ROBERT AYCOCK, MD, FACS

Patient Profile Date:_____/_____/_____

First Name: _____ Last Name: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: o **Male** o **Female**

Height: _____ Weight: _____ Marital Status: _____ Spouse Name: _____

Patient Contact Information

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell:_____

Email: _____

I give Robert Aycock, M.D. permission to contact me through these additional methods: Must CIRCLE Yes or No to the following:

YES **NO** Leave detailed message on home/work/cell voice mail

YES **NO** Contact me through Email message

YES **NO** Leave detailed message with family member, Name: _____

Employment Information

Patients Employer: _____ Occupation: _____

Work Phone: _____ Can we contact you at work? o Yes o No

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact

Name: _____ Relationship : _____

Cell: _____ Other:_____

Primary Health Insurance Company: _____

Policy#: _____ Group: _____Insurance Phone: _____

Referral Required: **Yes / No** Copay: **Yes / No** If yes, amount $ _____

Insured Name: _____ DOB: _____ Employer: _____

Secondary Heath Insurance Company: _____

Policy#: _____ Group: _____Insurance Phone: _____

Insured Name: _____ DOB: _____ Employer: _____

Authorization of Assignment of Benefits

I understand that cosmetic services are not usually covered by insurance and office visit charges are payable on the day service is rendered. When applicable, I authorize Dr. Robert Aycock to bill my insurance. I am responsible for paying all bills in a timely manner and I understand that I am solely responsible for my bill if the service provided is not covered by insurance.

No Show Policy

I understand that I will be charged a $50 fee for all "no-shows" and/or cancellations within less than 24 hours of my scheduled appointment.

Photography Consent

I consent to have photos taken of me before and after surgery. The photographs will be taken by one of the members of Dr. Robert Aycock's staff for preoperative planning, medical record documentation and educational purposes

Signature: _____ **Date:** _____/_____/_____

New Patient Cosmetic Interest Questionnaire

Which procedure are you interested in today?

_____

Would you like to be notified for any of the following?

□ Special, Discounts, Promotions and Seminars
□ Boutique Parties
□ Beauty Membership
□ None of the Above

Please check all that interest you:

Surgical	□ Mommy Makeover	□ Laser Hair Removal
□ Breast Reduction/Lift	□ Neck Lift	□ Neograft
□ Breast Augmentation	□ Nose Surgery	□ Scar Removal
□ Breast Reconstruction	□ Other _____	□ Skin Care Products
□ Ear Surgery	**Non-Surgical**	□ Skin Resurfacing
□ Eyelid Surgery	□ Brown Spots/Age Spots	□ Skin Care Facials
□ Face Lift	□ Cellulite Reduction	□ Skin Tightening
□ Gynecomastia	□ Chemical Peels	□ Wrinkle Reduction
□ Tummy Tuck	□ CoolSculpting	□ Vein Treatment
□ Labiaplasty	□ Facial Fillers	□ Other _____
□ Liposuction	□ Vaginal Rejuvenation	

Referral Source:

□ Realself □ Patient □ Physcian □ Other

Referred by: _____

May We Contact? □ Yes □ No

Tell us About Yourself

Do you or have you ever smoked tobacco? _____ Marijuana? _____

Do you drink Alcohol? Yes/No Frequency:_____

Are you allergic to any tape? o **Yes** o **No**

Medications

List medications you're currently taking (ie: thyroid, anti-depressants, diabetes,cholesterol, aspirin):_____

_____

Medication Allergies:_____

Family Physcian:_____ Phone:_____

Date of Last Exam:_____/_____/_____

Have you had a heart attack within the past 12 months? o Yes o No

Are you currently taking oral steriods? o Yes o No If yes please list:_____

Women Only

Number of pregnancies_____ Number of live births_____ Are you pregnant now? o **Yes** o **No**

Are you breastfeeding? o **Yes** o **No** Date of last mammogram?_____

Do you bruise easily? o **Yes** o **No**

Have you or anyone in your family ever had an adverse reaction to general or local anesthesia? o **Yes** o **No**

If yes, please explain: _____

Have you or any family member ever have problems with excessive bleeding? o **Yes** o **No**

Family History:

Family Member	Age	Condition of Health	Any Illness i.e. diabetes, cancer, high blood pressure, depression?
Mother			
Father			
Brother(s)			
Sister(s)			

Previous Surgeries:

Type of Operation	Year	Physician	Anesthesia

Are you being treated by a physician for any condition? o **Yes** o **No**

If yes, please explain: _____

Did you have any complications or problems after any of the above listed operations? **o Yes o No**

Please describe: _____

_____

ACKNOWLEDGEMENT FORM-Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Robert Aycock, M.D., P.C.'s notice of privacy policies detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and I request the following restriction(s) concerning the use of my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signature: _____

I understand I have the right to blog, rate or otherwise publish comments about my procedure and/or my doctor. In the event I publish negative comments, I hereby waive any medical privacy rights I may have at the time for the limited purpose of giving my doctor permission to respond in the same forum in a factually-accurate and non-defamatory manner.

NOTICE TO CONSUMERS

Medical doctors in California are licensed and regulated by the Medical Board of California

(800) 633-2322 / www.mbc.ca.gov

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical mal[practice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for 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 arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and children, whether born of unborn, at the time of the occurrence giving rise to any claim. In the case of the 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. 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 a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of 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 benefit. The parties agree that the arbitrators have the immunity of a judicial officer from 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.

Either party shall have the absolute right to arbitrate separately the issue 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 a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to heath care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** 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 California 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 California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation**: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **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 Representative's Initials

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

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS

_____	_____	_____	_____
Physician or Authorized Representative's Signature	**Date**	**Sign Patient's Name**	**Date**
Robert Aycock, M.D.		_____	
Print		**Print Patient's Name**	

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.