Skin Care Questionnaire

What are your main concerns:

__ Acne
__ Acne Scarring
__ Aging
__ Sun Damage
__ Hair Removal
__ Tone
__ Veins
__ Preventative Skin Cancers
__ Pigmentation
__ Fine Lines
__ Deep Lines
__ Enlarged Pores
__ Texture

Skin Type: Normal Oily Sensitive Dry Acne Combination

Do you or have you ever had acne? Yes No
Sunburn easy? Yes No
Sunbather? Yes No
Tanning Bed? Yes No
Smoker? Yes No
Pregnant? Yes No
Nursing? Yes No
Have you ever used Retin A? Yes No

Have you ever used Accutane? Yes No When? _____
Is there anything that irritates your skin? _____
Do you have sensitive areas on your skin? _____
Do you have any skin reactions or allergies? _____
What is your ethnic background/race? _____
Have you ever been diagnosed with cysts on your ovaries, endometriosis or hormonal imbalances? _____

Paul A. Blair, M.D., Inc.

Patient Information

Date: _____

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Male/Female

Marital Status: [ ] Married [ ] Single [ ] Other

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( )_____ Work: ( )_____ Cell: ( )_____

Do you have Text Messaging? { } Yes { } No

Email: _____

(Appointment confirmations are also sent via Text Messaging.)

Any restrictions for contacting you? { } Yes { } No

Preferred Method of contact:_____

Employer Name: _____ Occupation: _____

Spouse: _____

Employer: _____ Occupation: _____

Nearest friend or relative NOT living with you to contact in an emergency:

Name: _____ Phone: ( )_____ Relation: _____

How did you hear about Dr. Blair? (Mark all that apply)

{ } TV News { } TV Ad { } Phone Book { }Magazine { } Newsletter

{ } Internet { } Seminar { } Salon { } Other { } Doctor: _____

{ } Friend/Relative:_____ { } Other:_____

If you were referred by a specific person, may we thank them? { } Yes { } NO

Paul A. Blair, M.D., Inc.

Cosmetic Payment Policy

We consider it a privilege that you have chosen our office for your facial plastic needs! We strongly believe that an informed patient is a happy patient and that your clear understanding of our financial policy is important to our professional relationship. Therefore, we strive to inform you of all of the medical aspects of your needs as well as advise you on our payment policies for all cosmetic and surgical procedures.

Patients often have questions about the fees and payment process for cosmetic procedures. By definition, the cost of cosmetic surgery is NOT covered by insurance companies or third party payers, and patients are responsible for these themselves.

Payment is expected at the time services are rendered. There is also a 10% deposit required for all surgeries.
We accept cash, personal checks, ATM cards and all major credit cards. Please be advised that there is a $15 returned check fee.

We realize that every person's financial situation is different. For this reason, we offer 2 different payment plan options to help you obtain the cosmetic enhancement you desire with respect to your budget.

Care Credit and Chase Health Advance are the companies that you can apply for credit through them and make your payments to them. You will find them to be very easy to work with. Brochures are available for both companies upon request.

Cosmetic procedures are an excellent investment in an individual's self-esteem as well as psychological well-being!

Consent to Photograph

I understand that photography is a necessary part of planning and evaluating cosmetic procedures. I authorize the taking of photographs at the direction of Paul A. Blair, M.D. and under such conditions as may be approved by him. These photographs will be used solely for documentation purposes and will be kept confidential.

By signing below I acknowledge that I have read and understand the above listed payment policy and photography authorization.

_____ _____

Patient Signature Date

Paul A. Blair, M.D., INC.

3667 Teays Valley Road * Hurricane, WV 25526 * (304) 201-3223 P * (304) 201-6555 F

Date: ___/___/___

Patient: _____ DOB: ___/___/___

Age: _____ Weight: _____ Height: _____

Primary Care Physician: _____

Allergies to food, latex, dyes or medications? { } YES { } NO

Allergy	Reaction

Allergy	Reaction

Medications: (list all currently taking, including OTC and vitamins/herbs.)

Drug	Dose	Frequency

Drug	Dose	Frequency

Previous Surgery and Approx. Dates

_____ ___/___/___

_____ ___/___/___

_____ ___/___/___

_____ ___/___/___

_____

List of Doctors Currently Seeing and For What Reason:

_____

_____

_____

_____

Single { } Married { } Divorced { } Widowed { }

Employed: { } YES { } NO Occupation: _____

Tobacco Use: { } YES { } NO { } Quit _____packs per day_____for_____years

Alcohol Use: { } YES { } NO { } Rarely { } Moderate { } Daily

Family Medical Illness History:

Mother: _____

Father: _____

Siblings: _____

Review of Systems

DO YOU CURRENTLY HAVE..... (YOU MUST CHECK AND ANSWER FOR EACH INDIVIDUAL ITEM)

