

## STANISLAW FACIAL PLASTIC SURGERY CENTER PATIENT ENCOUNTER PROTOCOL

Stanislaw Facial Plastic Surgery Center considers your safety as well as ours a top priority during these difficult times. As a medical facility, antiseptic practices have always been a part of our everyday procedure. In this new era of COVID-19, extraordinary practices now need to be implemented to ensure our continued safety. As a result, we have taken the following steps to ensure that safety:

- All surfaces will continue to be disinfected between patients including clipboards and pens.
- We will limit the number of employees and patients in the office at any given time to reduce exposure.
- PPE will be worn by all staff (masks, face shields, gowns and gloves as appropriate for the task).
- Render services that minimize both prolonged contact and direct contact with patients whenever possible
- Establish negative pressure rooms.
- Walk-Ins are not permitted for any reason; all visitors are by appointment only.
- Appointments are buffered to minimize the risk of patients co-mingling.
- Acrylic barriers have been installed at the front reception areas.

We are pleased to announce our practice has been able to successfully acquire all the appropriate PPEs for the various levels of services we are now performing.

For the safety of patients and staff alike, we have established the following protocols for patients to adhere to:

- If you have an active cough or temperature, please reschedule your appointment.
- If you have been in contact with someone with a positive COVID-19 test or suspected COVID-19, please self quarantine for 14-days before scheduling an appointment.
- If you have recently traveled from a COVID-19 hotspot; please self-quarantine for 14-days before scheduling an appointment.
- You will be asked to wait in your car until we call you up. Please notify us when you arrive at the parking lot.
- You will be asked to wear an appropriate mask when entering the office-NO EXCEPTIONS
- Patients must come alone unless accompanying a minor child.
- A no-touch temperature scan will be performed on entry.
- You will be required to use a hand sanitizer upon entry.
- Patients will be brought immediately to a treatment room where you will remain until check out.
- The intent is to minimize exposure and time spent in confined spaces, therefore, please refrain from conversations not relevant to the visit.
- If you have rewards to redeem, you must contact the office 24-hours before your appointment to provide the certificate information including number, amount and expiration date otherwise, you will not be able to redeem certificate at your visit.
- We will continue to accept all forms of payments including Visa, MasterCard, cash and checks.
- We reserve the right to reschedule appointments if you are late or show signs of illness.

My signature acknowledges that I have read the Patient Encounter Protocol above and agree to abide by these protocols to ensure the safety of all parties.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

**Please call (860) 409-1515 upon arrival and we will advise you when to come up.**

# Stanislaw Facial Plastic Surgery Center LLC

Paul Stanislaw Jr., M.D.

## Patient Information

Chosen Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Legal Name: \_\_\_\_\_ Relationship Status:  Single  Married  
 Divorced  Widow/Widower

Street Address: \_\_\_\_\_ Primary Phone: \_\_\_\_\_  
 Cell  Work  Home  Other

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_  
 Cell  Work  Home  Other

Email: \_\_\_\_\_ Tertiary Phone: \_\_\_\_\_  
 Cell  Work  Home  Other

Ethnicity:  Caucasian  Hispanic  Asian  Native American  African American  Other

Gender at Birth: \_\_\_\_\_ Gender Identity: \_\_\_\_\_ Preferred Pronoun: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Town: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

Primary Care: \_\_\_\_\_ Town: \_\_\_\_\_ Primary Care Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Guarantor: \_\_\_\_\_ Relationship: \_\_\_\_\_ Guarantor Phone: \_\_\_\_\_  
 Cell  Work  Home  Other

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_  
 Cell  Work  Home  Other

Referred By: \_\_\_\_\_ To credit a patient for referral please enter name here: \_\_\_\_\_

I am interested in learning about the following:

