

METROPOLITAN PLASTIC SURGERY

Julia Spears, M.D., FACS

Patient Registration Form

Name: _____ Preferred Pronouns: _____

DOB: ___ / ___ / ___ SS#: _____ Marital Status: S M W Sep. D

Address: _____ City, State, Zip: _____

Cell Phone: _____ Permission to text? Yes No

Email Address: _____ Permission to email? Yes No

Reason for visit? _____

COVID-19 Vaccination? Yes No

Primary Care Physician: _____ PH #: _____

Referring Physician: _____ PH #: _____

Spouse's Name: _____ PH #: _____

Emergency Contact Name: _____ PH #: _____

Your Occupation: _____

INSURANCE INFORMATION

Subscriber (insured party): SELF SPOUSE PARENT OTHER (please specify) _____

Name of Subscriber: _____ DOB: ___ / ___ / ___

Subscriber's Address: _____ City, State, Zip: _____

Insurance (primary): _____ ID#: _____

Ph #: _____ Address: _____ City, State, Zip: _____

Insurance (secondary): _____ ID#: _____

Ph #: _____ Address: _____ City, State, Zip: _____

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization be used in place of the original.

I authorize Dr. Julia Spears to apply for benefits on my behalf for covered services rendered by her or by her order. I request payment from my insurance company be made directly to Dr. Spears. I certify that the information I have reported with regard revoked in writing by either me or my insurance company at any time.

Patient Signature: _____ Date: _____

METROPOLITAN PLASTIC SURGERY

Julia Spears, M.D., FACS

Patient Names: _____ Date of Birth: _____

Drug Allergies/Intolerance. List reaction

Table with 2 columns and 3 rows for drug allergies/intolerance.

Past Surgical History

Form for Past Surgical History with columns for procedure, No, Yes, and description.

Hospitalizations (non-surgical) _____

Family Medical History (not yours)

If Yes, please list relative and age

Form for Family Medical History with columns for condition, No, Yes, and relative/age.

Social History: Martial Status: S M W Sep. D Children: No Yes How many? _____

Alcohol Use: No Yes How much? _____ Tobacco use (past/present) No Yes ppd: _____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary services I may need and release information to others if necessary for my care.

Patient Signature: _____ Date: _____

METROPOLITAN PLASTIC SURGERY

Julia Spears, M.D., FACS

Patient Name: _____ Date of Birth: _____

Review of Systems

Gastrointestinal

Nausea/Vomiting No Yes
 Heartburn No Yes
 Food Sticking in throat No Yes
 Painful swallowing No Yes
 Vomiting Blood No Yes
 Yes
 Black stool No Yes
 Blood in stool No Yes
 Abdominal Pain No Yes
 Constipation No Yes
 Diarrhea No Yes
 Loss of appetite No Yes
 Feeling full quickly No Yes
 Bloating No Yes

Constitutional

Recent weight gain No Yes
 # of pounds _____
 Recent weight loss No Yes
 # of pounds _____
 Fever No Yes
 Fatigue No Yes

Cardiovascular

Abnormal Heart Rhythm No Yes
 Chest Pain No Yes
 Palpitations No Yes

Respiratory

Sore Throat No Yes
 Hoarseness No Yes
 Cough No Yes
 Wheezing No Yes
 Shortness of breath
 on exertion? No Yes
 Shortness of breath
 at rest? No Yes

Genitourinary

Frequent urination No Yes
 Kidney Failure/dialysis No Yes
 Painful urination No Yes
Is there a chance you may be pregnant? No Yes

Dermatology

Rash No Yes
 Acne No Yes

Psychiatric

Dementia No
 Depression No Yes
 Anxiety No Yes

Neurological

Seizures No Yes
 Headaches No Yes

Musculoskeletal

Joint Pain No Yes
 Arthritis No Yes

Are you taking any blood thinners (Coumadin, Warfarin, Plavix, Predaxa, Xarelto, etc...) No Yes

List your current medications with dosages, including Over the Counter and Herbal/Homeopathic products

Medical History

Ascites (extra fluid in abdomen)	No	Yes	Heart Attack	No	Yes
Anesthesia Problems	No	Yes	Hepatitis	No	Yes
Describe problem _____			What Type: _____		
Asthma	No	Yes	High Blood Pressure	No	Yes
Bleeding disorder	No	Yes	Kidney Failure	No	Yes
Body Dysmorphia	No	Yes	Kidney Stones	No	Yes
Cancer	No	Yes	Liver Disease	No	Yes
What type? _____			Migraine Headaches	No	Yes
Congestive Heart Failure	No	Yes	Pancreatitis	No	Yes
Coronary Artery Disease	No	Yes	Seizures	No	Yes
Depression	No	Yes	Sleep Apnea	No	Yes
Diabetes	No	Yes	Stomach Ulcer	No	Yes
Emphysema/COPD	No	Yes	Stroke/TIA	No	Yes
Gallstones	No	Yes	Thyroid Disease	No	Yes
Heart Arrhythmia (A.Fib/SVT/A.Flutter)	No	Yes	Valvular Heart Disease/Endocarditis	No	Yes

Metropolitan Plastic Surgery
Julia Spears, M.D., FACS

PATIENT POLICIES

We value our relationship with you and want to ensure its success through mutual understanding of our policies. After you have reviewed these policies, please sign and date this form. By signing this document, you are acknowledging that you have read the policy and that you understand it. If you'd like a copy for your record, please ask.

1. To cancel an appointment, you must give at least 24 hours' notice or a \$50.00 cancellation fee will be charged. If you are late for your appointment, you may be asked to reschedule for another day.
2. If you miss three or more appointments without providing advance notice, you may be released from the practice. If you are disrespectful to our staff or are found to be deceitful, you will be released from the practice.
3. You must present a current active insurance card at the time of your visit. If you do not have your insurance card, it may be necessary to reschedule your appointment or pay a \$275.00 self-pay fee prior to being seen.
4. If your insurance lapses or you do not have active coverage, you are responsible for all charges incurred while you are without coverage. Please keep our office updated on any insurance changes.
5. All Co-pays are due at the time of your visit upon checkout. ***It is the patient's responsibility to be aware of their individual insurance plan and benefits prior to their visits or surgery*** (i.e. Referrals, Co-pays, Deductible, and Co-insurance).
6. All cosmetic service fees (i.e. on-surgical treatments, injectables, etc) are due upon the time of treatment.
7. Return Policy: ***All sales are final.*** In the case of a documented allergic reaction or clearly defective product, exchanges can be made within 14 days for skincare credit only.
8. Refund Policy: There are no refunds once services have been provided. We offer no guarantee or warranty on surgical or non-surgical results. A perceived lack of improvement in one's condition does not translate into any type of refund.
9. ***All deposits are non-refundable but can be used as a credit towards another service if scheduled within 6 months.***
10. Surgery cancellations create serious scheduling difficulties. The surgical facility, anesthesiologist, surgeon and other staff are reserved and scheduled in advance. Therefore, please understand the importance of respecting our two-week cancellation policy.

TWO WEEK CANCELLATION POLICY FOR SURGERY:

Fifty percent (50%) of the surgeon's fee is NON-REFUNDABLE if you cancel your surgery or any portion of your surgery less than 14 days prior to your surgery date. One hundred percent (100%) of the surgeon's fee is NON-REFUNDABLE if your surgery or any portion of your surgery is cancelled less than 7 days before your surgical date. If the surgery is scheduled less than 14 days prior to the surgical date, all fees are due at the time of scheduling and all normal cancellation fees apply. Should you need to reschedule your surgery date, you must give 21 days' notice in order for any prepaid fees to be applied to a new surgery date. If your surgery is cancelled and rescheduled more than once, a \$250.00 rescheduling fee will apply. If a refund is due to a patient for any reason, we require a minimum of 7 days to process the refund check.

11. Surgical facility fees and anesthesia fees are charged on an hourly basis, your quote is based on an *estimate* of time required to complete your case. If the procedure takes longer than anticipated, there may be additional charges for additional facility or anesthesia fees. Please note that surgical and facility fees are paid to the surgical center directly via credit card or certified check.
12. You are responsible for all pre-operative lab tests required to be cleared for surgery. You are responsible for the cost of all prescriptions that are associated with your surgery. The surgical quote does not include the cost of these prescriptions.
13. Pre-operative photos will be taken by Dr. Spears or her staff for your medical record.
14. Any patient whose check is returned by the bank will be assessed a \$35.00 administrative fee in addition to any fees that may be assessed from the patient's bank. We will not provide any refund/credit to any patient on the basis of any returned check fees issued by the patient's bank.
15. To obtain medical records, a release form must be signed by the patient/guardian. There is \$15.00 processing fee. Please allow **5 business days** for turnover.
16. You may incur a charge to have our office complete certain documents, please inquire regarding your forms.
17. By signing below, you agree to receiving text messages and email notification from this practice.

