STANISLAW

FACIAL PLASTIC SURGERY CENTER

STANISLAW FACIAL PLASTIC SURGERY CENTER LLC
PAUL STANISLAW JR., MD

Patient Demographics

Name: _____ Date of Birth: _____

Street Address: _____City: _____ State: _____ Zip Code: _____

Preferred Phone Number: _____ ☐ Cell ☐ Work ☐ Home

Email: _____ Gender: _____

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower

Occupation: _____ Employer: _____

Referred By: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

What do you want to discuss today? Choose from the following:
☐ Earlobe repair ☐ Upper and Lower Blepharoplasty ☐ Rhinoplasty ☐ Acne Scars ☐ Earlobe Reduction
☐ Injectable Filler ☐ Botox/Dysport ☐ Browlift ☐ Facial Veins ☐ Skin Care ☐ Otoplasty ☐ Other Scars
☐ Brown Spots ☐Chemical Peel ☐ Tear Troughs ☐ Face/Neck Lift ☐ Tattoo Removal ☐ Hair Removal
☐ 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 immediately so we can prepare the appropriate contract.

Do you have Medicare Insurance? ☐ Yes ☐ No

If you answer yes to the question above, you will need to complete additional paperwork.

Patient's Signature: _____ Date: _____

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Missed Appointment/Cancellation Policy

Missed appointments and last-minute cancellations adversely affect you, our other patients, and the practice. They limit the availability of appointments for other patients and delay your treatment. As a courtesy, we provide reminder calls or text messages before your appointment, 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 by contacting us at (860) 409-1515.**

Our policy requires a pre-paid consultation fee, deposits on significant procedures, and a minimum of 24-hour cancellation notice. Appointment reservations of one hour or more require a minimum 48-hour notification, and as stated in our surgical quotes, surgical procedures require a four-week cancellation notice. We understand that emergencies happen and will make allowances when appropriate. **Failure to provide sufficient cancellation notice can result in forfeiture of your consultation fee or deposit**.

If you are an established patient scheduled for an injection, please be mindful when you schedule these appointments, especially during the holidays. Last-minute cancellations are unfair to patients waiting to come in. Providing our office with a minimum of 48 hours allows us to call the patients on the waitlist and enables them to accelerate their treatment.

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

Arrival Time & Appointment Preparation:

We appreciate your consideration in arriving on time and/or early to complete our new patient forms. We work hard to stay on schedule for our patients; when a patient arrives late for an appointment, it sets the entire day off. **We reserve the right to reschedule an appointment if you arrive ten or more minutes late.**

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

Patient's Signature: _____ Date: _____

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Stanislaw Facial Plastic Surgery Center

Due to the nature of our practice, confidentiality is paramount to our patients. As medical practitioners, we respect your privacy and 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 communication. If you prefer not to receive marketing communication, please select Opt-Out. You can also choose to receive your notifications by email, text, or both by selecting Opt-In to each. Please be advised that we may not necessarily send notifications by all methods of communication. Specials and events are also available on our website at www.StanislawMD.com.

About email and text communications:

Many of our patients have requested communication through email and text messaging as a more private means of relaying information. However, it is important to realize that email and text messaging are not secure means of communication since they are not encrypted. Any personal health information should be avoided or limited when using these methods of communication. If you wish to be contacted from our office via email or text, we can be reached at info@stanislawmd.com or by texting our office number (860) 409-1515. Your email or text will be answered during standard business hours, Monday through Friday.

YOU MAY CHOOSE TO OPT-OUT OR CHANGE PREFERENCES AT ANY TIME

If you would like to opt-in to any of the following, please check the box and add a cell phone number and/or an email address.

☐ Text Messaging: _____

☐ Emailing: _____

☐ Opt-out: _____

If at any point you decide to opt out of email communication, you can choose “unsubscribe” in the body of the email you receive. If you wish to opt out of text messaging, reply “STOP.” You can also call our office at (860) 409-1515 and we will immediately remove you from our subscriber list. We will never share your information with anyone.

Patient’s Signature: _____ Date: _____

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Acknowledgment of Receipt of Notice of Privacy Practices

Paul Stanislaw, Jr. MD

Patient's name: _____

I hereby acknowledge that I am entitled to a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that the current notice is available in the reception area and that I may request a copy of any amended Notice of Privacy Practices. I hereby acknowledge that I have 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.

Patient's Signature: _____ Date: _____

If signed by a parent or legal guardian, please sign below.

_____ Date: _____

For office use only:

Acknowledgment refused:

Efforts to obtain: _____

Reason for refusal: _____

Received by: _____ Date: _____