*Photo I.D. is required.* Please present valid identification to the front desk

# PATIENT REGISTRATION INFORMATION

Patient Name: ___________________________________ Date of Birth: __________________________

Home Address: ____________________________________________________________________________

City: ______________________________ State: _______________________ Zip Code: ______________

Home #: _________________________________ Work #: ______________________________________

Cell#: __________________________________________________________________

Email Address: ____________________________________________________________________________

Would you like to be added to our email list to be notified of specials/events? Yes No

Is it acceptable to leave a message on your phone and/or email? Yes No

Please select you preferred method of contact: Phone Email Text

**In Case of an Emergency, Please Provide A Person Whom We May Notify.**

**Do we have your permission to discuss medical information with the person listed below? YES☐ NO ☐**

Name: __________________________________ Relationship: ___________________________________

Phone# _________________________________ Work/Cell#: ____________________________________

**Patient Signature:** ___________________________________________ **Date:** _______________________

Name: ___________________________________ Height: ___________ Weight: ____________

Please check if you or any family members have any of the following:

| Condition | Self | Family Member | Condition | Self | Family Member |
|---|---|---|---|---|---|
| No Medical History | | | High blood pressure | | |
| Anxiety | | | High cholesterol | | |
| Asthma | | | HIV | | |
| Bleeding disorders | | | Headaches | | |
| Breast Cancer | | | Keloids/raised scars | | |
| Cancer | | | Seizures | | |
| Cold sores | | | Skin Cancer | | |
| Depression | | | Sunburn | | |
| Diabetes | | | Thyroid issues | | |
| DVT/ blood clots | | | Ulcers | | |
| Hepatitis | | | Other | | |

Please list all prior surgical procedures (including cosmetic procedures):

| Procedure | Year | Procedure | Year |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Have you ever had problems with anesthesia? Yes No ______________________________

Please list all medications and supplements you are currently taking:

| | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Please list any allergies to medication or food:

| Allergen | Reaction | Allergen | Reaction |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Do you smoke or use nicotine/tobacco products or vape? ☐ Yes ☐ No ☐ Former Smoker

If yes, how much per day? ________

If you smoked previously, when did you quit? __________

Do you live with a smoker or experience second hand smoke? ☐ Yes ☐ No ☐ Occasionally

Do you work in the healthcare industry? ☐ Yes ☐ No

Name of primary care physician _______________________________________________

How did you hear about Dr. Fugo's practice? _______________________________________________

# GENERAL CONSENT FOR TREATMENT

**CONSENT TO EXAMINATION AND TREATMENT**: I consent to necessary and advisable diagnostic and therapeutic procedures and care for the patient by Dr. Fugo and his assistants or designees. I acknowledge that the practice of medicine and surgery is not an exact science and that no guarantees have been made as to the result of the surgical care and medical treatment.

**GUARANTY OF PAYMENT**: I shall be fully responsible for the payment of the patient's plastic surgery bill, based upon Dr. Fugo Plastic Surgery and/or Futalo Aesthetics standard charges which are available to me prior to any examination or treatment being rendered. However, failure to demand immediate payments shall not release my obligation to make such payments.

**HEALTH CARE INSURANCE**: I understand that Dr Fugo Plastic Surgery and Futalo Aesthetics does not participate with my health care insurance network. As such, if any procedures that I elect to undergo are performed, my voluntary submission of billing information to my health insurance provider for the purposes of my personal reimbursement is at my sole discretion. Obtaining reimbursement of any amount or collection of such from my insurance provider for any procedures or services is also my sole responsibility.

**CREDIT BALANCE**: I understand that credit balances will occur in my favor, on this account may be applied by Dr. Fugo Plastic Surgery and/or Futalo Aesthetics to reduce any other outstanding account for which I am responsible.

**RELEASE OF INFORMATION/NOTICE OF PRIVACY**: I hereby authorize Dr. Fugo Plastic Surgery and/or Futalo Aesthetics to disclose all or any part of the patient record, as allowed and/or mandated by law.

**This form has been explained to me to my satisfaction, and I understand its content.**

______________________________________________________________________________________________

Patient/Relative/Guardian Signature     Print name     Relationship to Patient     Date

_______________

Witness Signature

This signature of the patient must be obtained unless the patient is an un-emancipated minor under the age of 18 or is otherwise incompetent to sign.

