IRVIN WIESMAN, MD, FACS

712 N Dearborn Street
4th Floor
Chicago, IL 60654
60035
(312) 981-1290

WIESMAN
Cosmetic Surgery

1160 Park Avenue West
Suite 2-E
Highland Park, IL

WELCOME TO OUR OFFICE!

Name: _____ Date: _____

Home Address: _____
City: _____ State: _____ Zip: _____
Primary Phone Number: _____ ☐ Home ☐ Work ☐ Cell
Birth Date: _____ Age: _____
Email Address: _____
May we contact you via email? ☐ Yes ☐ No
Would you like to receive emails about our promotions and special offers? ☐ Yes ☐ No

Complete this section only if someone other than the patient is financially responsible:

Responsible Party: _____
Relationship to Patient: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Primary Phone Number: _____ ☐ Home ☐ Work ☐ Cell
Birth Date: _____ Age: _____

Emergency Contact: _____
Relationship to Patient: _____
Primary Phone Number: _____ ☐ Home ☐ Work ☐ Cell

How did you learn about our practice? _____
If someone referred you, whom may we thank? _____
Do you wish phone calls to be confidential? ☐ Yes ☐ No
May we contact you at work? Yes ☐ No
Preferred method of contact: ☐ Home ☐ Work ☐ Cell ☐ Email

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PATIENT FINANCIAL RESPONSIBILITY

I, _____ ("Patient") hereby agree to pay any and all amounts and charges submitted by Wiesman Cosmetic Surgery, LLC ("Practice") for services rendered by Dr. Wiesman and other clinical professionals who are now employed or affiliated with Practice, during the course of treatment for the Patient, including surgical intervention ("Professional Services"). The Patient hereby acknowledges, understands, and agrees that if any amounts are sent to collections, they are financially responsible for thirty-three and one third percent (33.3%) of the unpaid balance, and failure to make payment for such Professional Services when requested is the basis for legal action. Patient further agrees to pay all costs of collection including a reasonable attorney's fee to the extent permitted by law. The Patient hereby acknowledges their understanding that the payment is due within thirty (30) days from receipt of invoice statement and agrees to pay a one percent (1%) per month late charge on all bills over thirty (30) days past due.

NAME (PLEASE PRINT): _____

SIGNATURE: _____

DATE: _____

USE OF IMAGES

I hereby agree and acknowledge that photographs will be taken of me before and after my procedure. I authorize Wiesman Cosmetic Surgery, LLC to use photographs and/or videos of me on their **website**, **social media platforms**, and **office photo albums**. I understand that these images and/or videos will not be used for any other commercial purpose and that my personal information will not be disclosed.

CHECK ALL THAT APPLY:

☐ **Cover** My Eyes

☐ Cover My Tattoos

☐ **Okay** to Show Face

NAME (PLEASE PRINT): _____

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HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as a patient. Additional information is available from the United States Department of Health and Human Services at www.hhs.gov.

WE HAVE ADOPTED THE FOLLOWING POLICIES:

1. Patient information will be kept confidential in EXCEPT as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open rack files and will not contain any coding that identifies a patient's condition or information that is not already a matter of public records. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

We utilize a number of vendors in the business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

You understand and agree to inspections of the office and review of documents that may include PHI by governmental agencies or insurance payers in normal performance of their duties.

You agree to bring any concerns or complaints regarding privacy to the attention of our office manager or physician.

We agree to provide patients with access to their records in accordance with state and federal laws.

We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

You have the right to request restrictions on the use of your protected health information and to request changes in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in WIESMAN COSMETIC SURGERY'S HIPAA INFORMATION AND CONSENT FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature

Date

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CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION & RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby give my consent to Wiesman Cosmetic Surgery
(Name of Patient or Authorized Agent)
to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____.
(Patient's Name)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available ***on the practice website at www.wiesmaninstitute.com, or*** by stopping by the office to pick up a copy.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____.

CONSENT FORM DEFINITIONS

"Health care operations" refers to many activities, including:

1. Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities (as defined in 42 C.F.R. 3.20) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
3. Except as prohibited under 45 C.F.R. 164.502(a)(5)(i), underwriting, enrollment, premium rating, and other activities related to creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
5. Business planning and development, such as conducting cost management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
6. Business management and general administrative activities including but not limited to: (a) management activities relating to HIPAA privacy rule compliance; (b) customer services, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer; (c) resolution of internal grievances; (d) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and (e) creating de-identified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not required.

"Payment" means the activities undertaken by the physician to obtain reimbursement for the provision of health care. These activities referred to in this definition relate to the individual to whom health care is provided and include, but are not limited to:

1. Determination of eligibility coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
2. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing;
3. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
4. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
5. Disclosure to consumer reporting agencies of any of the following information relating to reimbursement: name and address, date of birth, Social Security number, payment history, account number, and name and address of the physician.

"Treatment" means the provision, coordination, or management of healthcare and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider or another.

