THE KROCHMAL CENTER
FOR PLASTIC SURGERY

# Patient Medical History Intake Form

**Demographic Information**

Patient Name _____ Age _____ Date of Birth _____

Race _____ Ethnicity _____ Cultural/Religious Preferences_____

Street Address (Required) _____

City _____ State _____ Zip Code _____

Email Address _____

Home Phone _____ Mobile Phone _____

Occupation _____ Company _____ Work Phone _____

Relationship Status _____

Emergency Contact _____ Their Relation _____ Phone #_____

How did you hear about us? _____

If referred by a doctor, would you allow us contact them with a summary of our visit? □ Yes □ No

**History of Present Concern:**

What can we help you with today? _____

How long has it been bothering you? _____

Has it changed recently? If so, how has it changed?_____

If you have seen somebody else about this already, what did they say? _____
_____

Time frame for addressing the concern: □ ASAP! □ Sometime Soon □ At Some Point _____

**Past Medical History: Please Check A Box In Every Row**

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Hypertension (high blood pressure, even if normal with medications) |
| ☐ | ☐ | Diabetes □Type 1 □Type 2 Average Blood Glucose _____ Last Hgb A1C Level_____ |
| ☐ | ☐ | Asthma □ I have a rescue inhaler □ I do not have a rescue inhaler |
| ☐ | ☐ | Thyroid Problems □ Hypo □ Hyper □ Hashimoto's Thyroiditis □ Other _____ |
| ☐ | ☐ | Previous Heart Attack/MI/Coronary Artery Disease |
| ☐ | ☐ | Irregular Heart Rhythm (if so, please describe) _____ |
| ☐ | ☐ | Other Heart Condition (if so, please describe) _____ |
| ☐ | ☐ | Previous Stroke or TIA (if so, when, and what residual deficits) _____ |
| ☐ | ☐ | Kidney Disease (if so, please describe) _____ |
| ☐ | ☐ | Inflammatory Bowel Disease (if so, please describe) _____ |
| ☐ | ☐ | Irritable Bowel Syndrome (if so, please describe symptoms) _____ |
| ☐ | ☐ | Multiple Sclerosis |
| ☐ | ☐ | Other Neurological Issues (if so, please describe) _____ |
| ☐ | ☐ | Cancer (Breast, Skin, Other) _____ |
| ☐ | ☐ | Anxiety (even if controlled with medications) |
| ☐ | ☐ | Depression (even if controlled with medications) |
| ☐ | ☐ | Other Psychiatric Illness (if so, please describe) _____ |
| ☐ | ☐ | Rheumatoid Arthritis (not "regular" osteoarthritis) |
| ☐ | ☐ | Reynaud's Disease (only if formally diagnosed) |
| ☐ | ☐ | Other Autoimmune Disorders (not listed elsewhere) _____ |
| ☐ | ☐ | Anemia (if so, please describe what kind) _____ |
| ☐ | ☐ | History of Bleeding or Clotting (DVT) problems (if so, please describe)_____ |
| ☐ | ☐ | History of Infections (if so, please describe, include MRSA) _____ |
| ☐ | ☐ | Anesthesia Problems (Malignant Hyperthermia, Nausea, Slow Wake-Up, etc.)_____ |
| | ☐ | Other Current or Previous Medical Problems (please list everything, you never know what may end up being important): |

_____

_____

_____

**Previous Surgeries: (please include ALL surgeries, including "minor" cosmetic surgeries like liposuction)**

Procedure: _____Dr. _____ Date_____ Complication?_____
Procedure: _____Dr. _____ Date_____ Complication?_____
Procedure: _____Dr. _____ Date_____ Complication?_____
Procedure: _____Dr. _____ Date_____ Complication?_____
Procedure: _____Dr. _____ Date_____ Complication?_____
Procedure: _____Dr. _____ Date_____ Complication?_____
Procedure: _____Dr. _____ Date_____ Complication?_____
Procedure: _____Dr. _____ Date_____ Complication?_____
Procedure: _____Dr. _____ Date_____ Complication?_____
Procedure: _____Dr. _____ Date_____ Complication?_____
Procedure: _____Dr. _____ Date_____ Complication?_____
Procedure: _____Dr. _____ Date_____ Complication?_____
Procedure: _____Dr. _____ Date_____ Complication?_____
Procedure: _____Dr. _____ Date_____ Complication?_____

