IRA PAPEL, M.D.
&
THEDA KONTIS, M.D.
Facial Plastic Surgeons

**1838 Greene Tree Rd. Suite 370**
**Baltimore, MD 21208**
**(410) 486-3400**

# Patient Information

## (Please Print Legibly & Fill In or Correct All Fields)

Patient Name _____
*Last* *First* *M.I.*

Address _____
*Street & Apt #* *City* *State* *Zip*

Home Phone _____ Cell Phone _____

Email _____

*Any restrictions contacting you?* □ Yes □ No *Contact Restrictions:* _____

Age _____ Birthdate ____/____/_____ Gender: □ Male □Female

Primary Care Physician: _____

Marital Status: □ Single □ Married □ Partner □ Widowed

Race: □ Caucasian □ African American □ Asian □ Native American □ Other: _____

Ethnicity: □ Not Hispanic or Latino □ Hispanic or Latino □ Central American □ Puerto Rican
□ Mexican □ South American □ Decline to Provide □ Other: _____

Primary Language Spoken: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ *Is it okay to call you at work? □ Yes □ No*

Address _____
*Street& Suite #* *City* *State* *Zip*

**Primary Health Insurance:**

Insured (If not patient): Name:_____ DOB:_____ Employer:_____

**Secondary Health Insurance:**

Insured (If not patient): Name:_____ DOB:_____ Employer:_____

Emergency Contact_____ Relationship to Patient_____
*(Not in your household)*

Home Phone_____ Cell Phone_____ Work/Other Phone_____

I, the undersigned, consent to the use and disclosure of my protected health information for treatment, payment and operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act (HIPAA) without a written authorization. I accept that I am financially responsible for all services rendered on my behalf by Facial Plastic Surgicenter. For those insurance plans for which the practice accepts assignment, I accept personal responsibility for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage, and I agree to pay co-payments, deductibles and non-covered services, as dictated by my insurance coverage, and I agree to pay co-payments at the time of service. I authorize payment directly to Facial Plastic Surgicenter for services for which the practice accepts assignment. A copy of this agreement may be used in place of the original. I certify that the information stated on this form is correct.

*Signature*_____ *Date* _____

**Patient or Legal Guardian ONLY**

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# Health Information

Patient Name: _____ Reason for Visit:_____

Age:_____ Height:_____feet_____inches Weight:_____lbs.

Who referred you to our practice?_____

**Do you have or have you had any of the following:** (Circle each) **If None Check Here** ☐

| | | | | | |
|---|---|---|---|---|---|
| Abnormal Bleeding | No/Yes | Headaches/Migraine | No/Yes | Skin Cancer | No/Yes |
| Arthritis | No/Yes | Heart Disease | No/Yes | Skin Disease | No/Yes |
| Asthma | No/Yes | Heart Murmur | No/Yes | Sleep Apnea | No/Yes |
| Breast Cancer | No/Yes | Hepatitis | No/Yes | Stroke | No/Yes |
| Cancer (other) | No/Yes | High Blood Pressure | No/Yes | Thyroid Disorder | No/Yes |
| Chest Pain | No/Yes | High Cholesterol | No/Yes | Tuberculosis | No/Yes |
| Diabetes | No/Yes | HIV/AIDS | No/Yes | Ulcers (Gastric) | No/Yes |
| Fever Blisters | No/Yes | Kidney Disorder | No/Yes | Other _____ | |
| Hay Fever/Allergies | No/Yes | Sinus Problems/Infections | No/Yes | | |

When was the date of your last flu shot? _____ ☐ I **DO NOT** get the flu vaccination

**List All Medication Allergies:**

☐ No Known Allergies ☐ Latex Allergy

Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____

List ALL **(Prescription and Over-the-Counter)** Medications you are presently taking or have taken within the last month:

