LEBEAUCLINIC

FACIAL PLASTIC & RECONSTRUCTIVE SURGERY

Name_____ Date of Birth_____Age_____

Home Address _____ Social Security # _____-_____-_____

City_____ State _____ Zip _____

Home phone_____ Ok to leave a detailed message? ☐ Yes ☐ No

Cell phone_____ Email address _____

Work phone_____ Occupation _____

Place of Employment_____

How did you hear about LeBeau Clinic? _____

Has Dr. LeBeau treated anyone you know? Yes ☐ No ☐ Who? _____

Reason for today's Visit: _____

Drug Allergies/Reactions _____

Latex Allergy? Yes ☐ No ☐ Reaction _____

Do you have a history of fever blisters or cold sores in or around your mouth? Yes ☐ No ☐

Current Medications (Prescription and non-prescription drugs with dosage)

_____ _____ _____

_____ _____ _____

Vitamins and Herbs _____

Do you smoke? Yes ☐ No ☐ Packs/day? _____ Do you drink alcohol? Yes ☐ No ☐ How often? _____

Are you pregnant? Yes ☐ No ☐

MEDICAL HISTORY (Please circle those that apply and add additional information pertinent to your history)

High Cholesterol	Cancer	Heart Disease	Asthma
Hepatitis	Diabetes	Liver Disease	Reflux/Heartburn
HIV/AIDS	Hypertension	Stroke	Abnormal EKG
Bleeding Disorder	Thyroid Disease	Anesthetic Complications	Psychiatric Condition

OTHER_____

SURGICAL HISTORY (including cosmetic procedures)

_____

_____

REVIEW OF SYSTEMS (Please circle current conditions)

Global: fever chills weight loss fatigue weakness
Skin: rash itching
HENT: headaches hearing loss ear pain ear discharge nosebleeds congestion sore throat
Eyes: blurred vision double vision light sensitivity eye pain eye discharge eye redness
Cardiovascular: chest pain palpitations leg swelling
Respiratory: cough coughing blood sputum production shortness of breath wheezing
Gastrointestinal: heartburn nausea vomiting abdominal pain diarrhea constipation blood in stool
Musculoskeletal: muscle aches neck pain back pain joint pain
Endo/heme/allergy: bruise easily environmental allergies
Neurological: dizziness tingling tremor sensory change speech change focal weakness seizures
Psychiatric: depression suicidal ideas substance abuse nervous/anxious insomnia memory loss

FAMILY HISTORY Do you have a family history of the following? (Circle all that apply)

Hypertension	Stroke	Thyroid Disease	Diabetes	Cancer	Asthma
Hay Fever	Cancer	Asthma	Hay Fever	Tuberculosis	Bleeding Disorder
Heart Disease	Hepatitis	Hearing Loss	AIDS/HIV	Epilespy	Melanoma
Depression	Respiratory Disease		Kidney Disease		

Other_____

Marital Status: ☐ Single ☐ Married Children Yes ☐ No ☐ # _____

Do we have permission to discuss your medical information with anyone else ? Yes ☐ No ☐

Name _____ Relationship _____ Phone _____

In case of emergency notify:

Name _____ Relationship _____ Phone _____
Preferred Pharmacy _____

Person Financially Responsible: (If different than above)

Name_____ Relationship _____ DOB _____

Social Security # _____-_____-_____ Home phone_____Cell Phone _____

I certify that the above is true and correct and that I have not omitted any information that would hinder my treatment or care by Dr. LeBeau and his staff.

Signed_____Date _____

FINANCIAL RESPONSIBILITY

I understand that I am solely responsible for payment of cosmetic procedures. I also understand that based on the type of service scheduled, payment is required in full prior to or at the time of service.

If my services are submitted to my insurance company, I understand and agree that I am responsible for all insurance deductibles and co-payments. I will be reimbursed for any overpayments made by me. I authorize the release of any protected health information necessary to carry out treatment, payment or health care operations. I also authorize payment of medical benefits, including Medicare benefits, to Dr. LeBeau, the physician rendering the services, in reimbursable amounts as stated in my contract.

Regardless of insurance or litigation, account balances not paid within 60 days are the patient's responsibility. You may pay the balance by cash, check, credit card, or pre-approved payment plan. Unpaid balances will accrue a 6% monthly interest charge and/or a collection fee on delinquent payments beginning 60 days from date of service. Returned checks will have a $25 fee added.

Patient/Guardian Signature: _____Date _____

HIPPA CONSENT

The Department of Health and Human Services has established a "Privacy Rule" to help insure that Personal Health Information (PHI) is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of PHI about the patient to carry out treatment, payment, or health care 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 always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your PHI and information about treatment, payment, or health care operations.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose PHI for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your PHI, but this must be in writing. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice. If you choose to give consent to this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your PHI. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer.

By signing below, you are giving consent to the use or disclosure of your Personal Health Information according to the rules and regulations of the Health Insurance Portability and Accountability Act.

