IRA PAPEL, MD
THEDA KONTIS, MD
EMILE BROWN, MD
AESTHETIC CENTER AT WOODHOLME

1838 Greene Tree Road Suite 370
Baltimore, MD 21208
(410) 486-3400

Patient Information

Patient Name _____
First *M.I.* *Last*

Address_____
Street & Apt # *City* *State* *Zip*

Home Phone _____ Cell Phone _____

Email _____

Any restrictions contacting you? ☐ Yes ☐ No *Contact Restrictions:* _____

Birthdate _____ Gender: ☐Male ☐Female ☐Non-Binary ☐Other _____

Primary Care Physician: _____

Marital Status: ☐Single ☐Married ☐Partner ☐Widowed

Race/Ethnicity: ☐White ☐Black or African-American ☐Hispanic or Latino ☐Asian ☐American Indian or Alaskan Native ☐Native Hawaiian or Pacific Islander ☐Other: _____ ☐Decline to Provide

Primary Language Spoken: _____

Patient's Employer _____ Occupation _____

Address _____
Street & Apt # *City* *State* *Zip*

Primary Health Insurance:_____

Insured Name (If not patient):_____ DOB:_____ Employer:_____

Secondary Health Insurance: _____

Insured Name (If not patient):_____ DOB:_____ Employer:_____

Emergency Contact_____ Relationship to Patient_____

Home Phone_____ Cell Phone_____ Work/Other Phone_____

I, the undersigned, consent to the use and disclosure of my protected health information for treatment, payment and operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act (HIPAA) without a written authorization. I accept that I am financially responsible for all services rendered on my behalf by the Aesthetic Center at Woodholme. For those insurance plans for which the practice accepts assignment, I accept personal responsibility for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage, and I agree to pay co-payments, deductibles and non-covered services, as dictated by my insurance coverage, and I agree to pay co-payments at the time of service. I authorize payment directly to Facial Plastic Surgicenter for services for which the practice accepts assignment. A copy of this agreement may be used in place of the original. I certify that the information stated on this form is correct.

*Signature*_____ *Date* _____

Patient or Legal Guardian ONLY
(Okay to type signature)

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Health Information

Patient Name _____

Reason for Visit: _____

Age: 53 Height:_____feet_____inches Weight:_____lbs.

Who referred you to our practice?_____

Do you have or have you had any of the following? **If None Check Here** ☐

- ☐ Abnormal Bleeding
- ☐ Arthritis
- ☐ Asthma
- ☐ Breast Cancer
- ☐ Cancer (other)_____
- ☐ Chest Pain
- ☐ Diabetes
- ☐ Fever Blisters
- ☐ Hay Fever/Allergies
- ☐ Headaches/Migraine
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Kidney Disorder
- ☐ Sinus Problems/Infections
- ☐ Skin Cancer
- ☐ Skin Disease
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcers (Gastric)
- ☐ Other _____

List ALL (Prescription and Over-the-Counter) medications you are currently taking or have taken within the last month: ☐ No Current Medications

Medication:_____Dose:_____ Medication:_____Dose:_____

Medication:_____Dose:_____ Medication:_____Dose:_____

Medication:_____Dose:_____ Medication:_____Dose:_____

Medication:_____Dose:_____ Medication:_____Dose:_____

Medication:_____Dose:_____ Medication:_____Dose:_____

Medication:_____Dose:_____ Medication:_____Dose:_____

List All Medication Allergies:

☐ No Known Allergies ☐ Latex Allergy

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

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Health Information

Surgical History: List all surgeries and **Date** of occurrence, **especially cosmetic procedures**:

_____ Date:_____ _____ Date:_____

_____ Date:_____ _____ Date:_____

_____ Date:_____ _____ Date:_____

_____ Date:_____ _____ Date:_____

Do you have any personal or family history of problems with Anesthesia? ☐Yes ☐No

If yes, describe: _____

Social History:

Do you smoke or vape currently? ☐Yes ☐No If yes, how much? _____

Are you a former smoker? ☐Yes ☐No If yes, date quit? _____

Alcohol Use: ☐No Alcohol Use ☐Alcohol Use Socially ☐Alcohol Use Daily

Recreational Drug Use: ☐Yes ☐No If yes, describe:_____

Do you…..

Take Aspirin daily?	☐Yes	☐No	Dose _____
Have bleeding/bruising problems?	☐Yes	☐No	If yes, describe: _____
Have problems with scarring?	☐Yes	☐No	If yes, describe: _____
Have a history of fever blisters?	☐Yes	☐No	

Women only:

Are you pregnant or lactating? ☐Yes ☐No

The above information is accurate and complete to the best of my knowledge.

Signature_____ Date_____

(Okay to type signature)

Aesthetic Center at Woodholme

Ira D. Papel, M.D., F.A.C.S.
Theda C. Kontis, M.D., F.A.C.S.
Emile N. Brown, M.D.
Leslie B. Papel, Au.D., F.A.A.A.

