D. Scott Rotatori, M.D., P.A.

PATIENT INFORMATION

Patient Name _____
LAST *FIRST* *MIDDLE*

Today's Date _____ Account # _____

Date of Birth _____ Age _____ Sex _____ Race _____ SS# _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Occupation _____ **E-mail address*** _____
**** Would you like to receive specials and newsletters through email? _____Yes _____No****

Reason for Visit* _____
Have you been treated elsewhere for this problem? _____ If so, by whom? _____

How did you hear about our office?* ___Patient ___Physician ___Online ___Other: _____
If *patient* or *physician*, please indicate: _____
May we write a letter to your referral source, thanking them for referring you? ____Yes ____No

Would you like your records from each visit here, released to (if yes, please check and sign below)*
Your Primary Care Doctor? ____Yes ____No _____
Signature Date
Your referring Doctor? ____Yes ____No _____
Signature Date

If checked ***yes***, please indicate below:
Primary Care Doctor Name _____ Address _____

Referring Doctor Name _____ Address _____

PARENT OR SPOUSE INFORMATION

Name _____ Relationship _____ Date of Birth _____

Mailing Address (if different from Patient) _____

Home Phone _____ Work Phone _____

Employer _____ Address _____

EMERGENCY CONTACT PERSON

Emergency contact person (or friend) other than a relative, who does not reside with you:

Name _____ Address _____ Phone _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____
Group or Individual _____
If Group, Name of Employer _____
Policy # _____ Group# _____ Insured's Date of Birth_____
Insured's Name _____ Relation to Patient _____
Insured's SS# _____ Ins. Co. Phone # _____
Mail Claims To: _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____
Group or Individual _____
If Group, Name of Employer _____
Policy # _____ Group# _____ Insured's Date of Birth_____
Insured's Name _____ Relation to Patient _____
Insured's SS# _____ Ins. Co. Phone # _____
Mail Claims To: _____

INSURANCE RELATED SERVICES

The patient is responsible for all fees for services rendered by D. Scott Rotatori, M.D., P.A. and is subject to individual insurance requirements. We accept payment in the form of cash, check, or credit card. Payment for surgery fees other than initial deposit is accepted **only** in cash, cashier's check or credit card.
***** Any checks returned by your bank to us as NSF will be subject to a fee of $30.00 and the amount of the check will be due immediately in cash or credit card payment only. *****
When insurance coverage applies, our office will as a courtesy to the patient file claims directly to your insurance company to expedite payment Dependent upon your insurance benefits and coverage, you will be asked to pay co-payments, deductible amounts due, and any other related charges for non-covered services. **Should your insurance not cover payment for all or any portion of services, you the patient are ultimately responsible for any balances due. Any outstanding balances not paid will be sent to Collections (unless other arrangements have been made).**

I authorize release of medical information necessary to process this claim and also authorize direct payment from my insurance carrier of medical benefits to the physician. I hereby authorize D. Scott Rotatori, M.D., P.A. to furnish information to my insurance carrier/carriers concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents.

DATE: _____ SIGNATURE: _____

NON- INSURANCE RELATED SERVICES

The patient is responsible for all fees for any and all services provided by D. Scott Rotatori, M.D., P.A. I agree to pay for all services rendered by my physician and or any other Provider of Services per the office policy of D. Scott Rotatori, M.D., P.A.
MONIES FOR DEPOSIT TO HOLD SCHEDULED SURGERY DATES ARE NON-REFUNDABLE

DATE: _____ SIGNATURE: _____

MEDICAL HISTORY

Height _____ Weight _____ Exercise? _____ Diet? _____

Do you use Tobacco? _____ Alcohol? _____ Drugs? _____
If yes, how much? _____

Have you had a recent weight loss or gain? _____ If yes, please explain.
_____

Please list any allergies. _____

Do you have a history of Sleep Apnea or Snoring? _____yes _____no

Surgical History: _____
_____
_____

Other Hospitalizations: _____
_____
_____

Have you been treated for any medical problems? _____ If yes, please explain: _____
_____

Have you ever seen a psychologist or psychiatrist? _____
Are you currently under treatment by a psychologist or psychiatrist? _____