**Other Aesthetic Procedures: (such as Botox, Fillers, ThreadLifting, Lasers, Deep Chemical Peels)**

Botox/Dysport/Jeuveau: What areas? _____When last done?_____
Filler: What areas? _____What Filler?_____ When?_____
What areas? _____What Filler?_____ When?_____
What areas? _____What Filler?_____ When?_____
What areas? _____What Filler?_____ When?_____
ThreadLifting: What areas? _____When last done?_____
Laser Treatments: What areas? _____When last done?_____
What areas? _____When last done?_____
CoolSculpting, etc. What areas? _____When last done?_____
What areas? _____When last done?_____
Deep Chemical Peel: What areas? _____When last done?_____
What areas? _____When last done?_____

**Allergies:**

Allergies to Medications (please list all, with the reaction)

_____

_____

Allergies to Environmental/Food/Seasonal (please list all, with the reaction)

_____

Latex Allergy? □ Yes □ No Reaction: _____

Iodine Allergy? □ Yes □ No Reaction: _____

Tape/Adhesives? □ Yes □ No Reaction: _____

**Medications: (please list Accutane/Absorica/Isotretinoin if you've EVER taken it)**

Name_____ Dose _____ What For? _____

Name_____ Dose _____ What For? _____

Name_____ Dose _____ What For? _____

Name_____ Dose _____ What For? _____

Name_____ Dose _____ What For? _____

Name_____ Dose _____ What For? _____

Name_____ Dose _____ What For? _____

Name_____ Dose _____ What For? _____

Name_____ Dose _____ What For? _____

Name_____ Dose _____ What For? _____

Name_____ Dose _____ What For? _____

Name_____ Dose _____ What For? _____

**Dietary Supplements: Please List All Of Them**

Name_____What For? _____ Name_____What For? _____

Name_____What For? _____ Name_____What For? _____

Name_____What For? _____ Name_____What For? _____

Name_____What For? _____ Name_____What For? _____

Name_____What For? _____ Name_____What For? _____

**Family History: Please list who has it**

Heart Disease _____

Stroke _____

Diabetes _____

Pulmonary Issues _____

Kidney Issues _____

Anesthesia Problems _____

Cancer (Breast, Skin, Other)_____

Alzheimer's Disease _____

Alcoholism _____

Bleeding Problems _____

Blood Clots (DVT/PE) _____

**Social History:**

Smoking/Vaping: □ Never □ Current □ Previous - when did you quit?_____

If "current" or "previous", how many packs/day? _____

Marijuana (smoking or edibles): □ Never □ Current □ Previous - when did you quit?_____

Other Drug Use: □ Never □ Current □ Previous - when did you quit?_____

If "current" or "previous", which drugs? _____

Alcohol: □ Never □ Current _____drinks/wk □ Previous- when did you stop drinking? _____

**Female Questions:**

Number of Pregnancies: _____ Number of Children: _____ Ages?_____

Number of Vaginal Births _____ Number of C Sections and Dates _____

Last Mammogram _____ Any significant findings? _____

If Post-Menopausal, what age were you? _____

If Discussing Breast Surgery: Current Bra Size_____ Desired Cup Size_____

Back/Neck Pain □ No □ Yes Embarrassment? □ No □ Yes Restricts Activity? □ No □ Yes _____

Shoulder Grooving □ No □ Yes Prior Physical Therapy □ No □ Yes Rashes □ No □ Yes

**Physical Exam:**

Height _____ Weight _____ BMI (if known) _____

By signing below, I confirm that the information I have provided is complete and accurate. I am aware that any inaccuracies may result in medical problems and complications which may be severe and for which I will be responsible. My signature also confirms that I will inform Dr. Krochmal of any changes to my medical history if it changes.

_____ _____

Patient Name (Print) Parent or Legal Guardian (Print) if signing for a patient

_____ _____

Signature Date

THE KROCHMAL CENTER
FOR PLASTIC SURGERY

# HIPAA Notice and Privacy Policy

Please review this privacy policy in its entirety, and sign and return the last page (Privacy Policy Acknowledgement and Consent). Please contact our practice with any questions or concerns.

The Krochmal Center for Plastic Surgery maintains confidential information as part of your medical record. Your privacy is a high priority for us, as it is essential that you provide complete and accurate information about your medical history so we can provide the safest and best options for your care. The practice is required by law to maintain the privacy of this confidential information. The following notice describes how your Protected Health Information (PHI) may be used, disclosed, and accessed.

While we are required to abide by the terms of this notice, we may be required to update the provisions of the notice in the future. The current policy will be available on our website, available for review in our office, and available to be mailed to you upon your request.

**HIPAA- The Health Insurance Portability and Accountability Act, 2002.**
The HIPAA privacy rules dictate how PHI may be used and disclosed. PHI refers to your health history, medical conditions, identifiable demographic information, billing information, and payment methods. For the purposes of this notice "Use" means how we (physicians, staff) share, utilize, and analyze your PHI. "Disclose" means how we share and/or transfer your PHI to other entities such as other medical personnel and institutions, insurance companies, financial companies, our contracted business associates and partners, and yourself.

In order to provide medical services to you, including providing treatment, acquiring payment for those services, and supporting the operations of the practice in general, we may be required to use and disclose your PHI. For instance, to coordinate your treatment with other healthcare entities, we may need to disclose your PHI to acquire or provide necessary information for your care. We may also need to disclose PHI to health insurance plans and financial institutions (e.g. banks, credit card companies, third party payors such as CareCredit, and collection agencies) for insurance coverage and payment for your treatment. To support our practice operations, we may say your name in the office, contact you for appointments, and send electronic or print newsletters and marketing materials. For our contracted business partners, we will have a written contract verifying terms protecting your PHI.

Aside for the purposes of providing patient care, billing and acquiring payment for medical services, and supporting the general operations of the practice, we will not disclose your PHI (unless permitted or required by law) without your written authorization. Some common examples (not an exhaustive list) needed for your written consent would be transfer of your records to another provider, disclosure of your information to your employer.

In some circumstances, if you are not able to provide written authorization for disclosure, but your physician determines, based on his or her professional judgment, that it is in your best interest for that

information to be disclosed to so you are provided with the necessary medical care. In these instances, only the relevant PHI and medical documentation will be transferred for that particular situation. Examples may include emergencies or situations where you cannot be located but care is necessary.

With your authorization, once your PHI is transferred to an entity that is not bound by the HIPAA Privacy Rule, your PHI may not be protected. You may revoke your authorization at any time, in writing. However, any transfer of PHI prior to that revocation request may not be possible to be fully withdrawn from the entities to which your information was disclosed.

When family members, close friends (such as those who accompany you to clinical visits or procedures), and other care-takers are involved in your care, we may disclose PHI and medical information that is relevant for your care in that particular case. If you do not want us to disclosure certain information to other people who are involved in your care, please notify our office of your preferences.

Examples of situations where the law dictates we share PHI includes disclosure to a public health authority permitted by law to collect that information, to another person whom may have been exposed to a communicable disease, or government agencies responsible for healthcare regulation, accreditation, benefit programs and reporting of child and elder abuse/neglect. We may also be required by law to disclose your PHI in the course of any judicial or administrative proceeding (for instance, in response to a court order or subpoena) or to assist law enforcement with investigations and mitigating serious and imminent threats to personal or public safety. When we disclose PHI as legally required, we will notify you of that disclosure unless legally obligated to not share that disclosure with you.

We may disclose PHI to the US Food and Drug Administration (FDA), or a person or company required by the FDA to obtain that PHI. Such information is typically used to track adverse events with medication and medical devices.

For care involving Workers' Compensation or similar programs, we may be required to disclose your PHI.

You may submit a written request for instances in which your PHI has been shared with other entities. This is a special request, and does not require us to provide instances of "routine sharing" including for purposes including continuity of medical care, insurance, payment, to yourself or legal representatives that you have designated, or other designees for whom you have provided written authorization.

We periodically conduct research to further the practice of medicine. We will share your PHI with other researchers with your written approval of the research protocol, which may involve an external Institutional Review Board evaluating the research protocol.

