Frank L. Stile, MD, PC
Plastic & Reconstructive Surgery

NAME (Last, First, M.I.)____

DATE ____________ BIRTHDATE ____________ SOC. SEC. #______ - ______- ______

AGE _____ SEX: M / T / F CELL#________________HOME#________________

STREET ADDRESS: ____

CITY___________________________ STATE_______ ZIP CODE______________

MARTIAL STATUS: SINGLE MARRIED SEPARATED DIVORCED WIDOWED (CIRCLE ONE)

EMAIL ADDRESS: ____

PATIENT EMPLOYER: ____

EMPLOYERS ADDRESS: ____

OCCUPATION: ____

EMPLOYERS PHONE NUMBER: ____

RESPONSIBLE PARTY/EMERGENCY CONTACT: ______________________________

RELATIONSHIP TO PATIENT: ____

PHONE NUMBER (S): ____

HOW DID YOU HEAR ABOUT US? ____

PROCEDURES /TREATMENTS **THAT YOU PLAN ON DISCUSSING TODAY**:

BREAST AUGMENTATION
EYELID SURGERY
FACELIFT
NECK LIFT
LIPOSUCTION
BROW LIFT
RHINOPLASTY

TUMMY TUCK
BREAST LIFT
BREAST REDUCTION
LABIAPLASTY
EARLOBE REPAIR
EAR CORRECTION
GYNECOMASTIA

BREAST REVISION
IMPLANT EXCHANGE
JUVEDERM
RESTYLANE
TCA PEEL
BOTOX
CHIN AUGMENTATION

IF LIPOSUCTION WAS CIRCLED ABOVE, PLEASE LIST DESIRED AREAS:
____

OTHER PROCEDURE NOT LISTED:____

Patient Health Disclosure

Name: ____ **Age:** _____ **Height:** _____ **Weight:** _____
Are you under a doctor's care? ________ Reason: ____
List any serious chronic illnesses (past or present): ____
____
Operations (specify and list approx. dates): ____
____

Habits: Alcohol - Yes _____ No _____ If yes: Daily _____ Occasionally _____ Never _____
Tobacco - Yes _____ No _____ If yes: Daily _____ Socially _____ Never _____
If daily, how many packs per day? __________ How many years? __________
Exercise & Activity: Frequent _____ Occasionally _____ Never _____
Type of exercise (if applicable): ____

Pregnancies: _______ Births: _______ Are you currently breastfeeding? ________
Do you have: Dentures ____ Chipped Teeth ____ Bridges ____ Loose Teeth ____ Diseased Gums ____
Other Dental Problems ____
Do you wear: Glasses _____ Contact Lenses _____ Prosthetic Device ____________________

Allergies And Sensitivities:

YES	NO		YES	NO	
		Penicillin			Iodine
		Antibiotics			Betadine
		Sulfates			Chlorhexadrine Phisophex
		Morphine			Tetanus
		Codeine			Latex
		Demerol			Tincture of Benzoin
		Narcotics			Skin Adhesive/Tape
		Novacaine			Dairy Products
		Lidocaine			Other

Specify Other If Checked: ____

Have you taken any of the following medications in the last 6 months?

Yes	No	Medication	Yes	No	Medication
		Cortisone			Blood Pressure Medication
		Prednisone			Recreational or Illegal Drugs
		Steroids			Migraine Medication
		ACTH			Seizure Medication
		Diuretics			Antibiotics
		Water Pills			Insulin
		Heart Medication			Orinase
		Digitalis			Anticoagulants/Blood Thinners
		Lamoxin			Pain Medication
		Nitroglycerine			Stimulants
		Appetite Suppressants			Homeopathic/Herbal Medication
		Birth Control Pills			Antipsychotic Medication
		Phen-Phen/Redux			Asthma Med./Inhaler
		Allergy Medication			Other ____________

Please circle any of the following medications that you have taken in the last 2 weeks:

Aspirin   Ibuprofen (Motrin, Advil, Nuprin)   Vitamin E   Anti-Inflammatory Med

Other ______________________________

Have you ever received treatment for any of the following medical conditions?

