David Alessi, M.D., F.A.C.S

Alessi Institute for Facial Plastic Surgery

Patient Registration

Today's Date: _____

Welcome to David Alessi, MD and Alessi Institute for Facial Plastic Surgery. As a new patient, please fill out the information found below to the best of your ability. Please answer these health and beauty related questions to help us design the ideal experience for you. *All information will remain confidential.*

Name:_____ **Birthday:**____/____/_____ **Age:** ___
last first middle

Responsible Party (if minor) :_____ **Height:** _____ **Weight:** _____

Mailing Address:_____

City:_____ **State/Country:**_____ **Zip:**_____

Social Security # _____ **Driver's Lic #**_____

Telephone: Home _____ **Work** _____ **Cell** _____

Primary Email Address: _____ ☐ I would like to receive health-related information via email

Sex: ☐Female ☐Male **Marital Status:** ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Preferred method for leaving confidential medical information: ☐ Home phone ☐ Work phone ☐ Cell phone ☐ Email

Primary Physician Name _____ **Phone #** _____

Dentist Name _____ **Phone #** _____

EMERGENCY CONTACT

Name: _____ **Phone:** _____ **Relationship:**_____

INSURANCE

Primary Insurance Holder information: Name:_____ Date of Birth:_____

Name of Insurance Provider _____ Contract # _____ Group # _____

How did you hear about Dr. David Alessi?

☐ TV ☐ Internet ☐ Magazine ☐ Newspaper ☐ Radio ☐ Other _____ Referred by _____ ☐ patient

Patient Employed by: _____ **Spouse or Responsible Party Name:** _____

Address: _____ **Address:** _____

Occupation: _____ **Occupation:** _____ **Business Phone** _____

Dear Patient,

Thank you for choosing us as your health care provider. We are committed to provide you with the best medical care services. The following information is intended to Prevent uncertainties in regards to our financial policy. Our practice firmly believes that a good doctor-patient relationship is based upon understanding and good communications.

INSURANCE

We are **out of network for all insurances unless written below.** As a courtesy, our practice will review your coverage, estimate your insurance company payment, review your insurance form, and file your claim with your insurance carrier. You will be responsible for any portion of your bill which is denied or not paid by your insurance carrier. Your insurance coverage is a contract between you and your insurance carrier. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier. We feel it is necessary to work together to resolve any insurance problem.

DEDUCTIBLE

Your deductible will be verified at the time of service and if you have not met your deductible, you are required to pay at the time of service. All Medicare patients have a yearly deductible of $_____. Payment of services which qualify toward the yearly deductible begin on January 1st and conclude on December 31st of each year. For example, if your yearly deductible is $200.00, you must first pay the initial $200.00 to satisfy your deductible. The discount you receive from your insurance company will be calculated when we receive the explanation of benefits for your service and any adjustments will be made at the time.

COPAYMENT

All copayments must be made at the time of service. In Network for _____

UTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS. I hereby authorize Dr. David M. Alessi., M.D., F.A.C.S., to furnish information to surance carriers concerning this illness and the treatments I receive and I hereby irrevocably assign to the doctors all payments for medical services rendered. I understand I am ıancially responsible for all charges not covered by my insurance benefits. I also authorize that photographic copy of this authorization is as if such copy were original. I also thorize the doctors to file a formal written complaint with the insurance commissioner if my insurance fails to pay or deny a claim within 30 days.

I have read, understood and agree to the provisions of this form.

Signature:_____ **Date:**_____

REASON FOR YOUR VISIT:

_____

_____

_____

ALLERGIES AND SENSITIVITIES

Check Yes or No if you have a history of skin reaction or other illness following contact with:

YES NO

- ☐ ☐ Prior Allergy Test
  If yes, results_____
- ☐ ☐ Penicillin, Sulfa or other antibiotic
- ☐ ☐ Morphine, Codeine, Demerol
- ☐ ☐ Novocain or Lidocaine
- ☐ ☐ Tetanus toxoid or serums
- ☐ ☐ Iodine, Betadine, Chlorhexidine or Phisohex
- ☐ ☐ Tincture of Benzoin
- ☐ ☐ Latex rubber or Adhesive tape

List other drug, medicine, or other allergies here:

