Louis C. Cutolo, Jr., M.D., F.A.C.S. — Plastic Surgery

Patient Information Date: _____

Name: (Last) _____ (First) _____ (MI) _____ ❑Male ❑Female

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Email Address: _____

Marital status: □ Single □ Married □ Divorced □ Widowed Race:_____

Soc. Sec. No. _____

Employer: _____Occupation:_____

How did you hear about us? _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship:_____

City/Location: _____ Home Number:_____

REASON FOR COSMETIC CONSULT: Please indicate the nature of your visit and/or the procedure(s) you would like to discuss:

☐ Breast Enlargement ☐ Liposuction ☐ Botox / Fillers ☐ Body Lift ☐ Resurfacing/Peels/Laser
☐ Rejuvelift / Facelift ☐ Eyelid lift ☐ Zeltiq(CoolSculpting) ☐ Ear Reshaping
☐ Tummy Tuck ☐ Breast Lift ☐ Breast Reduction ☐ Fat Transfer ☐ Other _____

REASON FOR RECONSTRUCTIVE CONSULT: Please indicate the nature of your visit and/or the procedure(s) you would like to

☐ Facial Reconstruction ☐ Other _____

HEALTH AND MEDICAL INFORMATION:

Age: _____ Height: _____ Weight: _____ Primary Care Physician and Location: _____

Have you ever smoked? □ yes □ no If yes, ____packs/day for ____ Still smoke? □ yes □ no Date you quit: _____

How much alcohol do you drink? ___drinks per □ day □ week □ month How many cups of coffee/caffeine per day? _____

Additional Health History List the dates of your most recent:

Physical/Check-up _____ Normal? □ Yes □ No EKG (heart tracing) _____ Normal? □ Yes □ No
Chest X-Ray _____ Normal? □ Yes □ No Blood work _____ Normal? □ Yes □ No

Women Only: How many pregnancies have you had? _____How many children born alive? _____How many c-sections? _____

Is there any chance you could be pregnant? □ Yes □ No Date of most recent breast exam: _____

Are you having regular menstrual periods? ? □ Yes □ No Date of most recent mammogram: _____

Heavy bleeding with your periods? ? □ Yes □ No

MEDICATIONS: Please list all the medications you are currently taking, prescription and non-prescription, supplements, vitamins, diet pills and those medications you may not take *every* day. Please also include the dose of the medication.

Medication/Dose	Medication/Dose

ALLERGIES: Please list all allergies to medications, tape, latex, iodine, etc. and the reaction you have when exposed.

	☐ I have no known drug allergies

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Patient Name: _____

SURGICAL HISTORY:

Please list your surgical history and/or serious accidents or injuries. Please include the date of the surgery, accident or injury.

PROCEDURE	**DATE**

Have you and/or any of your family members had any anesthesia complications? ☐ Yes ☐ No

If yes, please describe: _____

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS: Please check all that apply to *YOU*:

NEUROLOGICAL
- □ Migraines
- □ Stroke
- □ Seizures
- □ Head Injury
- □ Depression

BLOOD
- □ Anemia
- □ Bleeding disorder
- □ Blood clots/DVT
- □ AIDS/HIV+
- □ Nose Bleeds
- □ Prior Transfusion

PULMONARY
- □ Asthma
- □ Tuberculosis (TB)
- □ Emphysema
- □ Pulmonary Embolism

CARDIOVASCULAR
- □ Heart Disease
- □ Chest Pain
- □ High Blood Pressure
- □ Heart Attack
- □ Heart Murmur
- □ Swollen legs/ankles
- □ Palpitations

SKIN/IMMUNE
- □ Arthritis/Joint Pain
- □ Back/Neck
- □ Skin disorder
- □ Autoimmune
- □ Lupus/Scleroderma
- □ Pigmentation

GENERAL
- □ Fever
- □ Weight loss/gain
- □ Night Sweats
- □ Loss of Appetite

HEAD/NECK
- □ Change in vision
- □ Nasal blockage
- □ Sore throat
- □ Sinusitis
- □ Wear contacts/glasses