Yes	No	Condition	Yes	No	Condition
		Hepatitis, Jaundice, Cirrhosis, or Liver Disease			Stomach Ulcers
		Asthma, TB, Pneumonia, Emphysema, or Chest Disease			Blood Transfusion
		Heart Attack, Angina, Palpitations, Irregular Heart Beats			HIV or AIDS
		Shortness of Breath or Fainting Spells			Chronic or Recent Cough
		Stroke, Seizures, Bell's Palsy or Neurological Problems			Anorexia or Bulimia
		Abnormal or Excessive Bleeding			High Blood Pressure
		Rheumatic Fever or Congenital Heart Disease			Low Blood Pressure
		Sexually Transmitted Disease or Venereal Disease			Hives, Rash, Skin Disease
		Kidney Failure, Kidney or Prostate Problems			Diabetes, Abnormal Blood Sugar
		Migraines, Headaches, or Chronic Head Pain			Thyroid Problems
		Shingles, Cold Sores, Fever Blisters, Oral Herpes			Edema or Persistent Swelling
		Abnormal Healing or Poor Scar Formation			Anemia or Blood Disorder
		Anxiety, Depression, Psychological or Emotional Problems			Lupus or Arthritis
		Nervous Breakdown or Personality Disorder			Autoimmune Disease
		Phlebitis, Blood Clots, or Varicose Veins			X-Ray Treatment or Radiation
		Chronic Cough > 3 weeks			Bloody Sputum
		Unexplained Weight Loss			Night Sweats
		Recent travel outside of the U.S. or live in concentrated housing with or without another Tuberculosis patient			

I certify that the above is true and correct. I realize that withholding information about my medical history could result in serious injury to me or harm those involved in my care. I am aware that providing false or incomplete information about my medical and surgical history may result in the cancellation of my proposed surgery and forfeiture of my surgical fee.

Patient Signature ______________________________ **Date** __________

Witness Signature ______________________________ **Date** __________

Dr. Frank Stile, M.D., P.C.
Cosmetic Surgery Center and Spa
Acknowledgement of Notice of Privacy Practices

Privacy Officer

The Provider's Privacy Officer, can be reached through the front office.

8954 Spanish Ridge Ave., Ste. #1, Las Vegas, NV 89148
Phone:(702) 243-9555 / Fax: (702) 243-9856

Acknowledgement
I Hereby acknowledge receipt of this Notice of Privacy Practices.

Print Name: ______________________________ Date: ______________

Signature: ____

- OR -

Acknowledgement Refused
On this date, the undersigned patient refused or failed to acknowledge receipt of this Notice of Privacy Practices.

Name of Patient: ______________________________ Date: ____________

Reason for refusal/ failure: ____________________________________

Witness: ____

ASSIGNMENT AND RELEASE

(Please sign even if not applicable to you)

I, the undersigned, understand that Dr. Stile does not take any insurance or supplement insurance, and assign directly to Dr. Stile all medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

______________________ ______________________________

Date **Patient Signature**

MEDICARE AUTHORIZATION

(This section MUST be signed by all patients, no matter your age)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Frank Stile for any services rendered to me by Dr. Stile. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim form or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and for the deductible, coinsurance, and no covered service. Coinsurance and the deductible are based upon the charge determine of the Medicare carrier.

______________________ ______________________________

Date **Patient Signature**

MUTUAL AGREEMENT TO MAINTAIN PRIVACY

Dr. Frank L. Stile and Premium Surgical Services Center/Esthetique Plastique agree to maintain the Privacy of (PATIENT'S NAME PRINTED BELOW) as outlined in the HIPAA form. The Physician takes pride in being able to extend a greater degree of privacy than is required by HIPAA, state confidentiality mandates, and common law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, HIPAA forbids physicians from receiving money selling lists of patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products and services, the patient can still be targeted with unwanted marketing information. Dr. Stile believes this is improper and may not be in the patients' best interest. Accordingly, Dr. Stile agrees not to provide any list for marketing or be paid for selling patient lists or protected health information to any party for the purpose of marketing directly to patients. Regardless of legal privacy loopholes, Dr. Stile never attempts to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

In consideration for treatment and the above noted patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Dr. Stile and his practice, expertise, and/or treatment – the sole exception being communication to a confidential medical-peer review body; to another healthcare provider; to a licensed attorney; to a governmental agency; in the context of a legal proceeding; or unless mandated by law. Publishing is intended to include attribution by name, by pseudonym, or anonymously. If patient does prepare commentary for publication about Dr. Stile, the Patient exclusively assigns all Intellectual Property rights, including Copyrights, to Dr. Stile for any written, pictorial, and/or electronic commentary. This assignment is in further consideration for additional privacy protections provided by Dr. Stile. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary. Dr. Stile has invested significant financial and marketing resources in developing the practice. In addition, patients will not denigrate, defame, disparage, or cast aspersions upon Dr. Stile and will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in any such activity. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage Dr. Stile's practice. Dr. Stile feels strongly about Patients' privacy as well as the practices' right to control its public image and privacy. Both Dr. Stile and Patient will work to prevent the publishing or airing of commentary about the other party from being accessed via internet, blogs, or other electronic, print, or broadcast media without prior written consent. Finally, this agreement shall be in force and enforceable (and fully survive) for a period of the longer of five years from Dr. Stile's last date of service to Patient; or three years beyond any termination of the Physician-Patient relationship. As a matter of office policy, Dr. Stile is requiring all patients in its practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all of Dr. Stile's patients.

