PATIENT INFORMATION and HISTORY

Full Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____/_____/_____ Marital Status: _____

Home #: _____Work #: _____ Cell #: _____

Email: _____

Occupation: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone Number: _____

Pharmacy Name: _____

Pharmacy Street Address: _____

How may we contact you? (Check all that apply)

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Mail

Preferred Contact Number:

☐ Home Phone ☐ Cell Phone ☐ Work Phone

Would you like to be added to our email list so that we may send you information regarding our monthly news, specials, and events? YES NO

How did you hear about the Falcone Center? _____

☐ I hereby acknowledge that I have received a copy of the Notice of Privacy Practices
☐ I understand that any appointments that area not cancelled within 48 hours of the arrival time are subject to a non-refundable fee or loss of my deposit.

Patient Signature: _____

Print Name: _____

Why did you schedule a consultation with the Falcone Center?

Have you consulted any other doctors about this? ☐ YES ☐ NO
If yes, please list their names:

Primary Care Physician: _____ **PHONE**: _____

When was your last visit to your Primary Care Doctor?

When was you last bloodwork?

MEDICAL/FAMILYHISTORY: Have you or a relative had any of the following?

	YOU	RELATIVE		YOU	RELATIVE
Diabetes – High Blood Sugar	☐	☐	High Blood Pressure	☐	☐
Heart Disease	☐	☐	Blood or Bleeding Disorders	☐	☐
Lung Disease	☐	☐	Thyroid Issues	☐	☐
Kidney Disease	☐	☐	Prostate or Testicular Cancer	☐	☐
Mental Illness	☐	☐	Breast, Uterine, Cervical Cancer	☐	☐

If you checked any of the above boxes, please explain below.

Answer the following questions by circling Yes or No

Have you ever had any problem from general anesthesia? Yes / No
Have you ever had a bad reaction to a local anesthetic (Novocain, Lidocaine, Marcaine)? Yes / No
Are you allergic to adhesive tape or band-aids? Yes / No
Are you allergic to suture material, such as catgut? Yes / No
Any history of blood clots, pulmonary emboli, DVT, or phlebitis? Yes / No
Have you ever had Scarlet Fever or Rheumatic Fever? Yes / No
Do you stop bleeding quickly (from cuts, surgery, tooth extractions, etc)? Yes / No
Have you had aspirin, Anacin, Motrin, Advil, Alka-Seltzer, etc in the last two weeks? Yes / No
Have you taken cortisone, prednisone, or steroid medications in the past month? Yes / No
Do you form large scars or keloids? Yes / No
Do you have any skin disease, hives, eczema, or rash? Yes / No
Do you have frequent infections, boils, or history of MRSA? Yes / No
Do you have, or have you ever had, herpes or mouth sores? Yes / No
Does your religion prohibit blood transfusions? Yes / No
Do you have, or have you ever had, any significant emotional problems? Yes / No
Have you ever had psychiatric care or been advised to see a psychiatrist? Yes / No
Do you have any piercings that cannot be removed? Yes / No

CIRCLE ALL THAT APPLY TO YOUR MEDICAL HISTORY

Acne	Endocrine disorders	Metal Implants
Artificial Heart Valves	Endometriosis	Permanent make-up
Artificial Joints	Excessive Sweating	Polycystic ovary disease
Autoimmune Disease	Fibroids	Psoriasis
Bleeding disorders	Gold therapy	Recent Weight Gain/Loss
Blood Clotting issues	Heart Defibrillator	Rosacea
Breast Cancer	Heart Disease	Shingles
Burns/skin grafts	Herpes/Cold Sore	Skin cancer
Botox/Dysport treatment	Hair Thinning	Surgical Mesh
Constipation	High blood pressure	Tattoos
Diabetes	Hirsutism/Excess Body Hair	Uterine Bleeding

EXPLAIN ANY PAST OR CURRENT MEDICAL PROBLEMS:

MEDICATIONS (Prescription and Over the Counter):

NUTRITIONAL SUPPLEMENTS:

PREVIOUS SURGERIES:

Have you had any complications from any of these surgeries? Yes/No. If Yes, please explain.

ALLERGIES:

DRUG ALLERGIES:
SKIN ALLERGIES:
ENVIRONMENTAL ALLERGIES:
FOOD ALLERGIES:

HABITS:

____I smoke cigarettes / cigars / marijuana
____I use e-cigarettes
____I drink alcoholic beverages
____I use other recreational drugs

Are you interested in any of our other treatments?

