IV SEASONS SKIN CARE

BY BOULDER PLASTIC SURGERY

The Beauty of You™

2525 4th Street, Suite 200, Boulder, CO 80304
Boulder Plastic Surgery: 303-443-2277
IV Seasons Skin Care: 303-938-1666
www.boulderplasticsurgery.com
Fax #: 303-443-7124

Welcome to Boulder Plastic Surgery/IV Seasons Skin Care! Thank you for contacting our office regarding an appointment.

Here at Boulder Plastic Surgery/IV Seasons Skin Care we strive to provide the most current, safe and effective procedures available today. By combining procedures that have stood the test of time with newly proven advances in technology, we feel that our office is on the cutting edge to provide you with the best options available for your individual needs.

Please note that consultations regarding procedures eligible for insurance coverage may result in claim submission for the consultation, as we must document our visit with you, especially if the resulting surgery will also be billed to your insurance company.

PLEASE NOTE, our office has a cancellation policy for appointments. If you need to change or cancel your appointment, please give us 48 hours' notice, at minimum, before your appointment. If you cancel your appointment inside of 48 hours, there is a $100 cancellation fee that will be charged to the credit/debit card that you provided when you booked your appointment.

COVID-19 Protocol: For your safety and ours as of February 2022, masks and/or proof of COVID vaccination are still required for services at IV Seasons Skin Care Clinic. Individual circumstances regarding this protocol will be considered.

Please rest assured that all information provided is kept confidential, secure, and HIPAA compliant. Please call the office at (303) 443-2277 if you have any questions.

Sincerely,

Boulder Plastic Surgery & IV Seasons Skincare

Financial Policy Update as of February 2022:

We ask that you carefully read this *Policy* and *Disclosure,* which you will sign at the time of your scheduled appointment.

- We require a valid credit card on file to hold your appointment, place a deposit for a scheduled treatment or charge your credit card for cancellations as outlined below.

Credit Card Information:
You will be asked to give us your credit card information when you schedule your treatment or consultation, and it will be kept on file unless you advise us otherwise.

Self-Pay Financial Policy:
I understand, as a self-pay patient, that I am responsible to pay the bill at the time the services are rendered. For scheduled appointments and outstanding balances must be paid prior to the visit.

Appointment Cancellation: Procedure or Treatment
Please be courteous and call IV Seasons Skin Care promptly if you are unable to attend an appointment for a procedure or treatment. If it is necessary to cancel your scheduled appointment, we require that you give at least **48 hours** notice. Less than 48 hours notice doesn't allow us to offer an appointment to another patient in need. There will be a $500.00 charge if you fail to show or cancel with less than 48 hours notice for your scheduled appointment. Unavoidable circumstances may warrant special consideration, but please note that the above charges will apply to most cancellations.

Appointment Cancellation: Consultation
Please be courteous and call IV Seasons Skin Care promptly if you are unable to attend an appointment for a consultation. If it is necessary to cancel your scheduled appointment, we require that you give at least **48 hours** notice. Less than **48 hours** notice doesn't allow us to offer an appointment to another patient in need. There will be a $100.00 charge if you fail to show or cancel with less than 48 hours notice for your scheduled appointment. Unavoidable circumstances may warrant special consideration, but please note that the above charges will apply to most cancellations.

Refunds:
Pre-paid packages, memberships or procedures are **NON-REFUNDABLE** unless we can no longer provide that treatment or procedure for you.

Welcome To Our Practice

Hans R. Kuisle, M.D., F.A.C.S.
Winfield Hartley, M.D., F.A.C.S.
Justin B. Maxhimer, M.D.
303 443-2277 Phone
www.boulderplasticsurgery.com

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IV SEASONS SKIN CARE

Confidential Skin Health Questionnaire

Patient's Concerns, Expectations, and History

First Name: _____ Last Name: _____
Date of Birth: _____
Referred By: _____
What is the reason for your visit today?

_____

What conditions of your skin would you like to improve?

- ☐ Acne Scarring
- ☐ Acne
- ☐ Age Spots
- ☐ Enlarged Pores
- ☐ Fine Line and Wrinkles
- ☐ Hyperpigmentation
- ☐ Broken Capillaries
- ☐ Surgical/Facial Scars
- ☐ Other: _____

Have you ever had a skin care treatment?

_____

If so, what kind of treatment did you have? How recent?

_____

How would you rate your skin? (Check One)

- ☐ Always burns
- ☐ Burns easily, tans slightly
- ☐ Burns moderately, tans gradually
- ☐ Seldom burns, always tans well
- ☐ Rarely burns, deep tan
- ☐ Never burns, deeply pigmented

What is your ethnic background: (i.e. German, Irish, French, English, etc.)

_____

How does your skin heal?

☐ Fast ☐ Scars ☐ Pigments

Do you ever use depilatories or wax on your face? ☐ Yes ☐ No
Do you ever get cold sores? ☐ Yes ☐ No
Do you have any family history of skin cancer? ☐ Yes ☐ No
Do you have any known drug allergies? (Please list all)

_____

_____

Are you currently on any medications: If so, please provide details.

_____

Have you had any of the following in the past or present?

Cancer	☐ Yes	☐ No	Radiation/Chemotherapy:_____
Diabetes	☐ Yes	☐ No	
Eczema	☐ Yes	☐ No	When?_____
Hepatitis	☐ Yes	☐ No	
HIV/AIDS	☐ Yes	☐ No	
Infections	☐ Yes	☐ No	
Thyroid	☐ Yes	☐ No	☐ Normal
Wear Contacts	☐ Yes	☐ No	

Lifestyle/Diet

Do you currently do/have any of the following?

