Stanislaw Facial Plastic Surgery Center LLC

Paul Stanislaw Jr., M.D.

Patient Information

Patient Name _____ Date of Birth _____ Age _____

Social Security # _____ Marital Status S M D W Sex M F

Address _____ Primary (_____) _____ Home Office Cell

City _____ State _____ Zip _____ Secondary (_____) _____ Home Office Cell

Primary Care Physician: _____ Tertiary (_____) _____ Home Office Cell

Pharmacy _____ Location _____ Phone (_____) _____

Email: _____

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Responsible Party (Complete only if someone other than patient is financially responsible)

Name _____ Relationship to you _____

Social Security # _____ Marital Status S M D W Sex M F

Address _____ Home (_____) _____

City _____ State _____ Zip _____ Cell (_____) _____

Employer _____ Work (_____) _____

Emergency Contact

Name _____ Relationship to you _____

Primary (_____) _____ Secondary (_____) _____

Referred By (Check all that apply-use the corresponding space to elaborate)

☐ Patient _____ ☐ Seminar _____

☐ Physician _____ ☐ Advertisement _____

☐ Internet Website _____ ☐ TV _____

☐ Other _____

Interest/Concern

☐ Aging Face (Non-surgical) ☐ Injectable Fillers ☐ Skincare Services/Products

☐ Aging Face (Surgical) ☐ Botox/Dysport ☐ Mineral Make-up

☐ Rhinoplasty (Nose) ☐ Other _____

Insurance

Please be advised that we do not participate with any insurance carriers therefore we will not submit insurance claims on your behalf. Your signature below acknowledges that you have agreed to enter into a direct contract with Stanislaw Facial Plastic Surgery Center. You further acknowledge that all services rendered through Stanislaw Facial Plastic Surgery Center will be on a cash basis. Medicare strictly prohibits the provider or patient from submitting claims when entered into a direct contract. If you are or become a Medicare patient, you must inform our office at once so we may prepare the appropriate contract. Do you have Medicare insurance coverage? ☐ Yes ☐ No

If you answered yes to this question, you will need to complete additional paperwork.

Patient Signature _____ Date _____

Internal Use Only: Contract Date _____/_____/_____

NAME: _____ DATE: _____
DATE OF BIRTH: _____

Who is your Primary Care Physician? _____
Who is your Dermatologist / Esthetician? _____

Have **YOU** or any *RELATIVES* had problems with any of the following conditions?

	MYSELF		*RELATIVE*		(What relationship?)
Heart disease	**Yes**	**No**	*Yes*	*No*	_____
High Blood Pressure	**Yes**	**No**	*Yes*	*No*	_____
Diabetes	**Yes**	**No**	*Yes*	*No*	_____
Stroke	**Yes**	**No**	*Yes*	*No*	_____
Excessive Bleeding	**Yes**	**No**	*Yes*	*No*	_____
Excessive Bruising	**Yes**	**No**	*Yes*	*No*	_____
Poor healing	**Yes**	**No**	*Yes*	*No*	_____
Excessive Scarring	**Yes**	**No**	*Yes*	*No*	_____
Cancer	**Yes**	**No**	*Yes*	*No*	_____
Skin Cancer	**Yes**	**No**	*Yes*	*No*	_____
Glaucoma	**Yes**	**No**	*Yes*	*No*	_____
Blood Clots	**Yes**	**No**	*Yes*	*No*	_____
Anesthesia	**Yes**	**No**	*Yes*	*No*	_____

Please Explain any "Yes" answer here: _____
_____
_____

Do you have a history of sunburns in childhood?	YES	NO
Do you have a heart murmur?	YES	NO
Do you have any artificial joints?	YES	NO
Do you have chest pain or pressure?	YES	NO
Do you have high cholesterol?	YES	NO
Do you have asthma or lung problems?	YES	NO
Do you have seasonal or environmental allergies?	YES	NO
Do you have any thyroid problems?	YES	NO
Do you have liver problems?	YES	NO
Have your ever had hepatitis? Type A , B, or C ?	YES	NO
Have you ever had a seizure or convulsions?	YES	NO
Do you have problems with your eyes (besides glasses)?	YES	NO
Is any part of your body paralyzed or numb?	YES	NO
Do you have any kidney problems?	YES	NO
Do you have anemia or any problems with your blood?	YES	NO
Have you ever had a blood transfusion?	YES	NO
Have you ever had cold sores, or fever blisters?	YES	NO
Do you have a history of dry eyes?	YES	NO
Women:		
Are you, or could you be pregnant?	YES	NO
Are you breast feeding?	YES	NO

NAME: _____ DATE: _____
DATE OF BIRTH: _____
Do you wear hearing aids? YES NO
Have you been diagnosed with MRSA? YES NO

Please list any other medical problems that have not been covered _____
_____
Please list all past surgeries / operations: _____
_____
Do you take any medications, including birth control pills or aspirin? YES NO
Please list: _____
_____
_____
Do you take vitamins, over the counter medications, or herbal supplements? YES NO
Please list: _____
_____
Have you taken steroid medication in the last year? YES NO
Have you ever taken the medication Accutane? YES NO
Are you allergic to any medications? YES NO
If yes, what medication and what was the reaction? _____
_____
Do you have a sensitivity / allergy to latex? YES NO
Do you have a sensitivity / allergy to tape? YES NO
Do you smoke? How Much? _____ YES NO
Do you use recreational drugs? YES NO
Do you drink alcohol? How much? _____ YES NO

Consent for Release of Information/Assignment of Benefits

I authorize Paul Stanislaw, Jr., MD to release any information pertaining to my diagnosis and treatment to my Primary Care Physician(s).

