history and physical

Name: _____ Date: _____

social:

Age: _____ **Sex**: ☐ M ☐ F **Married**: ☐ Yes ☐ No **Occupation**: _____

Responsible adult available to assist during recovery period: ☐ Yes ☐ No **Relationship**: _____

habits:

☐ **Smoke**, Amount _____ ☐ **Coffee/Tea/Cola**, Amount _____

☐ **Alcohol**, Amount _____ ☐ **Daily Exercise**, Amount _____

medications:

List dose or number of pills per day

Prescription Drugs

_____

_____

_____

_____

Non Prescription (Vitamins; Herbs)

_____

_____

_____

_____

☐ **Regular Aspirin Use**, Dosage & frequency _____

☐ **NSA (Advil, Motrin, Ibuprofen)**, Dosage & frequency _____

☐ **Cortisone Injections Past Year**, Date(s) and injection location _____

☐ **Drug Allergy**, List drug(s) and type of reaction _____

_____

☐ **Latex Allergy** ☐ **Tape Allergy**

family history:

Have any blood relatives ever had the following problems:

☐ Abnormal Bleeding ☐ Diabetes ☐ Cancer ☐ Tuberculosis

☐ Coronary Surgery ☐ Anesthetic Problems ☐ Hypertension ☐ Other Serious Illness

☐ Abnormal Clotting ☐ Heart Attack ☐ Kidney Disease

Please describe questions with a checkmark _____

_____

women patients only:

Number of pregnancies ____ Number of children ____ Last menstrual period ____ Did you breast feed? ☐ Y ☐ N

Bra size _____ Last MMG _____ Results _____ Additional breast studies _____

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beauty@drsimonplasticsurgery.com | www.drsimonplasticsurgery.com

personal past history:

Have you ever had:

- ☐ Abnormal Bleeding
- ☐ Abnormal Clotting
- ☐ Acid Regurgitation
- ☐ Anemia
- ☐ Angina
- ☐ Asthma
- ☐ Diabetes
- ☐ Fainting Spell
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Weight Change past 12 months
- ☐ Other Serious illness

Please describe questions with a checkmark _____

_____

Have you ever received a transfusion? ☐ Yes ☐ No **If yes, what year**? _____

Have you been tested for HIV? ☐ Yes ☐ No **If yes, what year**? _____ **Result**: ☐ Positive ☐ Negative

Do you wear:

- ☐ Contact lenses
- ☐ Eye glasses
- ☐ Hearing aid
- ☐ Dentures

Previous Surgery, year and type of procedure _____

_____

Indicate the type(s) of anesthesia received in the past, list any complications / reactions you experienced:

- ☐ **Local anesthesia** - (complications/reactions): _____
- ☐ **General anesthesia** - (complications/reactions): _____
- ☐ **Spinal / Epidural** - (complications/reactions): _____

Date last seen by Primary Care Physician _____ **Primary Care Physician** (name) _____

Telephone (____) _____ Address _____

review of systems:

- ☐ Loose Dental Devices
- ☐ Chest Pain
- ☐ Neck Mobility Problem
- ☐ Irregular Heart Beat
- ☐ Short Neck
- ☐ Vomiting
- ☐ Cough
- ☐ Difficult Voiding
- ☐ Shortness of Breath
- ☐ Seizure
- ☐ Recent Upper Respiratory Infection
- ☐ Current Pregnancy
- ☐ Normal Menstrual Period
- ☐ Black Out
- ☐ Stroke
- ☐ Obesity

Additional Form Comments:

_____

_____

_____

_____

Height _____ **Weight** _____ **Blood Pressure** _____ **Pulse** _____

patient information

SS# _____

Last Name _____ **First Name** _____ **MI** _____

Address _____ **Apt #** _____

City _____ **State** _____ **Zip** _____

Home Phone (____) _____ **Work Phone** (____) _____

E-mail address _____ **Cell Phone** (____) _____

Age _____ **Birth date** _____ **Sex** _____ **Married** ☐ Yes ☐ No

Referring Source

Doctor _____ Patient _____

Other _____ Hospital _____

Employment Status ☐ Yes ☐ No

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Spouse's Name _____

Spouse's Employer _____ Spouse Work Phone # (____) _____

FINANCIAL POLICY:
All deductibles, co-payments and co-insurance will be collected after services are rendered.
Cash, check or credit card payment will be accepted.

_____ _____

Signed Date

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SEAN A. SIMON, M.D.

3850 Bird Road - Suite 201 305-668-0496

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES
AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

I acknowledge that I was provided with a copy of the Sean A. Simon. M.D. Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. Provided that Sean A. Simon, M.D. continues in its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my health information for the purpose and the activities permitted under the federal privacy law, which are described in the Notice of Privacy Practices.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (305) 668-0496 or by requesting one at the office of Sean A. Simon, M.D.

