Facial Cosmetic Questionnaire

Date:_________________

Patient Name: ____________________________Is your contact information still the same ?___Yes___No

What are your areas of concern?

__Face __Nose __Eyelids __Forehead __Chin __Lips

__Ears __Neck __Cheeks __Skin tone __Acne __Crows Feet Lines

__Forehead Lines __ Hyperpigmentation __ Broken capillaries

__Frown lines between the brows __Lines around nose and mouth

Other, please specify:____

Are you interested in learning more about the following?

__Botox®/ Xeomin® __Microlaser Peel __Laser Resurfacing

__Spider vein removal __Sclerotherapy __Facial vein removal

__Radiesse™ injectable __Chemical Peel __Forever Young BBL

__BBL Pigment __Juvederm™ injectable gel __Facial fillers

__Microdermabraision __Laser Hair removal __Medical skin care

__Longer & thicker lashes (Latisse®) __Anti-aging acupressure/Reflexology

Other, please specify:____

How did you hear about us?____

Would you like to hear about our specials? __Yes__No, If yes please provide your email address:

____

Dr. Daria Hamrah

Patient Information (Facial Cosmetic Procedures and Laser Treatment)

PATIENT: New Pt. / Former Pt. Date of Visit ____

First Name ______________________________ M.I. ________ Last Name ____

Sex: M / F Date of Birth _____/_____/______ Age ___________ SS# ________-_____-___________

Home Phone ( ) ___________________ Cell Phone ( ) _____________________ Email*: ________________________________

Street ____ City _____________________ State ___________ Zip _______________

Referred By/ how did you found us:____ ________________________

Emergency Contact Person: ____________________________________ Phone ( ) ____

Student: (Full time / Part time / Not) School ______________________________ City _____________________________________

Employed: (Full time / Part time / Retired / Not) Married / Divorced / Widowed / Separated / Single

Who will be responsible for your account? (Self / Spouse / Father / Mother / Other) Name______________________________

Home address (if different) ________________________________ City ________________ State _________ Zip _______________

☐ **I would like to join NOVA SurgiCare VIP Reward Program. This program is free of charge and will earn you one point for every dollar spent. You will be eligible to redeem rewards depending on the amount of points received. Please see "Rules and Regulations" for more information about this program*.**

REASON FOR VISIT:

☐ Face Lift (Rhytidectomy)
☐ Neck Lift (Platysma plasty)
☐ Facial and Neck Liposuction
☐ Endoscopic Brow Lift (Forehead lift)
☐ Eyelid Surgery (Blepharoplasty)
☐ Nose Surgery (Rhinoplasty)
☐ Jaw Reconstructive surgery
☐ Lip Augmentation (including Implant)
☐ Facial Implants (Chin & Cheek)
☐ Dimple-Plasty (Cheek dimples)
☐ Ear Repair (Torn earlobes)
☐ Ear Surgery (Otoplasty)
☐ Laser Skin (face Resurfacing)
☐ Laser Hair Removal
☐ Chemical Peels
☐ Dermabrasion
☐ Microdermabrasion
☐ Botox/Dysport
☐ Juvederm
☐ Restylane/ Perlane
☐ Radiesse
☐ Skincare/ Facial
☐ Auricular Therapy
☐ Hair Analysis
☐ Other Service:____

*Emails are required for office-patient commutations. Please inform the front desk if you prefer not receive email or text communications from us.
Updated 11/2013

Are you under a physician's care for a particular condition? __________ If so, for what? ____

Have you had any serious illness, operations, or hospitalizations? __________ If so, describe ____

Are you pregnant, nursing a child, or planning a pregnancy? ____

Have you been tested for tuberculosis? __________ Results ____

Have you been tested for hepatitis? __________ Results ____

Have you been tested for HIV? ______________ Results____

Do you take or have you taken radiation or chemo treatment for cancer? __________ If so, date ____

Do you take or have you taken intravenous bisphosphonates (examples: Aredia, Zometa)? If so, date ___________________________________

Do you smoke? __________ Numbers of packs per day __________ How long have you been a smoker? ___________________________________

Have you had any type of implant surgery done? __________ If so, list type and date of surgery ____

Do you have any other health problems that the doctor should be aware of? __________ Please list _____________________________________