By signing this form, I acknowledge that I understand The Metropolitan Plastic Surgery Center's policies. I agree that I am personally responsible for all payments due for my medical/surgical care.

Print Name

Patient/ Responsible Party's Signature

Date

NOTICE OF PROVIDER PRIVACY PRACTICES

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.

Julia Spears MD. Must maintain the privacy of your personal health information and give you this notice that describes our legal duties and privacy practices concerning your personal health information. In general, when we release your health information, we must release only the information we need to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. We must follow the privacy practices described in this notice.

However, we reserve the right to change the privacy practices described in this notice, in accordance with the law. Changes to our privacy practices would apply to all health information we maintain. If we change our privacy practices, you will receive a revised copy.

Without your written authorization, we can use your health information for the following purposes:

1. **Treatment:** For example, a doctor may use the information in your medical record to determine which treatment option, such as a drug or surgery, best addresses your health needs. The treatment selected will be documented in your medical record, so that other health care professionals can make informed decisions about your care.
2. **Payment:** In order for an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the treatment provided to you. As a result, we will pass such health information onto an insurer in order to help receive payment for your medical bills.
3. **Health Care Operations:** We may need your diagnosis, treatment, and outcome information in order to improve the quality or cost of care we deliver. These quality and cost improvement activities may include evaluating the performance of your doctors, nurses and other health care professionals, or examining the effectiveness of the treatment provided to you when compared to patients in similar situations.

In addition, we may want to use your health information for appointment reminders. For example, we may look at your medical record to determine the date and time of your next appointment with us and then send you a reminder letter to help you remember the appointment. Or we may look at your medical information and decide that another treatment or a new service we offer may interest you. For example, we may contact a cancer patient to notify them that we have a new cancer research facility that offers new life-saving treatments.

Furthermore, we may want to use information found in your medical record, such as your name, address, phone number and treatment dates, to contact you for our fund-raising purposes. For example, in order to provide more charity care or otherwise improve the health of your community, we may want to raise additional money and therefore may contact you for a donation.

4. **As required or permitted by law:** Sometimes we must report some of your health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries, or to respond to a court order.
5. **For public health activities:** We may be required to report your health information to authorities to help prevent or control disease, injury, or disability. This may include using your medical record to report certain diseases, injuries, birth or death information of concern to the Food and Drug Administration, or information relate to child abuse or neglect. We may also have to report to your employer certain work-related illnesses and injuries so that your workplace can be monitored for safety.
6. **For health oversight activities:** We may disclose your health information to authorities so they can monitor, investigate, inspect, discipline or license those who work in the health care system or for government benefit programs.
7. **For activities related to death:** We may disclose your information to coroners, medical examiners and funeral directors so they can carry out their duties related to your death, such as identifying the body, determining cause of death, or in the case of funeral directors, to carry out funeral preparation activities.
8. **For organ, eye or tissue donation:** We may disclose your health information to people involved with obtaining, storing or transplanting organs, eyes or issue of cadavers for donation purposes.
9. **For research:** Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research. Such research might try to find out whether a certain treatment is effective in curing an illness.
10. **To avoid a serious threat to health or safety:** As required by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to you or the public's health or safety.
11. **For military, national security, or incarceration/law enforcement custody:** If you are involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your health information to the proper authorities so they may carry out their duties under the law.
12. **For workers' compensation:** We may disclose your health information to the appropriate persons in order to comply with the laws related to workers' compensation or other similar programs. These programs may provide benefits for work-related injuries or illness.
13. **For Julia Spears MD's directory:** Unless you object, we may use your health information, such as your name, location in our facility, your general health condition (e.g., "stable," or "unstable"), and your religious affiliation for our directory. It is our duty to give you enough information so you can decide whether or not to object to the release of this information for our directory. The information about you contained in our directory will be released to people who ask for you by name. However, the information about your

religious affiliation will only be disclosed to clergy. We may allow you to agree or disagree orally regarding the use of your health information for directory purposes.

14. **To those involved with your care or payment of your care:** If people such as family members, relatives, or close personal friends are helping care for you or helping you pay your medical bills, we may release important health information about you to those people. The information released to these people may include your location within our facility, your general condition, or death. You have the right to object to such disclosure, unless you are unable to function or there is an emergency. In addition, we may release your health information to organizations authorized to handle disaster relief efforts so those who care for you can receive information about your location or health status. We may allow you to agree or disagree orally to such release, unless there is an emergency. It is our duty to give you enough information so you can decide whether or not to object to the release of your health information to others involved with your care.

NOTE: Except for the situations listed above, we must obtain your specific written authorization for any other release of your health information.

