ESTHETICA
center for cosmetic surgery

PATIENT INFORMATION FORM

Patient Name:
Telephone Number: Home/Cell:
Address:
City: State: Zip code:
Email address:
How do you prefer to be addressed?
How would you prefer that we contact you? ☐ Home ☐ Cell ☐ Email
Date of Birth: **Age** **Sex:** M F **SSN:**
Marital Status: **Student?** N Y ☐ Full-Time ☐ Part-Time
Patient Employer: **Employer Address:**
City: State: Zip:
Allergies: **Reaction:**
Emergency Contact
Name: **Phone number:**
Relationship:
****If urgent matter arises may we call your emergency contact?** ☐ Yes or ☐ No **Initials:**
Who referred you to us? ☐ Friend / Name _____ May we thank them? ☐ Yes ☐ No ☐ Google ☐ Facebook ☐ Instagram ☐ Physician ☐ Other _____
Who is your primary care physician?

FINANCIAL AGREEMENT

All patients are expected to pay in full on the day of service.

PLEASE READ AND SIGN THE FOLLOWING
I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize Dr. Kouli to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ Date: _____

Esthetica of San Diego Del Mar
Del Mar Cosmetic Center
Wael Kouli MD, FACS
12845 Pointe Del Mar Way Suite 100
Del Mar, CA 92014
(858) 350-8400

ESTHETICA
center for cosmetic surgery

Cosmetic Patient Questionnaire

Name	Today's Date	Date of Birth	Age
What procedure(s) are you interested in?			
How long have you been thinking about this?			
Has anything happened recently to stimulate your interest in having this done at this time?			
What do you expect this surgery/procedure to do for you?			
Have you discussed this with your spouse, family and/or friends? Y N	❑ Spouse	❑ Family	❑ Friends
What was their opinion?	❑ Very supportive ❑ Against it	❑ Supportive ❑ Very much against it	❑ Uncommitted ❑ Other
Other family/friends comments			
Have you seen another doctor about this? Y N	What did the doctor suggest? Y N		
Have you visited our web site? Y N Did our web site influence your decision to see us? Y N			
When are you thinking of having this procedure done?	❑ ASAP	❑ 1-3 weeks	❑ 4-8 weeks ❑ 2-6 months
Do you have any concerns about having this surgery/procedure?			
Have you ever had any other cosmetic surgery/procedure(s)? Y N	What	Doctor	Year
What qualities do you consider most important in your choice of the doctor, staff, and facility to do your surgery/procedure?	❑ Quality ❑ Safety ❑ Results ❑ Guidance	❑ Trust ❑ Experience ❑ Financing ❑ Price	❑ Confidence ❑ Reputation ❑ Convenience ❑ Board Certification ❑ Superior Facilities
How will you pay for your surgery/procedure?	❑ Cash	❑ Check	❑ Credit card ❑ Financing
How much do you expect this surgery/procedure to cost?			
Have you ever filed a lawsuit against any physician for any reason? Y N			

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PATIENT INFORMATION

(This information is necessary for our files and will be considered CONFIDENTIAL)

Date_____ Chart #_____

Medical History

Name of Physician_____ City_____ Phone_____

Do you have a current or chronic medical problem? Yes_____ No_____

Please explain_____

Date of Last Medical Exam_____

Have You Ever Had Any of The Following? (Please check the following.)

____Major Operation. Explain_____

____Heart or blood vessel problems: ____ Heart Surgery ____Pacemaker ____Prosthetic Valve____Bypass
____ Heart Attack ____Heart Murmur ____Angina, chest pain or tightness ____ Valve Defect
____High Blood Pressure. Dates? _____
Other Condition(s)_____

____Rheumatic Fever Date_____

Lung or Respiratory Condition: ____ T.B. Date _____ ____ Emphysema ____Asthma
____Hay Fever ____Sinus trouble ____Other_____

____Shortness of Breath

____Liver Condition ____Jaundice ____ Hepatitis: Type____ Date_____ Kidney Disease_____

Positive HIV Test: Date_____ symptoms_____

____Arthritis: Type _____Locations_____ ____Hip or Joint replacement

____Nervous System Disorder: ____Stroke: Date _____ ____ Fainting Spells
____ Epilepsy ____ Seizure Disorder ____ Convulsions ____ Other_____

____Glaucoma

____Chronic Stomach upset ____Ulcer ____Gastritis: ____Eating Disorder_____

____Diabetes

____Blood Disease: ____ Bleeding Disorder _____ Leukemia ____Anemia

____Tumor or Cancer: Type_____ Date_____

Treatment_____

____Serious injury to the head or neck (explain)_____

____ Rash, Hives or other skin problems (explain)_____

Are You Now Taking Medication?