ENDOCRINE
- □ Heat/Cold intolerance
- □ Diabetes
- □ Thyroid Problems

GASTROINTESTINAL
- □ Constipation
- □ Reflux disease
- □ Diarrhea
- □ Hepatitis/Jaundice
- □ Frequent Urinary Infection

ALLERGY
- □ Tape Allergy
- □ Environmental
- □ Iodine Allergy
- □ Latex Allergy

□ **CANCER**, type: _____

□ **OTHER:** _____

□ **NONE OF THE ABOVE LISTED**

Family History Please check those that apply to your family members: □ **NONE OF THE FOLLOWING**

☐ Blood clots/DVT ☐ Bleeding disorder ☐ Asthma ☐ Breast Cancer ☐ Stroke
☐ High Blood ☐ Heart Disease ☐ Diabetes ☐ Other

PHYSICIAN NOTES:

_____

_____

_____

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Patient Name: _____

INSURANCE PATIENTS

Responsible Party Information

☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Date of Birth _____ SS # _____

Primary Insurance

Company _____

Address _____

City _____ State _____ Zip Code _____

Telephone _____ Policy Holder's Name _____

Group ID _____ Policy Holder's ID _____

Policy Holder's Date of Birth _____ Policy Holder's SS# _____

Co-Pay _____ Effective Dates _____

Company _____

Address _____

City _____ State _____ Zip Code _____

Telephone _____ Policy Holder's Name _____

Group ID _____ Policy Holder's ID _____

Policy Holder's Date of Birth _____ Policy Holder's SS# _____

Co-Pay _____ Effective Dates _____

If your visit arises from a Workers' Compensation Injury of Car Accident (No-Fault Insurance), please provide the following:

Claim # _____ Date of Accident or Injury: _____

Insurance Company _____

Address: _____

Phone Number: _____ Contact person: _____

Employer: _____

Address: _____

Phone Number: _____ Contact person: _____

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PRIVACY FORM

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. You will be given a copy of this notice.

Patient Health Information: Under federal law, your patient health information is protected and confidential. This information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information includes payment, billing, and insurance information.

How we use your Health Information: We use health information about you for treatment, to obtain payment, and for healthcare operations including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances we may be required to use or disclose the information without your permission.

Examples of Care, Payment, and Healthcare Operations: Treatment—We will use and disclose your health information to provide your medical treatment. For example, nurses, physicians, and other members of your treatment team will record and use it to determine your care. We may also disclose information to other healthcare providers who are helping in your treatment, to pharmacists filling your prescriptions, and to family members helping with your care. **Payment—**We will disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain your records of payment. **Health Care Operations—**We will use and disclose your health information to conduct our standard internal operations, including the administration of records, the evaluation of the quality of treatment, and the assessment of outcomes. **Quality Assurance-**We will also use your health information in the performance of physician's peer reviews, as required by law.

Special use: We may use your information to contact you with appointment reminders. We may also contact you to provide information about different treatment options.

Other Uses and Disclosures: We may use or disclose health information about you for other purposes. Subject to certain **HIPAA** requirements, we are permitted disclosure for the following purposes: **Required by Law—**We may be required by law to report gunshot wounds, suspected abuse, suspected neglect, or similar events. **Research—**We may use or disclose information for approved medical research. **Public Health Activities—**As required by law, we may disclose vital statistics, disease, information related to recalls of products, and similar information to health authorities. **Health Oversight—**We may disclose information to assist in investigation and audits, and eligibility for government programs. **Judicial Proceedings—**We will disclose information in response to subpoena or court order. **Law Enforcement Purposes—**We may disclose information subject to certain restrictions. **Workers' Compensation—**We may release information about your workers' compensation or other programs providing benefits for work-related injuries or illness. **Military or Special Government Functions—**If a member of the armed forces, we will release information as military authorities or correctional facilities command, or for national security. **Death—**We must report information regarding deaths to the coroner, medical examiner, funeral directors, and organ donation programs. **Serious Threat to Health and Safety—**We may share information when needed to prevent a serious threat to your health, safety, and/or to the public.

