



PLASTIC SURGERY • MED SPA • SALON
EDWARD J. GROSS, MD

1035 Primera Boulevard | Lake Mary, FL 32746 P. 407.333.3040 | F. 407.333.3496
WeDoFaces.com

Trust Your Face to a Facial Plastic Surgeon™.

Patient

Name: _____ Age: _____ Today's Date: _____

Street Address: _____ City/State: _____ Zip: _____

Best Number to Contact You: _____ Alt. Number: _____ DOB: _____ Sex: _____

Can we leave a message at this number? _____

Marital Status: S M W DV Occupation: _____

Employer Name: _____

*E-Mail (required): _____

Preferred method of communication: Cell Home Phone Text E-mail

(Required)

Spouse or Responsible Party (Emergency Contact Information)

Name: _____ Relationship: _____

Contact Number: _____ Employer Name and City: _____

Cosmetic/Medical Complaint

Reason for Visit: _____ Duration: _____

Prior Treatment(s): _____ When: _____

By Whom: _____ City: _____

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 \$250 WILL BE CHARGED.**

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

X _____
Signature of Patient or Personal Representative

Date

Name of Patient





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BOARD CERTIFIED

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.

_____ Date
Print Name

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.*





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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT
AND HEALTH CARE OPERATIONS (HIPAA)

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 PL** 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 health care 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. 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 in 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.

X _____
Signature Date



MEDICAL HISTORY

REVIEW OF SYSTEMS		
Have you previously or do you?		
	YES	NO
Scar Easily		
Bruise Easily		
ACCUTANE ®		
Cold Sores of Mouth or Lip		
Daily Aspirin		
Keloids		
Facial Radiation		
Prior Healing Difficulty		
Loss of Hearing		
Prior Anesthesia Difficulty		
Contacts		
Glasses		
Dry Eye Problems		
Glaucoma		
Lasik		
Cough		
Shortness of Breath		
Fibromyalgia		
Chest Pain		
Swollen Ankles		
Bridges or Dentures		
Daily Sun Exposure		
Stomach Problems		
Tanning Bed Use		
Phen / Fen for Weight Loss		
Blood Thinners		
Arthritis		
Frequent Headaches		
Seizures		
Anxiety		
Rashes		
Depression		
See a Mental Health Therapist		
WOMEN ONLY:		
Birth Control Pills		
Possibility of Pregnancy		
Nursing		

FAMILY HISTORY		
	YES	NO
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Mental Illness		
Kidney Trouble or Stones		
Cancer		
Bleeding Disorders		
Malignant Hyperthermia		
Anesthesia Problems		

List Other Medical Problems: None

List Prior Cosmetic & Surgical Procedures (w/ approx. dates): None

List all Pills, Medications & Herbs: None

MEDICAL HISTORY

PATIENT HEALTH HISTORY		
	YES	NO
Vascular Surgery		
Stroke		
Heart Attack		
High Blood Pressure		
Abnormal Heartbeat		
Diabetes		
Arthritis		
AIDS/HIV+		
Asthma		
Depression		
Kidney Trouble or Stones		
Skin Cancer		
Bleeding Disorders		
Alcoholism		
Serious Injuries		
Eye Problems/Injury		
Blood Clots		
Anemia		
Stomach Ulcers		
Hepatitis		
Thyroid Trouble		
Cancer		
Bleeding Tendencies		
Heart Stents		
Anesthesia Reactions		
Recent Weight Loss		

Social History

Most Recent Occupation _____

Retired

Married Single Divorced Widowed Student

Number of Children: _____

Smoking Never Yes Quit

Smoke packs a day _____

Alcohol Use Never Occasional Daily

Currently Use or Had:

Retin-A Botox Accutane Lasers

Fillers Chemical Peels

Allergies to Medicine:

None

How did you hear about Primera?

