DATE_____ AGE _____ DOB_____ SEX ◯ M ◯ F

MARITAL STATUS: ◉ Single ◯ Married ◯ Widow ◯ Divorced ◯ Separated RACE _____

LEGAL NAME_____ Nickname _____

ADDRESS _____

CITY_____STATE_____ZIP _____

MOBILE(_____)_____ Best time of day to call: ◯ AM ◯ PM May we text you?: ◯ Yes ◯ No

HOME PHONE(____)_____ MOBILE(____) _____

Best time to call: AM ◯ PM ◯ May we Text you? ◯ Y ◯ N Best time to call: ◯ AM ◯ PM

E-MAIL ADDRESS _____

May we Email you? ◯ Yes ◯ No

***PLEASE LIST ANY COMMUNICATION RESTRICTIONS**_____

SOCIAL SECURITY #_____ (This has to be obtained for any prescriptions)

PLACE OF EMPLOYMENT_____WORK# (____) _____

May we contact you at work? ◯ Yes ◯ No

OCCUPATION _____

CHILDREN: ◯ YES ◯ NO AGES_____

EMERGENCY CONTACT: NAME_____Relationship_____Phone _____

PRIMARY REASON FOR TODAY'S VISIT: _____

What time frame are you hoping to have your procedure/procedures?

Please check: ◯ 2, ◯ 4, ◯ 6, ◯ 8 weeks ◯ 3, ◯ 6, ◯ 9 months ◯ 1, ◯ 2 years other _____

Check which items below you would like to know more about:

__ Arm Reduction	__ CO2RE Intima	__ Forehead Lift	__ Thigh Lift
__ Bodytite	__ Dermal Fillers	__ Forever Young BBL	__ Tummy Tuck
__ Botox/Dysport	__ EMSELLA Chair	__ Fractora Microneedling	__ Ultra Femme 360
__ Breast Implants	__ Exilis Ultra 360	__ Labiaplasty	__ UltraShape Power
__ Breast Lift	__ Eyelid Lift	__ Liposuction	__ Urinary Incontinence
__ Breast Reduction	__ Facelift	__ Profound Microneedling	__ Vaginal Rejuvenation
__ Breast Revision	__ Facetite	__ O-Shot / G-Shot	__ Vampire Facial / Facelift
__ Brown Spots	__ Facial Veins	__ Skin Tightening	__ VASER Shape
__ CO2RE Laser	__ Fat Injections	__ Sciton Peel	__ Other_____

Name of Referral Source: _____

Patient: __ Physician: __ Magazine: __ Website: __ Friend: __ Other: __

FAMILY PHYSICIAN OR INTERNIST _____

FAMILY PHYSICIAN OR INTERNIST PHONE NUMBER _____

PHARMACY NAME:_____ PHARMACY NUMBER: _____

NAME:_____HEIGHT:_____WEIGHT: _____

Drug Allergies with Reactions: _____

Are you Allergic to Latex? ◯ **Y** ◯ **N** Other Allergies *(i.e. iodine, tape, skin sensitivity)*: _____

Present Medications: (*Include herbs, vitamins, over-the-counter meds, hormones and contraceptives.*) _____

_____

_____

Have you ever had surgery? ◯ Y ◯ N (Include Plastic/Cosmetic surgery) Please list the surgeon, procedure and year

_____

_____

Have you had any reactions to anesthesia? ◯ Y ◯ N If yes, please describe _____

_____

PLEASE INDICATE WHICH CONDITION(S) YOU HAVE BY CHECKING THE BOX(ES):

◯ Y ◯ N Abnormal Scarring
◯ Y ◯ N Asthma
◯ Y ◯ N Bleeding Disorder
◯ Y ◯ N Diabetes
◯ Y ◯ N DVT/PE
◯ Y ◯ N Glaucoma
◯ Y ◯ N Heart Problems
◯ Y ◯ N Hemangiomas
◯ Y ◯ N Hemophilia
◯ Y ◯ N Hepatitis (type)_____
◯ Y ◯ N Herpes Simplex 1
◯ Y ◯ N Herpes Simplex 2
◯ Y ◯ N High Blood Pressure
◯ Y ◯ N Hyperpigmentation
◯ Y ◯ N Keloid
◯ Y ◯ N Kidney Disease
◯ Y ◯ N Lupus
◯ Y ◯ N Port Wine Stain
◯ Y ◯ N Postive HIV Test
◯ Y ◯ N Respiratory Problems
◯ Y ◯ N Restless Leg Syndrome
◯ Y ◯ N Rheumatic Fever
◯ Y ◯ N Scleroderma
◯ Y ◯ N Seizures
◯ Y ◯ N STD (type) _____
◯ Y ◯ N Shortness of Breath
◯ Y ◯ N Thyroid

Other:_____

Have you ever been under the care of a psychiatrist/psychologist? ◯ Y ◯ N When_____

When was your last physical examination?_____Who was the physician?_____

Do you wear contact lenses? ◯ Y ◯ N Do you wear dentures? ◯ Y ◯ N

Have you ever had a mammogram? ◯ Y ◯ N When?_____Where? _____

Family History: Clotting Disorders ◯ Y ◯ N, Heart Problems ◯ Y ◯ N, Pulmonary Problems ◯ Y ◯ N, PE/DVT ◯ Y ◯ N, Diabetes ◯ Y ◯ N, Stroke ◯ Y ◯ N, Cancer ◯ Y ◯ N, Hypertension ◯ Y ◯ N,

Do you smoke? ◯ Y ◯ N Have you ever smoked? ◯ Y ◯ N If yes, for how long? _____When_____

When did you quit smoking? _____ Do you drink alcohol? ◯ Y ◯ N If yes, how much? _____

Do you take aspirin, Motrin, Nuprin, Ecotrin or Advil on a regular basis? _____if so, how much? _____

SIGN_____ DATE _____

PLEASE BE EXTREMELY ACCURATE WHEN ANSWERING ALL MEDICAL QUESTIONS. YOUR ANSWERS COULD INFLUENCE YOUR POST-OP RECOVERY AND FINAL RESULT!

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

Dr. Julene Samuels
502-897-9411

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.** ***You have the right to:***

Get an electronic or paper 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. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based 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.
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 example, home or office phone) or to send mail to a different address.
We will say "yes" to all reasonable requests.

Ask 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.

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 at 502-897-9411.
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 the following cases we never share your information unless you give us written permission: Marketing purposes, Sale of your information, Most sharing of psychotherapy notes.

How do we typically use or share your health information? 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. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization - We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services - We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

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 see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

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.

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.

If you have any requests, question, concerns or complaints, please contact:
Practice Administrator
9419 Norton Commons Blvd. Ste 101
Prospect, Kentucky 40059
502-897-9411

Effective Date: The effective date of this notice is May 2, 2017

NOTICE OF RECEIPT of the NOTICE OF PRIVACY PRACTICES*

Julene B. Samuels, MD, FACS
9419 Norton Commons Blvd. Ste 101
Prospect, Kentucky 40059

I hereby acknowledge that I have reviewed/received the Notice of Privacy Practices from the office of Julene B. Samuels, MD, FACS.

Printed Name:_____

Patients Signature:_____

Date:_____