____Thyroid Medication
____Heart or Blood Pressure Medication
____Diuretics
____Anticoagulants
____Diabetes Medication: ____Shots ____Pills
____Vitamins, herbs or minerals, weight loss supplements
____Any other medication List Medication(s) and dosage_____

____Aspirin, ____Ibuprofen, ___Tylenol
____Hormones (including birth control)
____Pain Medication
____Antibiotics
____Allergy Medications
____Cortisone (steroids)

Are You Sensitive To, Allergic To, Or Been Told Not To Take:

____Antibiotics: ____Erythromycin ____Tetracycline ____ Penicillin
____Codeine ____Aspirin ____Epinephrine (adrenalin) ____ Other Drugs or Medicines (please specify)

_____

Do You Have Any Non-Drug Allergies? (List)_____

Women: Are you pregnant? ____Yes ____No Due Date_____
Do you have any hormonal problems? _____
Do You Have Any Disease, Condition Or Problem Not Listed That You Think We Should Know About?_____

_____

_____

Notice of Privacy Practices

Date of Last Revision: 4/26/2023

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY THE PRACTICE, WHETHER MADE BY THE PRACTICE OR AN ASSOCIATED FACILITY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of our medical practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorization to use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to remind you of an appointment.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights
You have certain rights under the federal privacy standards. These include the following and are explained in greater detail in the PATIENT RIGHTS section of this notice:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Duties of the Practice
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, changes in our policies and practices will only be done so as per changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our receptionist or privacy officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints, Comments &Questions
If you would like to submit a comment, a complaint, including those regarding, health care decisions, quality of care, patient safety, informed consent, payment, and cost of care issues please inform the practice manager. Conflicts shall be resolved in an orderly and expeditious manner.

Wael Kouli, M.D., FACS
Veronica Rodriguez/Katie Hamp, Practice Managers
12845 Pointe Del Mar Way, Suite 100
Del Mar, CA 92014

Tel. (858) 350-8400

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint. The office manager, upon receipt of the complaint or upon obtaining knowledge of the fact that a patient has complained, will document how the complaint was investigated and document appropriate action to resolve the complaint. The patient will be notified of the result of the investigation by phone within 30 days of initial complaint.

Patients may also contact our accrediting agency, ***AAAHC*** or the ***Medical Board of California*** at:

AAAHC
5250 Old Orchard Road, Suite 200
Skokie, IL 6077
847-853-6060

Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
1-800-633-2322

PATIENT RIGHTS

THIS SECTION DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THIS PRACTICE REGARDING THE USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION.

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy
You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also disclosed.

To inspect and copy your medical record, you must submit your request in writing to our Privacy Officer. Ask the front desk person for the name of the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies (tapes, disks, etc.) associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you will be given a written explanation of the denial of request. You will be also given an opportunity to request a review of that decision by a licensed professional chosen by the practice who was not involved in the original decision to deny the request. The practice will complete this review with 30 days and the results will be communicated to you.

Right to Amend
If you feel that the medical information, we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the Practice maintains your medical record.

To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you. The practice has a specific form available for this purpose.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request to amend it. The amendment must be dated and signed by you. The practice has a specific form available for this purpose.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the medical information kept by or for the Practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is inaccurate and incomplete.

Right to an Accounting of Disclosures
You have the right to request and "accounting of disclosures." This is a list of the disclosures we made of medical information about you, to others.

To request this list, you must submit your request in writing. You request must state a time period not longer than six (6) years back a may not include dates before April 14, 2003 (the actual implementation date of the HIPAA Privacy Regulations). Your request should indicate in what form you want the list (for example, on paper, electronically). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or friend). For example, you could ask that we not use or disclose information about a particular treatment you received.

We are not required to agree to your request and we may not be able to comply with your request. If we do agree, we will comply with your request except that we shall no comply, even with a written request, if the information is accepted from the consent requirement or we are otherwise required to disclose the information by law.

To request restrictions, you must make your request in writing. In your request, you indicate:

- What information you want to limit;
- Whether you want to limit or use, disclosure or both; and
- To whom you want the limits to apply, (e.g., disclosures to your children, parents, spouse, etc.)

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail or e-mail.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all *reasonable* requests. Your request must specify how or where you wish us to contact you.

Advanced Directives

ADVANCE DIRECTIVE NOTIFICATION:

All patients have the right to participate in their own healthcare decisions and to execute Advance Directives or Power of Attorney that authorizes others to make healthcare decisions on their behalf based on the patient's expressed wishes when the patient is unable to make or communicate decisions.

This Center respects and upholds those rights.

However, unlike an acute care hospital setting, we do not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. However, you will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery and care after surgery.

IN THE EVENT OF AN EMERGENCY:

It is our policy to always initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation.

At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or healthcare Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current healthcare directive or healthcare power of attorney.

If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure.

Financial Disclosure

As of January 1, 1995, California law imposes disclosure requirements for physicians who have financial interest in any business to which they refer patients.

In compliance with this law, this is to inform you that, I am the Owner and CEO of The Del Mar Cosmetic Center, Inc., Esthetica of San Diego (Del Mar and Coronado) and Esthetica of Newport, PC and as such, have a financial interest in the facility where your surgery is to be performed. If you prefer your surgery to be performed at another facility, please discuss this with the surgical coordinator and we can make other arrangements for you.

WARNING
This facility contains chemicals known to the State of California to cause cancer, and birth defects or other reproductive harm.

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the:

Medical Board of California
(800) 633-2322
www.mbc.ca.gov

This requirement is the result of a regulation (Title 16, California Code of Regulations section 1355.4) approved by the Medical Board, as mandated by Business and Professions Code section 138. The purpose of this new regulation is to inform consumers where to go for information or with a complaint about California medical doctors.

You will receive a copy of this notice.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Signature
I have read a copy of the Notice of Privacy Practices for Del Mar Cosmetic Center.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient