AQUA

MEDICAL HISTORY

ABOUT DR. DAVID RANKIN-

Cosmetic and reconstructive surgery is where "art" and "science" blend to combine intuition, creativity and artistic sense with extensive surgical training, discipline and medical knowledge.

Dr. Rankin is a Board Certified Plastic and Reconstructive Surgeon specializing in cosmetic surgery and upper extremity surgery. He also has specialized training in reconstructive surgery for birth defects, traumatic injuries and deformities from cancer including microsurgery and breast reconstruction.

Dr. Rankin is committed to fully educating his patients about their individual procedures and will spend the time necessary to discuss all possible techniques and alternatives. His goal is to provide exceptional and natural appearing results on a consistent basis. He is privileged to have a diverse patient base from all parts of the United States and from numerous countries around the world.

In his quest to insure that his patients receive the benefit of the latest technologies and advances in cosmetic and reconstructive surgery, Dr. Rankin routinely attends seminars, training and continuing medical education **courses.**

Name: _____SS#: _____Date: _____
Street Address_____
City_____State_____Zip_____
Birthday: _____Age_____Sex_____Height_____Weight_____
Cell phone _____Home phone_____
In case of emergency notify_____Relationship_____
Telephone_____

Email:_____

May we send you email including news and specials about the practice? Yes No
May we request you on facebook? Yes No

Family Doctor: _____Location_____

Occupation:_____
Employer: _____Employer phone: _____
Employer address: _____

How were you referred to our office?

What is reason for your visit today? (Your concerns are very important to us. Please describe any concerns you would like the doctor or staff to discuss with you today)

Have you consulted with any other physician about this? If yes, whom?

List all **Medications** you currently take including **Herbal Supplements/**vitamins?

List any **Allergies** you have:

List past & current **Medical Problems**:

Describe all prior **Hospitalizations** & dates:

Past Surgical History

List any **Surgeries** you have had & dates:

Social History

Do you smoke? Yes No If yes, how many cigarettes/day?_____
Did you smoke in the past? Yes No If yes, how many for how long?_____
Do you drink alcohol? Yes No If yes, how many drinks per week? _____Do you take drugs not prescribed by a doctor? Yes No

Past/Current Medical History (check all that applies and describe above)

__ Anxiety	__ Embolism	__ Skin Disorder	__ Endocrine Disorder
__ Arthritis	__ Ear Problem	__ Stroke	__ Psychiatric
__ Asthma	__ Eye Problem	__ Thyroid Problem	__ Breast Problem
__ Bleeding Problem	__ Drug Dependance	__ Keloids	__ Intestinal Problem
__ Bladder Problem	__ Epilepsy	__ Kidney Problem	__ Muscle Disorder
__ Blood Clots	__ Hernia	__ Liver Problem	__ Bone Disorder
__ Bruise Easily	__ HIV/AIDS	__ Lung Problem	__ Fractures
__ Cancer	__ Infections	__ High Blood Pressure	__ Vascular Problem
__ Diabetes	__ Heart Attack (MI)	__ Neurologic Disorder	
__ Depression	__ Heart Problem	__ Seizure	__

Review of Systems:

Check any of the following that you have had **recently**:

__Fever/Chills	__Pain	__Bleeding	__Weight Loss
__Sort Throat	__ Redness	__Itching	__Vision Changes
__Cough	__Swelling	__Weakness	__Feeling Tired

__ Other: _____

Do you **scar** easily, or are you prone to hypertrophic or keloid scarring? Yes No

If you were injured, did it occur at work?

Family History

Is there **any** history of medical problems in your family? (For women, please include any history of breast cancer or disease)

Females*:* (if applicable)
Are you pregnant or possibly pregnant? Yes No
# of pregnancies_____ # of children_____
Do you have any history of breast disease or breast cancer? Yes No
Do you have any acute or chronic Breast Pain, Lumps, Discharge? Yes No
What was the date and findings of your last mammogram?

Have you had **Radiation Therapy** and/or **Chemo Therapy** in the past? (please describe) Yes No

Past Anesthesia History

Have you had **Anesthesia** in the past? Yes No What type of anesthesia? Local General
Describe any problems?

Are you interested in learning more about any of the following Aqua Med Spa procedures:

__ Botox
__ Laser Hair Removal
__ Laser Tattoo Removal
__ Laser Skin Resurfacing
__ Laser Skin Tightening
__ Laser Photofacials (Pigment Removal/IPL)
__ Laser Vein Removal
__ Acne Treatments
__ Skin Care Products
__ HCG Weight loss Program
__ Other: _____

__ Eyelash Enhancement
__ Permanent Make-up
__ Peels or Facials
__ Scar Revisions
__ Vibradermabrasion (Microdermabrasion)
__ Juvederm
__ Sculptra
__ Restylane
__ Radiesse

Notice of Privacy Practices Acknowledgement

I have reviewed a copy of Dr. Rankin's Notice of Privacy Practices.
(If you desire a printed copy of the notice, please notify the receptionist.)

X_____ _____
Patient Signature or Legal Representative **Date**

Malpractice Acknowledgement

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. **Dr. Rankin has decided not to carry medical malpractice insurance.** This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law. This decision does not in any way diminish Dr. Rankin's personal, medical, or financial commitment to his patients.

X_____ _____
Patient Signature or Legal Representative **Date**

Assignment of Insurance Benefits and Statement of Insurance

I hereby assign and authorize payment to be made directly to *Palm Beach Plastic Surgery* of the covered insurance benefits including major medical benefits, otherwise payable to me. I also authorize the release of medical information as may be required to process the claims for payment of the medical services rendered and it is expressly understood that the right of such information to be privileged is hereby waived.

X_____ _____
Patient Signature or Legal Representative **Date**

Release of Medical Records

If necessary, I authorize the release of all medical records including but not limited to progress notes, operative notes, laboratory test results, diagnostic tests to all medical personnel, insurance companies or entities associated with my care.

X_____ _____
Patient Signature or Legal Representative **Date**

For those patients under the age of 18 or unable to consent

_____ _____
Patient Legal Representative (if applicable) Date

_____ _____
Print Name of Legal Representative Date

AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS

INSTRUCTIONS

This is a consent document that has been prepared to help inform you concerning permission to take photographs and to use these images for a purpose as defined within this consent document. After reviewing, please sign the consent as proposed by your Medical Provider

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INTRODUCTION

Medical photographs may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images.
Additionally, patients may consent to release these medical photographs for a stated purpose.

1. CONSENT TO TAKE PHOTOGRAPHS

I hereby authorize David Rankin M.D. and or his associates or licensees to take pre-operative, intra-operative, and post-operative photographs. I additionally consent to photographs during my consultation/office visit.

2. CONSENT FOR RELEASE OF PHOTOGRAPHS

I hereby authorize David Rankin M.D. and or his associates or licensees to use pre-operative, intra-operative, and post-operative photographs for professional medical purposes deemed appropriate including but not limited to showing these for purposes of medical education, patient education, or during lectures to medical or lay groups. This also may include posting these pictures on the world wide web to educate other prospective patients.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images.

X_____

Patient Signature Date

FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your help, and your understanding of our payment policy. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

We will be happy to help you process your insurance claim. You must realize that:

1) Your insurance is a contract between you and the insurance company. We are not party to that contract.
2) Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3) Our fees are based on the quality of the service provided and generally fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50%, or 80%) of "U.C.R.". "U.C.R." is defined by your insurance company as usual, customary and reasonable fees for this region. Thus most companies consider our fees usual, customary and reasonable. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We do expect you to pay for services that your insurance carrier will not cover.

We do expect to be paid any balance exceeding 45 days of said professional service. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, please contact us promptly for assistance in the management of your account.

PATIENT PAYMENT RESPONSIBILITY

I have read the "FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE" form and I understand that all charges incurred are my responsibility whether my insurance company pays or not. I understand that I am responsible to meet my insurance deductible in addition to payment for any services or treatment not covered by my insurance carrier.

Aqua Plastic surgery has offered to file the necessary insurance forms with my primary carrier at no charge, for my convenience. I hereby agree that I will pay promptly to *Aqua Plastic surgery* any amount outstanding on my account after crediting by *Aqua Plastic surgery* of any and all payments when directly from any insurance carrier for the serviced performed. I will immediately (no later than 5 days after receipt) pay over such payments to *Aqua Plastic surgery*.

In the event that my insurance carrier refuses to make payments against my claim for services rendered by *Aqua Plastic surgery*, for any reason, I accept responsibility for prompt payment for any treatments and services I have received through *Aqua Plastic surgery*.

If for any reason an account balance is outstanding for six months, your account will be sent to collections. Once your account has been turned over to collections, your account will be listed at the credit bureau and no follow-up visits will be made for you until your account is paid in full.

All returned checks are subject to an additional fee of $25.00 per check.

X_____ _____

Patient signature Date