VILLANO | MD
TIMELESS BEAUTY | BEND

Patient Name: ____

PATIENT INFORMATION

REASON FOR TODAY'S VISIT: ____

Date of Birth: ________________ Gender: Male Female ________ Marital Status: M S W D

Phone (H): _________________ Phone (W): _______________ ext. _________ Phone (C): ________________

Address: ____ City/State: _______________________ Zip:__________

Email: ____

May we send you updates and information regarding the practice? (Circle) yes or no

Do you have an advance directive policy? Yes ________ No____________ (Our office does not keep Advanced Directives on file nor do we honor Advanced Directives. It is the patient's responsibility to implement an Advanced Directive.)

May we leave a telephone message? Yes _____________ No _____________

Notes on preferred method of contact:____

____

May we *email* you product/service special offers, seminar information, or newsletters at this address: Yes No

REFERRED BY: (please specify in the space provided)

Self_____________________________ Relative___________________________________

Bulletin__________________________ Another patient____________________________

Magazine_________________________ Spa/Salon__________________________________

Yellow Pages______________________ Employee__________________________________

Friend___________________________ Other_____________________________________

Seminar__________________________ Physician__________________________________

Website__________________________ Internet___________________________________

AUTHORIZATION FOR DISCLOSURE/RELEASE OF INFORMATION

I authorize Villano MD and Facial Plastic Surgery Center to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Villano MD and Facial Plastic Surgery Center determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and if applicable to process the insurance claim for services rendered at Villano MD and Facial Plastic Surgery Center.

Signature: ____ Date: _________________

PREVIOUS SURGERIES OR SERIOUS ILLNESSES

TYPE YEAR COMPLICATIONS? TYPE YEAR COMPLICATIONS?

____ ____

____ ____

CURRENT MEDICATIONS
(Include all over the counter and prescription drugs; including aspirin)

DRUG / DOSE PRESCRIBED BY: DRUG / DOSE PRESCRIBED BY:

____ ____

____ ____

ALLERGIES:
Do you have any drug allergies? YES NO
List any medications that you have had a bad reaction to: ____

Do you have any skin product or food allergies? YES NO
List any products/foods that you have had a bad reaction to: ____

PERSONAL INFORMATION
Height:_______ Current Weight:______Recent Weight Loss/Gain?:__________ If yes, how much?_________________

Do you smoke? YES NO How many packs? ___________ Drink Alcohol? YES NO How much? __________

How many years? ___________ How Often?___________

HISTORY
Have you had (Injected filler, Collagen, etc.) injections? _________ Last injection? ___________

Have you had Botox Cosmetic injections? __________________ Last injection? __________________

Have you had facial surgery? _______________ Type and date: __________________

Have you ever had laser resurfacing? _______________ Type and date: __________________

Have you ever had a chemical peel or dermabrasion? __________ Type and date: ______________________

Would you like to be contacted by our Medical Aesthetician about non-surgical procedures and treatments? YES NO

Have you had a bad reaction to local or general anesthesia? YES NO If yes, explain ___________________________

Have you had significant emotional problems? YES NO If yes, explain ___________________________

Have you had psychiatric care? YES NO If yes, explain ______________________

Patient Name:
Patient Account Number:

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Have you seen other plastic surgeons about this same concern? YES NO If yes, explain ________________________

Do you have high blood pressure? YES NO If yes, explain ______________________________________

Do you bleed easily from cuts or surgery? YES NO If yes, explain ______________________________________

Do you form large scars or keloids? YES NO If yes, explain ______________________________________

Do you have frequent infections, boils or canker sores? YES NO If yes, explain ________________________________

Do you have Glaucoma? YES NO If yes, explain______________________________________

Females:

Have you ever been pregnant? YES NO How many times?_____ Live births?___________

Are you currently pregnant? YES NO Are you planning more children? YES NO

Are you currently breast feeding? YES NO

HAVE YOU HAD ANY SERIOUS ILLNESSES OF THE FOLLOWING? (Please circle)

Brain	Nose	Heart	Blood	Extremities	Eyes	Cancer
Ears	Lungs	Abdomen	Urinary	Nervous	Diabetes	Reproduction

Other

Please explain, if you circled any of the above: ____

____

____

____

____

I hereby consent to be examined and treated by Michael E. Villano, MD and that the above information is correct.