_____ Heart Problems: _____
_____ Lung Problems: _____
_____ Kidney Problems: _____
_____ Coughing up or Vomiting Blood: _____
_____ Blood in urine or stool: _____
_____ Seizures or loss of consciousness: _____
_____ High Blood Pressure: _____
_____ Diabetes: _____
_____ Cancer: _____
_____ Hepatitis or yellow jaundice: _____
_____ Thyroid Disease: _____
_____ Other: _____

List any other medications you are currently taking, including over-the-counter drugs and herbal supplements: _____
_____

Personal or family history of anesthesia or bleeding problems? If so, please explain:
_____
_____

D. Scott Rotatori, M.D., P.A.

Notice of Privacy Practices

- This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.
- At D. Scott Rotatori, M.D., P.A., we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
- We may use of disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect you privacy.
- We may use your information to contact you. For example, we may send newsletters or other information or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond that above normal uses.
- As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have the right to see and receive a copy of your health information. With a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice.
- If we change any of the details of this notice, we will notify you of the change at your next appointment after the effective date of the change.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, SW, Room 509-F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
- However, before filing a complaint, or for more information, or assistance regarding your health information privacy, please contact our office at (407) 628-5476.

This notice goes into effect as of April 14, 2003

Acknowledgement

I have received a copy of the D. Scott Rotatori, M.D., P.A.; Notice of Privacy Practices.

Signed _____ Print Name_____ Date_____

If signing as a parent or guardian, please note the name of the patient _____

D. Scott Rotatori, M.D., P.A.
Contemporary Cosmetic Plastic Surgery
Cosmetic, Plastic and Reconstructive Surgery
www.scottrotatori.com

Certified – American Board of Plastic Surgery
Member – The American Society of Plastic Surgery

800 W. Morse Blvd. Suite 5
Winter Park, FL 32789

Phone: 407-628-5476
Fax: 407-628-4108

Patient Request for Allowances, Limitations And/or Restrictions of Protected Health Information

Please note: The practice is not required to agree to your request. Please refer to Our Notice of Privacy Practices for additional information about such requests.

Patient to complete the following:

Name: _____ Date of Birth: _____

Address: _____

_____

Type of Protected Health Information to be restricted or limited:

_____ _____

_____ _____

To whom may we release information: (ex: __ spouse, __ significant other, __ caretaker, __ etc.)

_____ _____

_____ _____

Note* Often spouses, significant others, caretakers, friends, may call on behalf of the patient especially after surgery to speak with the nurse or other staff members, or to confirm appointment dates and times. Without written consent of the patient we cannot give out any information to anyone other than the patient in compliance with HIPPA law.

To whom may we not release information:

