L&P
AESTHETICS

Patient Consent for Use & Disclosure of Protected Health Information & Written Reciept of Notice of Privacy Practices

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.

In accordance with the Health Insurance Portability and Accountability At we are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe the in this notice.

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

Ways in which we may use and disclose your protected health information:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician who we have requested to be involved in your care. For example, we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Payment: We will use and disclose your protected health information to obtain payment for the health care services we provide you. For example, we may include information with a bill to a third party payer that identifies you, your diagnosis, procedure performed, and supplies used in rendering the service.

Health Care Options: We will use and disclose your protected health information to support the business activities of our practice. For example, we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

Appointment Reminders: We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

Treatment Alternatives: We will use and disclose our protected health information to tell you about or recommend possible alternative treatments or options that may be of interest to you.

Others Involved in Your Care: We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

Research: We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required by Law: We will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

To Avert a Serious Threat to Public Health or Safety: We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Worker's Compensation: We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Signature of Patient / Legal Guardian / Authorized Person:_____

PRINT Patient Name:_____**Date:**_____/_____/_____

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Patient Health Information

Welcome to L&P Aesthetics!
L&P Aesthetics is the facial rejuvenation destination in Palo Alto owned and operated by two double-board certified facial plastic surgeons, Drs. David Lieberman and Sachin Parikh. Providing you the with the best care and results is the goal of everyone on our team. We are proud of our commitment to excellence and will always work to do our very best for our patients.

Patient Name: _____ **Date:**_____/_____/_____

Birthdate:_____/_____/_____ **Age:** _____ **Height:** _____ **Weight:** _____

Address:_____**City:**_____ **Zip:**_____

Home Phone:_____ **Mobile Phone:**_____

Email:_____ **Best way to contact you?** Home Mobile Email

I ____WOULD ____WOULD NOT like to receive emails for future specials, promotions and educational seminars.

Primary Physician:_____**Phone:**_____

Address:_____**City:**_____ **Zip:**_____

Preferred Pharmacy:_____**Phone:**_____

Address:_____**City:**_____ **Zip:**_____

Emergency Contact:_____**Phone:**_____

TODAY'S VISIT:

Main concern for today's consultation:_____

Whom may we thank for this referral (How did you learn about our practice?)_____

_____

ALLERGIES If yes, describe reaction:
Medication(s)_____

Latex:_____

Tape:_____

Soap:_____

Food:_____

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MEDICAL HISTORY: Please indicate which conditions you currently have, are under medication / treatment for or have had any of the following in the past:

- ◯ Diabetes (High Blood Sugar
- ◯ High Blood Pressure
- ◯ Heart Attack/Disease/Problems
- ◯ Irregular Heart Beat
- ◯ Lung Disease/Asthma/COPD
- ◯ Shortness of Breath/Chronic Cough
- ◯ Ulcers/GI Bleed/GERD/Reflux
- ◯ Fainting/Blackout/Stroke
- ◯ Muscle Weakness/Fatigue/Twitch
- ◯ Lower Back Pain/Neck Pain
- ◯ History of seizures/convulsion/paralysis
- ◯ Unusual Scarring/Keloid Formation
- ◯ Communicable diseases (Tuberculosis)
- ◯ **Other:**

- ◯ Thyroid (High or Low)
- ◯ Recent Illness/Flu/Cold/HIV-AIDS
- ◯ Kidney Problems/Dialysis
- ◯ Skin Disorders/Skin Cancer
- ◯ Hepatitis/Liver Failure/Liver Disease
- ◯ Herpes/Fever Blisters/Shingles
- ◯ Anemia (Low Blood Count)/Transfusions
- ◯ Sickle Cell Disease/Blood Disease
- ◯ Lupus/Rheumatoid/Autoimmune Disease
- ◯ History of Cancer
- ◯ Are you Pregnant
- ◯ Recently Hospitalized? Date:_____

Eye specific:

- ◯ Visual Loss (one or both eyes)
- ◯ "Dry" eyes
- ◯ Itching or irritation of eyes
- ◯ Blurred or double vision
- ◯ Crossed or lazy eyes
- ◯ Cornea problems
- ◯ Thyroid eye disease
- ◯ Wear glasses or contacts

SURGICAL / COSMETIC PROCEDURE HISTORY (Please list all operations you have had along with surgeon name & date)

Procedure/s:	**Surgeon / Facility:**	**Date:**

Has anyone in your family had a reaction to general anesthesia? Yes / No

If yes, please explain_____

Did you ever have any complication from surgery? _____ **If yes, what?**_____

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CURRENT MEDICATIONS & SUPPLEMENTS (Please list ONLY the medications / supplements you CURRENTLY take)

Medication /Supplement:	**Dosage:**

Are you taking Aspirin or medication containing aspirin? Yes / No **If so, what dosage:** _____

Have you taken ANY anti-inflammatory medications (NSAIDS) or blood thinners (Coumadin, Warfarin, Lovenox, etc) **within the past two weeks?** Yes / No

SOCIAL

Do you drink more than two drinks per day? Yes / No **If so, how often?**_____

Do you smoke? Yes / No **If so, how often?**_____

I certify that the above is true to the best of my knowledge.

_____

Patient Signature / Legal Guardian

Thank you for choosing L&P Aesthetics. We look forward to provding you with the best possible care!