You may inspect and obtain copies of your PHI and medical record, including billing information. To personally inspect, obtain copies of your record, or have them transferred to another entity of your choice, you must fill out and sign a "Review or Transfer of Medical Records" form and return it to our office. We will work to provide access to these records within 14 days or as applicable by law. There may be a charge to you for administrative, copying, and postage costs. There may be some circumstances where we may

need to withhold your information as required by law, including psychotherapy notes or in circumstances of criminal or civil proceeding. If we make a decision to withhold your records, this you may elect to have this decision reviewed.

In general, we will disclose relevant PHI for coordination of your care to other entities involved in your care (e.g. other providers, insurance companies, etc.). If you would like certain aspects of your PHI withheld, let us know which aspects of your PHI we SHOULD NOT disclose in writing. If you are a minor and do not want your PHI shared with your parents or guardian, submit a written request, and we will review your request and act based on our legal obligations.

We will contact you regarding your medical care using the methods you authorize. In general, confidential communication is shared with you personally through phone discussions or in-office visits. When calling your telephone number and leaving a message, we will identify our office and provide a contact phone number, but will not share PHI or confidential information unless you give us permission to do so (e.g. leaving a message to report test results). If you provide alternative locations for contact, we may need to verify financial and payment information in order to honor that request. If you authorize us to contact you by email, we may include only the PHI relevant to your care for that particular issue for which we need information or clarification. If you authorize text messaging, we may contact you regarding appointment reminders. We will not share PHI over text messaging unless you initiate the text to the physician or staff member (for example, you text to say you are having a fever and the doctor asks you for more information or asks for a picture). Please note that any form of communication, especially electronic communication via text and email, is discoverable by third parties (even if the practice and its physician and staff make reasonable safeguards to prevent this discovery).

If there are aspects of your medical record which you feel to be incorrect or incomplete, please fill out a "Medical Record Correction Request". We will review the request and notify you of our decision to amend. We may not amend the record if we determine that the information presented is accurate and complete. If amended, we will notify you of the change and notify any entities that may rely on that information. If we deny your request to amend your medical record, we will notify you of that reason in writing, and explain the process for including your statement of disagreement with our decision in your medical record for future reference (we may write a response to your statement of disagreement), as well as the process for filing a complaint.

Again, we take your privacy very seriously. If you have a question or concern regarding how your Privacy Rights have been handles, please bring it to our attention by calling, writing, or letting us know in person. We want to hear from you. We will investigate any concerns promptly and take corrective measures to prevent any unauthorized disclosures in the future. In no way will your care be affected by voicing your concerns. If you feel uncomfortable notifying our office of any real or perceived violations, you may contact the Department of Health and Human Services.

THE KROCHMAL CENTER
FOR PLASTIC SURGERY

# Privacy Policy Acknowledgement and Consent

Please review our HIPAA Notice and Privacy Policy.

I have reviewed the HIPAA Notice and Privacy Policy in its entirety, understand its provisions. If I have had any questions or concerns regarding its provisions, I have asked the office staff to clarify its contents.

By signing, below, I indicate that I agree with the provisions of the HIPAA Notice and Privacy Policy of The Krochmal Center for Plastic Surgery, version 09.22.2020. I understand that if I do not agree with the policy, I may be refused care by Dr. Daniel J. Krochmal and the staff of The Krochmal Center for Plastic Surgery.

_____ _____

Patient Name (Print) Parent or Legal Guardian (Print) if signing for a patient

_____ _____

Signature Date

## Contact Options:

Primary Address (Required): _____

City:_____ State/Province:_____ Zip Code: _____

Email Address: _____

Home Phone: _____ Mobile Phone: _____

**Preferred Method of Contact** □ Home Phone □ Mobile Phone Call or Text □ Email Address
(we will try this one first, but may try to reach you by the other methods also)

I understand that the practice typically conducts much of its patient communication electronically, including appointment reminders, sending documents, and general patient communication.

**I DO** □ or **DO NOT** □ authorize mobile texting reminder of appointments

**I DO** □ or **DO NOT** □ authorize email communication, including sending necessary documents. Note, if you send us an email and do not wish us to respond electronically, let us know that in the email. Otherwise we will assume you would like us to respond electronically.

The practice sends marketing/promotional materials to physical and electronic addresses on file unless a patient opts out. Note: you may miss information on events and specials if you opt out!