_____ _____

_____ _____

Signature of Patient or Legal Guardian Date

coolsculpting®

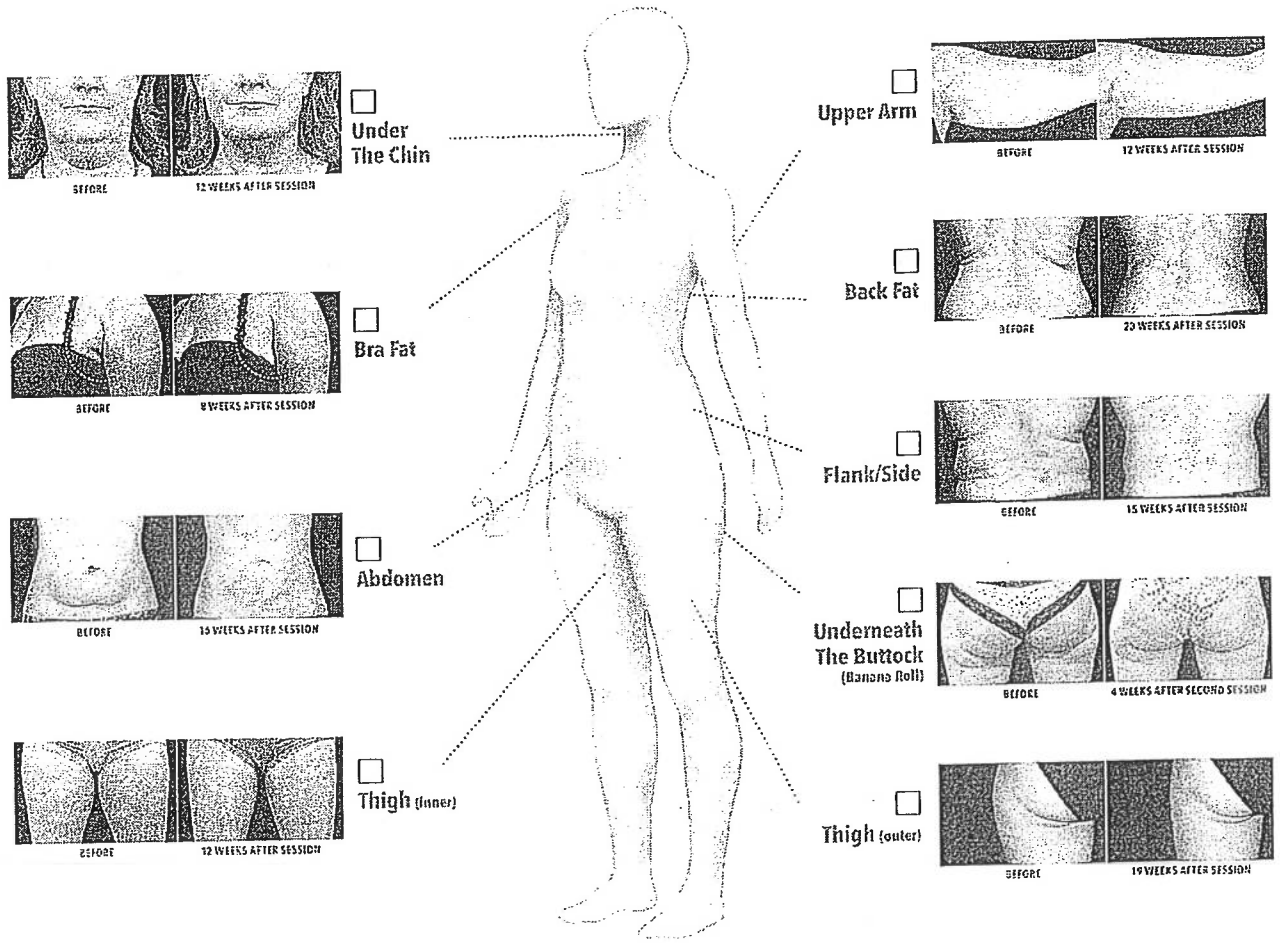
OUR OFFICE IS PROUD TO OFFER COOLSCULPTING®!

Discover how to freeze away fat with the world's #1 non-invasive fat reduction procedure[1]:

- » Transformational results without needles, surgery, or downtime
- » Millions of treatments performed worldwide
- » FDA-cleared, safe and effective

COOLSCULPTING CAN TARGET STUBBORN FAT IN THE AREAS THAT BOTHER YOU THE MOST.

Indicate below which problem areas would you be interested in transforming: (check all that apply)



1 CoolSculpting is the treatment doctors use most for non-invasive fat removal.

RESULTS AND PATIENT EXPERIENCE MAY VARY. Placements shown are approximate.

Before and After photos courtesy of (in order of appearance): A. Jay Burns, MD; Jason Rivers, MD; Christine Dierick, MD; Brian Hess, MD; Grant Stevens, MD; Scott Gerrish, MD; Amy Brenner, MD; Mark Beaty, MD, Premier Plastic Surgery.

In the U.S., the CoolSculpting procedure is FDA-cleared for the treatment of visible fat bulges in the submental area, thigh, abdomen and flanks, along with "bra fat, back fat, underneath the buttocks (also known as banana roll), and upper arms. In Taiwan, the CoolSculpting procedure is cleared for the reduction of fat in the flank (love handles), abdomen, and thigh. Outside the U.S. and Taiwan, the CoolSculpting procedure for non-invasive fat reduction is available worldwide. ZELTIQ, CoolSculpting, the CoolSculpting logo, and the Snowflake design are registered trademarks of ZELTIQ Aesthetics, Inc. © 2017. All rights reserved. PC03611-A

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Have you had any cosmetic procedure or laser procedure in the past year? Yes____No____

Have you had a facial before? Yes_____ No_____

Have you had a chemical peel before? Yes____No____

What skin care products are you currently using at home?

