URBANIAK
PLASTIC SURGERY
& MEDICAL SPA

Ginger L. Urbaniak, MD
BOARD CERTIFIED PHYSICIAN

Date: ____________________

Name: ____ DOB: ________________

Address: ______________________________ City: ______________ Zip: ________

Home Phone: ____________________________ Cell Phone: ____________________

Email Address: ____

Emergency Contact: __________________________ Phone: ____________________

Approval to contact you? ☐ No ☐ Yes Referred by: ______________________________

1) Have you been under the care of a physician, dermatologist or other medical professional within the past year?
☐ No ☐ Yes, explain: ____

2) Have you had any surgeries, including plastic surgery?
☐ No ☐ Yes, explain: ____

3) Have you ever had ☐ Botox, ☐ fillers, or ☐ facial lasers? If so, when? ____________________

4) List any medications (including prescription skin care products, acne medication, birth control, etc.)
you take regularly: ____

5) List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.)
you take regularly: ____

6) List any known drug allergies: ____

7) Have you ever had any of these health conditions in the past or present?
(Please check all that apply and provide additional information in the space provided)

Cancer __________(type)	☐	Headaches (chronic)	☐
Hormone imbalance	☐	Hepatitis	☐
High blood pressure	☐	Fever blisters/Cold sores	☐
Spinal injury	☐	Immune disorders	☐
Thyroid condition	☐	HIV/AIDS	☐
Thyroid condition	☐	Metal bone pins or plates	☐
Diabetes	☐	Blood clotting abnormalities	☐
Heart problem	☐	Psychological treatment	☐
Arthritis	☐	Skin diseases/skin cancer ________(type)	☐
Asthma/Breathing problems	☐	Any active infection	☐
Keloid scarring	☐	Any eye problems	☐
Seizure disorder	☐		

Any other medical problems: ____

____

8) Do you smoke? ☐ No ☐ Yes

9) Do you drink alcohol? ☐ No ☐ Yes If yes, how much do you drink? ______/day ______/week

10) Have you ever had an allergic reaction to any of the following?
(Please check all that apply and provide additional information in the space provided)

Cosmetics	☐	Medicine	☐
Skin Care Products	☐	Latex	☐
Fragrance	☐	Iodine	☐
Sunscreens	☐	AHAs (alpha-hydroxy acids)	☐
Food	☐	Drugs	☐
Shellfish	☐	Pollen	☐
Animals	☐		

Other: ______________________________

If yes, please explain: ______________________________

11) Do you form thick or raised scars from cuts or burns? ☐ No ☐ Yes

12) Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ☐ No ☐ Yes, describe: ______________________

13) How often are you exposed to the sun or use a tanning bed? ___Infrequently ___Frequently ___ Regularly

14) What SPF do you use on your face? ______________ How often/when? ______________

15) Have you recently used any self-tanning lotions, creams or treatments? ☐ No ☐ Yes, specify: ________

16) Have you used any of the following hair removal methods in the past six weeks? ☐ No ☐ Yes

Shaving	☐	Electrolysis	☐
Waxing	☐	Stringing	☐
Plucking	☐	Depilatories	☐
Tweezing	☐		

17) Have you ever had a body spa treatment before? ☐ No ☐ Yes, when: ______________________

18) What skin care products are you currently using? (List brand where known)

Soap ______________	Shower Gels ______________
Toner ______________	Body Lotions ______________
Mask ______________	Sunscreen ______________
Eye Product ______________	Night Moisturizer/Cream ______________
Cleanser ______________	Day Moisturizer ______________
Exfoliator ______________	Scrubs ______________

Makeup Products ______________________________

Other ______________________________

19) What areas of concern do you have regarding your: (Please check any that apply)

Skin:

- ☐ Breakouts/acne
- ☐ Blackheads/whiteheads
- ☐ Excessive oil/shine
- ☐ Rosacea
- ☐ Broken capillaries/redness
- ☐ Sun spot/liver spot/brown spot
- ☐ Thin eyelashes
- ☐ Uneven skin tone
- ☐ Sun damage
- ☐ Wrinkles/fine lines
- ☐ Dull/dry skin
- ☐ Flaky skin
- ☐ Dehydrated

Eyes:

Dehydrated ☐ Wrinkles ☐ Puffiness ☐ Dark circles ☐ None ☐

Other: ______________________________

Lips:

Dehydrated ☐ Cracked/chapped lips ☐ None ☐ Other: ____________

20) I would like to know more about:

Please check all that apply:

- ☐ Eyelash length, fullness, thickness, or darkness
- ☐ BOTOX® Cosmetic for wrinkles
- ☐ Facial Fillers (Restylane, Juvederm, Perlane, Radiesse, Sculptra)
- ☐ Cosmetic Eyelid surgery/Droopy eyelids
- ☐ Laser Skin Resurfacing or other treatments
- ☐ Volume loss/facial hollows
- ☐ Skin care products/advice
- ☐ Thin lips
- ☐ Facial veins/redness
- ☐ Liver spots/age spots
- ☐ Kybella for chin contouring
- ☐ ____________

Female Clients Only:

21) Are you taking oral contraceptives? ☐ No ☐ Yes, specify: ______________________

22) Are you pregnant or trying to become pregnant? ☐ No ☐ Yes

23) Are you breast feeding? ☐ No ☐ Yes

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the aesthetician/doctor of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

______________________________ ______________

Client Signature Date

URBANIAK PLASTIC SURGERY & MEDICAL SPA

Roderick M. Urbaniak, MD
BOARD CERTIFIED PLASTIC SURGEON
Ginger L. Urbaniak, MD
BOARD CERTIFIED PHYSICIAN

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: March 01, 2014

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.

This Notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

I. Your Rights.
You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means. You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us. You have the right to inspect and copy your Health Information. You may request your records in digital format and have your records sent digitally to another provider with written authorization. You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial. You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few. You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at 727-447-4536.

II. We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here Is One Example of Each:
We may provide your Health Information to other health care professionals — including doctors, nurses and technicians — for purposes of providing you with care. Our billing department may access your information — and send relevant parts to insurance companies to allow us to be paid for the services we render to you. We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.

III. We May Also Use or Disclose Your Health Information Under Certain Circumstances without Obtaining Your Prior Authorization. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to: To Notify and/or Communicate with Your Family. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to Family and Friends form. As Required By Law. For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings. In Response to Civil Subpoenas or for Judicial Administrative Proceedings. We may use or disclose your Health Information, as directed, in the course of any civil administrative or judicial proceeding. To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to comply with a court order or grand jury subpoena and other law enforcement purposes. For Purposes of Organ Donation. We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.
For Worker's Compensation. We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

IV. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time. Fundraising. Should our practice use patient information for fund raising we will inform individuals that they have the right to opt out of fundraising solicitations and explain that process. You do have the capability to opt back in with written notice. Marketing. Should our practice use patient information for marketing purposes we will first obtain your written authorization and fully explain the uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI will require a separate written authorization.

- Use or Disclosure of Psychotherapy Notes. *Written* authorization is required if our practice intends to use or disclose psychotherapy notes.
- Breach Notice. All patients will be informed if there is a breach, as defined by federal rules, of their unsecured protected health information as required by the HIPAA regulations.

Right to Request Restrictions for Disclosures Related to Self-Payment. Our practice is required to comply with a request not to disclose health information to a health plan for treatment when the individual has paid in full out-of-pocket for a health care item or service and signed our "Do Not File Insurance Form".

V. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:
Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you. Change of Ownership. In the event that our Business is sold or merged with another organization, your Health Information/record will become the property of the new owner. Electronic Exchange. Your information may be shared with other providers, labs and radiology groups through our EMR/EHR system: Eclinical works

VI. Our Duties.
We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice. We are also required to abide by the terms of this Notice. We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health Information — even if it was created prior to the change in the Notice. If any such amendment is made that materially changes this Notice, we will send you another copy.

VII. Complaints to our Practice and the Government.
You may make complaints to our HIPAA Privacy Officer or the Secretary of the Department of Health and we will review all complaints in a professional manner and keep you informed of your rights as our patient. We promise not to retaliate against you for any complaint you make about our privacy practices.

VIII. Contact Information.
You may contact us about our privacy practices or file a complaint by calling our Privacy Officer: Ginger L Wiersma, MD at 727-447-4536. You may contact the DHHS at: The U.S. Department of Health and Human Services, 200 Independence Avenue, S. W., Washington, D.C. 20201, Telephone: 202-619-0257, Toll Free: 1-877-696-6775

I ______________________________ hereby acknowledge that I have reviewed and received a copy of this practice's Notice of Privacy Practices, which has been updated for the new Omnibus Rule and has an effective date of May 2019
The notice describes: The ways that the Privacy Rule allows our practice to use and disclose protected health information. How our practice will get your permission, or authorization, before using your health records for any other reason. The practice's duties to protect health information privacy. The patient's privacy rights, including the right to complain to HHS and to the covered entity if you believe your privacy rights have been violated. How to contact our practice for more information and to make a complaint. I understand that the Notice of Privacy Practices may be revised from time to time and that I have a right to receive an updated copy upon request.

______________________________ ______________________________
PATIENT SIGNATURE DATE

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Roderick M. Urbaniak, MD
BOARD CERTIFIED PLASTIC SURGEON
Ginger L. Urbaniak, MD
BOARD CERTIFIED PHYSICIAN

OFFICE POLICIES

Thank you for choosing Dr. Roderick M Urbaniak as your physician. We recognize that you have a choice in your health care providers and we appreciate the trust that you have placed in us. Our office policies allow us to provide excellent health care to all of our patients based on mutual respect. Please review and **initial next to each** office policy acknowledging that you have read and understand the policy.

_____ (initial) We respect your time. We try our very best to stay on schedule, but occasionally a patient requires more than the allotted amount of time due to an urgent or complicated problem. Thank you for understanding that we will provide this same level of attention to you in the event that you should ever have the same need.

_____ **(initial) In the event that you have an urgent health care problem that requires immediate attention, please try to contact the office as soon as possible to reschedule your appointment. If possible we will still see you in the office that day. Appointment cancellations require 24 hour advanced notice. Appointments not cancelled within 24 hours of the appointment time will be coded "no-show". Three "no-shows" appointments may be reason to release you from care. If you need to cancel an appointment after our office is closed, please leave a message on our answering service. We realize that in rare cases you will be unable to provide the required 24 hour notice.**

_____ (initial) If you are going to be more than 15 minutes late for a scheduled appointment, it may be necessary to reschedule your appointment. We will make every effort to see you on the day of your appointment, however if the wait time exceeds the time needed for your appointment it will need to be rescheduled, unless your appointment is urgent.

NOTICE: In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, please note the following: PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE. For your convenience, we accept CASH, VISA, MASTERCARD, DISCOVER AND PERSONAL CHECKS. Your signature below indicates that you understand and accept this policy. A convenience fee of 3% will be made to all credit card transactions, except for Care Credit.

We look forward to the opportunity to work with you to meet your plastic surgery needs.

I have read, understand and agree to abide by the office policies described above.

_______________________________ _______________________________ __________
Print Patient Name or Legal Guardian | Signature of Patient or Legal Guardian | Date

P: 727-447-4536 F: 727-442-1600 13201 Walsingham Road. Ste. 200. Largo, Florida 33774 UrbaniakPlasticSurgery.com