THE CENTER FOR COSMETIC SURGERY &

DEAN P KANE, MD, FACS, PA
LAURI P KANE, RD, MPH, SCD

EXECUTIVE CENTRE AT HOOKS LANE
1 RESERVOIR CIRCLE, SUITE 201 • BALTIMORE, MD 21208
DeanKane@DrDeanKane.com • www.DrDeanKane.com
410.602.3322

Patient Demographic Information

Today's Date:___________ Who or How were you referred?:____

Person, eBlast, Website, Google, Bing, MSN, Magazine, Newspaper, Seminar, TV, Radio, Facebook / Social Media, Word of Mouth, other.

Name:____
First MI Last

Address:____
Street Apt City State Zip

Preferred Contacts: *Please circle how you wish to be contacted:* ***Home, Cell, Work, Text, email****.* ***Pharmacy*** *(see HIPAA Authorization)*

Home:___________________________Cell:____________________________Work:_________________________

Pharmacy: #:_______________________ / e-RX:________________________

eMail: ____

SSN:____________________________ DOB:__________________________ Age: ___________________

Reason for Visit:____

Employer Name:____

With whom may we discuss your personal health information and medical care?

Emergency Contact::____
Name Relationship Phone #

Medical Disclosure Contact:____
Name Relationship Phone #

Other Disclosure Contact(s):____
Name Relationship Phone #

Other Disclosure Contact(s):____
Name Relationship Phone #

Current regulations demand the presentation and copy of 2 forms of identification both unique to the you. One form will required photo identification (Driver's License or Passport). Your best second form of ID may is your Health Insurance Card. If you cannot comply, all services will be provided with cash payment only.
For those individuals who require the use of another person's ID or credit information, current regulations demand that this individual be with you with all forms of ID. I trust you will understand the difficulties imposed upon medical practices today. Thank you for your understanding. Dean P. Kane, MD, FACS, PA

____
Above named Patient Signature (and Responsible Adult if under 18 years old) Date

Base Medical Data

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Name: ________________________________ Nickname ________________ Age:________ Date:_______

Thank you for choosing our office for your consultation! Please check or fill in the following information so I may better help you.

Sex: M F; **Height:** , **Weight** . ***Reason for Visit:***

BMI: ***Your job description:***

List ALL your physicians:

Circle, list and explain all that apply:

Social Support: Single, Divorced, Separated, Widowed, Married: live with friend, other:

My **ethnic** background *includes*: Caucasian, N. European, Irish, Mediterranean, Middle Eastern, African, African-Am, Hispanic, Am-Indian, West-Indies, East-Indian, Asian. Other: Jehovah's Witness

Allergies: None Penicillin Sulfa IV Iodine Latex/Fruit **Other/ Reaction:**

Nicotine (any form**:** cigarette,gum, chew, vape, patch…): **N**ever. **Y**es, I now smoke_____ packs / day. I stopped smoking ______years ago. **2nd hand? Y N**

FAMILY Medical History: Malignant Hyperthermia…

YOUR Personal Medical History: Circle and / or explain ALL that apply: NONE

Accutane N Y: when_________
AIDS / HIV N Y
Malignant Hyperthermia **N Y**
Flu / COVID19 N Y
COVID Vaccine N Y: when_____

Anemia (Low blood)
Autoimmune Disease: RA, Scleroderma Lupus
Asthma / COPD
Bleeding or Clotting Disorders

Hypertension (High Blood Pressure)
Low Blood Pressure **BP: /**
Low Blood Sugar
Diabetes mellitus
GERD / Reflux / Hiatal Hernia
Motion Sickness / Glaucoma
Heart Disease / Heart Failure
Heart Attack / Stroke / bypass / stent
Peripheral Vascular (arterial) Dis
Heart Valve / MVP problems
Hepatitis, Liver Disease
High Cholesterol / Hyperlipidemia

