PATIENT'S FULL NAME: _____ DATE: _____

Date of Birth (Year Required): _____ SEX (Please Circle): FEMALE MALE

Social Security #:_____ E-mail: _____

Cell #: _____ Home#: _____ Work#: _____

Confidential Communication Preference: _____

Address: _____

City:_____ State: _____ Zip:_____

How Did You Hear About Us?

_____

If it was from a friend please list their name above so they will get their referral credit for sending you in! ☺

INSURANCE INFO (We will need a copy of your cards & Driver's License/State ID)

1. Name of Insurance Company:_____ Policy #: _____
   Address: _____ Group #: _____
2. Name of Insurance Company:_____ Policy #: _____
   Address: _____ Group #: _____

Do you have a living will? (please circle) Yes No

If yes-Do you want a copy placed in your file here? (please circle) Yes No

Emergency Contact (First & Last Name): _____

Relationship:_____ Phone#: _____

Reason for Visit Today: _____

Primary Care Physician: _____ Location of PCP: _____

Pharmacy & Location: _____ Pharmacy Phone #:_____

SOCIAL HISTORY

Do you use tobacco products? (please circle) YES NO

If NO, please list your quit date: _____ How many packs per day? _____

Occupation: _____ Height: _____ Weight: _____

MEDICAL HISTORY

Please list any X-Rays, Ultrasounds, or Mammograms that you've had within the past year:

_____

Please list all past surgeries with approximate dates they were done and the location:

SURGERY	**DATE**	**HOSPITAL/SURGERY CENTER**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been treated for or are you currently being treated for:
(check if you ever had OR are currently having)

HEALTH ISSUE	PAST OR CURRENT	DOCTOR MONITORING THIS ISSUE	HEALTH ISSUE	PAST OR CURRENT	DOCTOR MONITORING THIS ISSUE
HEART DISEASE or PROBLEMS			URINARY PROBLEMS		
BLOOD PRESSURE			HEPITITUS PROBLEMS		
ALCOHOLISM			SEIZURE DISORDERS		
DRUG ADDICTION			BOWEL/COLON PROBLEMS		
STROKE			LYMPHNODE PROBLEMS		
ANEMIA			CANCER		
HERNIAS			WEIGHT LOSS		
LUNG/BREATHING DISEASE			PSYCHIATRIC PROBLEMS		
DIABETES			EYE PROBLEMS		
THYROID			DIZZINESS		
BLEEDING PROBLEMS			ARTHRITIS/RHEUMATOID		
SKIN/RASH PROBLEMS			BREAST PROBLEMS		
COLD SORE/FEVER BLISTERS			AUTO IMMUNE DISORDERS		
HERPES SIMPLEX			EPILEPSY		
KELOIDS			SENSITIVITY TO LIGHT		

ARE YOU OR COULD YOU POSSIBLY BE PREGNANT? (please circle) YES NO

ARE YOU NURSING? YES NO

ARE YOU PLANNING ON BECOMING PREGNANT SOON? YES NO

IF YOU ARE CURRENTLY TAKING OR HAVE TAKEN ACCUTANE/RETINOL/TRETNOIN PLEASE LIST WHICH ONE YOU ARE TAKING CURRENTLY OR HOW LONG IT HAS BEEN SINCE YOU STOPPED TAKING ONE OF THESE:

_____

HAVE YOU EVER BEEN INFECTED WITH ANY COMMUNICABLE DISEASE? IF SO, PLEASE LIST:

_____

ANY OTHER MEDICAL ISSUES?

_____
_____
_____

FAMILY HISTORY-MOTHER,FATHER,BROTHER,SISTER,GRANDPARENTS,ETC.

_____
_____
_____

ALLERGIES- PLEASE SPECIFY NONE OR LIST ANY DRUG ALLERGIES- <u>MUST INCLUDE REACTION</u>:

_____
_____
_____

LIST ALL CURRENT MEDICATIONS & THEIR DOSAGE:

_____
_____
_____
_____
_____

PRIVACY POLICY

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its physicians and staff will:

• Adhere to the standards set forth in the Notice of Privacy Practices.

• Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.

• Use and disclose PHI to remind patients of their appointments unless they instruct us not to.

• Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will:

- Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy.
- Our practice and its physicians and staff respect the patient's individual dignity at all times.

• Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.

• Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will:

- Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
- Not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release or the release is otherwise authorized by law.

• Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will:

- Permit patient's access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.
- Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- All physicians and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their requests are in writing.
- All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations. Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

• In order to ensure optimal health care services provided to you, an officer from the Happy Clinic Denver Quality Assurance Program may contact you directly by phone to get your feedback or assist you further. You consent and give permission for HCD.com staff to do so.

_____	_____	_____
Patient Name (PRINT)	Patient Signature (SIGN)	Date

3543 West Memorial
OKC, OK 73134
405-256-2526

Photograph Consent Form

☐ I give my consent for pictures to be taken of specified areas before and after treatments have been performed. I also give my permission for these pictures to be used for medical purposes, including being shared with other medical professionals. I am aware that I will be notified before any pictures are taken, and that pictures will be taken of treatment areas only.

☐ I *do not* give my consent for pictures to be shared with other medical professionals of specified areas before or after treatments have been performed.

Patient Signature_____Date_____
(or legal guardian)

3543 West Memorial
OKC, OK 73134
405-256-2526

Media Consent Form

☐ I give my consent for pictures and videos to be taken before, during and after treatments and procedures. I am aware that I will be notified before any pictures or videos are taken and before they are posted to any media platform. I give my consent for pictures and videos to be posted on the following platforms. (please check which you give consent)

_____ Facebook

_____ Facebook Live

_____ Instagram

_____ Instagram Live

_____ Twitter

_____ Snapchat

_____ YouTube

_____ Holsey Cosmetic Surgery Website

☐ I *do not* give my consent for photos or videos of myself or treatment areas to be used on any media platforms.

Patient Signature_____Date_____
(or legal guardian)

3543 West Memorial
OKC, OK 73134
405-256-2526

Cancellation and Rescheduling Policy

Dr. Holsey and her team understand that sometimes it's necessary to postpone or cancel an appointment or procedure. Please review our guidelines regarding those situations and be sure to notify us as soon as possible if something comes up that results in rescheduling or cancellation.

- There is no charge for appointments cancelled or rescheduled **24 hours or more** in advance
- Cancellation or rescheduling with **less than 24 hours** notice will result in a Cancellation Fee of $50 charged to your card on file
- If you forget or choose to **not show up** for your appointment, you will be charged 50% of the total cost of the service you were schedule to receive. Surgery consultations will be charged $50

We ask for a credit card to keep on file. The cancellation fee will be charged to that card if you are unable to give at least 24 hours advanced notice. If we are unable to charge the card on file, the cancellation fee must be paid prior to your next scheduled appointment.

☐ I confirm I have read and understand the above Cancellation and Rescheduling Policy.

Patient Signature_____Date_____
(or legal guardian)