



CASCADE FACES

Aesthetics and Facial Plastic Surgery

Patient Name: _____

PATIENT INFORMATION

REASON FOR TODAY'S VISIT: _____

Date of Birth: _____ Gender: Male Female _____ Marital Status: M S W D

Phone (H): _____ Phone (W): _____ ext. _____ Phone (C): _____

Address: _____ City/State: _____ Zip: _____

Email: _____

May we send you updates and information regarding the practice? (Circle) yes or no

May we leave a telephone message? Yes _____ No _____

Notes on preferred method of contact: _____

May we email you product/service special offers, seminar information, or newsletters at this address: Yes No

REFERRED BY: (please specify in the space provided)

Self _____ Relative _____

Bulletin _____ Another patient _____

Magazine _____ Spa/Salon _____

Yellow Pages _____ Employee _____

Friend _____ Other _____

Seminar _____ Physician _____

Website _____ Internet _____

AUTHORIZATION FOR DISCLOSURE/RELEASE OF INFORMATION

I authorize Cascade Faces Aesthetics and Facial Plastic Surgery Center to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Cascade Faces Aesthetics and Facial Plastic Surgery Center determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and if applicable to process the insurance claim for services rendered at Cascade Faces Aesthetics and Facial Plastic Surgery Center.

Signature: _____ Date: _____



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Patient Name: [Patient->Full Name]
Patient Account Number: [Patient->AcctNo]

PREVIOUS SURGERIES OR SERIOUS ILLNESSES

TYPE	YEAR	COMPLICATIONS?	TYPE	YEAR	COMPLICATIONS?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

CURRENT MEDICATIONS

(Include all over the counter and prescription drugs; including aspirin)

DRUG / DOSE	PRESCRIBED BY:	DRUG / DOSE	PRESCRIBED BY:
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES:

Do you have any drug allergies? YES NO

List any medications that you have had a bad reaction to: _____

Do you have any skin product or food allergies? YES NO

List any products/foods that you have had a bad reaction to: _____

PERSONAL INFORMATION

Height: _____ Current Weight: _____ Recent Weight Loss/Gain?: _____ If yes, how much? _____

Do you smoke? YES NO How many packs? _____ Drink Alcohol? YES NO How much? _____
How many years? _____ How Often? _____

HISTORY

Have you had (Injected filler, Collagen, etc.) injections? _____ Last injection? _____

Have you had Botox Cosmetic injections? _____ Last injection? _____

Have you had facial surgery? _____ Type and date: _____

Have you ever had laser resurfacing? _____ Type and date: _____

Have you ever had a chemical peel or dermabrasion? _____ Type and date: _____

Would you like to be contacted by our Medical Aesthetician about non-surgical procedures and treatments? YES NO

Have you had a bad reaction to local or general anesthesia? YES NO If yes, explain _____

Have you had significant emotional problems? YES NO If yes, explain _____



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Have you had psychiatric care? YES NO If yes, explain _____

Patient Name: [Patient->Full Name]
Patient Account Number: [Patient->AcctNo]

Have you seen other plastic surgeons about this same concern? YES NO If yes, explain _____

Do you have high blood pressure? YES NO If yes, explain _____

Do you bleed easily from cuts or surgery? YES NO If yes, explain _____

Do you form large scars or keloids? YES NO If yes, explain _____

Do you have frequent infections, boils or canker sores? YES NO If yes, explain _____

Do you have Glaucoma? YES NO If yes, explain _____

Females:

Have you ever been pregnant? YES NO How many times? _____ Live births? _____

Are you currently pregnant? YES NO Are you planning more children? YES NO

Are you currently breast feeding? YES NO

HAVE YOU HAD ANY SERIOUS ILLNESSES OF THE FOLLOWING? (Please circle)

Brain Nose Heart Blood Extremities Eyes Cancer
Ears Lungs Abdomen Urinary Nervous Diabetes Reproduction

Other

Please explain, if you circled any of the above: _____

I hereby consent to be examined and treated by Michael E. Villano, MD and that the above information is correct.



