



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 treatments and procedures provided by IV Seasons Skin Care and Dr. Hans Kuisle, certain safety practices are in effect. Patients must either be fully vaccinated and provide proof of vaccination for office records, or provide a negative COVID test done within 72 hours of their scheduled treatment/procedure. These terms apply to all treatments and procedures that require a patient's mask be removed.

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/COVID Policy Update as of Nov. 1, 2021:

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

- Proof of Covid 19 Vaccination Status or a negative Covid 19 test within 72 hours of treatment will be required for treatment at IV Seasons Skin Care.
- 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.

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



IV SEASONS SKIN CARE

BY BOULDER PLASTIC SURGERY

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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation/Chemotherapy: _____ |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Eczema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ |
| Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| HIV/AIDS | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Thyroid | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Normal |
| Wear Contacts | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

Lifestyle/Diet

Do you currently do/have any of the following?

- | | | |
|----------------------|------------------------------|-----------------------------|
| Sun bathe | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Use tanning beds | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Use tobacco | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Consume alcohol | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Consume caffeine | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High stress level | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Normal sleep pattern | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Exercise regularly | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Food intolerances | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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

Women's Health

Are you currently?

- | | | |
|---------------------------------------|------------------------------|-----------------------------|
| Taking Oral Contraceptives | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pregnant or trying to become pregnant | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lactating | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Experiencing hormone imbalances | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Taking hormone replacement | <input type="checkbox"/> Yes | <input type="checkbox"/> 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?

- | | | |
|-----------------------------------|--|---|
| <input type="checkbox"/> Accutane | <input type="checkbox"/> Topical Antibiotics | <input type="checkbox"/> Alpha Hydroxy Aids |
| <input type="checkbox"/> Retina A | <input type="checkbox"/> Differin | <input type="checkbox"/> Hydroquinone |
| <input type="checkbox"/> Renova | <input type="checkbox"/> Tazarac | |

If yes, when? and for how long?

Patient Demographics

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



BOULDER
PLASTIC
SURGERY
& IV Seasons Skin Care

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Receive Text Message Appointment Reminders	<input type="checkbox"/> Yes	<input type="checkbox"/> 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**

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



**BOULDER
PLASTIC
SURGERY**
& IV Seasons Skin Care

Date _____ Name _____ Age _____

Reason for your consult: _____

Medical History:

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

<u>Previous Surgery or Hospitalization</u>	<u>Date</u>	<u>Complications?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

- 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: _____



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

ACKNOWLEDGEMENT: *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 _____