**I OPT OUT** of marketing/promotional material sent to my:

□ Primary Address □ Alternative Address □ Email Address □ Mobile Texting

THE KROCHMAL CENTER
FOR PLASTIC SURGERY

# Financial Policy

Thank you for contacting **The Krochmal Center for Plastic Surgery**. It's an honor and a privilege for us to help **Shape Your Future!** As there is sometimes some confusion regarding financial policies, we hope this notice is helpful for you. If you have any questions, please reach out to our office.

**Consults:** Dr. Daniel J. Krochmal and the staff of The Krochmal Center for Plastic Surgery want to make your consultation as helpful as possible for you to make decisions regarding your care. To do that, quite a bit of time and effort is spent preparing for your visit (gathering and interpreting necessary information, answering your questions beforehand, etc.), at the actual visit evaluating and discussing your options, and afterwards continuing to gather and interpret necessary information and answering questions. We therefore require a $200 reservation fee to secure your appointment (similar to buying a seat on an airline). This fee is refundable if you cancel your appointment more than 48 hours beforehand. Within 48 hours, much of the preparation work for your appointment has already been done, and we cannot refund your fee if you no-show (but we may allow you to use it toward another service with Dr. Krochmal at our discretion). The **GOOD NEWS** is that your fee is applied toward the professional fees for your surgery if paying out-of-pocket, so it's as if your consult were complimentary! **Note: If you ask us to engage your insurance company at any step (e.g. if you start with insurance but end up deciding to pay out-of-pocket), we will not apply the $200 to your surgery. The insurance process is very time and labor intensive for our practice, and the $200 will help cover these costs.**

**Reserving Your Surgery (Aesthetic):** To schedule your aesthetic surgery, we require a nonrefundable reservation fee of 20% of the professional fees. Full payment is required not less than 2 weeks before your surgery. If you cancel your surgery more than 2 weeks beforehand, all money except the 20% reservation fee will be returned. If you cancel within 2 weeks, only 50% of the professional fee will be returned (the 20% deposit plus 30% of the professional fee you paid). If you cancel the day of the procedure, no money will be refunded (as we wouldn't have had time to make alternative arrangements for Dr. Krochmal's schedule). Note: we will not accept insurance benefits for procedures performed for aesthetic purposes and will not assist with insurance submission unless agreed upon in writing prior to the procedure.

**Reserving Your Surgery (Insurance):** If the procedure will be done with insurance, we require a **nonrefundable $1000 reservation fee** to book a case where insurance benefits will be accepted. Once the surgery is performed and we receive payment from the insurance company, w**e will return the $1000 minus any copays/coinsurance** that your company indicates you are responsible for (so, you are basically just prepaying for any money you would have owned anyway).

**Revision Procedures:** Dr. Krochmal wishes he could control your biological healing and guarantee your satisfaction after procedures, however he obviously cannot. While it doesn't happen often, you may desire a revision to your procedure. If it's within 1 year of your original surgery, you were compliant with the treatment plan and instructions, and your health hasn't changed significantly (including significant weight changes), Dr. Krochmal typically waives his professional fee (but this is at his discretion). You will still be responsible for facility, anesthesia, labs, radiology, medication, services by other providers, and equipment/supply fees.

**Other Patient Responsibilities:** Dr. Krochmal can only control his professional fees. Other fees such as facility, anesthesia, supplies/equipment, medications, laboratory studies, pathology, radiology, other consultations and office visits, and management of complications are out of his control and are therefore the responsibility of the patient. Please review and become familiar with the financial responsibilities for other facilities, as these are likely different from Dr. Krochmal's policies, and may supersede the policies of Dr. Daniel J. Krochmal and The Krochmal Center for Plastic Surgery.

**Insurance:** Note, Dr. Krochmal is Out of Network for all insurance plans. This doesn't mean he doesn't accept insurance, only that he's out of network. You are responsible for understanding your Out of Network Benefits with your insurance plan. You are responsible for any fees not covered by your insurance company. Dr. Krochmal uses The Auctus Group as his billing service (we can provide the contact information if requested). **If we perform a service that is covered by your insurance, signing this form authorizes us to collect payment from your insurance company unless the permission is revoked in writing (will only apply to services provided after the written notice).**

**Payment:** All payments are due within 30 days of invoicing for services and products provided. After 90 days, Dr. Krochmal reserves the right to send a delinquent account to "Collections". To prevent this, you may elect to have Dr. Krochmal store your credit card information and charge your credit card when an invoice comes due by checking the "Keep The Tab Open" box and signing that section.

