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

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
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(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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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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SKINCARE DIVISION HISTORY – Today's Date: _____

Patient Name: _____ Ethnic Background: _____ Age: _____

Occupation: _____ Do you work? ☐ Inside ☐ Outside
☐ Travel by car ☐ Travel by plane If so, how often?_____

Outside activities: (gardening, outdoor sports, golf, swimming, running, **boating**, etc.)
Please list:_____
Do you work out/exercise? ☐No ☐Yes Type:_____

Present skin concerns - Please check all problems that apply:
☐Pimples ☐Pustules ☐White Heads ☐Black Heads ☐Cysts ☐Oily Skin ☐Dry Skin
☐Uneven Texture ☐Enlarged Pores ☐Scars/Keloids ☐Hypopigmentation (color loss)
☐Hyperpigmentation ☐Rosacea ☐Broken Blood Vessels ☐Psoriasis ☐Eczema
☐Melasma ☐Brown Spots ☐Under Eye Darkness ☐Fine Lines ☐Wrinkles ☐Sagging Skin
☐Sun Damage ☐Ingrown Hairs ☐Shaving Rash

Are you currently being treated by a Dermatologist? ☐No ☐Yes
Reason: _____

Have you been treated by a Dermatologist in the past? ☐No ☐Yes
Reason: _____

Rx: Have you used a medication specifically for treating the skin? ☐No ☐Yes
☐Retin A/Tretinoin ☐Differin ☐Tazorac ☐ Accutane ☐ Bleaching/Hydroquinone
☐Oral Antibiotic: _____ ☐Other:_____

Rx: Do you use a prescription topical agent on your face presently? ☐No ☐Yes
Reason: _____

Rx: Are you allergic to any topical products or ingredients? ☐No ☐Yes
Please list: _____ Do you have asthma? ☐No ☐ Yes

Skin Cancer: ☐No ☐Yes Type: _____ Area: _____
When?_____ Treatment/Results: _____

Hormones: Are you: ☐Pregnant ☐Lactating ☐Taking birth control ☐Regular menstrual cycle
☐In menopause ☐Past menopause, If so, how long? _____ ☐On HRT, Type: _____

Do you use tanning beds? ☐No ☐Yes Do you wax or use facial depilatories? ☐No ☐Yes

Do you take vitamins? ☐No ☐Yes
List: _____

Do you take herbal medicines? ☐No ☐Yes
List:_____

List any cosmetic facial treatments/procedures: _____
_____

Sun Exposure History: **PAST:** Did you live in a sunbelt area? ☐No ☐Yes
PRESENT: Do you wear SPF (UVA/UVB) now? ☐No ☐DAILY ☐ ONLY IN THE SUN

Fitzpatrick Scale: What happens to your skin when exposed to the sun?

PAST: When exposed in the past, I would . . .
☐**I** Burn
☐**II** Usually burn, never tan
☐**III** Sometimes burn, then tan
☐**IV** Rarely burn, usually tan
☐**V** Always tan
☐**VI** Never burn

PRESENT: When exposed currently, I . . .
☐**I** Burn
☐**II** Usually burn, never tan
☐**III** Sometimes burn, then tan
☐**IV** Rarely burn, usually tan
☐**V** Always tan
☐**VI** Never burn

Present Skin Care Routine
Morning: _____
Night: _____