PONSKY PLASTIC SURGERY
3700 Park East Dr., Suite 160 • Beachwood, OH 44122
(216) 508-4055 • www.drdianaponsky.com • info@drdianaponksy.com

Today's Date

ADULT PATIENT QUESTIONNAIRE

Name (Last, First)				M.I.
Address			City	
State	Zip	Email		
Cell Phone		Work Phone		
Height	Weight	D.O.B.	Age	
Sex __	Primary Care Physician			
Reason for Visit				

Marital Status

☐ Married	☐ Single	☐ Divorced	☐ Separated	☐ Widowed

Emergency Contact	**Who is the Responsible Party if Under 18?**
Name	Name
Phone	Phone
Relationship	Relationship
	DOB

How Did You Hear about Us?

☐ Friend/Family	☐ Facebook	☐ Instagram	☐ YouTube
☐ Google Search	☐ TikTok	☐ Other	
☐ Physician (Name)			

Whom may we thank for the referral?

PHARMACY

Name		City
Phone (optional)	State	Zip

INSURANCE

Insurance does NOT cover cosmetic procedures

Primary Insurance	Policy Number
Group Number	Policy Holder’s Name
Policy Holder’s DOB	
Secondary Insurance	Policy Number
Group Number	Policy Holder’s Name
Policy Holder’s DOB	

FAMILY HISTORY

Family Member	Age	Living?	Cause of Death	Chronic Health Problem
		__		
		__		
		__		
		__		

Have you ever had surgery? __	Procedures and approximate dates

Please check below any **current** or **past** medical conditions:

☐ Acid Reflux Disease	☐ Cataracts	☐ Prostate Problems
☐ Anemia	☐ Chest Pain	☐ Psychiatric Problems
☐ Arthritis	☐ COPD	☐ Seizures
☐ Asthma	☐ Diabetes	☐ Sickle Cell
☐ Autoimmune Disorders	☐ Coronary Heart Disease Depression	☐ Shortness of breath
	☐ Emphysema	☐ Sleep Apnea
	☐ Glaucoma	☐ Snoring
☐ Bladder Problems	☐ High Cholesterol	☐ Tuberculosis
☐ Bleeding Problems	☐ HIV/AIDS	☐ Ulcers
☐ Bronchitis	☐ High Blood Pressure	☐ Other
☐ Cancer	☐ Lung Problems	
	☐ Kidney Problems	

Have you or a family member had an unusual reaction to anesthesia? __	Are you currently pregnant or breastfeeding? __
Are you allergic to any medications? __	Please list what kind and describe what happens?
List any other allergies:	

Please provide a list of your medications and supplements:
including over the counter medicine, vitamins, and herbs

Name	Dosage	Name	Dosage

Do you smoke? __	Former smoker? __	Do you regularly use snuff or chewing tobacco smoker? __			
Select all that apply:	☐ Cigarettes	☐ Pipe	☐ Cigars	☐ Marijuana	☐ Other
If Cigarettes, how many per day?	How many years have you smoked?				
If you quit, when?					
Do you drink? __	☐ Beer	☐ Hard Liquor	☐ Wine		
How many drinks (per week/day)?	If you quit, when?				

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GENERAL CONSENT

Authorization for Treatment
Patient/Patient's legal representative agrees to permit authorized personnel of PONSKY PLASTIC SURGERY to perform such diagnostic and therapeutic procedures that my treating physician(s) deem necessary for care. By signing below, I agree to permit x-rays, laboratory tests, photographs for treatment purposes, routine medical treatment (for example, medications, injections, drawing blood for tests, emergency procedures as necessary and hospital services performed at the request of the physicians arising in my care. I understand that, except in an emergency, any further treatment or procedures will be performed only after I have been informed of the benefits, material risks, and complications associated with such treatment or procedures and I have been given my consent.

Authorization to Release Information
The undersigned hereby permits PONSKY PLASTIC SURGERY and/or their authorized personnel to access and/or release all or any part of the patient information to the appropriate healthcare insurer(s), employers for work-related injuries, third party payer(s), and/ or PONSKY PLASTIC SURGERY agent(s), attorney(s) for purposes including treatment of the patient, billing (or collecting payment) for services and healthcare operations.

Record Retention Policy
PONSKY PLASTIC SURGERY retains patient medical records in accordance with applicable law and pursuant to its record retention policies.

Computer Data
I understand that my medical records will be accessible to authorized PONSKY PLASTIC SURGERY personnel through computers and that the Company will comply with certain safeguards established by federal state and local law as well as PONSKY PLASTIC SURGERY policy.

