PATIENT INTAKE

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell #: _____ Email: _____

Emergency Contact Name: _____Phone #: _____

Occupation:_____

Liposuction Areas you are interested in treating.

- ☐ Abdomen
- ☐ Arms
- ☐ Upper Back/Axilla
- ☐ Chest
- ☐ Hip/Waist/Mid Back
- ☐ Chin/neck
- ☐ Inner thigh
- ☐ Outer thigh
- ☐ 360' Thighs
- ☐ Knee Complex
- ☐ Calves/Ankles/Knees

What Liposuction Areas you have already had done? (Date Performed)

- ☐ Abdomen
- ☐ Arms
- ☐ Upper Back/Axilla
- ☐ Chest
- ☐ Hip/Waist/Mid Back
- ☐ Chin/neck
- ☐ Inner thigh
- ☐ Outer thigh
- ☐ 360' Thighs
- ☐ Knee Complex
- ☐ Calves/Ankles/Knees

What Plastic Surgery Procedures you have had done? (Date Performed)

- ☐ Arm Lift/Brachio
- ☐ Rhinoplasty
- ☐ Thigh Lift
- ☐ Blepharoplasty
- ☐ Other _____
- ☐ Gynecomastia/Male Breast
- ☐ Breast Aug/Implants
- ☐ Breast Lift/Reduction
- ☐ Tummy Tuck
- ☐ Face/Neck Lift

PATIENT INTAKE

Are you interested in being treated for Lipedema or Cosmetic purposes? _____

Have you had Non-Invasive fat reduction procedures (ie, CoolSculpting, sculpture etc.)

_____

How long ago was it performed and in what area?

_____

Have you had a large weight loss, if so how much did you lose and when?

_____

Do you have skin looseness in areas you want lipo done? **Yes Or No**

Do you have any major medical issues? (Check all that apply)

- ☐ High Blood Pressure
- ☐ Hepatitis
- ☐ Lung Disease
- ☐ Autoimmune/Lupus/MS
- ☐ Cancer
- ☐ Bleeding disorder
- ☐ Heart Disease
- ☐ Diabetes
- ☐ HIV

Allergies: _____

Height_____ **Weight_____**

Artlipo Plastic Surgery
12634 Bassbrook Lane
Tampa, FL 33626
Phone 813-886-9090
Fax 813-886-9595

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

_____ _____

PATIENT NAME **DATE**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Artlipo Plastic Surgery may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Artlipo Plastic Surgery has a detailed document called the '***Notice of Privacy Practices***'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the '*Notice*' before signing this agreement. If I ask, Artlipo Plastic Surgery will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Artlipo Plastic Surgery to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Artlipo Plastic Surgery has taken action relying on this consent.

_____ _____

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

_____ _____

Relationship to Patient if signed by another party **DATE**

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our '*Notice*' at any time by contacting: Artlipo Plastic Surgery 12634 Bassbrook Lane, Tampa, FL 33626.

FORM Us