matters prior to surgery.

Social Services

We maintain a close working relationship with Social Services of Collier County to assist patients in financial hardship. Please ask the office manager for assistance. It is advisable to investigate available options BEFORE treatment. Our office accepts payment from Social Services as full and complete.

Emergency Services

Emergency services in the hospital or emergency room are rendered without payment considerations. Patients receiving emergency services are expected to demonstrate a good faith effort to reconcile their accounts in a timely fashion. Follow-up from an emergency room visit may not constitute emergency service. Patients presenting to the office will be asked to pay or present insurance information when they are seen. Financial hardship cases will not be denied care, but must accept responsibility for assisting the office in settling their account.

Collections

Each patient accepts full and total responsibility for payment of any service rendered through this office. While we are pleased to assist you in filing with your insurance agency, your contract with your insurance agency is completely separate from your responsibility to this office. All delinquent accounts will be subject to a 1.5% monthly service charge. All delinquent accounts are turned over to collections unless other arrangements are made with the office management. Once the account is in collections, you will be responsible to the collection agency for all bills, service fees, and collection costs.

Payment

All payments are due at the time services are rendered unless your insurance plan specifies otherwise, or you have made arrangements with the manager.

Non-Covered Services

Not all services are covered by all insurance health plans. Some services may not be covered by your specific or individual policy. Services not covered or considered not payable by the insurance company become the patient's responsibility.

I have read and fully understand this information and I agree to accept financial responsibility for the unpaid balance of all accounts in the event the following authorization is insufficient to liquidate the account.

I request that payment of authorized Medicare benefits be made on my behalf to Kent V. Hasen, M.D. for any services furnished me by this provider.

I hereby assign and transfer any insurance benefit due me for the professional services that I have received, to Kent V. Hasen, M.D.

I authorize the release of any medical information necessary to process insurance claims.

Signature of Patient

Date

- As patients approach surgery and in-office procedures, they frequently need information about the various payment options and cancellation/refund policies. We hope the following information will be helpful. Please read and sign the bottom after your questions have been answered.
- Our practice administrator is readily available to meet with you to provide the specific information you desire.

Payment of Balance:

- **DEPOSIT AND WHEN PAYMENT IS DUE:** To schedule and hold a cosmetic surgery date or an office procedure date, a **nonrefundable \$500.00 deposit** is required for in office procedures like Thermage, Fraxel Laser & Sculptra. For cosmetic surgical procedures, a **nonrefundable deposit of 20%** of the total surgery cost is required to hold a surgery date. We do not accept financing for this portion of the surgical fee. This amount is deducted from the total surgery fee. Payment for your procedure is due in full 14 days prior to your surgery date. This may coincide with your preoperative appointment. We provide a number of payment options which may be used individually or combined according to your needs.
- **PAYMENT OPTIONS:** Personal check, cashier's check, or cash. If paying with a personal check, the amount is due **10 business days** prior to the surgery date. Credit options include Debit Card, Visa, MasterCard, Discover, American Express, Care Credit or optional financing below.
- **OPTIONAL FINANCING PLANS:** To apply for patient financing, we provide these options:
 - **CareCredit:** 866-893-7864 or www.carecredit.com
 - **Advanced Patient Financing Services:** 866-784-9906 or www.apfservices.com
 - **Reliance Finance Company:** 800-322-6377 or www.reliancemedicalfinance.com
 - **MediCredit:** 800-963-6334 or www.medicredit.com** All discounts, incentives, or promotions cannot be applied when financing any portion of the surgical balance.**

Insurance Coverage: Most aesthetic surgery procedures are considered elective and are not covered by insurance.

Cancellation Policy & Refund Policy: We understand that a situation may arise that could force you to reschedule, postpone or cancel your surgery or procedure. Please understand that such changes affect not only your surgeon and anesthesiologist, but other patients as well. We appreciate your courtesy.

- Due to the necessary time and inconvenience, a \$100 fee will be added to the total surgery or procedure cost (and an additional \$100 fee will be added to the anesthesia cost, if applicable) every time the surgery or procedure is rescheduled or cancelled by the patient regardless of timing.
- If you cancel an in-office procedure (e.g. Thermage, Fraxel Laser, Sculptra injection, nevus excision), we will withhold the **\$500 nonrefundable deposit**.
- If you completely cancel your surgery more than 15 days in advance, we will refund all deposited monies **except for the original 20% nonrefundable deposit**, which will be applied to the payment for your rescheduled surgery or procedure, or reused for processing fees if you have not rescheduled within 90 days. **If you cancel between 7 – 14 days, one half (1/2) of the surgeon's fee will be kept and \$100 of the anesthesia fee for the anesthesiologist's inconvenience. If the cancellation occurs less than 7 days before the scheduled surgery, the entire surgeon's fee will be kept as well as \$500 of the anesthesia fee for the anesthesiologist's inconvenience.** We will also withhold 5% if you paid with a credit card for processing fees we are charged by these companies. There will be no refund for skin care packages.

If you have any questions or need assistance with financial matters, please ask us to help you.

I have read, understand and agree to follow the financial policies as outlined above.

Signature

Date

Consent for Purpose of Treatment, Payment or Health Care Operations

Kent V. Hasen, M.D., P.A.

I consent to the use or disclosure of my protected health information by Dr. Hasen for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Dr. Hasen’s practice.

I understand that diagnosis or treatment of me by Dr. Hasen may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations. Dr. Hasen is not required to agree to the restrictions that I may request. However, if Dr. Hasen agrees to a restriction that I request, the restriction is binding on Dr. Hasen’s practice and on Dr. Hasen.

I have the right to revoke this Consent, in writing, at any time, except to the extent that Dr. Hasen’s practice has taken action in reliance on this Consent.

My “protected health information” means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Dr. Hasen’s Notice of Privacy Practices prior to signing this document.

Dr. Hasen’s Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices for Dr. Hasen’s practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of Dr. Hasen’s health care operations.

A summary of the Notice of Privacy Practices for Dr. Hasen is also posted in the waiting room.

This Notice of Privacy Practices also describes my rights and the duties of Dr. Hasen’s practice with respect to my protected health information.

Dr. Hasen reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by contacting Dr. Hasen’s office at 4081 Tamiami Trail, North, Suite C-203, FL 34103 or (239) 262-5662.

Name of Patient (please print)

Signature of Patient or Representative

Date

Name of Patient or Representative (please print)

Employee Initial