Michele C DeVito MD FACS
8591 E. Bell Rd. Suite 102
Scottsdale AZ 85260

T 480.889.3000
F 480.889.1900
www.devitomd.com

DeVito Plastic Surgery

Patient Information

Patient Name: _____ SSN # _____-_____-_____

Age: _____ Date of Birth: ____/____/_____ Gender: F M Marital Status: S M D W

Address: _____ City: _____ St: ____ Zip: _____

Home: (_____) _____ Cell: (_____) _____ E-mail: _____

Preferred method of contact: _____

Appointment confirmation preferred method: □ Phone □ E-mail □ Text □ Other: _____

Referred By: □ Website □ Internet Search □ Friend/Family □ Other: _____

Reason for Visit: _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____ Phone: (_____) _____

City: _____ State: _____ Zip: _____

Employer

Employer: _____ Phone: (_____) _____

Address: _____

Primary Insurance Company

ID # _____ Policy # _____ Group # _____

Address: _____ City: _____ St: ____ Zip: _____

Policy Holder: _____ Rel to pt: _____ SSN: _____-_____-_____

Policy Holder DOB: ____/____/____ Address: _____

Primary Care Dr: _____ Phone: (_____) _____

I verify that the above information is accurate to the best of my knowledge.

Signature: _____ Date: _____

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Health History

Patient Name: _____ Date: _____

Family History

Have any blood relatives had any of the following (please check all that apply):

Breast Cancer	____	High Blood	____	Kidney Disease	____
Melanoma	____	Heart Disease	____	Depression	____
Stroke	____	Diabetes	____		

Personal Past Medical History

Have you ever had any of the following (please check all that apply):

Heart Disease	____	Cancer	____	Stomach Ulcer	____
High Blood Pressure	____	Glaucoma	____	Kidney Disease	____
Rheumatic Fever	____	Asthma	____	Anemia	____
Thyroid Disease	____	HIV or AIDS	____	Stroke	____
Bleeding Disorder	____	Diabetes	____	Hepatitis	____
Tuberculosis	____	Arthritis	____		
Mitral Valve Prolapse	____	Large Scars/Keloids	____		
Treatment / advised to seek psychiatric care	____	Significant Emotional Problems	____		

Other: _____

Women Only

Date of Last Mammogram: _____ Do you do regular self breast exams? Y / N
Number of pregnancies: _____ Did you breast feed? Y / N

List Any Previous Surgeries/Date

List Any Medications You Are Taking (including non-prescription drugs, vitamins, supplements)

Are You Allergic to Any Medications? (if so, please list below)

Do you smoke: Y / N **How much (per day): _____**
How many years: _____ **Former smokers – date quit: _____**
Do you drink: Y / N **How much: _____**

I verify that the above information is accurate to the best of my knowledge.

Signature: _____ Date: _____

Office Use Only:

Ht: _____ Wt: _____ BP: _____ Pulse: _____ Resp: _____

Chief Complaint:

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Patient Name: _____ Date: _____

Please check the appropriate non-prescription items below that you are currently taking:

_____ Multiple Vitamins If so, how many per day: _____

_____ Diuretic If so, name & dosage: _____

_____ Weight Loss Products If so, which ones: _____

_____ Energizer Products If so, which ones: _____

_____ Muscle Bulking Products If so, which ones: _____

_____ Vitamin E

_____ Ephedra/ Ma Hung

_____ Fish Oil

_____ St John's Wart

_____ Gingko Biloba

_____ Melatonin

_____ Echinacea

_____ Other: _____

_____ Zinc

_____ Garlic

_____ Ginseng

_____ Bromelain

_____ Ibuprofen

_____ Aspirin

_____ Arnica

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Patient Name: _____ Date: _____

My Appearance Concerns Are:

_____ Wrinkles
_____ Skin Texture
_____ Thin Lips
_____ Acne
_____ Skin Elasticity
_____ Sun Damage/Age Spots
_____ Skin Tone
_____ Acne Scars
_____ Enlarged or Clogged Pores
_____ Frown Lines
_____ Other Scarring
_____ Other: _____

I would be interested in knowing more about the following:
(check all that apply)