- |  |  |                                       |  |   |
|--|--|---------------------------------------|--|---|
| <input type="checkbox"/> Aging Face Non-Surgical | <input type="checkbox"/> Liquid Facelift   | <input type="checkbox"/> Gauge Repair | <input type="checkbox"/> Makeup          | <input type="checkbox"/> Rhinoplasty        |
| <input type="checkbox"/> Acne Scars              | <input type="checkbox"/> Torn Earlobe      | <input type="checkbox"/> Face Veins   | <input type="checkbox"/> Lower Lids      | <input type="checkbox"/> Rosacea            |
| <input type="checkbox"/> Earlobe Reduction       | <input type="checkbox"/> Hair Removal      | <input type="checkbox"/> Skincare     | <input type="checkbox"/> Scars           | <input type="checkbox"/> Microdermabrasion  |
| <input type="checkbox"/> Tattoo Removal          | <input type="checkbox"/> Cancerous Lesions | <input type="checkbox"/> Upper Lids   | <input type="checkbox"/> Brown Spots     | <input type="checkbox"/> Tear Troughs       |
| <input type="checkbox"/> Benign Lesions          | <input type="checkbox"/> Botox/Dysport     | <input type="checkbox"/> Otoplasty    | <input type="checkbox"/> Chemical Peel   | <input type="checkbox"/> Liquid Rhinoplasty |
| <input type="checkbox"/> Injectable Fillers      | <input type="checkbox"/> Browlift          | <input type="checkbox"/> Leg Veins    | <input type="checkbox"/> Face/Neck Lifts | <input type="checkbox"/> Laser Resurfacing  |
| <input type="checkbox"/> Other (specify): _____  |  |                                       |  |   |

## 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: Medicare Contract Date \_\_\_\_\_

FPSC Patient Registration REV 200422

# MEDICAL HISTORY QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Gender at Birth: \_\_\_\_\_ Gender Identity: \_\_\_\_\_ Preferred Pronoun: \_\_\_\_\_

Primary Care (PCP): \_\_\_\_\_ PCP Phone: \_\_\_\_\_

Dermatologist: \_\_\_\_\_ Derm Phone: \_\_\_\_\_

Esthetician: \_\_\_\_\_ Esthetician Phone: \_\_\_\_\_

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

	Yes	No	Self	Relative:	If yes, please explain:
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Excessive Bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Poor Healing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Excessive Scarring or Keloids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Difficulty with Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

**Please answer the questions below:**

	Yes	No		Yes	No
Do you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have kidney problems?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have artificial joints?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have anemia or any problems with your blood?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have chest pain or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had cold sores or fever blisters?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have asthma or lung problems?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a history of dry eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have thyroid problems?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear hearing aids?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have liver problems?	<input type="checkbox"/>	<input type="checkbox"/>	Have you been diagnosed with HIV?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had hepatitis A,B or C?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had difficulty healing or been diagnosed with MRSA?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems with eyes (besides wearing glasses)?	<input type="checkbox"/>	<input type="checkbox"/>			
Is any part of your body paralyzed or numb?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a history of sunburns?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had seizures or convulsions?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have seasonal or environmental Allergies?	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

**Yes No**

Do you have any medical problems not covered? If yes, Explain Below:

Have you taken steroid medication in the last Year? If yes, when did treatment end?

Have you ever taken Accutane? If yes, when did treatment end?

Are you allergic to any medications? If yes, what medication and what was the reaction?

Do you have a sensitivity/allergy to latex? *We do not use latex gloves.*

Are you or could you be pregnant or trying to become pregnant? If yes, elaborate:

Are you breastfeeding?

Do you take vitamins, over the counter medications or herbal supplements? If yes, please list:

Do you take any medications including oral contraceptives, hormones or aspirin? If yes, please list:

Medication	Dosage	Frequency	Treatment for
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you or have you ever drank alcohol?  Quit  Daily  Weekends  Socially  Never

Do you or have you ever smoked?  <1 pk a day  1 Pk a Day  <1 pk a week  >1pk a day  Socially  Quit  Never Smoked

Do you or have you ever used recreational drugs?  Quit  Daily  Weekends  Socially  Never

Please list all surgeries: \_\_\_\_\_ Month/Year  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had cosmetic injections? If yes, please list below:  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_

I authorize Paul Stanislaw, Jr. M.D. to release any information pertaining to any medical provider to facilitate my medical care. I understand that Dr. Stanislaw does not accept medical insurance and all services are at my expense. I further understand that a claim will not be issued for services.