Patient and Dr. Stile acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, Patient and Dr. Stile agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask question and receive satisfactory and adequate explanations.

SO AGREED TO THIS ________ DAY OF __________________________, ON THE YEAR ___________

X ____ (PATIENT PRINT NAME)

X ____ (PATIENT/GAURDIAN SIGNATURE)

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Extent of Authorization

I authorize Dr. Stile to use and disclose the following protected health information: name, address, date of birth, procedure description, social security number and method of payment information to any financial institution or company providing credit services that is seeking the information for disputed charges of any reason.

2. Effective Period

This authorization for release of information covers the period of healthcare of all past, present, and future periods.

3. This medical information may be used by Dr. Stile or the financial institution that is disputing charges to receive this information for billing or claims payment.

4. This authorization shall be in force and effect in perpetuity.

5. I understand that I have the right to request this authorization be revoked, in writing, at anytime. I understand that a request of revocation is not effective unless written authorization is obtained by Dr. Stile.

6. I understand that my treatment for procedures may be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclo sed by the recipient and may no longer be protected by federal or state law.

____

(Signature of patient or patient representative)

____

(Printed name of patient or personal representative and his or her relationship to patient)

____

(Date)

FRANK L. STILE, MD, FACS
COSMETIC PLASTIC SURGERY

Date: ___________

Media release form

I authorize Frank Stile MD., FACS, Esthetique Plastique and their agents to use my procedure information and images without charge, for educational and/or promotional purposes including but not limited to advertising and social media platforms.

Name: ____

Signature: ____

Email: ____

Phone: ____

Address: ____

City: ____________________________ State: ______ Zipcode: ____________

If under 18

Patient Name: ____

Guardian Signature: ____

coolsculpting®

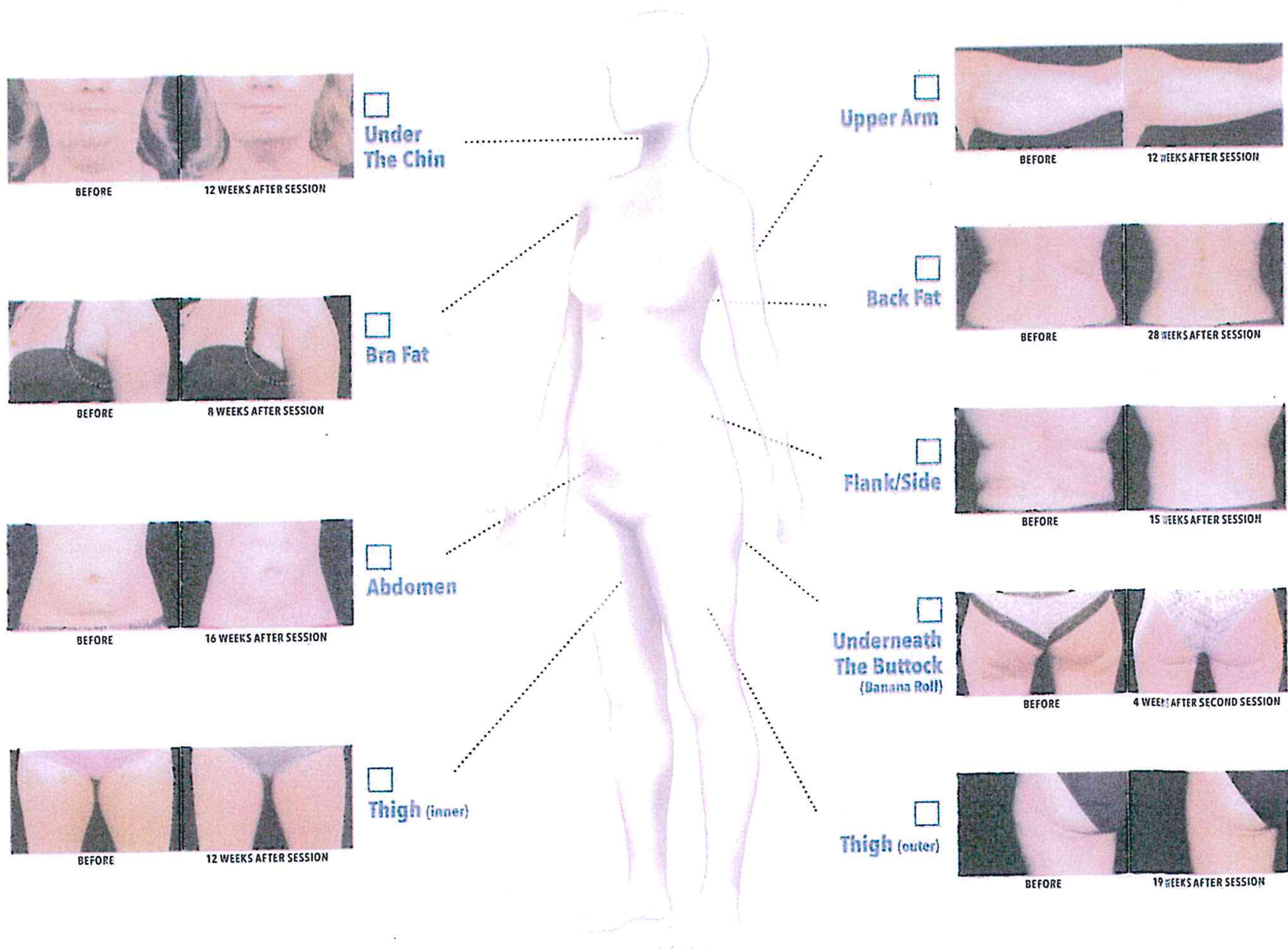
OUR OFFICE IS PROUD TO OFFER COOLSCULPTING®!

