JAY J GARCIA MD

WEIGHT LOSS & WELLNESS CENTERS

PATIENT INFORMATION

(please print)

FIRST NAME	LAST NAME	DATE

DATE OF BIRTH	AGE	GENDER	
		☐ Male ☐ Female	

STREET ADDRESS	CITY	STATE	ZIP

EMPLOYER	OCCUPATION

WORK PHONE	HOME PHONE
Can we leave a message at this number? ☐ Yes ☐ No	Can we leave a message at this number? ☐ Yes ☐ No

CELL PHONE	EMAIL ADDRESS
Can we leave a message at this number? ☐ Yes ☐ No	Can we email you appointment reminders? ☐ Yes ☐ No

EMERGENCY CONTACT NAME	PHONE NUMBER	PRIMARY PHYSICIAN NAME	PHONE NUMBER

How did you hear about us? ☐ Current Patient ☐ Practice Website ☐ Internet ☐ Other (please specify)

If you were referred by a patient, please provide their name:

Are you currently a beneficiary of Medicare? ☐ Yes ☐ No

If yes, Medicare may cover certain weight loss services and programs when it is a medical necessity. However, we are not participating providers of Medicare and do not accept assignment. Because of this, reimbursement will not be made from Medicare to this office. This office will not submit any bills to Medicare for weight management services or related fees. At your request, we will provide you a receipt of payment for services so that you may bill Medicare on your own for reimbursement. Regrettably, we are unable to assist you with explaining, completing, or submitting any forms that may be required by Medicare.

PATIENT SIGNATURE	DATE

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MEDICAL / AESTHETIC HISTORY
(please print)

PATIENT NAME	DATE

WHAT IS YOUR MAIN CONCERN TODAY?

HAVE YOU HAD RECENT MEDICAL, DENTAL OR PLASTIC SURGERY?

Year	Illness or operation

MEDICATIONS (please list the medications you are currently taking, and as needed)

Medication	Dosage	How Often	Reason

MEDICATIONS AND OVER THE COUNTER SUPPLEMENTS (please check all that apply and list date of last usage)

- ☐ Accutane
- ☐ Anti-coagulants
- ☐ Anti-inflammatory
- ☐ Aspirin
- ☐ Flax seed oil
- ☐ Garlic
- ☐ Ginkgo biloba
- ☐ Retin A / Retinol
- ☐ Steroids
- ☐ Vitamin A
- ☐ Vitamin E

ALLERGIES (please list any medications or food that you are allergic to)

MEDICAL HISTORY (please check all that apply)

- ☐ Acne
- ☐ Eczema
- ☐ Keloid
- ☐ Pigmented scars
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Telangiectasia
- ☐ Glaucoma
- ☐ Vision problems
- ☐ Anxiety
- ☐ Depression
- ☐ Epilepsy
- ☐ Manic depressive
- ☐ Nervousness
- ☐ Phobias
- ☐ Schizophrenia
- ☐ Excessive bleeding
- ☐ Sore throat
- ☐ Autoimmune disease
- ☐ Eaton Lambert disorder
- ☐ Lou Gehrig's disease
- ☐ Myestenia gravis
- ☐ Neuro-muscular disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Anaphylactic shock
- ☐ Hypertension
- ☐ Liver disease
- ☐ Lung disease
- ☐ Thyroid disease
- ☐ Metal implants
- ☐ Could you be pregnant?
- ☐ Are you breastfeeding?
- ☐ Other:

AESTHETIC HISTORY (please check all that apply and list date of last treatment)

- ☐ Botox/Dysport
- ☐ ArteFill
- ☐ Collagen/fat transfer
- ☐ Juvederm/Restylane
- ☐ Perlane
- ☐ Radiesse
- ☐ Silicone injections
- ☐ Chemical peel
- ☐ Facial waxing
- ☐ Other dermal fillers:
- ☐ Facial laser treatment, IPL, resurfacing...
- ☐ Do you use a tanning bed? If so, when was last visit?
- ☐ Have you had direct sun exposure in the last 14 days?
- ☐ Do you use a sunscreen? Brand & SPF

PLEASE LIST ALL FACIAL TOPICALS USED AT THIS TIME (cleanser, moisturizer, creams and brands of makeup)

Are you interested in meeting with one of our professional weight loss consultants in order to create a Personal Treatment Plan designed to meet your needs? ☐ Yes ☐ No, thanks ☐ Current patient

Patient signature Date

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WEIGHT LOSS & WELLNESS CENTERS

PATIENT ACKNOWLEDGMENT OF OFFICE POLICIES

(please print)

Please initial each item

____________ I understand that I must cancel my appointment within 24 hours prior to my scheduled appointment if I am unable to make it to the office.

____________ I understand that failure to cancel my appointment within 24 hours prior to my scheduled appointment will result in the posting of a $35.00 cancellation fee to my account.

____________ I understand that all returned checks will be subject to any applicable bank fees, as well as any applicable collection legal fees.

____________ I understand that payment is due at the time services are rendered.

____________ I understand that services are not reimbursed by insurance and that the office does not provide or fill out claim forms for insurance purposes.

____________ I understand if my account is turned over to a collection agency for non-payment, I will be responsible for the collection agency fee as well.

My signature below and initials above indicate that I have read and understand and I agree to comply with all the above.

Signature of responsible party____

Date____

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Receipt of notice of privacy practices written acknowledgment form and authorization for the use of disclosure of individually identifiable health information to business associates of Jay J. Garcia, MD.

I, (patient name) ______________________________ ,
have received a copy of Jay J. Garcia, MD's Notice of Privacy Practices.

Signature of patient ______________________ Date ______________

Patient authorization for disclosure of protected health information

I, ______________________ D.O.B. ______________ ,
SS# ______________________, authorize Dr. Garcia and/or staff to release information to the following individuals regarding my appointment and account history, and hereby authorize these individuals to reschedule, verify, make cancellation, and tender payment on my behalf.

Name ______________________________

Name ______________________________

Name ______________________________

Name ______________________________

Signature ______________________ Date ______________

Witness ______________________ Date ______________

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BRILLIANT DISTINCTIONS REWARDS PROGRAM

The Brilliant Distinctions® Program is an exciting program that offers a multitude of great rewards when you receive BOTOX® Cosmetic (onabotulinumtoxinA) and JUVÉDERM® treatments!

- Earn points for treatments using any of Allergan's injectable products.
- Redeem coupons for dollars off BOTOX® Cosmetic (onabotulinumtoxinA), JUVÉDERM® products and LATISSE® (bimatoprost ophthalmic solution) 0.03%.

PATIENT NAME	DATE OF BIRTH

PATIENT ADDRESS

CITY	STATE	ZIP

EMAIL ADDRESS (please print clearly)

PASSWORD
Botox

HAVE YOU EVER BEEN TREATED WITH ANY OF THE FOLLOWING? (check all that apply)

- ☐ BOTOX® Cosmetic (onabotulinumtoxinA)
- ☐ JUVÉDERM® Injectable Gel
- ☐ Restylane®/Perlane®
- ☐ Collagen
- ☐ Other injectable dermal filler
- ☐ None of the above

We will help manage your account to insure your discount. The center will access your account after a treatment to "deposit" your point and prior to your next treatment to print the voucher for your additional savings. By signing below you authorize the center to manage your account. You can change your password at any time. However, if the center cannot access your account, you will not receive the discount after services are provided.

PATIENT SIGNATURE	DATE

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WEIGHT LOSS, WELLNESS & AESTHETIC CENTERS

NOTICE OF PRIVACY PRACTICE

Effective Date: April 14, 2003

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.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of or notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice's privacy office (see overleaf).

Treatment: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example: we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in our medical care and need the information to provide you with medical care.

Payment: We may use and disclose Health Information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Health and care operations: We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. We also may share information with other entities that have another relationship with you (for example, your health plan) for their health care operation activities.

Appointment reminders, treatment alternatives, and health-related benefits and services: We may use and disclose Health Information to contact your medical care or payment for your care, such as your family or a close friend. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals involved in your care or payment for your care: When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research: Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As required by law: We will disclose Health Information when required to do so by international, federal, state or local law.

To avert a serious threat to health or safety: We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business associates: We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and tissue donation: If you are an organ donor, we may use of release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissue to facilitate organ, eye or tissue donations, and transplantation.

Military and veterans: If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers compensation: We may release Health Information for workers' compensation or similar program. These programs provide benefits for work related injuries or illness.

Public health risks: We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury, or disability, report births and deaths; report child abuse or neglect, report reactions to medications or problems with products; notify people of recalls or products that they may be using; inform a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

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NOTICE OF PRIVACY PRACTICE
(continued)

Health oversight activities: We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights law.

Lawsuits and disputes: If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law enforcement: We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime even if under certain very limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

Coroners, medical examiners, and funeral directors: We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National security and intelligence activities: We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective services for the President and others: We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of State, or to conduct special investigations.

Inmates or individuals in custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary: 1) for the institution to provide you with health care, 2) to protect your health and safety or health and safety of others, or 3) for the safety and security of the correctional institution.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:

Right to inspect and copy: You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to See Below.

Right to amend: If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing to See Below.

Right to an accounting of disclosures: You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request in writing, to See Below.

Right to request restrictions: You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or payment for your care, like a family member or friend. For example, you could ask that we not share information about particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to See Below. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to request confidential communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request, in writing, to See Below. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact See Below. All complaints must be made in writing. You will not be penalized for filing a complaint.

PRIVACY OFFICER'S ADDRESS AND PHONE NUMBER:

Holly Pavlicko
813-871-6465
2801 S Macdill Ave.
Tampa, FL 33629 USA