Patient or Guardian Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_  
 Self  Parent  Guardian

## **STANISLAW FACIAL PLASTIC SURGERY CENTER LLC TELEMEDICINE INFORMED CONSENT**

Telemedicine is also known as “telehealth” and referred herein, collectively, as “telemedicine” and outlines the benefits and risks of telemedicine. It is important that you read the whole document carefully. Signing the consent agreement means that you agree to a telemedicine session with Dr. Stanislaw or one of the doctor’s assistants (i.e. nurse, nurse practitioner, physician assistant, esthetician etc.). Please initial the first page and sign and date the second page.

### **GENERAL INFORMATION**

Telemedicine is the distribution of health-related services and information via electronic and telecommunication technologies, such as computers and mobile devices, to access and manage health care services remotely. Telemedicine may include technologies you use from home or that our providers use to improve or support health care services. Telemedicine allows out-of-office patient and clinician contact, care, advice, reminders, education, intervention, monitoring, and remote admissions. Examples of telemedicine include videoconferencing, teleconferencing, transmission of images, e-health including patient portals, and remote monitoring of vital signs. Alternative methods of medical care besides telemedicine is in-person care and is available to you. If the provider feels it necessary for an in-person appointment we strongly encourage you to accept the provider’s recommendation to ensure adequate care is provided to you. Not all services can be provided through telemedicine.

### **BENEFITS OF TELEMEDICINE**

The benefits of telemedicine include the following:

- Make health care accessible to people who live in rural or isolated communities.
- Provide long distance clinical care.
- Make services more readily available or convenient for people with limited mobility, time or transportation options.
- Obtain expertise of specialists.
- Improve communication and coordination of care among members of our healthcare team and patient.
- Provide support for self-management of health care.
- Quick and efficient medical evaluation and management.

### **RISKS OF TELEMEDICINE**

As with any medical care options, there are potential risks associated with the use of telemedicine. Three risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and assistant(s)
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- Security protocols could fail, causing potential breach of privacy and/or inadvertent disclosures of personal identifying information and/or protected health information.
- Lack of access to complete medical records may result in adverse drug interactions, allergic reactions or other errors.
- Overuse of medical care, unnecessary or overlapping care

**CONSENT FOR THE USE OF TELEMEDICINE**

1. I understand that the purpose of telemedicine is to provide health care services.
2. I permit Dr. Stanislaw and his assistant(s) to use telemedicine in my care.
3. I understand that telemedicine means using phone and/or video to communicate with my healthcare team instead of seeing my team in person (face-to-face).
4. I understand that reasonable efforts will be made to protect my privacy, though there may be risk of inadvertent disclosure of my personal identifying information and/or protected health information.
5. I understand that I can ask questions and discontinue the use of telemedicine at any time I choose.
6. I understand that telemedicine does not replace other types of medical assessment and care. If I am not improving and have serious health concerns, I will seek immediate medical attention at an emergency facility.
7. I may request a copy of this consent at any time.

I consent to the use of telemedicine as part of my medical care. All of my questions regarding telemedicine were answered, and the following was explained to me in a way that I understand:

- a. Concept of telemedicine
- b. Risk and benefits of the use of telemedicine
- c. Alternative methods of Medical Care

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# STANISLAW

FACIAL PLASTIC SURGERY CENTER

## Missed Appointment/Cancellation 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 canceling. 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: \_\_\_\_\_

## 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](http://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](mailto: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

## Acknowledgment 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 Riddell, 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: \_\_\_\_\_