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? *(Please Circle)*

Heart Attack / Heart Surgery	Stroke	High Blood Pressure
Jaundice	Ulcers	Mitral Valve Prolapse
Epilepsy or Seizure	Thyroid Problems	Abnormal Bleeding
Anemia	Prior Blood Transfusion	Emphysema
Asthma / Bronchitis	Shortness of Breath	Severe Coughing
Heart Murmur	Cold Sores	Alcohol or Drug Dependence
Congenital Heart Disease	Pneumonia	Rheumatic Fever
Glaucoma	Kidney Disease	Bruises Easily
Sinus or Nasal Problems	Diabetes	Breast Cancer/ Prostate Cancer

MEDICATIONS: *Are you allergic to any of the following?* *(Please check yes or no)*

	YES	NO		YES	NO
Local Anesthetic	____	____	Aspirin / Ibuprofen	____	____
Pencillin / Amoxicillin	____	____	Codeine	____	____
Latex / Rubber Products	____	____	Sulfa Drugs	____	____
Barbiturates / Sedatives	____	____	Other ____		

No Known Drug Allergies (Please Circle)

Are you currently taking any of the following? *(Please check yes or no)*

	YES	NO		YES	NO
Tagamet	____	____	Thyroid Medications	____	____
Antibiotics or Sulfa Drugs	____	____	Anticoagulants	____	____
High Blood Pressure Meds	____	____	Steroids	____	____
Tranquilizers	____	____	Insulin / Diabenase	____	____
Heart Medications	____	____	Aspirin / Ibuprofen	____	____ Qty ____
Antihistamines / Decongestants	____	____	Weight Loss / Herbal Supplements	____	____
Fosamax / Boniva / Actonel/ Zometa	____	____	Immune Suppressants	____	____

Please list any others ____

I certify that I have read and understood the questions above and that the above information is current and correct. I will not hold my surgeon, Dr. Daria Hamrah, or any of his staff responsible for any errors or omissions that I have made in the completion of this form. In addition, I am authorizing my credit card (number provided on page 1) to be charged for any outstanding balance of any 30 days overdue to NOVA SurgiCare, PC.

Patient / Legal Guardian Signature ___________________________________ Date ____________________________

Patient Disclosure Instructions

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (*check all that apply*):

- o **Home Telephone: ____________________**
- o *O.K. to leave message with detailed information*
- o *Leave message with call-back number only*

- o **Written Communication:**
- o *O.K. to Email to personal email address*
- o *O.K. to mail to my home address*
- o *O.K. to mail to my work/office address*
- o *O.K. to fax to number indicated*

- o **Other (Fax/Cell, etc.) ____________________**
  ____

- o **Work Telephone: ____________________**
- o *O.K. to leave message with detailed information*
- o *Leave message with call-back number only*

I allow you to give my clinical information to or answer questions from (check all that apply):

- o Spouse
- o Parent
- o Child
- o Other: (specify): ____
- o None

____
Patient Signature Date

____
Print Name Birth date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I have received a copy of this office's Notice of Privacy Practices. (A copy is located inside the white binder in the waiting area or simply ask for a copy)

____
Printed name

____
Signature Date

FOR OFFICE USE ONLY

This office attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Specify)

____

____

____

____

Subsequent law changes may require form revision

Dr. Daria Hamrah
Financial Policy - Elective Procedures

- This office will accept the following forms of payment for services rendered: Cash, Check, American Express, Discover, MasterCard, and Visa. Optional financing plans are also available (Care Credit, Chase Health).

- In order to schedule a procedure and to secure your desired date, we must obtain 25% of your total surgery amount as a deposit. The remaining balance of the fees will be due upon your preoperative visit or one week prior to your procedure. The deposit will be applied towards your elective procedure; however, if the procedure is canceled less than 7 days prior to your scheduled surgery date for any reason, deposit would be **non-refundable** except in case of documented emergency or medical disability.

- There is a $140 consultation fee that is due on the day of your consultation and it is applied towards your scheduled surgery or procedure. The consultation fee is a non-refundable fee in the case that surgery or procedure is not scheduled.

- If revisionary treatments are desired during the first year, there will be no surgeon's fee; however the cost of surgical supplies, facility fee and anesthesia will be the responsibility of the patients. Any further treatment will reflect the usual procedural fees.

- There is a $50.00 charge for post-operative appointments after 90-days from your surgical date. These global care standards are set forth by the American Medical Association.

- Any lab work required for your elective procedure will be the sole responsibility of the patient.

- Overpayments will be processed and refunded to the appropriate party according to generally accepted procedures. Refunds due to the patient/guardian will not be processed and remitted until all active and past due, including bad debt, accounts have been paid. This process generally takes about 60 days.