DRUGS AND MEDICINES

Check Yes or No if you have taken any of the following within the last 6 months:

YES NO

- ☐ ☐ Cortisone, prednisone or ACTH
- ☐ ☐ Diuretics or water pills
- ☐ ☐ Blood pressure medication
- ☐ ☐ Steroids or body building drugs
- ☐ ☐ Seizure medication
- ☐ ☐ Insulin or diabetes medication
- ☐ ☐ Headache or migraine medications
- ☐ ☐ Asthma medication
- ☐ ☐ Heart medication
- ☐ ☐ Anticoagulants or blood thinners
- ☐ ☐ Pain pills
- ☐ ☐ Appetite suppressants or diet pills
- ☐ ☐ Sedatives, tranquilizers or sleeping pills
- ☐ ☐ Antidepressants, antipsychotics or nerve pills
- ☐ ☐ Recreational or illegal drugs
- ☐ ☐ Homeopathic or herbal medicines
- ☐ ☐ Aspirin or aspirin-containing medications

List ALL drugs or medications currently used:

SURGERY

Check Yes or No for each question:

YES NO

- ☐ ☐ Abnormal healing or poor scar formation
- ☐ ☐ Adverse or unusual reaction to surgery
- ☐ ☐ Abnormal bleeding

IMPORTANT MEDICAL CONDITIONS

Check Yes or No if you have been diagnosed or ever received treatment for any of the following:

YES NO

- ☐ ☐ Anaphalaxis or severe allergy attack
- ☐ ☐ Migraines, headaches or chronic head pain
- ☐ ☐ Seizures
- ☐ ☐ Glaucoma
- ☐ ☐ Stiff neck
- ☐ ☐ Artificial joint replacement
- ☐ ☐ Bell's palsy or neurological problems
- ☐ ☐ Asthma, TB, Pneumonia or chest disease
- ☐ ☐ High blood pressure
- ☐ ☐ Heart problems, palpitation, or surgery
- ☐ ☐ Pacemaker
- ☐ ☐ Splenectomy (removal of spleen)
- ☐ ☐ Blood clots or varicose veins
- ☐ ☐ Gastro esophageal reflux
- ☐ ☐ Hepatitis, jaundice, cirrhosis or liver disease
- ☐ ☐ HIV or AIDS
- ☐ ☐ Frequent nosebleeds or Easy bruising
- ☐ ☐ Cancer
- ☐ ☐ Diabetes
- ☐ ☐ Thyroid problem or Graves' disease
- ☐ ☐ Kidney failure, kidney or prostate problems
- ☐ ☐ Lupus, arthritis or autoimmune disease
- ☐ ☐ X-Ray treatments or radiation therapy
- ☐ ☐ Severe snoring or sleep apnea

DENTURES

YES NO

- ☐ ☐ Capped teeth, bridges or veneers
- ☐ ☐ Loose teeth or gum disease
- ☐ ☐ Other oral/dental problems

ANESTHESIA

YES NO

- ☐ ☐ Adverse or unusual reaction to anesthesia
- ☐ ☐ Do you have a blood relative who had anesthesia complications of any kind

ADDITIONAL MEDICAL CONDITIONS

Check Yes or No if you have been diagnosed or ever received treatment for any of the following:

YES NO

- ☐ ☐ Drug or Alcohol abuse or addiction
- ☐ ☐ Smoking, currently or in the past
- ☐ ☐ Psychological or emotional problems
- ☐ ☐ Body Dismorphic Disorder (BDD)
- ☐ ☐ Currently in therapy or counseling
- ☐ ☐ Depressed or having Suicidal thoughts
- ☐ ☐ Is there violence in your home?
- ☐ ☐ Is anyone threatening you or making you feel bad about yourself?