"Use" means the sharing, employment, application, utilization, examination, or analysis of patient information within the physician's practice that maintains such information.

HEALTH INFORMATION AS OF _____ (enter today's date)

Confidential Record: Information contained here will not be released unless you have authorized us to do so.
Please answer all questions to the best of your knowledge.
(PLEASE PRINT LEGIBLY & COMPLETE ALL FIELDS)

Name: _____ **Reason for Visit:** _____

Age: _____ **Height:** _____**ft.**_____**in.** **Weight:** _____**lbs.**

Current Physician(s): _____

Please list any surgical operations (type and year) and/or any serious illnesses, if applicable:

Current breast implant size (If any)**:** _____ **Saline / Silicone** **Submuscular / Subglandular**

Do you have or have you had any of the following: (Check all that apply)

Artificial ☐	**Defibrillator** ☐	**Infection** ☐	**Psychiatric Condition** ☐
Asthma ☐	**Diabetes** ☐	**Kidney Problems** ☐	**Radiation Therapy/Chemotherapy** ☐
Arthritis/ gout ☐	**Eye Problems** ☐	**Liver Disease** ☐	**Stroke** ☐
Bleeding Tendency ☐	**Heart Disease** ☐	**Malignant Hyperthermia** ☐	**Thyroid Disease** ☐
Blood Clots ☐	**Heart Murmur** ☐	**MRSA** ☐	**Tuberculosis** ☐
Breast Cancer ☐	**Hepatitis** ☐	**Neurologic Disease** ☐	**Venereal Disease** ☐
Cancer ☐	**Hereditary defects** ☐	**Pacemaker** ☐	
Chest Pain ☐	**High Blood Pressure** ☐	**Other:** _____	
Convulsions ☐	**HIV** ☐		

Social History – TAobacco/Alcohol/Drugs:

Smoker: Yes / **No** (If yes, please answer the following)

Packs Per Day (If any): _____
How Often Do You Smoke: _____
Number of Years Using: _____
Quite How Long Ago: _____

☐ **Cigarettes**
☐ **Pipe**
☐ **Vapor**
☐ **Cigar**
☐ **Chew**

Alcohol Use: Yes / No (If yes, please answer the following)

Alcohol Use Occasionally ☐
Alcohol Use Socially ☐
Alcohol Use Daily ☐

Do you use recreational drugs? **If yes, please describe:** _____

Female Only:

Are you currently pregnant? Yes No **Have you had c-sections?**_____
How many times have you been pregnant? _____ **How many births?** _____
Did you breast feed? Yes No **If yes, for how long?** _____

Do you or have you ever had an abnormal mammogram results? Yes No
If yes, please describe: _____
When was your last mommagram?_____

Please list any family member health history condition or illness:

Please list any known allergies, reaction to medication, or anesthesia problems:

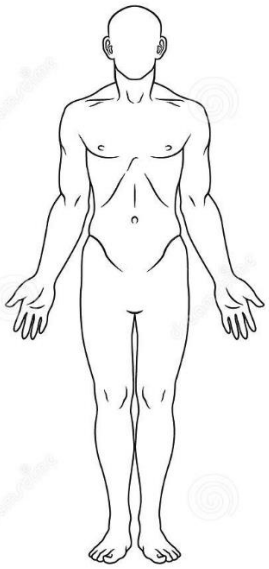
Regular use of Aspirin or Ibuprofen?

Please list all medications you are presently taking or have taken within the last month (i.e. over-the-counter medications, vitamins, herbal supplements, etc.). Please include the name of the drug, prescribed dosage, and frequency:

I affirm that the above information is accurate and complete to the best of my knowledge:

Signature: _____ **Date:** _____

PATIENT NAME: _____ NEXTECH ID: _____ DATE: _____



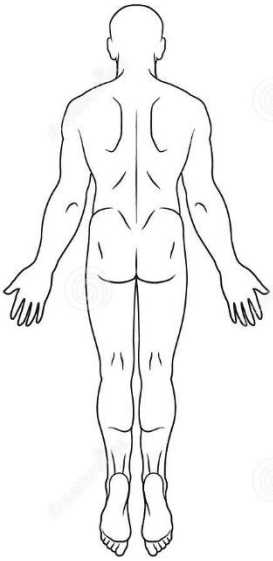
COMPLAINTS:_____

_____

_____

_____

_____



ASSESMENT:_____

_____

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_____

_____

PLAN:_____

_____

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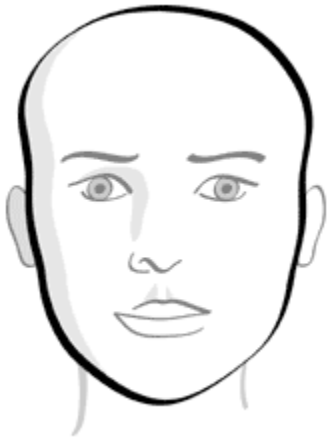

NOTES:_____

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