CONSTITUTIONAL SYMPTOMS	
Weight Loss	{ }YES { }NO
EYES	{ }YES { }NO
Glaucoma	{ }YES { }NO
Glasses or Contact Lenses	{ }YES { }NO
Dry Eyes, Excess Tearing	{ }YES { }NO
EARS, NOSE, MOUTH AND THROAT	
Decreased Hearing	{ }YES { }NO
Airway Obstruction (Nasal)	{ }YES { }NO
CARDIOVASCULAR	
Heart Attack	{ }Yes { }NO
Chest Pain/Angina	{ }Yes { }NO
Palpitation or Irregular Heartbeat	{ }Yes { }NO
Heart murmur	{ }Yes { }NO
High Blood Pressure	{ }Yes { }NO
Low Blood Pressure	{ }Yes { }NO
Abnormal EKG	{ }Yes { }NO
Rheumatic Fever	{ }Yes { }NO
On Heart Medication	{ }Yes { }NO
Heart Failure	{ }Yes { }NO
Swelling in Ankles	{ }Yes { }NO
Chest Pain with Exercise	{ }Yes { }NO
RESPIRATORY	
Asthma/Wheezing	{ }YES { }NO
Bronchitis	{ }YES { }NO
Pneumonia (or history of)	{ }YES { }NO
Tuberculosis	{ }YES { }NO
Smoker Cough	{ }YES { }NO
Emphysema	{ }YES { }NO
Shortness of Breath	{ }YES { }NO
Chronic Breathing Difficulty	{ }YES { }NO
Other Lung Problems	{ }YES { }NO
ALLERGIC/IMMUNOLOGIC	
Hay Fever	{ }YES { }NO
Major Allergies	{ }YES { }NO
Lupus, Scleroderma	{ }YES { }NO
Rheumatoid Arthritis	{ }YES { }NO

GASTROINTESTINAL	
Hepatitis (or history of}	{ }YES { }NO
Yellow Jaundice	{ }YES { }NO
Gallstones	{ }YES { }NO
Gallbladder Trouble	{ }YES { }NO
Cirrhosis of the Liver	{ }YES { }NO
Ulcers	{ }YES { }NO
Gastritis/Colitis	{ }YES { }NO
Constipation	{ }YES { }NO
Chronic Adbominal Pain	{ }YES { }NO
Hernia: Hiatal	{ }YES { }NO
Abdominal	{ }YES { }NO
Groin	{ }YES { }NO
Heartburn/Indigestion	{ }YES { }NO
GENITOURINARY	
Kidney Disorder	{ }YES { }NO
Blood in Urine	{ }YES { }NO
Kidney Infection (or history of)	{ }YES { }NO
Bladder Infection (or history of)	{ }YES { }NO
Kidney Stones (or history of)	{ }YES { }NO
Difficulty Urinating	{ }YES { }NO
Urinary Retention	{ }YES { }NO
SKIN	
Skin Disorders, Dermatitis	{ }YES { }NO
Heavy Sun Exposure/Tanning Beds	{ }YES { }NO
Blistering Sunburn in Past	{ }YES { }NO
Rash	{ }YES { }NO
Skin Cancer (or history of)	{ }YES { }NO
Changes in Moles (growth/color)	{ }YES { }NO
Pressure Ulcers/Diabetic Ulcers	{ }YES { }NO
INFECTIOUS	
Postive blood test for:	
AIDS/Hepatitis/HIV	{ }YES { }NO

MUSCULOSKELETAL	
Arthritis/Joint Pain	{ }YES { }NO
Fracture of Neck (or history of)	{ }YES { }NO
Fracture of Spine (or history of)	{ }YES { }NO
NEUROLOGICAL	
Tingling or Numbness	{ }YES { }NO
Weakness in Extremities	{ }YES { }NO
Seizures/convulsions	{ }YES { }NO
Fainting spells/Black outs	{ }YES { }NO
Stroke	{ }YES { }NO
Palsy or Paralysis (what level}	{ }YES { }NO
PSYCHIATRIC	
Nervous Breakdown	{ }YES { }NO
Anxiety Disorder	{ }YES { }NO
Insomnia	{ }YES { }NO
Alcohol Addiction	{ }YES { }NO
Drug Dependency	{ }YES { }NO
Self-Destructive Tendencies	{ }YES { }NO
Bipolar Disorder/Depression	{ }YES { }NO
Psychiatric Hospitalization	{ }YES { }NO
ENDOCRINE	
Thyroid Problems/Goiter	{ }YES { }NO
Diabetes	{ }YES { }NO
Insulin Dependency?	{ }YES { }NO
Diabetic foot ulcers/infection	{ }YES { }NO
Cortisone Treatment	{ }YES { }NO
Steroid Treatment	{ }YES { }NO
HEMATOLOGIC/LYMPHATIC	
Bleeding Tendency or Disorder	{ }YES { }NO
Abd. Bleeding after Tooth Extraction	{ }YES { }NO
Blood Transfusion	{ }YES { }NO
Anemia	{ }YES { }NO
Easy Bruising	{ }YES { }NO
Lymphedema	{ }YES { }NO

Health Questions

*When was your last physical exam? _____ and by whom? _____

*Have you had recent blood work? _____ { }YES { }NO Where? _____

*Is there anything else you think the doctor should know? _____

_____

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Signature: _____ **Date:** _____

Reviewed by: _____ _____ _____

Paul A. Blair, M.D. Inc

3667 Teays Valley Road * Hurricane WV 25526
(304) 201-3223

RESPONSIBILITY

I accept full responsibility for the cost of all health services rendered by Paul A. Blair, M.D., Inc.