1838 Greene Tree Road Suite 370
Baltimore, MD 21208
(410) 486-3400

This notice describes how your medical information may be used and disclosed and how you can get access to this information.
Please review carefully.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for examples, home or cell phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice - You can request a paper copy of this notice at any time.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information above.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

I acknowledge that I have read and received the Practice's Privacy Notice.

_____	_____	_____
Printed Name	Signature (Okay to type)	Date

OUR USES AND DISCLOSURES

We typically use or share your health information in the following ways:

Treat you

We can use your health information and share it with other professionals who are treating you.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Sign-in-sheet

The practice may use a sign in sheet at the registration desk. The practice may also call your name in the waiting room when your physician is ready to see you.

Appointment Reminder

The practice may contact you to provide appointment reminders.

On Call Coverage

In order to provide on-call coverage for you, it is necessary that the practice establish relationships with other physicians who will take you call if a physician from the practice is not available. Those on-call physicians will provide the practice with all health information that they create and will, by law, keep your health information confidential.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information visit:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

To obtain more information on, or have your questions about your rights answered you may contact the practices Privacy Officer at 410-486-3400.

Effective Date This Notice is in effect as of July 1, 2006
Updated April 29, 2015

The Office for Civil Rights and Office of the National Coordinator for Health Information Technology collaborated to develop this Notice of Privacy Practices.
http://www.hhs.gov/ocr/privacy/hipaa/modelnotices.html

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AESTHETIC CENTER AT WOODHOLME

STANDING AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH DESIGNATED PERSONS
*All items on this authorization must be completed or the request will not be honored. Use N/A if not applicable.

Patient Name: _____
(First) (Middle Initial) (Last)

For this authorization, "My Health Information" means any and all information relating to my course of examination and treatment. Including general information and inquires, arranging appointments, identifying medications, discussing billing and payment, insurance and any other related matter.

I authorize Drs. Papel, Kontis & Brown to discuss My Health Information with:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone Number: _____ Phone Number: _____

☐ I refuse permission to disclose my heath information to anyone with the exception of my primary care physician and/or referring physician.

I understand that:

- This authorization is voluntary. My treatment will not be impacted, no matter if I sign this authorization or not.
- If I do not sign this authorization, the Aesthetic Center at Woodholme will not disclose my health information, with the exception of my primary care physician and/or referring physician.
- This authorization is valid for as long as you are a patient with the Aesthetic Center at Woodholme.
  If you wish to revoke this information you must request to fill out another authorization with updated information and a new signature.
- Once my health information is disclosed as requested, it may no longer be protected by federal and state privacy(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature of Patient only: _____ Date: _____
(Okay to type signature)

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1838 Greene Tree Rd. Suite 380
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(410) 486-7371

Consent for All Laser Procedures:

Name: _____

All Laser Patients *(Circle correct answer for each question)*:

- Do you have skin/auto-immune/photo dermatitis issues ☐Yes ☐No
  - If yes, please explain: _____
- Do you have any implants, including IUD, dental and/or a pacemaker? ☐Yes ☐No
  - If yes, please explain: _____
- Do you take aspirin, ibuprofen, vitamin E, or other blood thinners? ☐Yes ☐No
  - If yes, how recently? _____
- Have you undergone chemotherapy or radiation in the past? ☐Yes ☐No
- Do you experience Herpes or cold sore breakouts? ☐Yes ☐No
- Do you have an allergy to Gold? ☐Yes ☐No
- Do you develop keloids (Raised, Bumpy scars)? ☐Yes ☐No
- Have you had an injury to the skin in the area to be treated? ☐Yes ☐No
- If yes, what describe injury _____
- Have you been on Accutane in the last 6 months? ☐Yes ☐No
- Do any of your skin care products contain the following:
  Retinoid and/or Hydroquinone, alpha hydroxyl acids, glycolic acids? ☐Yes ☐No
  - If yes, when was the last time you used the product? _____
- Do you have any tattoos or permanent make up? ☐Yes ☐No
- Are you on any medication that may make you sensitive to sunlight? ☐Yes ☐No
- Have you been sunburnt in the past two weeks? ☐Yes ☐No
- How often do you wear sunscreen? ☐Daily ☐When outside ☐Never
- Do you/have you ever used a tanning bed? ☐Yes ☐No
  - If yes, when was the last time you spent any time in a tanning bed? _____
- Do you currently have a self-tanner on the area to be treated? ☐Yes ☐No

Skin Procedure History:

Microdermabrasion	☐Yes ☐No	When? _____		Botox/Filler	☐Yes ☐No	When? _____	
Chemical Peel	☐Yes ☐No	When? _____		Thermage	☐Yes ☐No	When? _____	
Laser Resurfacing	☐Yes ☐No	When? _____		Fraxel	☐Yes ☐No	When? _____	
Laser Hair Removal	☐Yes ☐No	When? _____		Sclerotherapy	☐Yes ☐No	When? _____	
Waxing/Threading	☐Yes ☐No	When? _____		Facial	☐Yes ☐No	When? _____	
IPL/Photo facial	☐Yes ☐No	When? _____					

I understand and give consent to be ***charged $50.00*** for a ***NO SHOW*** fee or I ***FORFEIT*** a treatment of a package already purchased if I ***DO NOT*** call ***within 24 hours*** to reschedule or cancel my appointment. Please Initial (OK to type): _____

*****ALL LASER PACKAGES ARE NON-REFUNDABLE*****

I give consent for photographs to be taken before, during and after treatment, and give my permission for use of these photographs in scientific presentations, medical publications, and to be placed on the internet for marketing purposes. ☐YES ☐NO

By signing this form, I acknowledge that blistering, burning, scarring, hyperpigmentation (darkening of the skin), and hypopigmentation (lightening of the skin) are possible risks of all laser procedures. I understand that these risks increase with sun exposure and changes in medication.

_____ _____

Client Signature (Okay to type) Date

Revised 5/8/2020

Fitzpatrick Skin Scale

Name: _____ Date: _____

The success of your treatment is partly dependent on the correct typing of your skin. Your treatment provider will consider your skin type when planning your treatment program for most aesthetic procedures, including hair removal, vein therapy, and skin rejuvenation.

Skin type is often categorized according to the Fitzpatrick Skin Scale which ranges from very fair (Skin type I) to very dark (Skin type VI).

In addition, recent tanning (sun bathing, artificial tanning, or tanning creams) have a considerable impact on the evaluation of your skin color.

Help us determine your skin type so we can treat you effectively and appropriately. Please take a few moments to fill out this questionnaire.

Genetic Disposition (Please circle one per question)

Score	0	1	2	3	4
What is your natural eye color?	Light Blue, Light Gray, Light Green	Blue, Gray, Green	Blue	Brown, Hazel	Brown/Black
What is the natural color of your hair?	Sandy, Red	Blonde	Light Brown, Dark Blonde	Brown	Black
What is the color of your skin (Non-exposed areas)?	Pink, Reddish	Pale	Beige	Light Brown, Olive	Dark Brown
Do you have freckles on Non-exposed areas?	Many	Several	Few	Incidental	None

Reaction to Sun Exposure (Please circle one per question)

Score	0	1	2	3	4
What happens to your skin when you stay in the sun too long?	Painful Burning, Blistering, Peeling	Red Burns, Often Followed by Peeling	Burns, Sometimes Followed by Peeling	Rarely Burns	Never Burns
To what degree do you turn brown?	Hardly, or Not at All	Light Tan	Reasonable, Average Tan	Tans Very Easy	Tans Quickly Dk. Brown
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to sun exposure?	Very Sensitive	Sensitive	Normal	Very Resistant	No Reaction

Tanning Habits (Please circle one per question)

Score	0	1	2	3	4
When did you last expose your body to sun, or artificial tanning?	More than 3 months ago	2-3 Months Ago	1-2 Months Ago	Less than 1 Month Ago	Less than 2 weeks ago
Do you currently have self tanner in the areas to be treated?	Yes	No			

Total Score: Genetic Disposition	
Total Score: Reaction to Sun	
Total Score: Tanning Habits	
Total Skin Type Score	

Skin Type Score	Fitzpatrick Skin Type
0-3	**I**
4-12	**II**
13-21	**III**
22-26	**IV**
Over 27	**V-VI**

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AESTHETIC CENTER AT WOODHOLME
1838 Greene Tree Road, Suites 370 & 380
Baltimore, MD 21208

Patient Financial Policies

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies. Many of our patients have health insurance or other medical benefits that are provided through a private insurance company or other program.

If you do not have any medical benefits…Full payment is due at the time we provide services unless we have agreed to different arrangements in advance and in writing.

If you have medical benefits, but your health plan determines a service we provide is "not covered" by your benefits…You will be responsible for the full cost of the service. If your health plan pays part of the cost, we may require you to pay the balance or any co-pays that are due. Payment will be due upon the receipt of our bill.

Please note that we reserve the right to…

- Require patients to pay a non-refundable deposit at the time of scheduling certain procedures.
- Submit any patient account with a balance older than 30 days to a collection agency, and to require the patient pay all legal fees and collection costs we incur.
- Charge a fee of $50.00 for each returned check.
- Charge a fee for services that do not directly involve patient care, such as preparing workers compensation forms, disability forms, and other written correspondence for patients.
- Charge a fee for a missed appointment or failure to cancel within 24 hours.
- Amend these policies from time to time.

Patient Acknowledgement:

I have read and understand Aesthetic Center at Woodholme's financial policies set forth above, and I agree to be bound by such policies, as they may be amended from time to time.

_____

Signature of patient (or responsible person) Date

_____

Please print name of patient