_____ _____

Patient Name Date

_____ _____

Signature of Patient or Personal Representative If personal representative, personal representative's relationship to patient

If you received this form electronically, please sign and date the form and return it to the office of Sean A. Simon, M.D. at 3850 Bird Road - Suite 201 Miami, FL 33146 or fax it to (305) 667-7459.

For Physician Office's use only:

Complete this section of the form if not signed and dated by the patient or patient's representative.

Patient Name: _____ Date of Birth: _____

SS# _____ Phone Number: (____) _____

Address: _____ Date signature requested: _____

Reason that the signature and date not obtained: _____

disclaimer

IMPORTANT NOTICE UNDER FLORIDA STATUTE LAW 458320 PLEASE READ THIS IMPORTANT DOCUMENT AS THESE ARE YOUR RIGHTS UNDER FLORIDA STATUTE LAW 458.320

Dear Patient:

Under Florida law Statute (458.320 F.S.), physicians are generally required to carry medical malpractice insurance or demonstrate financial responsibility to cover potential claims for medical malpractice. I HAVE DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law under certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant of Florida law statute (459.320 F.S.).

This document MUST BE SIGNED AND WITNESSED before you initiate or continue under the care of Sean A Simon, M.D.

Thank-you.

_____

Sean A. Simon, M.D.

Note: No treatment can be provided by Sean A Simon, M.D. unless this form has been read and signed. This form is provided to protect your rights under Florida Statute 458320.

I, _____, have read this document and acknowledge and understand its contents.

(PRINT FULL NAME HERE)

Signature: _____, Date: _____

Witness: _____, Date: _____

Copy received by patient: _____

COPY OF STATUE PROVIDED ON REQUEST OR SIGNS CONCERNING THE FLORIDA STATUTE LAW 458320 ARE POSTED IN OUR OFFICE

physician-patient arbitration agreement

Preface:

I, Dr. Sean Simon, have decided under Florida Law to practice without Malpractice Insurance. Under this practice, this Arbitration Agreement ("Agreement") should be read carefully and fully understood. If you have any questions before or after reading and signing this statement please ask the staff or my office manager. Please read this document clearly. Thank you for your consideration.

Article 1: Agreement to Arbitrate: It is understood that my dispute as to medical malpractice that is, as to whether any medical services rendered under this contract were unnecessary, authorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by the Florida Arbitration Code, Chapter 682, and not by a lawsuit except as Florida law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this Agreement bind all parties whose claims may arise out of or related to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of a pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties and must be made within the time frame set forth in F.S. 95.11 dealing with medical malpractice. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of demand for neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees to the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefits. Arbitration shall take place within 30 days after the completion of discovery as provided in the Florida Rules of Civil Procedure (Rules 1.280-1.390) and the decision of the arbitration panel shall be binding upon the parties for all purposes. The time for responding to discovery requests shall be 10 days. All discovery shall be completed within 2 months after the appointment of the panel of arbitrators, unless the time for discovery is extended for good cause by the panel. The arbitration panel shall decide any disputes regarding

discovery. The arbitration panel is expressly authorized to award all reasonable fees and costs, including attorney's fees, to the prevailing party against any party who has violated this Agreement. The parties agree that the arbitrators have the immunity of a judicial officer for civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law provisions.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be proper additional party in court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

Article 4:

General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable Florida statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for the arbitrators shall be governed by the Florida Rules of Civil Procedure provisions relation to arbitration.

Article 5:

Retroactive Effect: If patient intends this Agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below.

Effective as of the date of first medical services _____

(Patient's or Patient's Representative's Initials)

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and effect and shall not be affected by the invalidity of any other provisions.

I understand that I have the right to receive a copy of this Arbitration Agreement.

authorization for and release of medical photographs/slides and/or video footage

authorization for release of patient image

Name: _____

Address: _____

(STREET ADDRESS, CITY, STATE AND ZIP CODE)

I consent to the taking of photos, sliders or video footage by Dr. Sean Simon or his designee of me or parts of my body in connection with the plastic surgery procedure's) to be performed by Dr. Sean Simon. I further authorize Dr. Sean Simon or one of his/her associates to release to the American Society of Plastic Surgeons ("ASPS") such images.

I provide this authorization as a voluntary contribution in the interest of public education. I understand that such photographs shall become the property of ASPS and may be retained by ASPS or released by ASPS for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

I hereby grant permission for the use of my medical records including illustrations, photographs, or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by the American Board of Plastic Surgery, Inc.

Neither I nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the images may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, from Dr. Sean Simon.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire one year from the date written below.

I understand that the information disclosed, or some portion thereof may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPPA"). I further understand that because ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPPA the information described above may no longer be protected by HIPPA.

I release and discharge Dr. Sean Simon, ASPS, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

Signature: _____, Date: _____

I have read the above Authorization and Release, I am the parent, guardian, or conservator of _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

Signature: _____, Date: _____