PLASTIC SURGERY ▪ DAY SPA ▪ SALON

*EDWARD J. GROSS, MD*
*Board Certified Facial Plastic Surgeon*

Trust Your Face to a Facial Plastic Surgeon™.

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

**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 $50 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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**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 required at the time the service is rendered.
2. Payment for cosmetic surgery is due two (2) weeks prior to the date of procedure.
3. I understand that I am responsible for payment of all charges and services.
4. I understand that additional treatment for touch-ups or revisions has additional costs.
5. I understand that plastic surgery is elective and there are no guarantees as to outcomes or patient satisfaction.
6. Missed, changed, or cancelled office appointments with less than 24 hrs notice will have additional charges.
7. I understand that once a service has been provided, there are no refunds.
8. I understand the practice is cosmetic (fee for service) and that insurance is not accepted.

_______________________________________ ____________________
Print Name Date

X_____________________________________ ____________________
Patient Signature Witness

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## 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.*

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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

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## MEDICAL HISTORY

| REVIEW OF SYSTEMS<br>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:**<br>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

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

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## 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 | | |
| Thryroid 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:**

______________________________

______________________________

______________________ X ______________________ ______________
Print Name Signature Date

______________ ______________ ______________________ ______________
Age Weight Height Gender

*Office Use only:* *Reviewed:* ___________ *ASA:* ___________

**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.

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.

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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.

__________ Initials

## 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

__________

Initials