Certification
I certify that to the best of my knowledge and belief the information provided is complete and correct. I understand that this consent is subject to revocation by me at any time except if the person or entity authorized to make a disclosure has already acted in reliance on this form. Otherwise, subject to applicable law, this consent will expire at the same time PONSKY PLASTIC SURGERY record retention period for this document expires.

Patient Personal Property/Payment for Non-Reimbursable Items
I understand that PONSKY PLASTIC SURGERY is not responsible for loss or damage to money and valuables left unattended.

I AM THE PATIENT OR AUTHORIZED TO SIGN THIS DOCUMENT. I HAVE READ ALL THE ABOVE AND UNDERSTAND ITS TERMS.

____
Printed Patient Name

____ _________________________
Signature of Patient Date

____ _________________________
Signature of Legal Representative Relationship

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HIPAA PRIVACY POLICY ACKNOWLEDGEMENT (1 OF 2)

1. OUR POLICY

PONSKY PLASTIC SURGERY (the "Company" "we," or "us"), respects and understand our website www.drdianaponsky.com (the "site") users' concerns about confidentiality and privacy and we take all reasonable steps to ensure that any information you give us is handled in a safe and responsible manner. Because of our respect and understanding of your privacy, we have developed this policy which discloses the Company's privacy practices and describes the information we collect about you during your use of our site and what use we may make of that information.

It is important to remember that by using our site, you agree to the terms of this policy. Because the technology in this area is expanding and improving at such a rapid pace, we suggest that you refer to this policy on a regular basis as it may change, at any time in the Company's sole discretion, in order to allow us to take advantage of any technological advances or for business purposes or legal reasons.

2. INFORMATION THAT WE MAY COLLECT

We collect your information in different areas of our site. The exact information collected varies depending on the areas of our site that you use. We collect all information that you voluntarily disclose in the course of using our site, or in becoming a registered user of our site. In the future, we may require further information as dictated by the nature of the services that we may offer.

In the course of using our site, we automatically track certain information about you. This information includes the URL that you just came from (whether this URL is on our site or not), which URL you go to next (whether this URL is on our site or not), what browser you are using, and your Internet Protocol (IP) address. Many sites automatically collect this information. In addition, we may decide to use cookies on certain pages of our site. Cookies can help us provide information which is targeted to your interests. Cookies are stored on your hard drive, not on our site. Most cookies are "session cookies," meaning that they are automatically deleted at the end of a session.

3. OUR USE OF YOUR INFORMATION

We internally use personally identifiable information to improve our services, to statistically analyze site usage, to improve our content, to customize our site's content and layout and for other customer service purposes. We believe these uses allow us to improve our site and better tailor it to meet our users' needs.

We will also use personally identifiable information to deliver information that, in some cases, is targeted to your interests, such as promotional emails. If you supply us with your email address, you may receive occasional email from us announcing services, product information, promotional events, or updates to our website. If you do not wish to receive such mailings, please send us an email indicating your email address.

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HIPAA PRIVACY POLICY ACKNOWLEDGEMENT (2 OF 2)

4. OUR DISCLOSURE OF YOUR INFORMATION

We do not sell, lend or rent any personally identifiable information about you to any third party outside of the Company, its affiliates, subsidiaries, authorized agents, operating companies and other related entities. We only disclose information to third parties when it is reasonably necessary in order to allow us to perform our services and deliver information, goods and services to you.

We cooperate with all law enforcement inquiries and with all third parties to enforce the rights of others and all and any federal, state or local law or regulation. We can (and you authorize us to) disclose any information about you to law enforcement or other government officials, including any government officials, as we, in our sole discretion, believe necessary or appropriate. Unfortunately, due to the existing regulatory environment, we cannot ensure that all of your private communications and other personally identifiable information will never be disclosed in ways not otherwise described in this Privacy Policy. By way of example (without limiting the

foregoing), third parties may unlawfully intercept or access files, transmissions or private communications. Therefore, although we use industry standard practices to protect your privacy, we do not promise, and you should not expect, that your personally identifiable information or private communications will always remain private.

5. THIRD PARTY COLLECTORS OF INFORMATION

Our policy only addresses the use and disclosure of information we collect from you. To the extent that you disclose your information to third parties, whether service providers, advertisers or other sites throughout the Internet, different rules may apply to their use or disclosure of the personal information you disclose to them. Third party service providers, advertisers and other website operators adhere to their own privacy customs and policies. Because we do not control the privacy policies of third parties, you are subject to the privacy customs and policies of that third party. We do not make any representations or warranties as to how such third parties may use your information.