EAR, NOSE & THROAT

Check Yes or No if you have been diagnosed or ever received treatment for any of the following or are having syptoms:

YES NO

- ☐ ☐ Eye Pain, Itchy or Water Eyes
- ☐ ☐ Double Vision, Sudden Vision changes
- ☐ ☐ Hearing Loss or Dizziness
- ☐ ☐ Ear Noises
- ☐ ☐ Ear Pain
- ☐ ☐ Nasal Congestion
- ☐ ☐ Shortness of Breath
- ☐ ☐ Problems with the Sense of Smell
- ☐ ☐ Snoring
- ☐ ☐ Sinus Pressure or Pain
- ☐ ☐ Post Nasal Drip
- ☐ ☐ Sneezing
- ☐ ☐ Hoarseness
- ☐ ☐ Difficulty Swallowing
- ☐ ☐ Coughing
- ☐ ☐ Daytime sleepiness
- ☐ ☐ Throat clearing
- ☐ ☐ Throat Pain
- ☐ ☐ Lip or Tongue Swelling

List other medical conditions here:

List all previous surgical procedures you have undergone & approximate date(s):

I certify that the above is true, correct and complete. I am aware and accept that withholding information about my medical history could result in serious injury to me or harm to those involved in my care. I am aware that providing false or incomplete information about my medical and surgical history may result in the cancellation of my proposed surgical procedure and also result in forfeiture of my surgical fees.

Patient Initials _____

Please Check All of Dr. Alessi's Surgical & Facial Institute's Non-Surgical Procedures That May Be of Interest To You:

FACE

- ☐ Facelift, Neck Lift, Brow Lift
- ☐ Eyelid Surgery
- ☐ Nose Surgery (cosmetic and
- ☐ Lip Surgery
- ☐ Facial Contouring, Implants, Fat
- ☐ Prominent Ear
- ☐ Other _____

BREAST

- ☐ Breast Augmentation
- ☐ Breast Revision/Reconstruction
- ☐ Breast Lifts
- ☐ Breast Reduction
- ☐ Scar Revisions
- ☐ Nipple Surgery
- ☐ Other _____

BODY

- ☐ Surgical Body
- ☐ Tummy Tucks
- ☐ Brazilian Butt Lift/Fat Transfer
- ☐ Body Lift, Arm Skin Reduction
- ☐ Scar Revisions (e.g., C-Sections)
- ☐ Labia Contouring/Reduction
- ☐ Other _____

NON INVASIVE PROCEDURES

- ☐ Botox or Dysport Injections
- ☐ Dermal Fillers (e.g.,Restylane, Juvederm)
- ☐ Lip Enhancements
- ☐ Non-Surgical Fat Reduction
- ☐ Hair Regeneration for thinning or receding hair
- ☐ Laser Treatments to Improve Skin Quality
- ☐ Laser Therapy to Improve Pigmentation or Spots
- ☐ Laser Therapy for Skin Tightening or Firming
- ☐ Medical Facials and Peels
- ☐ Anti-Aging, Prevention Skincare
- ☐ Alessi Skin Care
- ☐ PRP-Stem cell injections
- ☐ Hydrofacial
- ☐ Sun Damage Repair
- ☐ Acne Treatments
- ☐ Scar Treatment
- ☐ Eyelash Enhancement
- ☐ Not sure, need consultation
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____

Check Yes or No if you have used in the past or are currently using:

YES	NO	
☐	☐	Retin-A or other Retinoids
☐	☐	Skin Lightening products
☐	☐	Accutane
☐	☐	Waxing or Depilatories
☐	☐	Laser treatments
☐	☐	IPL/Photofacial
☐	☐	Microdermabrasion
☐	☐	Facials
☐	☐	Injections (Botox/Dysport)
☐	☐	Dermal Fillers (Juvaderm)

Patient Initials _____

Patient & Photo Consent Form

Privacy and Confidentiality Notice

Privacy and Confidentiality Notice for David M. Alessi, M.D., A Medical Corporation

We understand that many patients are concerned about the privacy surrounding their decision to have surgery. Your decision to enhance your look is a personal one and it is our pledge that we will safeguard the information you provide to the best of our abilities. Please review this form carefully and sign below. If you have any questions, please do not hesitate to speak with our office manager, Surgical and/or our Plastic Surgery Coordinator.

Our efforts to safeguard your personal and medical information include training our staff on the principals and importance of patient confidentiality, keeping patient charts and photographs safe and secure, and transmitting only necessary information to facilities such as the surgery center, anesthesiologist, and in some cases the hospital.