Word of Mouth TV Billboard Drive-by

Orlando Mag Doctor Referral Web Event

List your Primary Care Doctor & City:

Print Name

X

Signature

Date

Age

Weight

Height

Gender



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HEALTHCARE PROVIDER-PATIENT BINDING ARBITRATION AGREEMENT

1: Agreement to Arbitrate. It is agreed and understood that any dispute as to medical malpractice, or whether any medical services rendered under this contract were unnecessary or unauthorized, or were improperly, negligently, or incompetently rendered, will be submitted by the patient and physician to arbitration for resolution, as provided by Florida law.

2: Waiver of Jury Trial. BY ENTERING INTO THIS AGREEMENT, THE PATIENT AND PHYSICIAN UNDERSTAND THAT THEY ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY CLAIM OR DISPUTE BETWEEN THEM DECIDED IN A COURT OF LAW BEFORE A JURY. The patient and physician agree that by entering into this arbitration agreement, they voluntarily waive recourse to any other remedy, except as provided in Article 9, and agree to arbitration for resolution and settlement of any and all present and future disputes or claims that arise between them.

3: All Claims Must Be Arbitrated. This Agreement binds all parties whose claims may arise out of or are related to treatment or services provided by the undersigned healthcare provider, or any member of the undersigned healthcare provider's office staff, including the patient, the patient's estate, the patient's spouse and any children, whether born or unborn, and any other heirs of the patient, at the time of the occurrence giving rise to any claim. By signing this Agreement, the patient and physician consent to the participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action if they had been involved in any way in the care of the patient. This may include claims of the patient against another physician, nurse or medical professional, or a hospital or other facility. Additionally, this Agreement is intended to resolve all claims for vicarious liability of the aforementioned individuals and/or entities.

The patient and physician agree that all claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. All claims for monetary damages made against the undersigned healthcare provider, and the undersigned healthcare provider's partners, associates, professional association, corporation or partnership, and employees, agents and estates, related to the diagnosis, care, and/or treatment of the patient must be arbitrated, including, without limitation, claims for personal injury, loss of consortium, wrongful death, emotional distress, or punitive damages, whether the claims regard future care and treatment or past care and treatment.

4: Procedures and Applicable Law. The patient and physician agree that the provisions of Florida Statutes, Chapter 766, which govern the medical malpractice pre-suit process, shall apply to the patient/ physician. If there is no agreement between the patient and physician to settle the claim under 766.106 or to voluntarily arbitrate the claim under Florida Statutes 766.106 and 766.207 at the conclusion of the pre-suit process, the patient and physician shall resolve any claim through arbitration pursuant to this Agreement. Any demand for arbitration triggered by this Agreement must be made before the statute of limitations applicable to such a claim has run or will be considered void.

Written notice of the demand for arbitration shall be provided to the opposing party within sixty days from the termination of the pre-suit process, or within the remainder of the statute of limitations, whichever is greater. Written notice shall be sent certified mail, return receipt requested.

The arbitration will be conducted by three arbitrators who will hear the dispute and render a binding decision. Each party shall appoint one arbitrator with experience in medical malpractice claims arbitration (referred to as a "party arbitrator"), and one alternate arbitrator within thirty (30) days of the written demand for arbitration, and shall notify the other party of such appointment. In the event of multiple plaintiffs or multiple defendants, the arbitrator selected by the side with multiple patient and physician shall be the choice of those patient/ physician. A neutral arbitrator shall be selected by the party arbitrators (excluding alternates), within thirty (30) days of their appointment. In the event of a party arbitrator's inability to complete the arbitration process, then the alternate arbitrator will be provided opportunity to review the proceedings to

date, and will replace the departing arbitrator. The arbitrators shall appoint a time and place for the hearing, which shall be held within a reasonable time after the appointment of the neutral arbitrator.

Except as provided herein, the patient and physician agree that the arbitration shall be conducted in accordance with the Florida Arbitration Code, found in Florida Statutes, Chapter 682. The patient and physician agree that Florida law applicable to medical malpractice claims and damages shall be applied, including, but not limited to, those concerning the Wrongful Death Act and any and all statutory caps on damages.

The patient and physician in this Agreement hereby agree that the decision and award of the arbitrators is final and binding on both parties. The award rendered by the arbitrators may be entered in any court having jurisdiction thereof. The decision of the arbitrators only may be appealed in a limited amount of circumstances, which are those consistent with the provisions of the Florida Arbitration Code.