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SIGNATURE OF PATIENT OR SPOUSE OR RESPONSIBLE PARTY

DATE

Financial Policy

Patient Name: [Patient->Full Name]

Patient Account Number: [Patient->AcctNo]

Thank you for choosing Cascade Faces Aesthetics and Facial Plastic Surgery for your cosmetic needs. Our goal is to make your surgical experience a pleasant one. For your convenience, and to avoid any future confusion, we would like to outline our policies and procedures for you.

CONSULTATION

A **complimentary cosmetic consultation** is scheduled from your initial telephone call. This consultation is designed for you and Dr. Villano to meet and discuss your surgical needs, outline the procedure, and inform you of the fees. If insurance is involved, there will be an office visit charge. Also, if you do not show up for your appointment or do not cancel within 24 hours, you will be charged a 50.00 non-refundable fee.

SCHEDULING

After your consultation, if you decide to go ahead with surgery you will work with our patient care coordinator to select a date for your surgery.

PRE-PAYMENT

There is a \$500.00 or 10% whichever is greater scheduling fee deposit required before the date selected can be reserved exclusively for you. This is a non-refundable deposit. This fee is used to cover the booking and scheduling expenses involved with your surgery. This amount will be deducted from your total cost.

PRE-OP VISIT

Prior to surgery, preferably two (2) weeks, you will meet with the medical assistant and Dr. Villano. Our medical assistant will explain all pre-operative instructions, order lab tests required, review your surgical procedure and post-operative limitations with you, and give you your post-operative prescriptions with instructions for their use. Post-operative appointments are scheduled at this time. Any questions you may have will be answered at this consult.

FINAL PAYMENT

Two (2) weeks prior to surgery, you will be expected to pay the remaining balance due on your account. We accept: Visa, Mastercard, Money Orders, Cashiers Checks. We are sorry but we are unable to accept personal checks for surgery payment.

Cancel Policy: If for any reason, medical or personal, you cancel two weeks or less prior to your scheduled surgery date fees will be charged as follows:

- Two (2) weeks prior to surgery – 10% or \$500 whichever is greater of your surgery fee for expenses incurred.
- One (1) week prior to surgery – 25% of surgical fee
- One (1) day (24 hours) prior to surgery – entire surgical fee.

If you have any questions, the staff will be happy to assist you. We look forward to caring for you.



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Please sign and date.

Financial Guarantor Signature: _____ Date: _____

CONSENT TO TAKING AND PUBLICATION OF PHOTOGRAPHS

By my signature below, I hereby consent to before and after surgery photography for the purpose of documenting my plastic surgery in my medical records maintained in the ordinary course of business by Michael E. Villano, MD LLC. In addition, by checking the appropriate box below, I grant or deny additional limited use(s) of my photographs. For the additional uses, I understand that my name will not be revealed and my photographs will be carefully edited to remove or obliterate personal identification marks. Any photographs used will be cropped to focus on the area of the surgery.

Yes No Show my photographs to other patients in Dr. Villano's office.

Yes No Post my photographs on Dr. Villano's website, or web pages in plastic surgery sites displaying Dr. Villano's photos.

Yes No Use my photographs to illustrate lectures and presentations to an audience of medical professionals, and to illustrate scientific journal articles or books for medical professionals.

Yes No Use my photographs to illustrate newspaper and magazine articles featuring Dr. Villano, or to illustrate presentations or lectures by Dr. Villano to the general public.

All photographs will be taken only with the approval of Dr. Villano, and under such conditions and at such times as may be approved by Dr. Villano. Photographs may be taken by Dr. Villano, or by an employee or photographer selected by him who has signed a confidentiality agreement concerning patient medical records.

NAME OF PATIENT (PRINT)

SIGNATURE OF PATIENT OR GUARDIAN (IF PATIENT IS UNDER 18)



Acknowledgment and Consent

I understand that **Michael E Villano, MD**
(referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I acknowledge that I have been informed that at times, new information about the practice may be promulgated via e-mail. I have the right to refuse receiving this information at any time by notifying the practice in writing.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____ (Patient)	Date: _____
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-OR-

By: _____ (Patient representative)	Date: _____
Description of Representative's Authority _____	