Cleanser_____ Toner_____ Exfoliant/Scrub_____ Serum_____ Day Moisturizer_____ Night Moisturizer_____ Eye Cream_____ Sunscreen_____

Brand(s): _____

Have you ever had a reaction to skin care products or ingredients? No_____ Yes_____
Explain_____

When in the sun, do you: Always burn___Usually burn____Sometimes burn_____
Rarely burn_____Very rarely burn____Never burn_____

Are you prone to cold sores/fever blisters? Yes_____No_____

Do you have sensitive skin? Yes_____No____

What is your skin type? Normal____Dry/dehydrated____Oily____Acne_____Rosacea_____

Are you using any prescribed exfoliants? (Retin-A, Diferen, Renova etc.) No_____ Yes_____
How often_____

In order of importance, please rank 1(Most important)—5(Least important)
____Reduction of fine lines_____Reduction of brown spots/sun damage
____Reduction of oil/acne_____Acne scarring_____Reduction of redness

Are you pregnant, lactating or plan on becoming pregnant soon? No_____ Yes_____

Do you smoke? _____Yes_____No

Are you on hormone replacement therapy? _____Yes_____No

Are you interested in hearing more about our skincare services and systems? Yes_____No_____

Are you interested in hearing more about CoolSculpting? Yes_____No_____

D. SCOTT ROTATORI, M.D., P.A.

Plastic and Reconstructive Surgery

Electronic Communication Agreement

Electronic communications, including but not limited to, emails and text messages, for example (hereinafter "Electronic Communications"), provide an opportunity to communicate with the healthcare providers at D. Scott Rotatori, M.D., P.A. ("D. Scott Rotatori, M.D., P.A.").

The following is intended to assist you with your determination of whether you wish to electronically communicate with D. Scott Rotatori, M.D., P.A.

General Considerations

- As your healthcare provider, D. Scott Rotatori, M.D., P.A., will treat Electronic Communications with the same degree of privacy and confidentiality as written medical records. D. Scott Rotatori, M.D., P.A. has taken reasonable steps with internal information technology systems to protect the security and privacy of your personal identifying and health information in accordance with the security guidelines required by the Health Information Protection and Accountability Act of 1992, as amended ("HIPAA").
- Standard email services, including, but not limited to, AOL, Yahoo, Hotmail, and Gmail, are not secure. This means that the email messages, including any individually identifiable health information and other sensitive or confidential information that may be contained in such email messages, are not encrypted and could be misdirected, disclosed to, read or intercepted by, unauthorized third parties.
- Standard text messaging services are also not secure, meaning that any individually identifiable health information and other sensitive or confidential information that may be contained in such text messages, are not encrypted and could be misdirected, disclosed to, read or intercepted by, unauthorized third parties.

I have read and understood the above description of the risks and responsibilities associated with Electronic Communications with D. Scott Rotatori, M.D., P.A. I acknowledge that commonly used Electronic Communications are not secure.

Please check <u>one</u> of the three below statements:

A. ____ Having been informed of the risks associated with Electronic Communications, I consent to, accept the risk in and still desire to communicate with D. Scott Rotatori, M.D., P.A. via Electronic Communications. I understand that I can withdraw this consent authorizing D. Scott Rotatori, M.D., P.A.to communicate with me via Electronic Communications at any time by written notification to D. Scott Rotatori, M.D., P.A.

   ✓ My email address is _____.

   ✓ My cell phone number is ( )-_____-_____.

B. ____ Having been informed of the risks associated with Electronic Communications, I consent to, accept the risk in and still desire to communicate with D. Scott Rotatori, M.D., P.A. via Electronic Communications *<u>only with respect to appointment reminders</u>*. I understand that I

can withdraw this consent authorizing D. Scott Rotatori, M.D., P.A.to communicate with me via Electronic Communications at any time by written notification to D. Scott Rotatori, M.D., P.A.

- ✓ My email address is _____.
- ✓ My cell phone number is ( )-_____-_____.

C. ____ Having been informed of the risks associated with Electronic Communications, I ***do not consent to***, accept the risk in and desire to communicate with D. Scott Rotatori, M.D., P.A. via Electronic Communications. I understand that I can change my mind and provide a consent authorizing D. Scott Rotatori, M.D., P.A.to communicate with me via Electronic Communications at a later time by written notification to D. Scott Rotatori, M.D., P.A.