I understand that I have insurance coverage and authorize payment of medical benefits to Paul Stanislaw, Jr., MD for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the release of any medical information necessary to process the claim and secure payment of benefits.

Signed: _____ **Date:** _____
PATIENT SIGNATURE

The above information was reviewed and confirmed with the patient.

Signed: _____ **Date:** _____
PAUL STANISLAW, JR., MD., FACS

STANISLAW FACIAL PLASTIC SURGERY CENTER

Due to the nature of our practice, confidentiality is paramount to our patients. As medical practitioners, we highly respect your privacy. In fact, we are legally and ethically bound to protect your personal information. We can also appreciate your need to be informed of special promotions, events and medical updates.

The intent of this consent is to determine your preference for marketing communications. If you prefer not to receive marketing communications please select Opt Out. **You can also choose to receive your notifications by mail, email or both by selecting Opt In to each.** Please be advised that we may not necessarily send notifications by both methods of communications. Specials and events are also available on our website at www.StanislawMD.com.

ABOUT EMAIL NOTIFICATIONS

Many of our patients have requested communications through email as a more private means of relaying information as opposed to mail or discussions on the telephone while at work. As a general rule, it is a great means of communication to relay information regarding specials and events. It is important to realize however that email is not a secure means of communications since it is not encrypted. Any personal health information should be avoided or limited when using email. If you wish to contact our office through email we can be reached at info@StanislawMD.com. Your email will be answered during normal business hours Monday through Friday.

Email is an excellent choice for communications because it is a private, cost-effective and an eco-friendly way to deliver information when used responsibly. Our office will be limiting email communications to ensure you only receive appropriate and periodic emails which will include Quarterly Specials, Seminars or Events. At any point should you choose to Opt Out of email communications, you can select "Unsubscribe" in the body of the email you receive. Please DO NOT select SPAM since that adversely affects our practice. You can also call our office at (860) 409-1515 and we will IMMEDIATELY take you off our list. **We will NEVER share your email address with ANYONE.**

YOU MAY CHOOSE TO OPT OUT OR CHANGE YOUR PREFERENCE AT ANY TIME

☐ EMAIL OPT IN _____. _____

If you would like to enroll in Stanislaw Rewards and earn points for our newsletter enrollment you must opt-in.

☐ MAIL OPT IN _____

Mailing Address

_____

City, State, Zip code

☐ OPT OUT I do NOT wish to receive any promotional communications.

_____ _____

Signature Date

Please return this completed form to

Stanislaw Facial Plastic Surgery Center
35 Nod Road Suite 204
Avon, CT 06001

REV 4/12/17

Acknowledgement of Receipt of Notice of Privacy Practices

Dr Paul Stanislaw, Jr., M.D.
Julie Brookman, Licensed Esthetician

Stanislaw Facial Plastic Surgery Center, LLC
35 Nod Road, Suite 204
Avon, Connecticut 06001

Privacy Officer: Debra Kehoe, Office Manager, (860) 409-1515

Name of Patient: _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices.

Signed: _____ Date: _____

If signed by other than patient, please indicate your relationship to the patient:

_____

***For Office Use Only*:**

Acknowledgment refused:

Efforts to obtain:_____

Reasons for refusal:_____

Received By: _____ Date: _____

STANISLAW
FACIAL PLASTIC SURGERY CENTER

Missed Appointment/Cancelation Policy

Missed appointments and last minute cancellations adversely affect you, our other patients and the practice as a whole. It limits the availability of appointments for other patients and delays your treatment. We provide reminder calls before your appointment as a courtesy, but we may not always reach you. For this reason, we expect that you will be responsible for remembering scheduled appointments. If you must cancel a scheduled appointment, please provide as much notice as possible. **Please contact us at (860) 409-1515 if you need to cancel or change an appointment.**

Our policy requires a pre-paid deposit for consultations and a minimum of 24-hour notice of cancellation. We understand that emergencies happen and will make allowances when appropriate. *Failure to provide sufficient notice of cancellation can result in the forfeiture of your deposit. Forfeited consultation fees are donated to the Crohn's & Colitis Foundation.*

Appointment reservations of 1-hour or more require a minimum of 48-hour notification. As stated on our surgical quotes, surgical procedures require 4-week notice when cancelling. Lengthy appointments are much harder to fill on short notice. *Patients that do not abide by our cancellation policy may be subject to forfeiture of their deposits.*

If you are an established patient and are scheduled for an injection, please be mindful of when you schedule these appointments, especially during holidays. Last minute cancellations are unfair to those patients that are waiting to come in. Providing our office a minimum of 48-hours allows us to call the patients that are on our Wait List and give them the opportunity to come in sooner. We actively use this Wait List and our patients are very grateful when given the opportunity to accelerate their treatments.

If you repeatedly cancel without adequate notice, you may be asked to pre-pay for appointments at the time they are scheduled. In cases where this becomes a chronic issue, Stanislaw Facial Plastic Surgery Center reserves the right to ask you to find a new practice for medical care.

Arrival Time & Appointment Preparation

We appreciate your consideration in arriving for your scheduled appointment on time and with forms completed in advance. Forms can be found on our website under the Patient Resources tab. We work hard to stay on schedule for our patients; when a patient arrives late for an appointment it sets the entire day's schedule off. *We reserve the right to reschedule appointments if you arrive 10 or more minutes late for your appointment.*

If you are using manufacturer's rewards points we ask that you have those codes ready prior to your arrival and present them at check-in.

By signing below, I acknowledge the cancellation and arrival policy and will do my best to abide by them.

Patient_____ Date _____/ _____/ _____