5: Separate Arbitration of Liabilities and Damages. Upon request by either party to this agreement and approval of the arbitrators, the issues of liability and damages may be arbitrated separately.

6: Legal Representation During the Arbitration Proceedings. The patient and physician and/or claimants are entitled to be represented by legal counsel during any arbitration proceedings or hearings.

7: Effect of Refusal to Proceed With Arbitration. In the event that any party to this Agreement refuses to go forward with arbitration, the party seeking to enforce this Agreement may make application to the court for an order directing the patient and physician to proceed with arbitration. If the court grants the application, the party compelling arbitration reserves the right to proceed with arbitration and the appointment of an arbitrator. In such a case, the party proceeding with arbitration in the absence of the other party shall make application to the court to appoint one or more arbitrators. Any party to this Agreement who refuses to go forward with arbitration hereby acknowledges that the arbitrators will go forward with the arbitration hearing and proceedings and render a binding decision without the participation of the absent party.

8: Nature of the Proceedings. The patient and physician agree that the arbitration proceedings are to be private. The privacy of the patient and physician and of the arbitration proceedings shall be preserved and confidentiality shall be maintained.

9: Arbitration Expenses. Each party to the arbitration shall pay their own pro rata share of the expenses and fees, of the neutral arbitrator, and of the other expenses of the arbitration incurred or approved by the neutral arbitrator, except that each party shall be responsible for the payment of his/her own legal counsel fees, witness fees, or other fees incurred by a party for his/her own benefit.

10: Retroactive Effect. This Agreement is effective as of the first date medical services were rendered to the patient. The patient has the right to refuse to accept the arbitration agreement, at which time a listing of available physicians in the same medical specialty will be provided to the patient.

11: Revocation: This Agreement is irrevocable. It is the intent of this agreement to apply to all medical services rendered at any time for any condition of the patient.

12: Severability. In the event that any one or more of the provisions contained herein shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision of this Agreement, but this Agreement shall be construed as if such invalid, illegal or unenforceable provision or provisions had never been contained herein unless the deletion of such provision or provisions would result in such a material change as to cause continued performance of this Agreement as contemplated herein to be unreasonable or materially and adversely frustrate the objectives of the patient and physician as expressed in this Agreement.

13: Governing Law. This Agreement is governed by the laws of the State of Florida.

14: Patient Acknowledgments. By signing this Agreement, the patient hereby acknowledges the foregoing:

- **Right of Counsel.** By signing this Agreement, the patient acknowledges and understands that this Agreement is a legal document, and that he or she has the right to consult with an attorney of his or her choice prior to signing this Agreement, and to receive explanations or clarification of any of the terms of this Agreement.

Initials

- **No Undue Influence.** The patient hereby acknowledges that he or she has not been pressured, induced, coerced, or intimidated in any way into signing this Agreement, and has signed this Agreement of his or her own free will and accord. The patient further acknowledges that he or she has not signed this Agreement under duress.

Initials

- **Receipt of Copy of Arbitration Agreement.** The patient hereby acknowledges that he/she has received a copy of this Arbitration Agreement.
- **The Patient's Understanding of the Terms of the Agreement:** By signing this Agreement, the patient hereby acknowledges that he/she has read this Agreement and understands and agrees to its terms. The patient acknowledges that he/she has been given every opportunity to ask questions and receive answers concerning the specifics and intent of this Agreement.

NOTICE

BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE RELATED TO YOUR MEDICAL/ SURGICAL DIAGNOSIS, CARE AND/OR TREATMENT DECIDED BY ARBITRATION. IN DOING SO, YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

This Agreement shall be effective as of the date of the patient's and/or the patient's representative below. Upon such signature, this Agreement shall be deemed to be fully executed and binding upon all parties.

Patient :

Print Name

X _____
Patient Signature

Date

Healthcare Provider:

Healthcare Provider Signature

Date

Witness:

Print Name

Witness Signature