**Disputes:** On occasion there is confusion regarding charges or payment. We encourage you to contact our office first to discuss any concerns. If you contact a company (e.g. your bank, credit card company, insurance company, third party payors such as CareCredit) with a disputed payment, and that company contacts us for information on the disputed charge, you authorize us to provide the company with relevant documentation to support our charges and billing (which may include Protected Health Information that would otherwise remain private and confidential).

**Payment Options:**

**Cash:** We accept cash, and will provide a receipt for your payment. Do not send cash through the mail.

**Cashier's and Personal Checks:** Please make checks payable to The Krochmal Center for Plastic Surgery. There is a $35 fee for any returned checks.

**Credit Card:** We accept all major credit cards. Card information can be provided over the phone, by our Credit Card Authorization Form, or through an invoice we can email you to pay online at your convenience (preferred).

**Financing:** We offer financing options through several third party companies. If interested, please ask us about your options. We do not offer in-house financing option.

By signing, I acknowledge that I have reviewed the Financial Policy and agree with the terms of this notice. If I had questions or concerns, I asked the staff at The Krochmal Center for Plastic Surgery and these were addressed to my satisfaction. I understand that if I choose not to sign this form, Dr. Krochmal and his staff may not provide any future services beyond completing treatment plans already initiated (however I will still be responsible for payment for services already performed).

_____ _____

Patient Name (Print) Parent or Legal Guardian (print) if signing for a patient

_____ _____

Signature Date

THE KROCHMAL CENTER
FOR PLASTIC SURGERY

# Photographic Consent Form

Patient Name _____ Parent or Legal Guardian (if applicable) _____

I understand that Plastic Surgery is a "visual" specialty, and that medical photography is an integral part of my patient record. I understand that the photographs and videos taken of me are to remain in my medical record unless specified by me in writing.

I also understand the importance of photographs, images, and videos to others. The Krochmal Center for Plastic Surgery and Dr. Daniel J. Krochmal are active in research, educating providers and patients, and promoting the services of The Krochmal Center for Plastic Surgery and Dr. Daniel J. Krochmal. Photographs and/or videos may be included in seminars and presentations, professional and consumer publications (print or electronic), websites, marketing and informational brochures, during patient consultations to demonstrate treatment outcomes, and advertisements.

I understand that if my images are to be used outside of my medical record, my name and identity (demographic information) will be protected and not shared with any third party that doesn't have a confidentiality agreement with the practice. I also understand that certain identifying information may be present in my images (tattoos, birthmarks, and other distinguishing features), so I may still be recognized even if my name and identity are not explicitly divulged.

I understand that if I give consent for The Krochmal Center for Plastic Surgery and Dr. Daniel J. Krochmal to use my images outside of my medical record, I may withdraw my consent at any time. Any consent given shall continue until such time as it is revoked in writing. The Krochmal Center for Plastic Surgery and Dr. Daniel J. Krochmal will make a good-faith effort to remove my images from the relevant sources, however in certain cases this may not be possible (e.g. presentations that have been filmed, magazine and journals that have been distributed, social media, etc).

I understand that by consenting to have my images used outside of my medical record, I waive all rights to claims of payment and royalties in connection to those images.

The Krochmal Center for Plastic Surgery and Dr. Daniel J. Krochmal may use my pictures and videos for (please select from the following options):

□ Professional Education (e.g. seminars, presentations, research publications)

□ Patient Education (e.g. presentations, during consultations)

□ Advertising (e.g. practice website, third party website such as RealSelf, magazines, brochures)

□ Social media (e.g. Facebook, Instagram)

□ When showing my images, please obscure (circle) tattoos birthmarks eyes other _____

Or

□ I do not give consent for The Krochmal Center for Plastic Surgery or Dr. Daniel J. Krochmal to use my images outside of my medical record

Procedures covered by consent: _____

_____ _____
Signature Date

email: lookinggood@krochmalplasticsurgery.com phone: 312.847.1230 fax: 312.753.3161