If you sign an authorization form, you may withdraw your authorization at any time, as long as your withdrawal is in writing. If you wish to withdraw your authorization, please submit your written withdrawal to Julia Spears MD, the Privacy Officer.

Your Health Information Rights

You have several rights with regard to your health information. If you wish to exercise any of the following rights, please contact Julia Spears MD, the Privacy Officer. Specifically, you have the right to:

1. **Inspect and copy your health information:** With a few exceptions, you have the right to inspect and obtain a copy of your health information. However, this right does not apply to psychotherapy notes or information gathered for judicial proceedings, for example. In addition, we may charge you a reasonable fee if you want a copy of your health information.
2. **Request to correct your health information:** If you believe your health information is incorrect, you may ask us to correct the information. You may be asked to make such requests in writing and to give a reason as to why your health information should be changed. However, if we did not create the health information that you believe is incorrect, or if we disagree with you and believe your health information is correct, we may deny your request.
3. **Request restrictions on certain uses and disclosures:** You have the right ask for restrictions on how your health information is used or to whom your information is disclosed, even if the restriction affects your treatment or our payment or health care operation activities. Or you may want to limit the health information provided to family or friends involved in your care or payment of medical bills. You may also want to limit the health information provided to authorities involved with disaster relief efforts. However, we are not required to agree in all circumstances to your requested restriction.

If you receive certain medical devices (for example, life-supporting devices used outside our facility), you may refuse to release your name, address, telephone number, social security number or other identifying information for purpose of tracking the medical device.

4. **As applicable, receive confidential communication of health information:** You have the right to ask that we communicate your health information to you in different ways or places. For example, you may wish to receive information about your health status in a special, private room or through a written letter sent to a private address. We must accommodate reasonable requests.
5. **Receive a record of disclosures of your health information:** In some limited instances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years, but the request cannot include dates before April 14, 2003. This list must include the date of each disclosure, who received the disclosed health information, a brief description of the health information disclosed, and why the disclosure was made. We must comply with your request for a list within 60 days, unless you agree to a 30-day extension, and we may not charge you for the list, unless you request such list more than once per year. In addition, we will not include the list disclosures made to you, or for purposes of treatment, payment, health care operations, our directory, national security, law enforcement/corrections, and certain health oversight activities.
6. **Obtain a paper copy of this notice:** Upon your request, you may at any time receive a paper copy of this notice, even if you earlier agreed to receive this notice electronically.
7. **Complaint:** If you believe your privacy rights have been violated, you may file a complaint with us and with the federal Department of Health and Human Services. We will not retaliate against you for filing such a complaint. To file a complaint with either entity, please contact Julia Spears MD, the Privacy Officer, who will provide you with the necessary assistance and paperwork.

Again, if you have any questions or concerns regarding your privacy rights or the information in this notice, please contact Julia Spears MD, the Privacy Officer at 856-345-2240.

This Notice of Medical Information Privacy is Effective: April 14, 2003.

Acknowledgement of Receipt of Privacy Notice Form

ACKNOWLEDGEMENT OF PRIVACY NOTICE

For office use only:

Patient Name: _____

Medical Record #: _____

Date of Admission: _____

By signing this form, you acknowledge that Julia Spears, MD has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after April 14, 2003.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

- I have received Julia Spears MD's Privacy Notice.
- Julia Spears, M has given me the chance to discuss my concerns and questions about the privacy of my health information.

Patient's Signature

Date

Julia Spears MD's staff should complete if Acknowledgement Form is not signed:

Does the patient have a copy of the Privacy Notice?

- Yes No

Please explain why the patient was unable to sign an acknowledgement form and Julia Spears, MD's efforts in tryin to obtain the patient's signature.

Metropolitan Plastic Surgery
Julia Spears, M.D., FACS

Patient Name: _____

Date: _____

Aesthetic Interest Questionnaire

I would like to be advised on:

What is the main reason for your visit today?