Individual Rights: You have the following rights with your health information. **Request Restrictions—**You may request restrictions on some uses of this information, although we are not required to agree with this request. **Confidential Communications—**You may request that we communicate with only you. You may request a special address or phone number. **Inspect and Obtain Copies—**In most cases you have the right to look and receive a copy of your information. **Amend Information—**If you believe there are errors in your information, or information is missing, you may request that it be modified. **Accounting of Disclosure—**You may request a history of the disclosure of the information about you for reasons OTHER than treatment, payment, or operations.

Our Legal Requirement: We are required to provide you with this notice, to protect your information, and to abide by the terms of this notice.

Changes in a Privacy Practice: We may change these terms at any time. We will change our notice to reflect the terms that we change. We will also post the terms changes in our waiting room. You may request a copy of this notice and/or the changes at any time. You may contact the Center Director below to answer any questions.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

FINANCIAL INFORMATION

You may receive bills from several different providers for the care rendered to you today: the physician performing the procedure, the Ambulatory Surgery Center (ASC), hospital, and a laboratory if specimens are obtained during your procedure.

FINANCIAL AGREEMENT

If you have insurance, we will help you receive maximum benefits by filing for you; however, we will expect payment of co-pays, co-insurance, and deductibles at the time of service. The undersigned individual guarantees prompt payment of all charges if the insurance carrier rejects the claim of any charges related to this account. If charges remain unpaid, it may become necessary to turn the account over to a collection agency.

ASSIGNMENT OF INSURANCE BENEFITS

Medicare/Other Insurance

I hereby assign benefits to be paid, on my behalf, to Dr. Louis C. Cutolo, Jr., M.D.. I understand and agree to be financially responsible for charges not paid within a reasonable time by insurance or other third party payer. I certify the information given with regard to insurance coverage is correct.

RELEASE OF INFORMATION

I authorize the office to release all or part of my medical records when required for the submission of any insurance claims for payment to the Centers for Medicare and Medicaid Services and their agents, my insurance company(s), or to my employer (if this is a workers compensation claim).

I also authorize reports of my evaluation, treatments, and any follow up evaluations to be sent to or discussed with my referring Doctor, the Doctor requesting the consultation, my family Physician(s), as well as any other healthcare providers, hospitals, or outpatient facilities that I have or will identify to you.

I permit a copy/fax of this form to serve as an original signature of authorization.

DISCLOSURE OF OWNERSHIP

I have been advised of the following:

A physician performing the procedure may have an ownership interest in this facility.

CERTIFICATION

I have read and fully understand the information in this form.

Patient Signature **Date**

Witness Signature **Date**

Patient Name: _____ Sex: Physician Name: _____

MR Number: _____ DOB: Admission Date: _____

MUTUAL AGREEMENT TO MAINTAIN PRIVACY

Dr. Cutolo, Jr agrees to provide treatment to: _____.
(Please print patient's name)

Dr. Cutolo, Jr., takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal date is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Dr. Cutolo believes this improper and may not be in the patients' best interest. Accordingly, Dr. Cutolo agrees not to provide medical information for the purpose of marketing directly to patients. Regardless of legal privacy loopholes, Dr. Cutolo will never attempt to leverage his relationship with a patient by seeking a patient's consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Dr. Cutolo has invested significant financial and marketing resources in developing this practice. Nothing in this Agreement prevents a patient from posting commentary about Dr. Cutolo – his practice, expertise, and/or treatment – on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if a patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Dr. Cutolo, the patient exclusively assigns all Intellectual Property rights, including copyrights, to Dr. Cutolo for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be in force and enforceable for a period of five years from Dr. Cutolo's last date of service to the patient. As a matter of office policy, Dr. Cutolo is requiring all patients in this practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all of Dr. Cutolo's patients. Further, this agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship.

Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief.) Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanation.