- ☐ Awake Liposuction Treatment
- ☐ Brazilian Butt Lift (BBL)
- ☐ Fat Transfer Procedures
- ☐ Cellulaze Cellulite Treatment
- ☐ Cellulite Treatment-Tempsure
- ☐ SculpSure Non-Surgical Fat Reduction
- ☐ Smartlipo
- ☐ Body Jet Liposuction
- ☐ Vaser Liposelection
- ☐ PRP Hair Restoration
- ☐ Hair Loss Treatment
- ☐ Botox/Dysport/Daxxify
- ☐ Injectable Fillers
- ☐ Lip Plumper/ Lip Filler
- ☐ Liquid Facelift or Y lift
- ☐ PRX Biomodulation
- ☐ Functional Med Evaluation
- ☐ Medical Weight Loss
- ☐ Nutritional Counseling
- ☐ Underarm Odor Reduction
- ☐ MiraDry for Underarm Sweat Reduction
- ☐ Biote Hormone Pellets
- ☐ Hormone Replacement
- ☐ PRP O-Shot or P-Shot
- ☐ Mona Lisa Touch Treatment
- ☐ Vaginal Rejuvenation
- ☐ ThermiVa
- ☐ Chemical Peels
- ☐ Clogged Pore treatments
- ☐ Acne or Acne scar Treatment
- ☐ Age spots/Brown Spot Removal
- ☐ Co2 Laser Treatment
- ☐ Dry Skin treatments
- ☐ Enlarged Pore Treatment
- ☐ Vi Peel for Face or Body
- ☐ Microdermabrasion
- ☐ Facials
- ☐ PRP Vampire Facial
- ☐ Oily Skin Treatment
- ☐ Wrinkle Treatment
- ☐ Rosacea/Red spot treatment
- ☐ Skin Laxity Treatments
- ☐ Skin Texture Improvement
- ☐ Spider Vein Treatment
- ☐ Sun Damage Treatment
- ☐ Microneedling
- ☐ Potenza-Radiofrequency Microneedling

IF YOU HAVE CONCERNS WITH YOUR FACE OR SKIN, FILL OUT THIS SECTION

Do you suntan? Yes/No
When was your last exposure to the sun or a tanning bed?
Do you use sunscreen Yes/No
Have you ever used Retin-A or Tretinoin? Yes/No
Have you ever used Hydroquinone to bleach the skin? Yes/No
Have you ever been on Accutane? Yes/No If Yes, when?
Have you ever had herpes, hives, cold sores, fever blisters? Yes/No
How would you characterize your skin? (Circle) Sensitive. Rough Dry Oily/Acne Prone

List the skin care products you are currently using to take care of your skin

If you had one complaint about your skin, what would it be?

Patient Signature: _____ Date: _____

Consultant Signature: _____ Date: _____

Reviewed by Clinician: _____ Date: _____

Reviewed by Dr. Victoria Falcone: _____ Date: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain he privacy of your Protected Health Information (PHI). PHI is personal information about you, including demographic information that we collect from you, that may be used to identify you and relates to your past, present, or future physical or mental health or condition, including treatment and payment for the provision of healthcare.

This Notice explains our legal duties and privacy practice with regard to your PHI. We are required by federal law to provide you with a copy of this Notice and to abide by the terms of this Notice. Accordingly, we will ask you to sign a statement acknowledging that we have provided you with a copy of the Notice. If you have elected to receive a copy electronically, you still have the right to obtain a paper copy upon request.

We reserve the right to change the terms of this Notice any time. The change may be retroactive and cover PHI that we received or created prior to the revision. If we do not change the Notice, a copy of the new Notice will be posted in the waiting room and on our website, if any. We will provide you with a copy of the revised Notice upon your request.

I. PATIENT RIGHTS

You have six rights as a patient of The Falcone Center for Functional, Cosmetic, & Integrative Medicine.

1. *The right to consider and sign an authorization for a non-authorized use.* The law only allows us to use or disclose your PHI in certain circumstances, as explained more fully below. If we need to make a use or disclosure that does not fall into one of those exceptions – including the disclosure of immunization records to schools or results of work physicals to employers – we will ask you to sign an authorization. If we do not have a valid authorization on file specifically authorizing the proposed use or disclosure, then we will not make that use or disclosure. You make revoke an authorization at any time in writing, but the revocation will not apply to uses or disclosures we have already made in reliance on your original authorization.

2. The right to access your PHI. You have a right to access and receive a copy, summary, or explanation of your PHI. If you want to exercise this right, please ask one of our employees for a Request to Access Medical Records form. You will need to complete this form and submit it to us. This right does not extend to psychotherapy notes, information compiled in reasonable anticipation of legal action, and confidential information relating to certain lab tests. *We have the right to deny you access*, but you will be notified of the reason for denial and be given the right to have the denial reviewed under certain circumstances.

3. *The right to request restrictions on certain uses and disclosures.* You may request restrictions of uses or disclosures of your PHI when it is used to carry out your treatment, obtain payment for your treatment before we have used or disclosed the relevant information. We are not required to agree to the restriction, and we have the right to decide not to accept the restriction and not to treat you.

4. The right to receive confidential communications: You may request that we make confidential communications to you by an alternative means or at an alternative location. The request must be in writing, but we will ask for an explanation from you. We will accommodate reasonable requests, but we may condition the accommodation on information as to how payment, if any, will be handled and specification of an alternative address or other method of contact.