CONSENT FOR EXAMINATION AND TREATMENT

I hereby consent to examination and/or treatment as recommended by the professional staff of Paul A. Blair, M.D., Inc.

Our practice focuses on elective cosmetic plastic surgery enhancements of individuals. It is our specialty and patients seek us out to fulfill their aesthetic plastic surgery needs. Insurance, including Medicare and Medicaid programs do not cover any expenses for procedures done for cosmetic reasons, therefore we do not participate or bill any insurance companies. Plastic surgery patients, not their insurance carriers are responsible for all charges.

Clearly, costs of plastic surgery are a major issue for most cosmetic patients. Cost, however, should not be the sole reason for choosing your plastic surgeon. We recommend that you consider cost last and choose a board certified surgeon based on qualifications and experience first.

We request that our charges for services be paid at each visit.

If this account is assigned to an attorney or collection agency, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.

REVOCATION OF AUTHORIZATION

This authorization may be revoked by me at any time by delivering to Paul A. Blair, M.,D., Inc. a written statement of revocation. I understand that I may not revoke any acceptance of financial responsibility and consent to examination or treatment (paragraph 1 & 2) with respect to any medical services rendered by them prior to the date of such revocation.

RESPONSIBLE PARTY

If this authorization and consent is signed by responsible party on behalf of a patient, such party assumes full responsibility as set forth in paragraph 1 from above, and all liability for the other consents and authorizations set forth above.

A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges.

_____ ____/____/____

Patient's Name Date

_____

Person Authorized To Sign For Patient

_____

Relation

Paul A. Blair, M.D., Inc.

Paul A. Blair, M.D., Inc.

medispa ALEX ALEXA

My Cosmetic Concerns

Date:

Forehead:	[ ] Wrinkles	[ ] Low Brow	[ ] Frown Lines
Eyelids:	[ ] Excess Skin Upper Eyelids [ ] Bags Lower Lids		[ ] Wrinkles
Nose:	[ ] Hump	[ ] Boxy Tip	[ ] Crooked
Lips:	[ ] Wrinkles	[ ] Thin	
Jawline:	[ ] Laxity	[ ] Jowls	
Neck:	[ ] Laxity	[ ] Wrinkles	[ ] Turkey Neck
Skin:	[ ] Wrinkles [ ] Acne	[ ] Texture [ ] Scarring	[ ] Blemishes
Other:	_____		
	_____		

Dr. Blair's Recommended Treatment

Surgery: _____

Laser: _____

Filler: Radiesse Juvederm Restylane # Syringes ___

Wrinkle Relaxer: Botox Dysport Xeomin # Units ___

Thermage: _____

Other: _____

_____

~ Please see attached quote for pricing.

Notice of Privacy Practices
The Health Insurance Portability Act
"HIPPA"

This notice describes how medical information about you may be used, disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY!

The Health Insurance Portability Act of 1996 ("HIPPA") is a federal program that requires all medical records and other individually identifiable health information be used or disclosed by us in any form, whether electronically, on paper or orally are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA we have prepared this explanation of how we are required to maintain your privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, Payment and Health Care Operations.

- TREATMENT means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit.
- HEALTH CARE OPERATIONS include the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with the respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain issues and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are however, not required to agree to a requested restriction. If we do not agree to a written restriction, we must abide by it unless you agree in writing to remove it.
- The right to a reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make new provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a Notice of Privacy Practices from this office.

You will have the recourse if you feel that your privacy protection has been violated. You have the right to file a written complaint with our office or with the department of Health & Human Services, Office of civil rights about violations of this notice or the policies and procedures of our office. We will not retaliate against you for filling a complaint.

Please contact us for more information.

HIPPA Privacy Officer
Paul A. Blair, M.D. Inc
Jane A. Kurucz, M.D. Inc
3667 Teays Valley Road
Hurricane, WV 25526
(304)201-3223

The U.S. Department of Health & Human Services
Office of civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202)619-0257
(877)696-6775

Notice of Privacy Practices Acknowledgement

I have received, read and understand your Notice of Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or health care operations. I understand you are not required to agree to my requested restrictions, but if you agree then you are bond to abide by such restrictions.

_____
Patient Signature

_____
Date

Have you ever had any of the following:

__ Cold sores/fever blisters
__ Eczema
__ Skin infections or MRSA
__ Genital Herpes
__ Psoriasis
__ Radiation Therapy
__ Shingles
__ Rosacea

Have you had any of the following facial procedures in the past month:

__ Electrolysis
__ Waxing
__ Shaving
__ Facial Hair
__ Hair plucking
__ Bleaching
__ Acid peel

Previous Laser History:
Please provide as much information about your previous laser treatments as you can so that we will know if we need to adjust your treatment settings.

Date	Number of Treatments	Frequency	Response	Device

Current Skin Care: _____

Please list any medications you are taking:

_____ _____ _____
_____ _____ _____

Drug Allergies:

_____ _____ _____