Patient/Guardian Signature: _____Date _____

LEBEAUCLINIC

FACIAL PLASTIC & RECONSTRUCTIVE SURGERY

AUTHORIZATION FOR RELEASE AND USE OF PHOTOGRAPHS FOR PEER REVIEW

NAME:_____ DOB:_____, is a patient of Jacque P. LeBeau, MD ("the treating physician") and has been or will be photographed during the course of treatment. (By the term "photographs," this form also includes digital images.) Those photographs will become part of the medical record in the patient chart. Under the Health Insurance Portability and Accounting Act of 1996 (HIPAA), those photographs may be supplied as part of the medical records to medical specialty boards and hospital medical staffs reviewing the treating physician's credentials under a "Business Associate Contract" prescribed by HIPAA. In addition, the undersigned grants to the treating physician the on-going and unrestricted right to use those photographs (but not the patient'' name) in the following way (check all applicable):

____Use by medical specialty board in formulating its examination of applicant physicians

____Medical research, education, or science

____Professional medical journals, videos, or books

____Patient education purposes, including the treating physician's procedural and general information brochures, newsletters and photo book for prospective patient viewing

____Slides, computer images, website and television media providing information about physician's practice to the interested public (including public relations)

The undersigned acknowledges that the persons to whom the photographs may be disclosed for above stated purposes include other practicing physicians, medical students, health care providers, credentialing organizations (such as the American Board of Facial Plastic and Reconstructive Surgery), and their staffs. Prospective patients and the public may, under some of the above alternatives, also view the photographs. Under HIPAA, if the organization or person authorized to receive the photographs is not a health plan or health care provider, the released information may not be covered by HIPAA's protections from further disclosures or use by federal privacy regulations.

This authorization may only be revoked in writing, signed by the undersigned and delivered to the physician at treating physician's address below. Such revocation shall thereafter be effective as to any further use not already committed to by the physician. Unless earlier revoked, this authorization will expire on the end of the treating physician's practice of facial and reconstructive surgery, except there will be no expiration for the purpose of medical or scientific research or use in specialty-board examinations. Revocation will not affect uses and disclosures made before receipt of the revocation. This authorization is in consideration of services performed and consultations conducted or to be performed or conducted by the physician, and there have been no representations or inducements concerning this authorization except as set forth herein. The treating physician will not condition treatment on whether the individual signs this authorization.

The undersigned may see and copy any photographs described on this form upon request and may receive a photocopy of this Authorization form upon request.

Signed: Dated:

_____ _____

Patient

Witnessed:

_____ _____

LEBEAUCLINIC

FACIAL PLASTIC & RECONSTRUCTIVE SURGERY

AGREEMENT ON RESOLUTION OF CONCERNS

I understand that I am entering into a contractual relationship with Dr. Jacque P. LeBeau and The LeBeau Clinic for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Dr. LeBeau and The LeBeau Clinic I agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against Dr. LeBeau or The LeBeau Clinic.

Should I, initiate or pursue a meritorious medical malpractice claim against Dr. LeBeau or The LeBeau Clinic I agree to use as expert witness (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Facial Plastic and Reconstructive Surgery and the American Board of Laser Surgery.

Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the medical specialty society to which Dr. LeBeau belongs. I agree the expert will be obligated to adhere to the guidelines or code of conduct defined by Dr. LeBeau's specialty society.

I agree to require any attorney I hire and any physician hired by me on my behalf as an expert witness to agree to these provisions.

In further consideration, Dr. LeBeau also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting evidence of a frivolous or meritless claim.

Patient and physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, spouses and other dependents.

Physician and patient agree that these provisions apply to any claim for medical malpractice whether based on theory of contract, negligence, battery or any theory of recovery and is effective from the initial date of treatment.

Patient acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

Patient or Legal Guardian: X _____

Jacque P. LeBeau M.D. X _____

Date: _____

LEBEAUCLINIC

FACIAL PLASTIC & RECONSTRUCTIVE SURGERY

MUTUAL AGREEMENT TO MAINTAIN PRIVACY

Dr. Jacque LeBeau and LeBeau Clinic, (collectively labeled "Physician") agree to maintain Privacy of

_____ ("Patient/Responsible party") as outlined in the HIPAA form. The Physician takes pride in being able to extend a greater degree of privacy than is required by HIPAA, state confidentiality mandates, and common law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, HIPAA forbids physicians from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician believes this is improper and may not be in the patients' best interest. Accordingly, Physician agrees not to provide any list for marketing or be paid for selling patient lists or protected health information to any party for the purpose of marketing directly to patients. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

In consideration for treatment and the above noted patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Physician and his practice, expertise and/or treatment - the sole exceptions being communication to a confidential medical-peer review body; to another healthcare provider; to a licensed attorney; to a governmental agency; in the context of a legal proceeding; or unless mandated by law. Publishing is intended to include attribution by name, by pseudonym, or anonymously. If Patient does prepare commentary for publication about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment is in further consideration for additional privacy protections provided by Physician. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary. Physician has invested significant financial and marketing resources in developing the practice. In addition, Patient will not denigrate, defame, disparage, or cast aspersions upon the Physician; and (ii) will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in any such activity. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage Physician's practice. Physician feels strongly about Patients' privacy as well as the practices' right to control its public image and privacy. Both Physician and Patient will work to prevent the publishing or airing of commentary about the other party from being accessed via Internet, blogs, or other electronic, print, or broadcast media without prior written consent.

Finally, this Agreement shall be in force and enforceable (and fully survive) for a period of the longer of (a) five years from Physician's last date of service to Patient; or (b) three years beyond any termination of the Physician-Patient relationship. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients. Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

SO AGREED THIS _____DAY OF _____, 20_____.

_____ _____

Patient/Responsible Party Physician