☐ No Current Medications

Medication:_____Dose:_____ Medication: :_____Dose:_____
Medication:_____Dose:_____ Medication: :_____Dose:_____
Medication:_____Dose:_____ Medication: :_____Dose:_____
Medication:_____Dose:_____ Medication: :_____Dose:_____
Medication:_____Dose:_____ Medication: :_____Dose:_____
Medication:_____Dose:_____ Medication: :_____Dose:_____

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# Health Information

**Family History:** Have any of your family members had any of the following? (Circle each; give family member if answer is yes)

| | | |
|---|---|---|
| No Relevant Family History | No/Yes | |
| Unknown – Adopted | No/Yes | |
| Autoimmune Disorder | No/Yes | Member: _____ |
| Colon Cancer | No/Yes | Member: _____ |
| Diabetes | No/Yes | Member: _____ |
| Glaucoma | No/Yes | Member: _____ |
| High Blood Pressure | No/Yes | Member: _____ |
| High Cholesterol | No/Yes | Member: _____ |
| Liver Disease | No/Yes | Member: _____ |
| Lung Disease | No/Yes | Member: _____ |
| Malignant Melanoma | No/Yes | Member: _____ |
| Obesity | No/Yes | Member: _____ |
| Premature Coronary Heart Disease | No/Yes | Member: _____ |
| Skin Cancer | No/Yes | Member: _____ |
| Thyroid Disease | No/Yes | Member: _____ |

Other (Please Specify): _____

**Surgical History:** List all surgeries and **Date** of occurrence, **especially facial procedures**:

_____

_____

_____

Do you have any history of problems with Anesthesia? □ Yes □ No If yes, describe: _____

**Social History:**

**Smoking** (Please select one): □ Every Day Smoker □ Some Day Smoker □ Former Smoker □ Never Smoked

**Date Quit Smoking** (if applicable): _____ **How much per day?** _____

**Alcohol Use** (Please select one): □ No Alcohol Use □ Alcohol Use Daily □ Alcohol Use Socially

**Do you…..**

| | | | |
|---|---|---|---|
| Take Aspirin daily? | □ Yes | □ No | Dose _____ |
| Use recreational drugs? | □ Yes | □ No | If yes, describe: _____ |
| Have bleeding/bruising problems? | □ Yes | □ No | If yes, describe: _____ |
| Have problems with scarring? | □ Yes | □ No | If yes, describe: _____ |

**Females ONLY:**

| | | |
|---|---|---|
| Do you have regular periods? | □ Yes | □ No |
| Are you pregnant or lactating? | □ Yes | □ No |
| Are you going through menopause? | □ Yes | □ No |

During pregnancy did you ever get hyperpigmentation or masking? □ Yes □ No

**The above information is accurate and complete to the best of my knowledge.**

Signature_____ Date_____

# FACIAL PLASTIC SURGICENTER

**Ira D. Papel, M.D., F.A.C.S.**
**Theda C. Kontis, M.D., F.A.C.S.**
**Leslie B. Papel, Au.D., F.A.A.A.**

**1838 Greene Tree Road Suite 370**
**Baltimore, MD 21208**
**p: (410) 486-3400**

This notice describes how your medical information may be used and disclosed and how you can get access to this information.
**Please review carefully.**

**YOUR RIGHTS**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

**Get a copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable fee.

**Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for examples, home or cell phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

**As us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice -** You can request a paper copy of this notice at any time.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information above.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

**YOUR CHOICES**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

**CONTINUE ON BACK** ➡

**I acknowledge that I have read and received the Practice's Privacy Notice.**

| _____ | _____ | _____ |
|---|---|---|
| Printed Name | Signature | Date |

**OUR USES AND DISCLOSURES**

We typically use or share your health information in the following ways:

**Treat you**

We can use your health information and share it with other professionals who are treating you.

**Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

**Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

**Sign-in-sheet**

The practice may use a sign in sheet at the registration desk. The practice may also call your name in the waiting room when your physician is ready to see you.

**Appointment Reminder**

The practice may contact you to provide appointment reminders.

**On Call Coverage**

In order to provide on-call coverage for you, it is necessary that the practice establish relationships with other physicians who will take you call if a physician from the practice is not available. Those on-call physicians will provide the practice with all health information that they create and will, by law, keep your health information confidential.

**HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information visit:
**www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions** - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**OUR RESPONSIBILITIES**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

**CHANGES TO THE TERMS OF THIS NOTICE**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

**To obtain more information on, or have your questions about your rights answered you may contact the practices Privacy Officer at 410-486-3400.**

**Effective Date** This Notice is in effect as of July 1, 2006
*Updated April 29, 2015*

The Office for Civil Rights and Office of the National Coordinator for Health Information Technology collaborated to develop this Notice of Privacy Practices.
http://www.hhs.gov/ocr/privacy/hipaa/modelnotices.html

# FACIAL PLASTIC SURGICENTER

STANDING AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH DESIGNATED PERSONS

*Not to be used in connection with health information from substance abuse treatment or mental health problems.
*All items on this authorization must be completed or the request will not be honored. Use N/A if not applicable.

Patient Name: _____
(first) (m. initial) (last)

For this authorization, "My Health Information" means any and all information relating to my course of examination and treatment. Including general information and inquires, arranging appointments, identifying medications, discussing billing and payment, insurance and any other related matter.

I authorize the Facial Plastic Surgicenter to discuss My Health Information with:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone Number: _____ Phone Number: _____

☐ refuse permission to disclose my heath information to anyone with the exception of my primary care physician and/or referring physician.

I understand that:

- This authorization is voluntary. My treatment will not be impacted, no matter if I sign this authorization or not.
- If I do not sign this authorization, the Facial Plastic Surgicenter will not disclose my health information, with the exception of my primary care physician and/or referring physician.
- This authorization is valid for as long as you are a patient with Facial Plastic Surgicenter. **If you wish to revoke this information you must request to fill out another authorization with updated information and a new signature.**
- Once my health information is disclosed as requested, it may no longer be protected by federal and state privacy(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature of Patient only: _____ Date: _____

IRA PAPEL, M.D.
THEDA KONTIS, M.D.
Skincare & Laser Division

1838 Greene Tree Rd. Suite 380
Baltimore, MD 21208
(410) 486-7371

# Consent for All Laser

**Name:** _____

**All Laser Patients** *(Circle correct answer for each question)*:

- Do you have skin/auto-immune/photo dermatitis issues Yes No
  - If yes, please explain: _____
- Do you have any implants, including IUD, dental and/or a pacemaker? Yes No
  - If yes, please explain: _____
- Do you have an allergy to Gold? Yes No
- Have you undergone chemotherapy or radiation in the past? Yes No
- Do you experience Herpes or cold sore breakouts? Yes No
- Do you develop keloids (Raised, Bumpy scars)? Yes No
- Do you/have you ever used a tanning bed? Yes No
  - If yes, when was the last time you spent any time in a tanning bed? _____
- Do you currently have a self-tanner on the area to be treated? Yes No
- Are you on any medication that may make you sensitive to sunlight? Yes No
- Have you been on Accutane in the last 6 months? Yes No
- Do any of your skin care products contain the following:
  Retinoids and/or Hydroquinone, alpha hydroxyl acids, glycolic acids? Yes No
  - If yes, when was the last time you used the product? _____
- Have you been sunburnt in the past two weeks? Yes No
- Have you had an injury to the skin in the area to be treated? Yes No
  - If yes, what describe injury _____
- Do you take aspirin, ibuprofen, vitamin E, or other blood thinners? Yes No
  - If yes, how recently? _____
- How often do you wear sunscreen? Daily When outside Never
- Do you have any tattoos or permanent make up? Yes No

**Skin Concerns** *(Please circle all that apply to you):* Excessive/Unwanted Hair Rosacea Enlarged Pores Oily Skin Fine lines Age/Sun Spots Broken Capillaries Acne Oily T-Zone Dry Skin Scarring Black/Whiteheads Flushing/blushing Rough, dull tone & texture Red Spots on body Unwanted tattoo Loose skin on face/neck/body Other (describe):_____

**Skin Procedure History:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Microdermabrasion | Yes | No | When? _____ | Botox/Filler | Yes | No | When?_____ |
| Chemical Peel | Yes | No | When? _____ | Thermage | Yes | No | When? _____ |
| Laser Resurfacing | Yes | No | When? _____ | Fraxel | Yes | No | When? _____ |
| Laser Hair Removal | Yes | No | When? _____ | Sclerotherapy | Yes | No | When? _____ |
| Waxing/Threading | Yes | No | When? _____ | Facial | Yes | No | When? _____ |
| IPL/Fotofacial/Photofacial | Yes | No | When? _____ | | | | |

I give consent for photographs to be taken before, during and after treatment, and give my permission for use of these photographs in scientific presentations, medical publications, and to be placed on the internet for marketing purposes. YES / NO

***By signing this form, I acknowledge that blistering, burning, scarring, hyperpigmentation (darkening of the skin), and hypopigmentation (lightening of the skin) are possible risks of all laser procedures. I understand that these risks increase with sun exposure and changes in medication.***

_____ _____

Client Signature Date

# Fitzpatrick Skin Scale

Name: _____ Date: _____

The success of your treatment is partly dependent on the correct typing of your skin. Your treatment provider will consider your skin type when planning your treatment program for most aesthetic procedures, including hair removal, vein therapy, and skin rejuvenation.

- Skin type is often categorized according to the Fitzpatrick Skin Scale which ranges from very fair (Skin type I) to very dark (Skin type VI).
- In addition, recent tanning (sun bathing, artificial tanning, or tanning creams) have a considerable impact on the evaluation of your skin color.

**Help us determine your skin type so we can treat you effectively and appropriately. Please take a few moments to fill out this questionnaire.**

**Genetic Disposition (Please circle one per question)**

| Score | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| What is your natural eye color? | Lt. Blue, Gray, Green | Blue, Gray, Green | Blue | Brown, Hazel | Brown/Black |
| What is the natural color of your hair? | Sandy, Red | Blonde | Lt. Brown Dk. Blonde | Brown | Black |
| What is the color of your skin (Non-exposed areas)? | Pink/ Reddish | Pale | Beige | Lt. Brown Olive | Dk. Brown |
| Do you have freckles on Non-exposed areas? | Many | Several | Few | Incidental | None |

**Reaction to Sun Exposure (Please circle one per question)**

| Score | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| What happens to your skin when you stay in the sun too long? | Painful Burning, Blistering, Peeling | Red Burns, Often Followed by Peeling | Burns, Sometimes Followed by Peeling | Rarely Burns | Never Burns |
| To what degree do you turn brown? | Hardly, or Not at All | Light Tan | Reasonable, Average Tan | Tans Very Easy | Tans Quickly Dk. Brown |
| Do you turn brown within several hours after sun exposure? | Never | Seldom | Sometimes | Often | Always |
| How does your face react to sun exposure? | Very sensitive | Sensitive | Normal | Very Resistant | No Reaction |

**Tanning Habits (Please circle one per question)**

| Score | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| When did you last expose your body to sun, or artificial tanning? | More than 3 months ago | 2-3 Months Ago | 1-2 Months Ago | Less than 1 Month Ago | Less than 2 weeks ago |
| Do you currently have self-tanner in the areas to be treated? | Yes | No | | | |

| | |
|---|---|
| **Total Score: Genetic Disposition** | |
| **Total Score: Reaction to Sun** | |
| **Total Score: Tanning Habits** | |
| | |
| **Total Skin Type Score** | |

| Skin Type Score | Fitzpatrick Skin Type |
|---|---|
| **0-3** | **I** |
| **4-12** | **II** |
| **13-21** | **III** |
| **22-26** | **IV** |
| **Over 27** | **V-VI** |