_____ Professional Skin Care Treatment Products

_____ Soft Tissue Fillers (Belotero, Juvederm, Perlane, Prevelle, Restylane, Radiesse, Sculptra and Artefill)

_____ Neurotoxin Treatments (Botox, Dysport and Xeomin)

_____ Acne Treatments

_____ Facials
_____ Facial Waxing
_____ Chemical Peels
_____ Laser Resurfacing
_____ Skin Tightening Treatments
_____ Laser Hair Removal
_____ Sunscreen Advice
_____ Skin Care Advice

Please list the skin care products you currently use:

_____

_____

Do you use sunscreen regularly? **Y / N** If Yes, what SPF? _____

We offer a wide variety of Surgical Procedures, In-Office Spa Treatments, & Professional Skin Care Products. Please inform our staff if we may assist you with any further questions regarding any of our services*

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS INFORMATION CAREFULLY.

The Department of Health and Human Services has established a "Privacy Rule" (HIPAA) to help ensure that personal healthcare information is protected for confidentiality. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patients' consent for uses and disclosures of health information about the patient with the purpose of carrying out treatment, payment and other healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum information to only those we feel are in need of your healthcare information. This may include information about treatment, payment, or other healthcare operations, in order to provide healthcare that is in your best interest.

We support full access to your personal medical records. We may perhaps have indirect treatment relationships with you (such as laboratories that exclusively interact with physicians and not patients), and may have to disclose personal health information for purposed of treatment, payment, or healthcare operations. These entities are most often not requires to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, however, this refusal must be in writing. Under this law, we also have the right to refuse to treat you should you in fact choose to refuse to disclose your personal health information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. Still you may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy note, to request restrictions and revoke consent in writing after you have reviewed our privacy policy notice.

I have read and understand this notice regarding Patient Privacy.

Print Name: _____ Signature: _____

Date: _____/_____/_____

□ I wish to receive a copy of this Patient Privacy Notice

□ I decline a copy of this Patient Privacy Notice

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Financial Policy

Please review this information carefully. Your clear understanding of our Financial Policy is extremely important to our patient/provider relationship. Should you have any questions, please ask our staff.

Cosmetic Consultation Fees range from $50-150 depending on the length and complexity of the consultation. In most cases this fee may be applied as a credit towards your surgery.

Surgery Fees
Following your consultation, you will be given a cosmetic surgery cost estimate. In order to schedule a surgery date, we require a **$500.00 non-refundable** scheduling fee. Your surgery will not be scheduled until this fee is received. Your remaining balance is due no later than 2 weeks prior to your surgery date, and must be paid in full before your pre-operative appointment. Should payment not be received by this time, your surgery will be cancelled. **Surgical Facility Fees** are due the day of your surgery and **Anesthesia Fees** are due 5 days prior to your surgery. You will be held responsible for any extra anesthesia or facility fees incurred due to an overage as well as any necessary lab or pathology fees.

Cancellation/Rescheduling
In the event that you decide to cancel your surgery, **no refunds will be given**.
Should you need to reschedule due to a true medical emergency, we must be provided with **documentation from your Physician** and you may reschedule your procedure **within 90 days of the original date of surgery**.

Injectable Fees
In order to schedule an appointment with Dr. DeVito for neurotoxins and/or soft-tissue filler injections, our office requires a **$250.00 non-refundable** deposit. This deposit holds your appointment time and will be applied towards your total for injections.

Insurance
It is not the responsibility of DeVito Plastic Surgery Center to know your benefits. Please come prepared with complete and accurate insurance information and necessary referrals for a specialist. All co-pays and deductibles are due at the time that service is rendered. In the event that your insurance company does not pay, we reserve the right to transfer balances to your responsibility.

Authorization to Release Information and Assignment of Benefits
By signing below, I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and the signature will bind me as though I personally signed the claim. I also authorize the release of my medical information as necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees.

Payment Options
We accept cash, check, debit, Visa, MasterCard, Discover and American Express.
Additional financing options are available through www.CareCredit.com and www.SurgeryLoans.com.
**Please note that payment for services or procedures is subject to an administrative processing fee when credit cards or outside financing are used.

I have read, understand, and agree with the Financial Policies of DeVito Plastic Surgery Center.

Signature: _____ Patient/Payor Name: _____

Witness: _____ Date: _____