



1035 Primera Blvd • Lake Mary, FL • 32746 • 407-333-3040

PATIENT INFORMATION

**Patient**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_
Street Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_
Best Number to Contact You : ( ) \_\_\_\_\_ Alternate Number: ( ) \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_
Can we leave a message at this number? \_\_\_\_\_ Social Security Number: \_\_\_\_\_
Marital Status: S[ ] M[ ] W[ ] DV[ ] Occupation/Student: \_\_\_\_\_
Employer Name and City: \_\_\_\_\_
E-Mail: \_\_\_\_\_

**Spouse or Responsible Party (Emergency Contact Information)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_
Street Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_
Home Phone: ( ) \_\_\_\_\_ Work Phone : ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ DOB: \_\_\_\_\_
Employer Name and City: \_\_\_\_\_

**Cosmetic/Medical Complaint**

Reason for Visit: \_\_\_\_\_ Duration: \_\_\_\_\_
Prior Treatment(s) : \_\_\_\_\_ When: \_\_\_\_\_
By Whom: \_\_\_\_\_ City: \_\_\_\_\_
Referring Physician: \_\_\_\_\_ City: \_\_\_\_\_ Phone# \_\_\_\_\_
Family Physician: \_\_\_\_\_ City: \_\_\_\_\_ Phone# \_\_\_\_\_

**How did you hear about Dr. Gross?** \_\_\_\_\_

**Authorization for Release of Medical Information**

I, \_\_\_\_\_, hereby authorize **Dr. Gross** to discuss my care & health information with:

**(List name(s)/family relationship)**

I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to **Dr. Edward Gross at 1035 Primera Blvd, Lake Mary, FL. 32746**

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Edward J. Gross, M.D. will not condition my treatment on whether I provide Authorization for this release.

**\*\*24 HOURS NOTICE MUST BE GIVEN TO CANCEL OR RESCHEDULE YOUR CONSULTATION OR A CANCELLATION FEE OF \$50 WILL BE CHARGED.**

I agree to be financially responsible for all charges. I have read this information and understand it.

\_\_\_\_\_  
Signature of Patient or Personal Representative Date \_\_\_\_\_ Name of Patient \_\_\_\_\_



**Facial Plastic Surgery  
BOARD CERTIFIED**

**FINANCIAL AGREEMENT**

Welcome to our office. This form is intended to clarify your financial responsibilities. We value our patients and are committed to providing the highest quality services from a Board Certified Facial Plastic Surgeon. Thank you for choosing our office for your plastic surgery care.

1. I understand that payment for service is due the day the service is rendered. Payment for cosmetic surgery is due two (2) weeks prior to the date of procedure.
2. I understand that outstanding balances must be paid prior to being seen by the provider.
3. I understand and agree that I am responsible for payment of all charges on my account.
4. I understand that additional treatment for touch-ups or revisions has additional costs.
5. I understand and agree that plastic surgery is elective and there are no guarantees as to outcomes or patient satisfaction.
6. I understand and agree that if my account is placed into collection action, I will be responsible for all the costs of such action (collection agency and attorney’s fees included).
7. Missed, changed, or cancelled office appointments with less than 24 hrs notice have additional costs.
8. I understand that once a service has been provided, there will be no refunds.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

X \_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness



## Photographic Consent

I consent to being photographed in connection with the consultation, medical and surgical services which I may receive from Edward J. Gross, M.D.

Medical photography is necessary for a variety of reasons. To document outcomes, skin conditions, healing, findings, and before and after results.

Medical photographs will be part of your medical record and will be kept Confidential in keeping with physician's office standards.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

X\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness

### Additional Consent Notice

*\*\* On occasion, Dr. Gross may request use of your pictures for teaching or patient education purposes. In such cases, an additional consent would be presented to you. This would be completely voluntary and require your additional signature on a separate consent form.*



## Consent for Purposes of Treatment, Payment and Healthcare Operations

I \_\_\_\_\_ consent to the use or disclosure of my protected health information by **Edward J. Gross MD, PL** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Edward J. Gross MD, PL**. I understand that diagnosis or treatment of me by **Edward J. Gross MD** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Edward J. Gross MD, PL** is not required to agree to the restrictions that I may request. However, if **Edward J. Gross MD, PL** agrees to a restriction that I request, the restriction is binding on **Edward J. Gross MD, PL**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Edward J. Gross MD, PL** has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Edward J. Gross MD, PL’s** “Notice of Privacy Practices prior to signing this document. The **Edward J. Gross MD, PL’s** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operation of the **Edward J. Gross MD, PL**. The Notice of Privacy Practices for **Edward J. Gross MD, PL** is also provided at 1035 Primera Blvd, Lake Mary, FL and on the website at [www.wedofaces.com](http://www.wedofaces.com). This Notice of Privacy Practices also describes my rights and **Edward J. Gross MD, PL’s** duties with respect to my protected health information.

**Edward J. Gross MD, PL** reserves the right to change the privacy practices that are described I the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the **Edward J. Gross MD, PL’s** website, calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

Signature \_\_\_\_\_ Date \_\_\_\_\_