- How I can look better for my age
- How I can change something that has been bothering me for years
- How I can look more attractive
- Other: _____

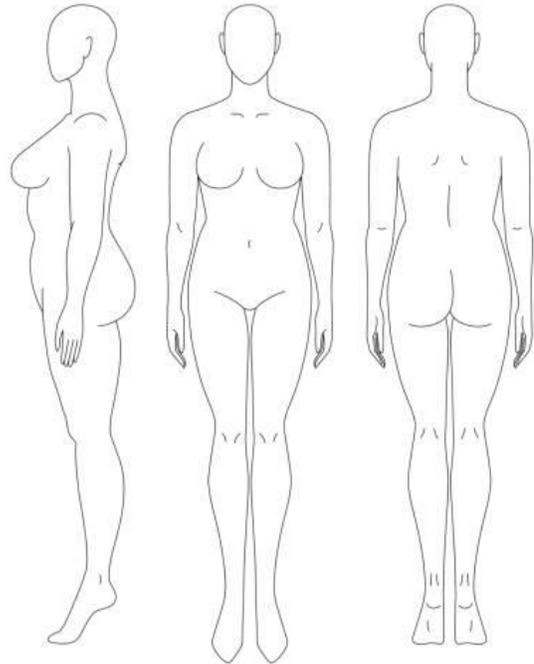
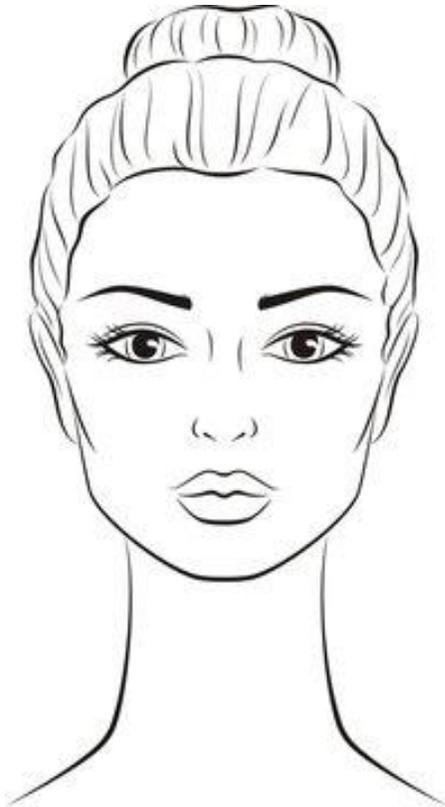
Have you had a consultation or treatment for a cosmetic procedure before? Yes No

How often do you think about wanting a cosmetic procedure? Most days Weekly Monthly

Which three statements best reflect how you would like to look and feel after your treatment?

- I want to look less tired
- I want a less saggy appearance
- I want my face to look slimmer
- I want to look less angry
- I want to look more youthful
- I want softer features
- I want to look less sad
- I want to look more attractive

Please circle the area(s) of your interest:



How would you rate the quality of your skin? Poor Fair Good Very Good Excellent

If you could enhance an aspect of your skin, what would it be? Hydration Elasticity Smoothness
 Color

The treatments/concerns I would like to discuss further are:

- Acne
- Scars
- Blotchy skin
- Dull skin
- Moles
- Sun damage
- Rosacea
- Love handles
- Sagging skin
- Thin lips
- Hair loss
- Belly fat
- Loose skin
- Stubborn fat
- Male breasts
- Arm fat
- Back fat
- IPL treatments
- Loss of volume in breasts
- Fine lines/wrinkles
- Dermal fillers
- Botox
- Retinol/Tretinoin
- Fat grafting
- Liposuction
- Loss of facial volume
- Microneedling
- Spider Vein Injection

What is your preferred **maximum** budget: \$1,000 \$5,000 \$10,000

How much down time are you able to take? _____

How soon do you want results? _____

How did you hear about us?

- My doctor
- Search engine
- My insurance company provider
- Social media platform
- Advertisements/periodicals
- Seminar
- A friend/family member
- Other

Contact information:

- I would like to receive information about new products/trends/our clinic.
- You are allowed to contact me for further questions concerning an appointment at your clinic.

Phone number: _____

E-mail address: _____

Signature: _____



Metropolitan Plastic Surgery

Consent For Photography

During my care here at Metropolitan Plastic Surgery, Dr. Julia Spears, MD., or her staff may take clinical pre-operative and post-operative photographs of me. I understand that such photographs are for confidential clinical records and that all photographs remain the property of the doctor. Occasionally, such photographs are used for teaching purposes and for ethical surgical publications for the advancement of surgical knowledge. In addition, they are occasionally used to give new patients an indication of the possible surgical results. These photographs may be used on differing social media platforms and in ads. The staff will comply with any of my requests to hide identifiable traits (face, tattoos, birthmarks, etc.). I will permit the use of my photographs for the reasons stated above.

Patient Signature _____ Date _____

Please list any area(s) you would like hidden from photo's (ex. Face, tattoos, birthmarks, etc..)

I DO NOT agree that my photographs can be used or shared for any reason.

Patient Signature _____ Date _____