____

SIGNATURE OF PATIENT OR SPOUSE OR RESPONSIBLE PARTY DATE

431 NE Revere Ave Suite 110 Bend, OR 97701
p. (541)312-3223 f. (541)330-2499
www.villanomd.com

V I L L A N O | M D
T I M E L E S S   B E A U T Y | B E N D

Financial Policy

Thank you for choosing Cascade Faces Aesthetics and Facial Plastic Surgery for your cosmetic needs. Our goal is to make your surgical experience a pleasant one. For your convenience, and to avoid any future confusion, we would like to outline our policies and procedures for you.

CONSULTATION
A **$150.00 consultation fee that we collect for this visit does go towards any surgical or aesthetic services.** This consultation is designed for you and Dr. Villano to meet and discuss your surgical needs, outline the procedure, and inform you of the fees. If insurance is involved, there will be an office visit charge. Also, if you do not show up for your appointment or do not cancel within 24 hours, you will be charged a 50.00 non-refundable fee.

SCHEDULING
After your consultation, if you decide to go ahead with surgery you will work with our patient care coordinator to select a date for your surgery.

PRE-PAYMENT
There is a $500.00 or 10% whichever is greater scheduling fee deposit required before the date selected can be reserved exclusively for you. This is a non-refundable deposit. This fee is used to cover the booking and scheduling expenses involved with your surgery. This amount will be deducted from your total cost.

PRE-OP VISIT
Prior to surgery, preferably two (2) weeks, you will meet with the medical assistant and Dr. Villano. Our medical assistant will explain all pre-operative instructions, order lab tests required, review your surgical procedure and post-operative limitations with you, and give you your post-operative prescriptions with instructions for their use. Post-operative appointments are scheduled at this time. Any questions you may have will be answered at this consult.

FINAL PAYMENT
Two (2) weeks prior to surgery, you will be expected to pay the remaining balance due on your account. We accept: Visa, Mastercard, Money Orders, Cashiers Checks. We are sorry but we are unable to accept personal checks for surgery payment.

Cancel Policy: If for any reason, medical or personal, you cancel two weeks or less prior to your scheduled surgery date fees will be charged as follows:

- Two (2) weeks prior to surgery – 10% or $500 whichever is greater of your surgery fee for expenses incurred.
- One (1) week prior to surgery – 25% of surgical fee
- One (1) day (24 hours) prior to surgery – entire surgical fee.

If you have any questions, the staff will be happy to assist you. We look forward to caring for you.

Please sign and date.

Financial Guarantor Signature: ______________________________ Date: ______________________________

CONSENT TO TAKING AND PUBLICATION OF PHOTOGRAPHS

By my signature below, I hereby consent to before and after surgery photography for the purpose of documenting my plastic surgery in my medical records maintained in the ordinary course of business by Michael E. Villano, MD LLC. In addition, by checking the appropriate box below, I grant or deny additional limited use(s) of my photographs. For the additional uses, I understand that my name will not be revealed and my photographs will be carefully edited to remove or obliterate personal identification marks. Any photographs used will be cropped to focus on the area of the surgery.

Yes □ No □ Show my photographs to other patients in Dr. Villano's office.

Yes □ No□ Post my photographs on Dr. Villano's website, or web pages in plastic surgery sites displaying Dr. Villano's photos.

Yes □ No □ Use my photographs to illustrate lectures and presentations to an audience of medical professionals, and to illustrate scientific journal articles or books for medical professionals.

Yes □ No □ Use my photographs to illustrate newspaper and magazine articles featuring Dr. Villano, or to illustrate presentations or lectures by Dr. Villano to the general public.

All photographs will be taken only with the approval of Dr. Villano, and under such conditions and at such times as may be approved by Dr. Villano. Photographs may be taken by Dr. Villano, or by an employee or photographer selected by him who has signed a confidentiality agreement concerning patient medical records.

____

NAME OF PATIENT (PRINT)

____

SIGNATURE OF PATIENT OR GUARDIAN (IF PATIENT IS UNDER 18)

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Acknowledgment and Consent

I understand that **Michael E Villano, MD**
(referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I acknowledge that I have been informed that at times, new information about the practice may be promulgated via e-mail. I have the right to refuse receiving this information at any time by notifying the practice in writing.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By:______________________________ Date:____________________
(Patient)

By:______________________________ Date:____________________
(Patient representative)

Description of Representative's Authority______________________________

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