- If payment has not been made to an account thirty - (30) days after service is rendered, and no contact or appropriate arrangements have been made, the account will accrue monthly interest of 24% of the outstanding balance.

- It is our policy to charge a $25.00 fee for all returned checks.

- To schedule your desired date, a 50% surgical deposit is required and will be applied towards your balance.

- If you are unable to keep your scheduled appointment, you have 7 days prior to your appointment to reschedule or cancel with no penalty.

- All broken appointments (no shows) and/or cancellations 48 hours or less notice may result in forfeiture of your deposit and/ or incur an additional $50 no show fee.

- Please be aware that under **<u>no circumstances</u>** does this office file insurance for elective cosmetic procedures. This applies regardless of participation in patients plan. Patient understands and accepts that this office will assist in providing a receipt of services rendered on day of surgical procedure. Any reimbursement received by insurance plans will be patient's responsibility and patient understands that for such cosmetic procedures, negotiated rates will not apply.

- All patients are charged the same for same services rendered, and this office does not accept reasonable and customary charge calculation by outside parties unless provided in an arrangement such as a managed care contract.

I have read and agree to the above policies. I understand that it is my responsibility to pay any fees to this office. This signature on file is also my authorization for the release of information necessary to process any insurance claims and credit card for any unpaid balance. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Patient/Legal Guardian Signature___________________________________Date_________________

Dr. Daria Hamrah, DMD, FAACS, FADSA
8201 Greensboro Dr, Ste #601
McLean, VA 22102
(703) 288 - 4495

Cancellation, Rescheduling and Missed Appointment Policies

At NOVA SurgiCare, we pride ourselves on offering you personalized care and reserve appointment times to accommodate your needs. We understand that sometimes schedule adjustments are necessary. Therefore, we respectfully request at least **48-hours (2 business days) advance notice** for cancellations or rescheduling of appointments.

Dr. Hamrah and Tetyana (Esthetician) only see one patient at a time in order to give each patient their full attention, and they only sees a limited number of patients per day.

Please understand *late arrivals*, *missed* appointments or *canceled* appointments without sufficient notice, create a gap in our providers' schedule. We also miss the opportunity to fill that appointment time, and patients on our waitlist miss the opportunity to receive services. Therefore, we have a **strictly enforced 48-hour** *cancellation* and *rescheduling* policy.

Last-Minute Cancellations and Missed Appointments:

❖ **We do require a 48-hour (2 business days) notice on all cancellations.**
- As a courtesy to our patients, we have an automated reminder system to call, text, or email you to confirm all appointments.
- We understand that emergencies occur and are willing to make *exceptions* for true emergencies; however, it is imperative that you contact our office immediately to notify us of your cancellation in a timely manner.

(For example, if your appointment is scheduled for Monday at 10 a.m., you must cancel the appointment no later than 10 a.m. the Thursday before the appointment. If the appointment is on Wednesday at 2 p.m., it must be cancelled no later than Monday at 2 p.m.)

❖ Late cancellations made *within* the 48-hour window will be billed at the following rates:
- **$25 fee** for rescheduling or canceled appointment
- **$50 fee** for NO-SHOW

Late Arrivals:

❖ A late arrival is **15 minutes** or greater from the appointment time
❖ Arriving late may cause the appointment to be rescheduled at a later date and time to accommodate other patients on the schedule who arrived on time.

By signing below, I acknowledge that I have read and understand this policy.

Signature of Patient or Parent: ____

Patient Name (printed): ____

Date: ____________________

Updated 9/24/2019

NOVA SurgiCare, PC
Dr. Daria Hamrah

*Authorization For Release of Photographs and/or Video**

I hereby authorize the release any/ all of the photographs and/or video taken preoperatively, during surgery, or postoperatively, without limitation regarding my physical and mental condition.
*I consent to these photographs and/or video for the purpose of patient viewing (before and after gallery), teaching or journal publication for **NOVA SurgiCare, PC and Dr. Daria Hamrah**.*

Name of Patient ______ Date of Birth ______ Social Security # ______

Patient or Legal Guardian Signature ______ Date ______

Witness Signature ______ Date ______

*NOVA SurgiCare can use patients' before and after pictures for the purpose of teaching, journal publications, before and after picture gallery (advertising), assuming patients' identity is deleted or hidden (ie: nose surgery, only showing the nose) without patients' consents.