I am the patient or authorized to sign this document. I have read all the above and understand its terms.

____
Printed Patient Name

______________________________ ____________________
Signature of Patient Date

______________________________ ____________________
Signature of Legal Representative Relationship

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AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

To maintain your privacy, PONSKY PLASTIC SURGERY requires written authorization from you in order to discuss your private medical information with another individual.

There are situations where we do not need family member(s) or other individual(s) listed above in order to discuss your medical condition(s), treatment(s) and other relevant medical information. However, we need a copy of the legal documents in some circumstances. Below are examples of situations:

- A personal representative is someone that has the authority to act on behalf of an individual in making decisions related to healthcare.
    - Examples: Guardians, Power of Attorney
- Minor(s) are individuals generally under the age of 18 years old, therefore we do not need authorization to speak with the parent(s). However, there are exceptions for minors.
    - Emancipated minors are generally at least 16 or 18 years of age and have established some level of independence from parents.
    - If not emancipated, the minor may have the authority to control their health information in the following instances:
        - The parent has agreed to the confidentiality between the provider and the minor
        - Law in place such as a court order

☐ I hereby understand that this authorization will remain in place unless PONSKY PLASTIC SURGERY is notified by me in writing revoking or changing the family member(s) or individual(s) listed below..

☐ I hereby authorize PONSKY PLASTIC SURGERY to discuss my medical condition(s), treatment(s) and any other relevant medical information with the following family member(s) or other individual(s):

Person's First and Last Name	Relationship to you	Phone
Person's First and Last Name	Relationship to you	Phone
Person's First and Last Name	Relationship to you	Phone

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PRIVATE PAY ACKNOWLEDGEMENT FOR COSMETIC PROCEDURES

NOTE: You have a choice to make about receiving elective health care items or services.

PONSKY PLASTIC SURGERY collects payment at the time of service unless other financial arrangements are made.

Insurance Coverage: It has been our experience that the majority of cosmetic procedures are not covered by insurance plans. However, benefits paid by insurance companies do vary, therefore, you should check with your carrier regarding coverage for cosmetic surgery.

By signing below, **you acknowledge and accept financial responsibility for any items or services provided by PONSKY PLASTIC SURGERY.** The reason may be that your doctor is not in network with your insurance company, certain services are not covered by your insurance company, or you are choosing to not use your insurance even though your selected clinician is participating in your insurance plan.

For more information about specific plan coverage, you will need to consult with your insurance carrier or your benefits booklet.

Printed Patient Name ______________________ Date of Birth ______________________

Signature of Patient ______________________ Date ______________________

Signature of Legal Representative ______________________ Relationship ______________________

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PHOTO RELEASE CONSENT

I understand that photographs will be taken during my visit. I accept that I may be recognized from my likeness or case history. Nevertheless, I authorize my plastic surgeon to use my photographs, videotapes, and case information in the settings that I have checked:

- ☐ For all of the below
- ☐ Lectures and multimedia presentations for an audience of medical professionals
- ☐ Pre- & post-operative patient photographs for prospective patients to view in office
- ☐ For use by the American Academy of Facial Plastic and Reconstructive Surgery
- ☐ My surgeon's personal website or webpage
- ☐ Social media, including but not exclusive to Facebook and Instagram
- ☐ Newspaper and magazine articles in which my surgeon participates
- ☐ Television programs in which my surgeon participates
- ☐ Lectures and multimedia presentations given by my surgeon to the general public
- ☑ For office and surgical use

Printed Patient Name

Signature of Patient | Date

Signature of Legal Representative | Relationship

The consent provided in this document shall be valid immediately and until such time as a patient affirmatively withdraws, in a writing addressed to PONSKY PLASTIC SURGERY, from the consent provided herein. Such withdrawal shall be effective upon its receipt by PONSKY PLASTIC SURGERY.

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PERSONALIZED TREATMENT GOALS

I am seeking cosmetic treatment in order to (check all that apply):

- ☐ look less saggy
- ☐ look more attractive
- ☐ look healthier
- ☐ look slimmer
- ☐ look perfect
- ☐ look more approachable
- ☐ look sexier
- ☐ look less like my older relatives
- ☐ look 20 again
- ☐ look more feminine
- ☐ look more masculine
- ☐ look more youthful
- ☐ look like I can compete in the workplace
- ☐ look perfectly symmetrical
- ☐ look more vibrant
- ☐ look like I didn't spend too much time in the sun
- ☐ look less tired
- ☐ fix one particular flaw
- ☐ look happier