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

Patient Information

Last name: ________________________________ First name: _______________________ Middle initial:__________

Date of Birth: ________________ Gender: ________________ Marital status: M S W D SS#:_______________

Address: ____ City/State: __________________ Zip: _______________

Phone: (C) ____________________ (H) _____________________Can we leave a message on this voicemail? Yes No

Email address: _____________________________________

Reason for Visit: ____ Duration of Symptoms: __________________

Previously treated? If so, by who and when?____

Does anything make your symptoms worse?_______________________ Improve your symptoms:__________________

Primary Care Physician (PCP): _____________________________________ Office Name: _________________________

Referring Physician, if different from PCP: ______________________________Preferred Pharmacy: ________________

Insurance Information: (Primary)

Please complete all lines.
We require that a current insurance card be presented at the time of the appointment.

Insurance: _______________________________________ Relation to policy holder: _____________________________

Policy Holder First and Last Name: ____Policy holder DOB: _____________

Policy holder employer: ______________________________Policy holder phone number:_________________________

Address on insurance card:____________________________________City/State:_________________ Zip:___________

Policy Holder SSN: ________________Insurance Group Number: _______________ Policy Number: _________________

Secondary Insurance (if applicable)

Insurance: _______________________________________ Relation to policy holder: _____________________________

Policy Holder First and Last Name: ____Policy holder DOB: _____________

Policy holder employer: ______________________________Policy holder phone number:_________________________

Address on insurance card:____________________________________City/State:_________________ Zip:___________

Policy Holder SSN: ________________Insurance Group Number: _______________ Policy Number: _________________

Patient Information and History

Allergies to Medications:

Medication Name	Reaction
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Current prescription medications:

Medication Name	Dosage	Frequency
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

What conditions are you taking the above medications for? ____

Are you up to date with immunizations: Yes No Unsure

Social History:

Occupation: ____________________________________ Would you consider this a noisy environment? Yes No

Tobacco/Nicotine use: Yes No Vape / Chewing Tobacco / Cigarette How many cigarettes per day?_____________

Number of alcoholic beverages per week:__________________ Recreational drug use:_________________________

Height:__________ Weight:___________ Recent weight gain/loss, if so how much:_________________________

List dates for the following radiology tests:

Head X Ray____________________________ Thyroid X Ray___________________________

CT/MRI Scans__________________________ Upper GI/Barium Swallow________________

<u>Cosmetic Patients Only:</u>

History of Filler: Yes No Date last injected___________ Botox/Dysport: Yes No Date last injected__________

History of facial surgery: Yes No What was the surgery?___________________________ Date of Surgery:_________

History of bad reaction to local or general anesthesia? If so, what type of reaction?_______________________________

Have you had significant emotional problems in the past 5 years? Explain._________________________________

Have you received psychiatric care in the past year? Explain.____

Do you have a history of body dysmorphic disorder? Explain. ____

Have you been seen by another plastic surgeon? ____

If so, when and why didn't you proceed with treatment? ____

Do you bleed easily from cuts or surgery? Explain. ____

Do you have frequent infections? (i.e. boils or canker sores) ____

Do you have a history of glaucoma? Explain. ____

Females Only:

Are you currently pregnant or breastfeeding? Yes No Have you ever been pregnant? Yes No

How many times: _________________ Number of live births:______________

Are you planning on having more children? Yes No

Would you like to be contacted by our medical aesthetician about non-surgical procedures and treatments? Yes No

Past Medical History	**Yes**	**No**	Type		**Yes**	**No**
High blood pressure	____	____		Thyroid Disease	____	____
Kidney Disease	____	____	______	Lliver Disease	____	____
Diabetes	____	____		Tuberculosis/TB	____	____
Heart Disease/Angina	____	____		HIV/AIDS	____	____
Asthma/Emphysema	____	____		Rheumatic Fever	____	____
Stroke/Mini stroke	____	____		Arthritis	____	____
Cancer	____	____	______	Other:____________________________		

Past Surgical History	**Yes**	**No**		**Yes**	**No**
Surgery for cancer	____	____	Heart Surgery	____	____
Mastectomy	____	____	Lung Surgery	____	____
Skin cancer surgery	____	____	Colon Removal	____	____
Sinus Surgery	____	____	Neck/spine	____	____
Tonsillectomy	____	____	Ear Surgery	____	____