Signature of Patient _____ Date _____

PHOTOGRAPHY AND OUR PRACTICE

The use of photographs is essential to the planning and evaluation of aesthetic or reconstructive surgery. Dr. Cutolo plans to take photos of your case before, possibly during, and after planned surgeries or treatments. These photos become part of your medical record and will not be shown to anyone without your consent.

For various reasons, Dr. Cutolo is often asked to show before and after photos of patients. Many patients have given permission to use their photos anonymously, and we now ask that you do so as well.

AUTHORIZATION FOR THE USE OF PHOTOGRAPHS

I 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 effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire thirty years from the date written below. I understand that I may refuse to sign this authorization and that such refusal will have no effect on the medical treatment I receive from Dr. Cutolo.

I understand that the information disclosed may be protected by state law and/or the federal Health Insurance Portability and Accountability act of 1996 (HIPAA). I further understand that any third-party receiving this information may not be protected by HIPAA and that this information may be re-disclosed (for example if the third party is not a health care provider or health plan).

PERMISSIONS:

I hereby grant permission for the use of any of my medical records, illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc. Additionally, I grant permission for the use of such information in conjunction with coordinating my medical and surgical care.

Please review the following circumstances for the anonymous use of your photos, and <u>clearly strike-through any use to which you object</u>:

- Prospective patients, such as myself, in the process of evaluating procedures during consultation
- In consultation or review with other physicians during seminars, professional conferences or teaching courses for the purpose of informing the medical profession or general public about plastic surgery methods.
- Health insurance company authorizations, if required

For any of the following uses, Dr. Cutolo will ask for your permission in advance:

- Articles written by Dr. Cutolo for publication in magazines, newspapers or professional journals, *so long as I am notified in writing of such use prior to publication.*
- Television interviews of Dr. Cutolo or programs produced for television, *so long as I am notified in writing of such use prior to production.*
- Internet or website use by Dr. Cutolo, *so long as I am notified in writing of such use prior to production.*
- Patient education brochures, *so long as I am notified in writing of such use prior to production.*

Patient Signature	Printed Name	Date
Witness	Printed Name	Date

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NON-MEDICAL PATIENT INFORMATION

Patient Name _____DOB_____Age_____Date_____

What area(s) is your concern? _____
What surgery(s) are you interested in? _____
What improvement/change do you hope to make? _____
How long have you thought about a procedure? _____
Why is now the right time for a procedure? _____
Have you had any other consultations? _____
What do you still need that you didn't get in your previous consult? _____
Is your significant other/family supportive of your desire for a procedure? _____
Have you ever had surgery(s)? _____What type? _____
_____
Who will your care provider be? _____
How much time will you have off work/down time? _____
Do you understand that cosmetic surgery aims to improve appearance, not perfect? ____
Any fears/concerns that you have about surgery? _____
_____
Have you educated yourself on this procedure?____What ?s do you have?_____
_____
Do you take a multivitamin? ___ Aspirin ____ Ibuprofen? ___ Herbs? ____ Fish Oil?___

IF INTERESTED IN BREAST SURGERY:
Do you have a family history of breast cancer? _____
Have you ever had a mammogram or breast biopsy? _____
Have you had children _____Did you breastfeed? _____How long? _____
What size bra do you wear?_____What size do you hope to be?_____
Are you interested in saline or silicone gel implants?_____

IF INTERESTED IN BODY SURGERY:
Is your procedure related to weight gain?_____Weight loss?_____
Have you gained or lost more than 10 pounds in the last year?_____
What type of foods do you eat?_____Are you on a special diet?_____

IF INTERESTED IN FACIAL SURGERY:
Have you ever had any injury/surgery to the face?_____
Are you having any problems with breathing?_____
Do you understand that facial surgery can result in extended bruising/swelling? _____

OTHER: _____
_____
_____

Our office is located at 1557 Victory Boulevard, Staten Island, NY. 10314 and is easily accessible from the Staten Island Expressway Todt Hill Road/Slosson Avenue Exit (Exit 12). Since we are located in a beautiful tree lined residential area next to PS 29, parking is readily available.