A description of the information typically collected is listed here:

- To ensure the highest quality of medical care, you will be asked to share medical history information such as previous surgeries, allergies to medications and general health status.
- Additionally you will be asked to discuss with Dr. Alessi the reasons for your visit and your plastic surgery goals. Dr. Alessi often records this information in his chart notes.
- Pre and post procedure digital photographs are either sent ahead of your visit (by you) or taken in our office. These assist Dr. Alessi in planning surgery.
- For tracking and invoicing purposes, you will be asked to share personal information such as name, address, phone numbers, e-mail, social security number and credit card number(s). Again, we take the utmost care in handling this information.

Furthermore, I authorize my surgeon to use my **photographs, videotapes and case information in educational and scientific settings** (including lectures and multi-media presentations for an audience of medical professions, at which members of the press may be present, and medical, surgical and scientific journal articles).

Neither I, nor any member of my family will be identified by name in any publication. I understand that in some circumstances the photographs may portray features, which shall make my identity recognizable.

I authorize the use of my photographs, videotapes and case information in the following **commercial/educational settings**: my surgeon's office patient education materials; my surgeon's file of pre- and postoperative patient photographs available to prospective patients for viewing in the office; newspaper and magazine articles in which my surgeon participates; television programs in which my surgeon participates; my surgeon's personal website or webpage; and, lectures and multi-media presentations given by my surgeon for the general public.

I release and discharge David M. Alessi M.D., F.A.C.S. and all parties acting under his license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above authorization and release and fully understand its terms.

I have read and understand the Privacy and Confidentiality Notice and all questions have been answered to my satisfaction. I understand I may have a copy of the Privacy and Confidentiality Notice if I wish.

Patient Signature	Print Name	Date
Witness/Physician Signature	Print Name	Date

David Alessi, M.D., F.A.C.S
9735 Wilshire Blvd, Suite 300
Beverly Hills, California 90212

MUTUAL AGREEMENT

Dr. David Alessi agrees to provide treatment to: _____("Patient")

Dr. Alessi takes pride in being able to extend a greater degree of privacy than is required by law.

Some medical offices try to find loopholes around State and Federal laws protecting patient privacy. For example, physicians are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Dr. Alessi believes this is improper and not in the patients' best interest. Accordingly, Dr. Alessi agrees not to provide medical information for the purpose of marketing directly to Patients. Regardless of legal privacy loopholes, Dr. Alessi will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

Dr. Alessi has invested significant financial and marketing resources in developing his/her practice and in return for enhanced protection of patient privacy Dr. Alessi asks for the ability to protect the reputation of his/her practice from attacks from his/her competitors. Nothing in this Agreement prevents a patient from posting commentary about the Physician — his/her practice, expertise, and/or treatment - on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Dr. Alessi, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Dr. Alessi for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be in force and enforceable for a period of five years from Physician's last date of service to Patient. As a matter of office policy, Dr. Alessi is requiring all patients in its practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all of Dr. Alessi's patients. Further, this Agreement will survive for a minimum of five years beyond any termination of the Physician-Patient relationship.

Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996(HIPAA).

Our Commitment to Your Privacy:
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and Disclosure of Your Health Information in Certain Special Circumstances:
The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court or administrative order.

3. If required to do so by law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

5. Right to a copy of this note. You are entitled to receive a copy of this Note of Privacy Practices. You may ask us to give you a copy of this notice anytime. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact David M. Alessi, M.D., F.A.C.S. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other used and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have question regarding this notice or our health information privacy policies, please contact the office of David M. Alessi, M.D. F.A.C.S.

I hereby acknowledge that I have been presented with a copy of David M. Alessi, M.D., F.A.C.S.

Notice of Privacy Practices

Signature:_____ **Date:**_____

Notice to Consumers
Medical doctors are licensed and regulated by the
Medical Board of California
(800) 633-2322
www.mbc.ca.gov

A MESSAGE TO MY PATIENTS ABOUT ARBITRATION

The attached contract is an arbitration agreement. By signing this agreement, we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between heath care providers and their patients have long been recognized and approved by the California courts. By signing this agreement, you are changing the place where your claim will be presented. You still can call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. This is because the time to conduct an arbitration hearing is farless than for a jury trial. Further, both parties are spared some of the rigors of trial and the publicity which may accompany judicial proceedings. Our goal, of course is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.