# Patient Photograph and Video Release Form

I understand that photographs and/or videos may be taken of me or parts of my body before, during, and after aesthetic procedures and/or surgery. These images may be shared with staff, other physicians or health professionals, and members of the public for educational and marketing purposes. I hereby give my consent for Dr. Fugo, members of his staff and representatives of Dr. Fugo Plastic Surgery, PLLC to use these photographs and/or videos under the following circumstances:

## Please initial __JUST ONE__ of the following*:*

____ EDUCATIONAL PURPOSES ONLY: Photographs taken of me or parts of my body as well as details regarding services that I have received may be used for scientific presentations and/or publications.
_____ ALL MEDIA EXCLUDING SOCIAL MEDIA: Photographs taken of me or parts of my body as well as details regarding medical services that I have received may be used in any print or broadcast media, including but not necessarily limited to newspapers, pamphlets, educational films, practice website, and television, in order to inform and educate the public or other physicians about plastic surgery.
_____ ALL MEDIA INCLUDING SOCIAL MEDIA: Photographs and/or videos taken of me or parts of my body as well as details regarding medical services that I have received may be used on social media sites, including but not necessarily limited to Facebook, Instagram, Snapchat, Twitter, RealSelf, TikTok, YouTube and other outlets, in order to inform the public or other physicians about plastic surgery. I understand that once my images are published, I lose control and rights to these images. I understand that once my images are published, the individual social media platforms may assume control and rights to those images. I also understand that images posted on the Internet can be altered and/or archived, and are permanent and searchable.
_____ PRACTICE WEBSITE ONLY: Photographs taken of me or parts of my body as well as details regarding medical services that I have received may be used on our website without disclosure of personal information in order to inform the public about plastic surgery methods. I understand that once these images are placed on a digital platform, they can be altered and archived, and are permanent, and searchable.
_____ I OPT OUT. I do not want my photographs to be used for advertising or marketing. They will only be used for my medical chart.

## PLEASE REVIEW AND INITIAL __EACH__ OF THE FOLLOWING:

_____REVOCATION: I understand that I may revoke this authorization at any time; however, such revocation must be in writing and received via registered mail. Revocation affects disclosure moving forward and is not retroactive.
_____EXPIRATION: This authorization expires 99 years from the date signed
_____VOLUNTARY CONSENT: I understand that my participation is voluntary. If I do not sign this form, my healthcare and payment for my healthcare will not be affected.
_____I will not receive compensation for my participation.
_____By signing this form, the personal health care information I relay or allow to be relayed to an outside source, such as social media platform or news source, is no longer protected by state and federal privacy laws and may be re-disclosed by that source.
_____I have received a copy of this consent.
_____Before signing this document, I have considered my decision carefully.
Date___________________Witness__________________________________________
Patient Name: ______________________________________________________________
Patient or Guardian Signature: _________________________________________________

**APPOINTMENT CANCELLATION / NO SHOW / RE-SCHEDULING POLICY**

Upon booking any initial consultation or appointment for treatment, it is required that you place a $1 deposit via credit card to formally reserve your appointment. Your billing information will be securely stored with your electronic medical record.

Should you "No Show" or fail to cancel or reschedule your appointment within 24 hours of your appointment date, you will be charged a non-refundable $75 as a "Missed Appointment Fee". Simply notifying us of a scheduling change can prevent that charge. A second missed appointment will incur the missed appointment fee of $75 and will also require a $75 prepayment to schedule all future appointments, that can be applied to your appointment.

Surgical and procedure deposits are Non-Refundable.

Upon booking any surgical procedure, a 10% deposit is required to reserve your surgical date. Once surgical procedure deposit/payments have been paid to the practice, should I cancel my surgery without an approved medically acceptable reason, submitted in writing and acceptable to the practice, this entire fee is forfeited. While this may appear to be a charge for services which were not provided, this fee is necessary to reserve time in the OR and in the practice, which are done when I scheduled my surgery or procedure.

All "no shows" for surgery or procedures will result in loss of your payment amounts.

☐ I agree & understand the above policy.

Patient name (printed): ____________________________________

Patient name: (sign): ______________________________________ DATE ______________