Other: ____

Review of Systems:	**Yes**	**No**		**Yes**	**No**
Ringing R Ear	____	____	Hoarseness	____	____
Ringing L Ear	____	____	Throat Clearing	____	____
Dizziness	____	____	Swallowing Pain	____	____
Pain in R Ear	____	____	Discomfort in throat	____	____
Pain in L Ear	____	____	Something in throat	____	____
Drainage in R Ear	____	____	Cough	____	____
Drainage in L Ear	____	____	Heartburn/Sour taste	____	____
Hearing loss R, L Ear	____	____	White balls on tonsils	____	____
Nasal congestion	____	____	Large tonsils	____	____
Nasal drainage	____	____	Itchy nose/ears/eyes	____	____
Facial pain	____	____	Runny/watery eyes	____	____
External facial deformity	____	____	Sneezing fits	____	____
Nasal bleeding (please circle)	Right	Left	Runny nose	____	____
Loud snoring	____	____	Scratchy throat	____	____
Stop breathing while asleep	____	____	Daytime sleepiness	____	____
Skin cancers	____	____	Blood in stool	____	____
Vomiting	____	____	Neck/back pain	____	____
Nausea	____	____	loss of sensation	____	____
Recent weight loss	____	____	Paralysis of arm/leg	____	____
Fever/Chills	____	____	Loss of speech	____	____
Night sweats	____	____	Facial droop	____	____
Fatigue	____	____	Chest pain/tightness	____	____
Shortness of breath	____	____	Poor circulation	____	____
Wheezing	____	____	Irregular heartbeat	____	____

Other:____

Family History:	**Yes**	**No**		**Yes**	**No**
Hearing loss	____	____	Stroke	____	____
High blood pressure	____	____	Diabetes	____	____
Cancer	____	____	Alcoholism	____	____

Medical Information Authorization:

By listing someone in the following area, we are allowed to give them any information from medical, to billing, to appointment times, whether they call us or we are calling you and they answer:

Name: ____Relation: ___________________________________

Patient or Guardian's Signature:____Date:_________________

Medicare Assignment:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who may be responsible for paying for my treatment. (Section 112B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding information.) Regulations pertaining to Medicare assignment of benefits also apply.

Signature____Date________________________

Authorization and Consent:

I authorize medical treatment of the person named above and agree to pay all fees and charges for such treatment. I am signing this as a lifetime authorization for Michael E. Villano, MD, FACS to bill my insurance, Medicare, Medicaid and/or Medigap for these services; and to accept assignment oif the benefits for Medicare, Medicaid, And/or Medigap. I authorize Michael E. Villano, MD, FACS 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 Michael E. Villano, MD, FACS 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 Michael E. villano, MD, FACS.

I understand that I am responsible for any balance due for professional services more than the benefits provided by my policy. I agree to pay for services not covered by my insurance policy. I understand I am responsible for obtaining any prior authorizations required by my insurance policy. I understand that in the event of collection action, I am responsible for any legal fees that are incurred.

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

Signature:____Date:___________________________

Authorization for Disclosure/Release of Information:

I authorize Villano MD to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatemnet, to those individuals who, in Villano MD's 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.

Signature:____Date: ____________________________

Photo Consent and Publication:

By my signature below, I hereby consent to before and after surgery photography for those 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 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 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 or 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 an employee or photographer selected by him who has signed a confidentiality agreement concerning patient medical records.

Printed First and Last Name: ____

Signature:____Date:__________________________

HIPPA Acknowledgment and Consent

I understand that ***<u>Michael E Villano, MD</u>*** (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 <u>have received</u> a copy of the Notice of Privacy Practices.

By:_______________________________ Date:______________________
(Patient)

-OR-

By:____ Date:______________________
(Patient representative)

431 NE Revere Ave Suite 100 Bend, OR 97701
541-312-1145 www.cascadeent.com

Financial Policy

Thank you for choosing VillanoMD 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
The $200.00 consultation fee that was collected 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 and you will need to fill out additional paperwork. Also, if you do not show up for your appointment or do not cancel prior to 24 hours before your scheduled appointment, the consultation fee of $200.00 is non-refundable.

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: ______________________________________