Discover how to freeze away fat with the world's #1 non-invasive fat reduction procedure[1]:

- » Transformational results without needles, surgery, or downtime
- » Millions of treatments performed worldwide
- » FDA-cleared, safe and effective

COOLSCULPTING CAN TARGET STUBBORN FAT IN THE AREAS THAT BOTHER YOU THE MOST.

Indicate below which problem areas would you be interested in transforming: (check all that apply)



1. CoolSculpting is the treatment doctors use most for non-invasive fat removal.

RESULTS AND PATIENT EXPERIENCE MAY VARY. Placements shown are approximate.
Before and After photos courtesy of (in order of appearance): A. Jay Burns, MD; Jason Rivers, MD; Christine Dierickx, MD; Brian Hass, MD; Grant Stevens, MD; Scott Gerrish, MD; Amy Brenner, MD; Mark Beaty, MD; Premier Plastic Surgery
In the U.S., the CoolSculpting procedure is FDA-cleared for the treatment of visible fat bulges in the submental area, thigh, abdomen and flank, along with bra fat, back fat, underneath the buttocks (also known as banana roll), and upper arm. In Taiwan, the CoolSculpting procedure is cleared for the breakdown of fat in the flank (love handle), abdomen, and thigh. Outside the U.S. and Taiwan, the CoolSculpting procedure for non-invasive fat reduction is available worldwide. ZELTIQ, CoolSculpting, the CoolSculpting logo, and the Snowflake design are registered trademarks of ZELTIQ Aesthetics, Inc.

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Dr. Frank Stile – Medical Director
Stile Aesthetics

COSMETIC INTEREST QUESTIONNAIRE

Patient Name:	Date:

General appearance or products of interest to you (please check all that apply).

❑ Skin care advice & products	❑ Vaginal Rejuvenation	❑ Tummy Tuck
❑ BOTOX® Cosmetic/ Dysport/Xeomin	❑ Thin Lips	❑ Liposuction
❑ Restylane / Juvederm / Fillers	❑ Rhinoplasty	❑ Armlift / Thighlift
❑ Facial fine lines	❑ Skin Tightening	❑ Cellulite Reduction
❑ Facial wrinkles / folds	❑ Face and/or Neck Lift	❑ Coolsculpting
❑ Facial veins / redness	❑ Eyelid Lift	❑ Fraxel
❑ Sun damage	❑ Breast Augmentation	❑ Microdermabrasion
❑ Liver spots/age spots	❑ Breast Lift / Reduction	❑ Severe Sweating

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

How did you hear about us?

❑ My Physician	*Physician's Name:*
❑ Healthgrades /RealSelf / RateMDs / Yelp	*Other Review Site:*
❑ Print	*Specify Ad:*
❑ A Patient, Friend, or Family Member	*Name:*
❑ Internet	*Which Site:*
❑ Established Patient	*Name of Patient:*
❑ Facebook / Instagram / Twitter	*Social Meda:*
❑ Other	*Please Specify:*

Are you interested in meeting with one of our professional cosmetic consultants in order to create a Personal Treatment Plan designed to meet your cosmetic needs?

❑ YES ❑ No thanks Timeframe: ASAP 1 month 3-6 monts

❑ Approval to contact you.	*Best phone number to reach you:*
❑ Approval to send you information on special offers, products, and services	*Email address:* ***This e-mail address will not be shared with any outside sources***

Patient Signature: ***Date:***

For Office Use Only

Physician (provider) name:		
Follow-up	*Date*	*Completed by (name)*
❑ Initial Inquiry/Information Mailed		
❑ Free Consultation		
❑ Follow Up Call/Text		
❑ Follow Up Letter		
❑ Procedure scheduled		
❑ Procedure completed		

Comments: