



**Rinnova Med-Surgical & Laser Institute
4933 Mile Stretch Dr
Holiday, FL 34690**

Welcome,

We are happy that you have chosen to visit Rinnova Med-Surgical & Laser Institute. Our facility is dedicated to providing you with an informative consultation in a friendly and comfortable environment.

Enclosed in this packet are our New Patient Information and Medical History forms, as well as our Privacy Practices. Please bring these completed and signed forms to our office when you visit us for your consultation.

Our office is open Monday through Friday from 9:00 a.m. to 5:00 p.m. and our staff is always available during these hours to answer your questions. Please feel free to call us at 727-942-7000.

For cosmetic procedures, we require full payment 4 months prior to surgery. For your convenience we accept cash, check or credit cards (American Express, MasterCard, Visa or Discover). We also offer financing through Care Credit & Capital One Financing. If you are interested in any of these financing options please contact our office at 727-942-7000.

If you have any questions, please do not hesitate to contact our office.

BELIEVE IN THE BEAUTY IN YOU

PATIENT REGISTRATION

Patient Name: _____ Birth Date: _____ Age: _____
(please print) (last) , (first) (middle)

Mailing Address: _____

City: _____ State: _____ Zip: _____ Social Security Number: _____

Marital Status: Single Married Divorced Widowed Sex: Male Female

I may be reached at the following number(s), and will contact you if I wish to be removed from the contact list
(check preferred):

Home Number: _____ Work Number: _____ Cell Number: _____

Best Time to Call: Morning Afternoon Evening Other: _____

E-mail: _____

Employer: _____ Occupation: _____

Spouse: _____ Occupation: _____ Phone No: _____

In case of emergency, who should we notify?

Name: _____ Relationship: _____

Home Number: _____ Work Number: _____ Cell Number: _____

HOW DID YOU HEAR ABOUT OUR FACILITY?

Return Patient Drove By Mailing Billboard

Seminar Magazine

Patient Referral: _____ Friend: _____

Web Search Engine: _____ Other: _____

SIGNATURE: _____ **DATE:** _____

MEDICAL HISTORY

Name: _____ Date of Birth: _____ Age: _____

Family Doctor: _____ Phone: _____

Height: _____ Weight: _____

Review of Systems: Please answer yes and give date if you have had or now have any of the following:

General:	Yes	Date	Head, Neck, and Nervous System:	Yes	Date
Weight change	_____	_____	Meningitis	_____	_____
Bleeding disorder	_____	_____	Seizures	_____	_____
Anemia	_____	_____	Head injury	_____	_____
Diabetes	_____	_____	Paralysis	_____	_____
			Deafness	_____	_____
Heart and Lungs:			Eye infection/disease	_____	_____
Asthma-bronchitis	_____	_____	Vision difficulty	_____	_____
Pneumonia	_____	_____	Nose bleed	_____	_____
Emphysema	_____	_____	Thyroid disorder	_____	_____
Cough up blood	_____	_____			
Tuberculosis	_____	_____	Abdomen:		
Shortness of breath	_____	_____	Ulcers/pain	_____	_____
Chest pain/angina	_____	_____	Vomit blood	_____	_____
Ankle swelling	_____	_____	Black/bloody stool	_____	_____
High blood pressure	_____	_____	Hepatitis/Jaundice	_____	_____
Rheumatic fever	_____	_____	Gallbladder disorder	_____	_____
Heart murmur	_____	_____			
			Kidney and Genital:		
Female:			Blood in urine	_____	_____
Menopause (age)	_____	_____	Kidney disease	_____	_____
Nipple discharge	_____	_____	Venereal disease	_____	_____
Breast lump	_____	_____			
Fibrocystic	_____	_____			
			Arthritis:		
Cancer:	_____	_____			

MEDICAL HISTORY

Past Medical History:

Major illness and diseases: _____

Surgeries: _____

Hospitalizations (the date and reason of hospitalizing):

Allergic history/Sensitivity: (please check if you have or have had)

Penicillin: _____ Sulfa: _____ Codeine: _____ Demerol: _____ Tetanus: _____ Latex: _____

Anesthesia: _____ Tape: _____ Other: _____

Please list what type of reaction and how severe the reaction is: _____

Medications: List any medications you now take or have taken in the past years, and for what reasons. (Please include birth control pills, vitamins and herbal supplements): _____

Habits: Do you smoke? _____ Packs per day? _____

Do you drink? _____ How many per week? _____

Family History: List any diseases known in your family: _____

I verify that the above information is true and accurate to the best of my knowledge.

SIGNATURE: _____ **DATE:** _____

Notice of Privacy Practices

This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

Introduction

At Rinnova Med-Surgical and Laser Institute we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective February 2008, and applies to all health information as defined by federal regulations.

Understanding Your Health Record

Each time you visit Rinnova Med-Surgical and Laser Institute a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information often referred to as your health or medical record serves as a:

- Basis for planning your care and treatment
 - Means of communication among the many health professionals who contribute to your care
 - Legal document describing the care you received
 - Means by which you or a third party can verify that services billed were actually provided
 - Tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.
- Understanding what is in your record and how your health information is used helps you to ensure it's accuracy, better understand who, what, when, where, how and why others may access your health information, and make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of Rinnova Med-Surgical and Laser Institute, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of privacy practices upon request
- Inspect and have a copy made of your health record
- Amend your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or locations
- Request a restriction of certain uses and disclosures of your information
- Revoke your authorization to use or disclose health information from a certain date forward, not retroactively

Our Responsibilities

Rinnova Med-Surgical and Laser Institute is required to:

- Maintain the privacy of your health information
- Provide you with a copy of this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable request you may have to communicate health information by alternative means or at alternative location

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the revisions and have an updated copy available at your request. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received proper written revocation of the authorization. If you have any questions and would like additional information, you may contact our Privacy Officer at 727-942-7000. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Office for Civil Rights {OCR}, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with the Privacy Officer or with the OCR.

The address for the OCR is Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH building, Washington, DC 20201, Web address: www.hhs.gov/ocr/

Disclosures for Treatment, Payment and Health Operations

Treatment

We will use your information for treatment. For example information obtained by a nurse, physician or other member of your health care team will be recorded in your file and used to determine the course of treatment that will work best for you. Your provider will document in your health record his expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, your provider will know how you are responding to treatment, upon your authorization to do so, we will also provide copies of various reports or tests to another physician to assist him or her in treating you if you are discharged from this practice.

Payment

We will use your information for payment. For example, a bill may be sent to you or a third-party payer. The information accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies.

Regular Health Operations

We will use your information for regular health operations. For example, members of our medical staff or the risk or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort for continually improving the quality and effectiveness of the healthcare services we provide. Other administrative departments may use your health information when they have an operational function and need the information in order to complete their job duties.

Business Associates

There are some services provided in our organization through contacts with business associates. Examples include diagnostic testing facilities, laboratories and inpatient/outpatient facilities. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, we may require the business associate to appropriately safeguard your information.

Communications with Family

We may use or disclose information to notify or assist notifying a family member, personal representative, or another person responsible for your care, your location and general condition. Health professionals, using their best judgment, may disclose to a family member, or other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment.

Marketing

We may disclose health information to provide appointment reminders, either by telephone or via message on your telephone answering machine, or information about treatment alternatives or other health –related benefits and services that may be of interest to you.

Food and Drug Administration {FDA}

We may disclose health information to the FDA relative to adverse events with respect to supplements, products or product defects, or post marketing surveillance information to enable product recalls, repairs or replacements.

Workers Compensation

We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs.

Public Health

As required by law, we may disclose your health information to the public health or legal authorities charged with the prevention or control of disease, injury or disability.

Law Enforcement

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of a Notice of Privacy Practices from Rinnova Med-Surgical and Laser Institute. I understand that the Notice may be amended at any time, and notice of such amendment will be posted in the front office, and I may obtain an updated copy from the office during regular business hours.

Patient Name: _____ (Printed)

SIGNATURE: _____ DATE: _____

Cosmetic Surgery

Dear Patient:

As you may know, Dr. Cappiello performs multiple surgical procedures. Below we have listed the most commonly performed procedures. We would ask that you check the procedure(s) in which you are interested so that we will be prepared to answer all of your questions during your consultation.

- | | |
|---|--|
| <input type="checkbox"/> Abdominoplasty (tummy tuck | <input type="checkbox"/> Non Surgical Facelift |
| <input type="checkbox"/> Breast Enlargement using Breast Implants | <input type="checkbox"/> Or |
| <input type="checkbox"/> Breast Enlargement using Fat Transfer | <input type="checkbox"/> Short Scar Facelift |
| <input type="checkbox"/> Breast Lift | <input type="checkbox"/> Fat Injections |
| <input type="checkbox"/> Eyelid surgery (blepharoplasty) | <input type="checkbox"/> Liposuction |
| <input type="checkbox"/> Thermage | <input type="checkbox"/> Lip Enhancement |
| <input type="checkbox"/> Sclerotherapy | <input type="checkbox"/> Lipotherme |

Other: _____

Please list all of your questions, or concerns that you may have for Dr. Cappiello, as you will be given ample time to ask all of your questions during your consultation.