Kidney Failure
Osteo/degenerative Arthritis
Seizure
Skin Cancer
Sun Response: tan, no response, burn
Thyroid Disease
Venous Disease: clots, phlebitis, DVT PE
Behavior Issues: anxiety, depression, Body dysmorphic synd, dementia, Gender change, suicidal syndrome
Implant(s) / Prostheses: breast, joints
Body Piercing(s): tongue, nipples, labia

Infections: Yeast, Viral cold sores Bacterial, MRSA
Snoring, sleep apnea, B/C-PAP

Sickle Cell
Skin-Cold vasoconstriction syndromes: Raynauds

Pregnant NOW
Lactating NOW

Review of Systems:

Pregnancies _________, # Births _________, # Miscarriages _________, # Abortions ___________

Anesthesia Concerns: None, Malignant Hyperthermia or List:

Recreational Drugs: **N Y:** (circle): cocaine, crack, meth, heroin, narcotic, marijuana (medical, CBD) synthetic cannabinoids (K2, Spice), other:

Alcohol: NONE, wine, beer, liquor: _______ ounces / week.

Chronic RX Narcotics / Benzo's / Sedatives use: NONE eg: codeine, codones, oxycontin, suboxone, methadone, valium, Xanax, Ativan, other:

Are you planning or involved in a law suit regarding any areas of medical concern? N, Y (if yes, explain):

List ALL prior SURGERY, PROCEDURES and INJURIES: NONE

tonsil & adenoids, tubal ligation, appendectomy, lap/open gall bladder, caesarean section, D&C, CABG, stent, Gastric Bypass / Lap Band, neck / back surgery, other:

Cosmetic & Plastic Surgeries:

List ALL MEDICATIONS: NONE

Hormones: HRT, Estrogen, Testosterone, IUD, Birth Control:
Acne: Spironolactone
Coagulant: Tamoxifen
Erectile Drugs: Viagra; Cialis, Levitra

Cholesterol:
Blood Pressure:
Anti-Coagulants: Coumadin Plavix
Auto-Immune: Humira, Remicade, Rituxan, Herceptin, other:

Heart Meds: Nitroglycerine:

Herbals, Teas or Supplements? Circle or List: NONE

Inhibits:MAOI & SSRI: **St. Johns Wort** {incr photosensitivity & induces cytoP450 which decr Rx activity!}; Yohimbe; Licorice root;
GABA & Serotonin stimulation = Sedation: 5 Hydroxy Tryptophan; **Valerian**; **Kava** {hepatic dysfunction}; Melatonin
Anti-coagulants: Arnica; Bromelain; Black Mushrooms; Clove oil; **Gingko** biloba; **Ginseng** {hypoglycemia}; Ginger; **Garlic** {decr BP}; Bilberry; Dong Quai; Feverfew; **Vitamin E;** Honeysuckle; Wintergreen; **Aspirin; Ibuprofen; Naprosyn; Chondroitin/Glucosamine**; **Saw Palmetto; Fish Oil / Essential Fatty Acids; Co-Q-10; Other NSAIDS**:
Stimulants: **Phentermine**; Ma Huang; MetaboLife; MetaBoost; **Ephedra** {halothane potentiates CV effects}; Other Weightloss Supplements:
Liver Dysfunction / Immunosuppression / inhibits cytoP450 which potentiates Rx: **Echinacea**; **Goldenseal**; Milk Thistle;
Flap Vasoconstrictor: marijuana, cocaine/crack, meth, migraine Rx, erectile Rx,
Other: Aloe {dermatitis, low K}
Multi-Vitamin, Other OTC's:

Any incorrect or missing information may adversely affect my care and my results.
I hereby confirm that all the information provided is complete and accurate to the best of my knowledge.

Base Med Data 121820

Signed: Date:

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Practice Authorizations and Policies

The practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me as to the results of any treatment, procedure or product.

- Although good results are desired, there is no guarantee or warranty expressed or implied on the result(s) that may be obtained. Dissatisfaction with any result does not constitute a basis for reimbursement, refund or cancellation of payment. Regret, remorse, anguish or any other show of apology does not express any admission of fault or constitute a show of guilt, liability, error or blame.
- Should complications or dissatisfaction occur, additional surgery or other treatments may be necessary. Your insurer may not cover the cost of complication(s), side-effect(s) or revisional therapy for elective cosmetic procedures. You should expect additional fees and these fees may be non-refundable. Risk of complications and side-effects may occur with primary and any additional procedures. I agree to be personally and fully responsible for all fees.

____ initial

Dean P. Kane, MD, FACS, PA (Practice) no longer participates with medical insurance companies. Both "insurance-pay" and "self-pay" procedures are offered. I remain personally and fully responsible for immediate payment of all fees. Should I wish to submit a claim for reimbursement of "insurance-pay" services from my insurer, I will request a receipt within 30 days of the services rendered. Payment for cosmetic services are irrevocable.

____ initial

I understand that I / we personally guarantee to be financially responsible to pay for any and all charges not covered by my insurer. As a guarantor, I fully accept the medical services provide to me / the patient. I also remain totally responsible to the bill if my insurer including Medicare or HMO's, PPO's and the like deny payment as deemed not necessary, not reasonable, cosmetic or otherwise. In the event collection efforts are required to obtain payment of the charges incurred by me / the patient, I agree to pay any costs incurred in the collection of this account including but not limited to court costs, private processing service fees and the like. All persons executing this form are guarantors and agree that their obligation to pay is joint and several in nature.

____ initial

I understand that "failure to show" (FTS) for an appointment imposes a great burden on the Practice. **Forfeiture of a pre-paid service or a FTS fee will be collected for the date missed prior to new services provided.**

____ initial

Services performed that are paid for with a credit card, debit card or with financing, are not eligible for post-care payment challenges. I agree that this credit, debit card or financing challenge agreement is irrevocable. Your Protected Health Information will be used if required to recover a practice expense claim. I agree and authorize the use of my credit card on file to pay for unpaid services.

____ initial

Red Flag Rules and Anti-Fraud Regulations are followed. We require a minimum of 1 (one) current photo-identification such as a driver's license and a second non-photo ID for proof of identity.

____ initial

I consent to the **use or disclosure of my individually identifiable health information ("Protected Health Information")** as defined in this offices "Notice of Privacy Practices" by Dean P. Kane, MD, FACS, PA in order to carry out treatment, payment, or health care operations. A "Notice of Privacy Practices" is available for my review.

____ initial

I acknowledge that it is the policy of the practice of Dean P. Kane, MD, FACS, PA to follow **all federal and state laws and reporting requirements regarding Identity Theft**. I will provide all necessary documents to prove the authenticity of my identity. Should there be any claim or concern of Identity Theft, The Practice will report the incident to the appropriate authorities. Should I wish to defer these policies, all products, services and surgery may be provided with a cash payment only.

____ initial

I hereby authorize Dean P. Kane, MD, FACS, PA and his associates to **take photographs, slides, videotapes and other documentary images, quotations or testimonials during and for documentation of my care.** Digital Imaging or HIPPA protected information other than medical documentation will be requested under separate authorization.

____ initial

It is the policy of Dean P. Kane, MD, FACS, PA to **protect your digital communication to and from our practice** to the best of our ability**.** I acknowledge that current technology may not fully conceal and / or protect the confidentiality of your identity with email, social media or other digital contact. I will not hold Dean P. Kane, MD, FACS, PA, Dean P. Kane, MD, FACS nor any employees or contractors responsible for a breach in such communication.

____ initial

I am aware that many **prescription medications sold by this "Practice" maybe available by at local pharmacies**. I have chosen to purchase said medications at the "Practice" location for my convenience.

____ initial

I am made aware that the Dean P Kane, MD, FACS, PA follows **2017 Maryland Heroin and Opioid Prevention, Treatment, and Enforcement** Initiative has mandated an Opioid Education, Discovery and Consent process for those patients who receive peri-operative controlled substances prescriptions.

____ initial

I acknowledge that this Practice provides medical and surgical services during the COVID-19 pandemic and may expose me and those around me to the SARS-CoV-2 virus. I will not hold Dean P Kane, MD, PA or his employees responsible should I develop COVID-19 or resultant complications and remain financially responsible to all its complications. I have read, understand and signed the additional COVID-19 screening questionnaire and consent form(s).

____ initial

I acknowledge that this Practice **recommends me to obtain an executed Power of Attorney and Advanced Directives** with an appropriate attorney..

____ initial

By signing below, the undersigned certifies that the foregoing paragraphs have been read in full, are understood and agreed upon by the undersigned.

By signing below, the undersigned certifies that ALL information provided to the Practice is truthful and up-to-date.

Signature:____Date:_______________

Refusal to sign acceptance to the above items indicates non-compliance by the patient / surrogate / guarantor to the policies of this practice and elective, non-emergency services will not be provided.

Practice Authorization 052720

It is our desire to provide the best opportunity to meet your desired expectations. When these expectations are not met and disappointment occurs, misunderstandings in the transfer of information is usually the cause. Disparaging remarks to or about the Practice on any social media platform including word-of-mouth helps no one! It doesn't help you as your issue is not addressed and it does not help the Practice or its members as I can assure you the incident is rare and does not help address a change if needed.

When wrongful remarks are made, it is legally considered to be slander and libel and may initiate legal action. This again, helps no one as it escalates rather than fixes the misunderstanding and miscommunication. Please notify us if there is any misunderstanding.

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NOTICE OF PRIVACY PRACTICES:

ACKNOWLEDGEMENT OF NOTIFICATION

By signing this form, you acknowledge having been offered the *Notice of Privacy Practices of Dean P Kane, MD, FACS, PA.* Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. While a summary is found on the reverse side of this form, we encourage you to read the Notice of Privacy Practices in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our practice in writing.

If you have any questions about our *Notice of Privacy Practices,* please contact our practice in writing.

I acknowledge having been offered the *Notice of Privacy Practices* of *Dean P Kane, MD, FACS, PA.*

Signature: ________________________________ Date: ________________
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF NOTIFICATION

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

☐ Patient refusal
☐ Other:

Signature of Dr. Kanes representative: ________________ Date: ________________

HIPAA, HITECH and the Omnibus Final Rule
Notice of Privacy Practices – Summary

To improve the efficiency and effectiveness of the health care system, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 required HHS [Health and Human Services] to adopt national standards for electronic health care transactions. At the same time, Congress recognized that advances in electronic technology could erode the privacy of health information. Consequently, Congress incorporated into HIPAA provisions that mandated the adoption of Federal privacy protections for individually identifiable health information. The Health Information Technology for Economic and Clinical Health Act of the American Recovery and Reinvestment Act of 2009 (HITECH) provides additional requirements beginning in 2013. Both are provided to you as a Notice of Privacy Practices (NPP).

A. HIPAA:

1. Protected Health Information maybe used or disclosed for treatment, payment or healthcare operations
2. The patient has a right to request restrictions on identifiable "data.
3. The unique and identifiable data that maybe used or disclosed is listed below.

B. Dean P Kane, MD, FACS, PA also known as the Center for Anti-Aging Medicine and Cosmetic Surgery complies with the HIPAA Privacy Standards by requesting a patient signature for each patient visit on the Encounter Form (superbill) authorizing that Protected Health Information (PHI) maybe used or disclosed for treatment, payment or healthcare operations. A review of our Notice of Privacy Practices is available in our library. A copy of our Notice of Privacy Practices is available in upon request.
C. PHI includes: name, address, email, dates, social security number, medical record number, health plan beneficiary number, account number certificate number, license number, vehicle identifiers, facial photographs, telephone numbers, device identifiers, URL's, IP addresses, biometric identifiers, geographic units and other unique identifiers or codes.
D. PHI may be disclosed by a Covered Entity without the individual's consent or authorization when:

a. Used for Research if requested by:
   i. A Privacy Board
   ii. A Institutional Review Board
b. Used for facility directories (for clergy and other visitors), or to update family members and those involved in the individual's care, provided the patient is given an opportunity in advance to object.
c. In the certain limited circumstances, such as those required by law or public health activities.
d. Limited patient information (demographics and dates of service), are used for marketing and fund raising activities.
e. Disclosures of PHI may be made to Business Associates where a Business Associate Contract is in place, eg medical insurance company.
f. Your Protected Health Information will be used if required to recover a healthcare expense claim to include and not limited to your medical insurance, banking, finance companies and credit card companies.
g. Your Protected Health Information will be used for this office to contact you regarding appointments, medical and emergency care. Please provide secure and confidential contact information on the demographic form. Should this information change or become discovered, please inform us immediately and provide another form of contact. All efforts will be made to preserve your privacy in accordance with HIPAA rules.

E.Individual Access to Protected Health Information:

a. Only the patient or surrogate may request to review their medical record and only when a Release of Medical Information Authorization is signed.
b. Any contested information will be reviewed by Dean P Kane, MD, FACS and added to the medical record as a addendum

F.Patient Rights:

a. The individual has a right to inspect and copy his or her PHI, in whole or in part, for as long as the covered entity maintains the information.
b. The patient has the right to amend the PHI as above
c. Any person who believes that a Covered Entity is not complying with the applicable requirements of HIPAA may file a complaint with the Secretary of HHS. A complaint must be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred, unless the time limit is waived by the HHS Secretary for good cause shown.

G.HITECH:

a. You have the right to be notified following a breach os unsecured PHI.
b. If you pay "out-of-pocket" for products or services, you have the right to restrict disclosures of PHI to your health plan.
c. Any other uses and disclosures of your PHI will be made only with your authorization.
d. Any notes from a social worker, psychologist, psychiatrist or other mental health professional will require a separate authorization for release of PHI.
e. Any PHI used for marketing purposes including subsidized treatment will require your authorization.
f. You have the right to "opt-out" of any fund raising communications.
g. You must authorize the "sale" of your PHI.
h. Providers may charge a reasonable cost-based fee when providing medical records.

H. HIPAA Final Rule Summary 2014

a. Breaches of PHI are reportable unless there is a "low probability of PHI compromise."
b. A patient may request their physician not to disclose PHI to a health plan for those services for which the patient has paid for out-of-pocket, unless it is required for treatment purposes or in the rare event the disclosure is required by law.
c. Limited marketing communications may be provided without the patient's authorization.
d. It is prohibited to sell PHI.

G. Our receptionist is designated as the contact person to receive requests, amendments and complaints in writing and provide privacy practice information when requested.
H. Authorization is requested for specific use or disclosure of PHI not for TPO (treatment, payment, operation).

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COVID19 Patient Responsibility and Instructions for COVID19 Safety

Dear Patient, In the interest of **SAFETY FIRST**, Team Kane wishes for you to understand there have been many modifications in our practice to provide you with a caring, safe and efficacious environment. We hope you understand that these changes are all meant to protect your wellbeing. Please let us know if we can be of any further help. Thank you, Dean Kane, MD, FACS

In order that we may open and provide services to you, you must follow the following Government, Plastic Surgery and Best-in-Care guidelines. Thank you.

1. Make an appointment for your service(s). No Walk-In services available.
2. Please download and complete and send or bring your COVID19 Patient Consent, updated Medical Information: **drdeankane.com>patient info>patient forms.**
    a. All Patients must read and sign the COVID19 FORMS for EACH office visit.
    b. If it has been more than 1 year since we last saw you, please include: Practice Authorization, HIPAA Acknowledgement, Patient Demographics, Base Medical Data form
3. Please obtain your own temperature at home. If it is more than 100.0 degrees F. Please reschedule and call your PMD for recommendations.
4. Arrive to the Office 15 minutes prior to the schedule appointment time.
5. From your car, call the office to indicate you have arrived and the receptionist will indicate whether we have the proper Patient-Distancing for you to enter the office.
6. Cell phone use will not be allowed in the office.
7. Only the patient can enter the office. ALL family, friends, children, pets and associates must remain outside.
8. All patients must wear a mask and bring your own pen! The patient will be expected to properly wash their hands upon entering the office. Be prepared to have your temperature taken. If more than 100.0 degrees F, you will be offered your options.
9. For patients receiving any services to the face and neck, please wash your face and arrive with no make-up.

COVID Pt Sched Inst 050520

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COVID-19 INFORMED CONSENT AGREEMENT

Symptoms of CoronaVirus (SARS-CoV-2 infection) COVID19:

- *Fever (above 100.0 degree F.*
- *Cough: dry or wet*

Print Patient Name

Medical Record Number

☐ I, the undersigned patient, consent to have my Doctor and/or his/her staff (hereinafter collectively "my Doctor") perform medical evaluation and procedures, whether regarded as necessary, elective or aesthetic, during the time of the COVID-19 pandemic and after. I understand having my procedure performed at this time, despite my own efforts and those of my Doctor, may increase the risk of my exposure to COVID-19. I am aware that exposure to COVID-19 can result in severe illness, intensive therapies, extended intubation and/or ventilator support, life-altering changes to my health, and even death. I am also aware of the possibility that the procedure itself, whether performed in my Doctor's office or in a hospital, may result in a more severe case of COVID-19 than I might have had without the procedure.

☐ I also understand that having my procedure performed at this time increases the risk of my transmission of COVID-19 to my Doctor. This virus has a long incubation period, there may be as yet unknown aspects of its transmission, and I realize that I may be contagious, whether or not I have been tested or have symptoms. To reduce the possibility of COVID-19 exposure or transmission at my Doctor's office, I accept that my Doctor will implement infection-control procedures with which I must comply, before, during and after my procedure, for my own protection as well as that of my Doctor. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures to be necessary. I understand that COVID19 vaccination and boosters are recommended.

☐ I will inform my Doctor of any positive COVID-19 testing or symptoms including: ***Fever*** *(above 100.0 degree F or dry/wet* ***Cough*** that I or any person living or working with me developed during the past 14 days. I understand that my Doctor may require that I be tested, possibly at my own expense and regardless of any prior testing, and that the results of that testing must be satisfactory to my Doctor, before I may receive my procedure. I remain totally financially responsible for all COVID-19 exposure and complications.

☐ All my questions have been answered to my satisfaction. Being fully informed, I accept the risk of COVID-19 exposure and I will bear the cost of any COVID-19 treatments required. I have been given the opportunity to postpone my procedure until the COVID-19 pandemic is less prevalent, but I choose to have my procedure performed now. If I am the parent, guardian or conservator of the patient, I hold his/her health care power of attorney. I have read this COVID-19 Informed Consent Agreement and am authorized to consent on the patient's behalf.

☐ I acknowledge that the Practice of Dean P. Kane, MD, FACS, has made every effort within reason to protect me from contact with and contamination from Corona virus (SARS-CoV-2) recognizing that the protection from and care of this illness is changing and ongoing.

Patient Signature　　　　　　　　　　Date

Notice and Disclaimer. Medical information changes constantly. This COVID-19 Informed Consent Agreement sets forth the modified recommendations of Dean Kane, MD, PA.

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Name:_________________________________ Date:___________

Modified COVID19 Patient Screening Questionnaire to confirm your Appointment

Dear Patient,

In the interest of **SAFETY FIRST**, Team Kane continues to follow COVID-19 precautions.
We require that you complete the COVID-19 screening questionnaire below prior to each office visit.
We must receive it within the next 24 hours to confirm your appointment.
Without this completed form, your appointment will be canceled.

Including today and during the past 14 days, I have *NOT* had symptoms of COVID19 / COLD / FLU including but not limited to **FEVER** over 100.0 F without Tylenol, and wet or dry **COUGH**, **SNEEZING** or **RUNNY NOSE.**

_____________________________ ____________________
Patient Signature Date

We require employees and patients to wear a proper mask covering your nose and mouth during your visit.

Thank you!