Sun bathe	☐ Yes	☐ No
Use tanning beds	☐ Yes	☐ No
Use tobacco	☐ Yes	☐ No
Consume alcohol	☐ Yes	☐ No
Consume caffeine	☐ Yes	☐ No
High stress level	☐ Yes	☐ No
Normal sleep pattern	☐ Yes	☐ No
Exercise regularly	☐ Yes	☐ No
Food intolerances	☐ Yes	☐ No

If **yes** for Food Intolerances, please list:

_____

Women's Health

Are you currently?

Taking Oral Contraceptives	☐ Yes	☐ No
Pregnant or trying to become pregnant	☐ Yes	☐ No
Lactating	☐ Yes	☐ No
Experiencing hormone imbalances	☐ Yes	☐ No
Taking hormone replacement	☐ Yes	☐ No

Present Skin Regimen

Are you currently using any skin care products? If so, please provide details.

_____

_____

Have you ever used any of the following products?

☐ Accutane	☐ Topical Antibiotics	☐ Alpha Hydroxy Aids
☐ Retina A	☐ Differin	☐ Hydroquinone
☐ Renova	☐ Tazarac	

If yes, when? and for how long?

_____

Patient Demographics

Hans R. Kuisle, M.D., F.A.C.S.
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Please complete the following confidential information, please print legibly.

Please provide your LEGAL name for medical record purposes.

Last Name: _____ First Name: _____ Nickname/Preferred Name: _____

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

SS#: _____ - _____ - _____ Date of Birth: _____ Age: _____

Home Phone: _____/_____ Cell Phone: _____/_____ Work Phone: _____/_____

Preferred Method of Contact (Check One): Home # ☐ Cell #: ☐ Work #: ☐ Email: ☐

Email Address: _____ Receive Email Promotions? ☐ Yes ☐ No

Receive Text Message Appointment Reminders ☐ Yes ☐ No

Check One: ☐ Female ☐ Male ☐ Other

Check One: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Spouse Name: _____ Spouse's Phone: _____

How did you hear about us? ☐ Google ☐ Friend _____ ☐ Physician _____
☐ Email ☐ Facebook/Instagram ☐ Print Ad

Patient's Employer: _____ Occupation/Position: _____

Emergency Contact: _____ Relationship to Emergency Contact: _____

Home Phone #: _____/_____ Cell Phone #: _____/_____

Name of Referring Physician:_____ Phone #: _____

Name of Referring Individual: _____ Relationship: _____

If Patient is under 18 years of age, Parent or Guardian Name: _____

Home Phone #: _____/_____ Cell Phone #: _____/_____

Health Questionnaire
COMPLETE *ALL* FIELDS

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Date_____ Name _____ *Age*_____

Reason for your consult: _____

Medical History:

- ☐ Asthma
- ☐ Auto-Immune Disease
- ☐ Breast Cancer
- ☐ Cancer (other – specify)
- ☐ Depression
- ☐ Diabetes
- ☐ Fainting/Black Out Spells
- ☐ Heart Problems
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ HIV/TB/Hepatitis (circle one)
- ☐ Kidney
- ☐ Lupus / Scleroderma
- ☐ Rheumatoid Arthritis
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Ulcer
- ☐ Thyroid

Previous Surgery or Hospitalization | Date | Complications?

_____

_____

_____

_____

Have you had an allergic reaction to anesthesia? ☐ Yes ☐ No If yes, please list: _____
Have you had a history of clots or phlebitis? ☐ Yes ☐ No
Have you had any problems with excessive scarring? ☐ Yes ☐ No

PLEASE LIST ANY MEDICATIONS TAKEN REGULARLY (include aspirin/birth control pills, or state "None," do NOT leave blank):

_____

_____

_____

PLEASE LIST ANY HERBAL/VITAMINS TAKEN REGULARLY (or state "None," do NOT leave blank):

_____

_____

_____

ALLERGIES:
PLEASE LIST ANY MEDICATIONS THAT HAVE CAUSED ALLERGIC REACTIONS (or state "None," do NOT leave blank):

_____

_____

PERSONAL HISTORY: Height and weight are required for *all* surgical procedures

Height:_____ Weight:_____ ☐ Do you Smoke/Vape? Frequency:___ ☐ Do you drink Alcohol? Frequency:____ ☐ Substance Use? Frequency:___

*IF YOU ARE HAVING A CONSULTATION REGARDING YOUR *BREASTS*, PLEASE FILL OUT THE FOLLOWING*

Number of Pregnancies: _____ Number of Children: _____ Did you breast feed? _____ Present Bra Size? _____
Do you routinely perform self-breast exam? _____
Do you have a history of breast problems or breast cancer? _____ If yes, please explain: _____
Is there a family history of breast cancer? _____ If so, who? _____
Do you or someone in your family have a history of Rheumatoid arthritis? _____
Do you or someone in your family have a history of Collagen Disease? _____
Do you or someone in your family have a history of Auto-Immune Disease? _____

MAMMOGRAPHY:
Have you had a Baseline Mammogram performed? _____ When was your last test? _____
Facility where test was performed: _____ Results: _____

HIPPA Form

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NOTICE of PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

- At Boulder Plastic Surgery Prof., LLC and IV Seasons Skincare, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new plastic surgeon.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have the right to see and receive a copy of your patient health information. Give us a written request regarding the information you want to see. We may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice.
- If we change any of the details of this notice, we will notify you of the changes in writing.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated for filing a complaint.
  However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at 303/443-2277. This notice goes into effect as of April, 2003

ACNOWLEDGEMENT: *I have received a copy of Boulder Plastic Surgery Prof., LLC and IV Seasons Skincare Notice of Privacy Practices*.

_____ _____ ___/___/___

Signed Print Name Date

If signing as a parent or guardian, please note the name of the patient _____