5. *The right to amend PHI*: You have the right to ask us to amend your PHI. If you want to exercise this right, please ask one of our employees for a Request for Amendment of Medical Records form. You will need to complete this form, provide a reason for the request and submit it to us. We have the right to deny your request for amendment, if we determine that your record was not created by use, is not maintained by us, would not be available for access, or is accurate and complete. Your records will not be changed or deleted as a result of our granting your request, but the amendment will be attached to your record and its existence noted in your record as necessary. (Note: use of this procedure is not necessary for routine changes to your demographic information, such as address, phone number, etc.

6. *The right to receive an accounting*: You have the right to receive an accounting of our uses and disclosure of your PHI. If you want to exercise this right, please ask one of our employees for a Request for Accounting form. You will need to complete this form and submit it to us. The accounting does not have to list disclosures made (i) to carry out treatment, payment, and healthcare operations; (ii) to you; (in) pursuant to an authorization; (iv) for national security or intelligence purposes; (v) to correctional institutions or law enforcement personnel or (vi) that occurred prior to April 14, 2003. (Note: compliance with this right is time-consuming, so we reserve the right to charge you a fee if you request more than one accounting in a twelve-month period.)

II. USES AND DISCLOSURES

We intend to limit the disclosure of your PHI to that necessary for Treatment, Payment, and Operations:

- *Treatment* refers to specific sharing and use of your PHI relating to your direct care by our employees, including consulting other professionals and the use of disease management programs.
- *Payment* refers to specific sharing and use of your PHI for purposes of obtaining payment for our treatment of you, including billing and collection activities, related data processing and disclosure to consumer reporting agencies. For example, your PHI will be disclosed on forms we submit to your insurance to receive payment.
- *Operations* refers to specific sharing and use of your PHI necessary for our administrative and technical operations, within the limitations imposed by professional ethics. Permissible activities would include, but are not limited to, accounting or legal activities, quality assessment, employee review, student training and other business activities. For example, we might need to disclose your PHI to a medical student as part of the educational process.

We will not permit the following disclosures without your written authorization, and your refusal to provide such authorization will not affect our duty to treat you:

- Marketing
- To your employer, except where necessary for provision of care or payment purposes (for example, if your employer is self-insured)
- Disclosures outside our offices, unless for treatment, payment, or operations
- For research purposes, unless certain safeguards are taken

We may make disclosures in certain situations as required by law, even without your written authorization. These situations include, but are not limited to:

- If all identifying information is removed so your identity cannot be ascertained from the information disclosed, i.e., on a completely anonymous basis
- When required by law, for example, public health reporting purposes or to a person who may be affected by a communicable disease
- To your employer, if we are providing car to you at your employer's request to evaluate a work-related illness or injury, or medical surveillance of your workplace
- Pursuant to a warrant or court order
- For health oversight purposes as authorized by law, for example, an investigation of our practice for purposes unrelated to your treatment
- To a public health authority as required by law, including those designated to receive notification of abuse or neglect
- To the U.S. Food and Drug Administration, in the event of an adverse event
- To law enforcement for certain purposes
- Related to a judicial or administrative proceeding, including subpoenas
- For national security and intelligence purposes, or to correctional institutions
- For purposes of worker's compensation law (or a similar law).
- Regarding a decent, including to a funeral director
- For military or veteran's activities
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III. ORGANIZATIONAL POLICIES

To facilitate the smooth and efficient operation of our practice, we engage in certain practices and policies that you should understand. You can avoid any of the following practices by discussing your concerns with us and working out an alternative;

- We contact our patients by telephone (which might include leaving a message on an answering machine or voicemail) or mail to provide appointment reminders or routine test results
- We call out names in our waiting room to manage patient flow
- Our staff will conduct routine discussions at our front desk with patients.
- We may contact our patients by telephone or mail to provide information about treatment alternatives or other health-related benefits and services that may be of interest
- We may use your name and address to send you a newsletter about our practice and the services we offer
- We may disclose your PHI to a member of your family or a close friend that relates directly to that person's involvement in your healthcare

You should also be aware of the following policies regarding our uses and disclosures of your PHI. You cannot avoid these uses and disclosures, but you should discuss any questions or concerns you might have with us.

- We share PHI with third-party "business associates" that perform various functions for us (for example, billing and transcription), but we have written contracts with those entities containing terms that require the protection of your PHI.
- We may disclose your PHI to your personal representative(s), if any, unless we determine in the exercise of our professional judgment that such disclosure should not be made.

IV. QUESTIONS AND COMPLAINTS

If you have any questions about this Notice, the matters discussed herein or anything else related to our privacy, please feel free to ask for an appointment or call 215-586-3304 to speak with our Office Coordinator and Physician.

You may complain to our Office or the United States Secretary of Health and Human Services if you believe your privacy rights have been violated. To complain to the Secretary, your complaint must be in writing, name us, describe the acts or omissions believed to be in violation of your privacy rights and be filed within 180 days of when you knew or should have known that the act or omission occurred.

You can file a complaint with us as well. We will not retaliate against you for filing a complaint.