To the extent that I have checked Box A or B, I release and hold harmless D. Scott Rotatori, M.D., P.A., its provider(s) and their staff, employees, affiliates, agents, officers, and principals from any and all expenses, claims, actions, liabilities, attorney fees, damages, losses of any kind that I may have resulting from Electronic Communications between D. Scott Rotatori, M.D., P.A. and me based on this authorization given to D. Scott Rotatori, M.D., P.A. to communicate with me via Electronic Communications.

_____
Patient Name (printed)

_____ _____
Patient Signature Date

_____
Witness

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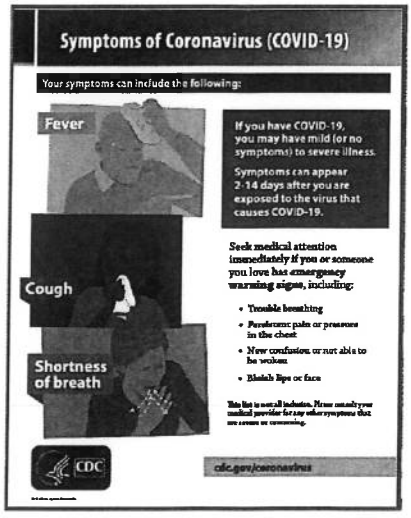
COVID-19 INFORMED CONSENT AGREEMENT

☐ I, the undersigned patient, consent to have Dr. Rotatori and/or his/her staff (hereinafter collectively "my Doctor") perform medical procedures, whether regarded as necessary, elective or aesthetic, during the time of the COVID-19 pandemic and after. I understand having my procedure performed at this time, despite my own efforts and those of my Doctor, may increase the risk of my exposure to COVID-19. I am aware that exposure to COVID-19 can result in severe illness, intensive therapies, extended intubation and/or ventilator support, life-altering changes to my health, and even death. I am also aware of the possibility that the procedure itself, whether performed in my Doctor's office or in a hospital, may result in a more severe case of COVID-19 than I might have had without the procedure.

☐ I also understand having my procedure performed at this time increases the risk of my transmission of COVID-19 to my Doctor. This virus has a long incubation period, there may be as yet unknown aspects of its transmission, and I realize that I may be contagious, whether or not I have been tested or have symptoms. To reduce the possibility of COVID-19 exposure or transmission at my Doctor's office, I accept that my Doctor will implement infection-control procedures with which I must comply, before, during and after my procedure, for my own protection as well as that of my Doctor. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures to be necessary.

☐ I have informed my Doctor of any COVID-19 testing I or any person living with me during the past 14 days has received, as well as the results of that testing, and if I am tested between now and the date of my procedure, I will immediately provide the results of that testing to my Doctor. I understand my Doctor may require that I be tested, possibly at my own expense and regardless of any prior testing, and that the results of that testing must be satisfactory to my Doctor, before I may receive my procedure.



☐ I confirm neither I nor any individual living with me has any of the COVID-19 symptoms listed by the Centers for Disease Control https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf, which website I have consulted; neither I nor any individual living with me during the past 14 days has experienced any such symptoms; and that I and all persons living with me for the past 14 days have practiced all personal hygiene, social distancing and other COVID-19 recommendations contained within all governmental orders issued by my city and state. I understand I must honestly disclose this information to avoid putting myself and others at risk.

☐ All topics above have been discussed with me, and all my questions have been answered to my satisfaction. Being fully informed, I accept the risk of COVID-19 exposure and I will bear the cost of any COVID-19 treatments required. I have been given the opportunity to postpone my procedure until the COVID-19 pandemic is less

prevalent, but I choose to have my procedure performed now. If I am the parent, guardian or conservator of the patient, I hold his/her health care power of attorney. I have read this COVID-19 Informed Consent Agreement and am authorized to consent on the patient's behalf.

☐ _____ _____

Patient/Authorized Representative Signature and Initials Print Name & Date **[First encounter]**

☐ _____ _____

Patient/Authorized Representative Signature and Initials Print Name & Date **[Day of procedure]**