LOOK NATURAL HAIR RESTORATION

535 Sycamore Ave., Shrewsbury, NJ 07702 (732) 977-0301, fax (732) 747-2606

Date:_____

PATIENT INFORMATION

Patient's Name:_____
(Last) (First)

Address:_____ City: State: Zip_____

Home Phone: (____)_____ Cell Phone :(____)_____

Work Phone: (____)_____ Email:_____

Do you accept our office's use of your email? Please initial: Yes_____or No _____

Age:_____Sex:_____ Date of Birth:_____

Social Security #:_____Married:____Single:____Widowed:____Divorced:____

Occupation:_____Employer:_____

Business Address:_____

Race: ☐African-American ☐Caucasian ☐Hispanic ☐Other_____ ☐Decline to Provide

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Provide

Language: ☐English ☐French ☐Spanish ☐Other_____ ☐Decline to Provide

Spouse or Parent's Name:_____SS#:___-_____

Spouse or Parent's Employer:_____

Employer's Address:_____

Nearest relative not living at same address:_____

Relative's address: _____

Other physician(s) you have seen in the last year: _____

Name of person or physician who referred you to this office: _____

ALLERGIES TO MEDICINE Yes____; No____ Please list:_____

Do you have a seafood allergy? Yes___; No _____

Do you have a latex allergy? Yes _____ ; No_____

Allergies to other substances: _____

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Date:_____

Medical History

General State of Health: Good_____; Fair_____; Poor_____

If not "Good", please explain and list treating Physician(s) and medications:_____

_____

_____

Height:_____; Weight_____Weight loss or gain in past year? Loss_____lbs.; Gain_____lbs.

Serious illness, please list:_____

Is there any risk of pregnancy at this time? Yes____; No __

Do you drink alcohol: ☐ Yes ☐ No If Yes, how many drinks per week?_____

Do you smoke: ☐ Yes ☐ Former ☐ N If Yes, how many cigarettes per day?_____

If former, when did you quit?_____

Do you/have you taken prescription medicare for:

High Blood Pressure ☐ Yes ☐ No Medication:_____

Elevated Cholesterol ☐ Yes ☐ No Medication:_____

Depression/Anxiety ☐ Yes ☐ No Medication:_____

Anemia (low iron) ☐ Yes ☐ No Medication:_____

Have you ever been diagnosed with:

Hormonal Abnormalities ☐ Yes ☐ No Eating Disorder ☐ Yes ☐ No

Menstrual Cycle Abnormality ☐ Yes ☐ No Recent Pregnancy ☐ Yes ☐ No

Menopause ☐ Yes ☐ No

Do you have a heart condition? ☐ Yes ☐ No If Yes, please explain ?_____

Are you currently taking Vitamin E? ☐ Yes ☐ No

Are you currently taking any Aspirin products, NSAIDs (anti-inflammatories) or blood thinners? ☐ Yes ☐ No

Have you ever had a reaction to local anesthesia? ☐ Yes ☐ No If Yes, please explain: _____

Please list ALL medications, their dosages and the prescribing Physician (including BIRTH CONTROL PILLS, DIURETICS (water pills), BLOOD PRESSURE or HEART MEDICATIONS, TRANQUILIZERS, HORMONE, BLOOD THINNERS, NOSE DROPS and SPRAYS, INHALER MEDICINES, ASPIRIN, and HERBAL SUPPLEMENTS. Please include any over-the-counter medications, nutritional supplements or diet pills:

_____ _____

_____ _____

_____ _____

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Hair History

Have you ever had a hair restoration consultation in the past? ☐ Yes ☐ No

If Yes when and with whom? _____

Have you ever had a hair transplant? ☐Yes ☐No If YES, when and with whom? _____

How many grafts? _____ Strip or FUE? _____

What is your main area of concern? ☐ Hairline/Temples ☐ Frontal Area ☐ Crown (top) ☐ All☐ Other

Is your hair loss: ☐ Just starting ☐ Accelerating ☐Slowing down ☐ Basically done ☐ Not sure

Tried any of the following to prevent hair loss? (Check all that apply)

☐ Propecia/Proscar ☐ Rogaine/Minoxidil ☐Avodart/Dutasteride ☐ LaserComb ☐ Therapy Hood

☐ Vitamins/Supplements ☐Special shampoo-which_____ ☐ None of the above

Are you currently taking Propecia or Proscar? ☐ Yes ☐ No Approximate date when you started:_____

Do you feel it has bee effective: ☐ Yes ☐ No

Are you currently using Rogaine or Minoxidil? ☐ Yes ☐ No Approximate date when you started:_____

Please identify any specific areas of interest (check all that apply)

☐ Propecia ☐ Rogaine/Minoxidil ☐Hair Transplant ☐ Hair Care Products ☐ Laser Therapy

☐ Nutritional Therapy ☐ PRP ☐ Eyebrows ☐ Beard

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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Look Natural Hair Restoration ("LNHR") has my consent to use and disclose my Protected Health Information ("PHI") to carry out treatment, to obtain payment from third parties and to perform healthcare operations as outlined below. _____ (**Initial**)

I have been given a copy of the HIPAA Notice of Privacy Practices ("HIPAA Notice") which contains a complete description of PHI. _____ (**Initial**)

I have the right to review, and to the extent I desire to do so, I have reviewed the HIPAA Notice prior to signing this Consent form. _____ (**Initial**)

I authorize LNHR to use and disclose my PHI in the following manner:

1. Transmit my PHI through the following means in order to carry out treatment, obtain payment from third parties and perform healthcare operations:
   a. Cell Phone Number: _____
   b. Home Phone Number: _____
   c. Email Address: _____
   d. Mailing Address: _____
   e. Fax Number: _____

2. Disclose my PHI to the following family members in order to carry out treatment, obtain payment from third parties and perform healthcare operations:
   a. Name: _____ Contact Information: _____
   b. Name: _____ Contact Information: _____
   c. Name: _____ Contact Information: _____

OR I do *not* authorize disclosure of my PHI to anyone other than myself.: _____ (Initial)

3. Transmit my PHI to other health care providers as well as my health insurance carrier in order to carry out treatment, obtain payment and perform healthcare operations _____ **(Initial)**

By signing this form, I consent to LNHR's use and disclosure of my PHI as outlined above:

I, _____ , acknowledge that I have read and understand the above.

Patient Signature (or authorized representative)	**Date**

I may revoke my consent in writing except to the extent that LNHR has already made disclosures in reliance upon my prior consent. If I do not sign this Consent, LNHR may decline to provide treatment.

If you have any questions about the HIPAA Notice, please contact our office at (732) 977-0301 and ask to speak with the Office Manager.

HIPAA NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of this would be:

- the coordination of your health care with all of your health care physicians.
- contacting you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization reviews. Examples of this would be, the use and disclosure of your health information:

- on a bill for your visit sent to your insurance company.
- about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

Public Health Risk means disclosure of your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability to the public.

Required by law means we may use and disclose your health information about you:

- when required by State and Federal law.
- to authorized federal officials for intelligence, counterintelligence, and other National Security activities as authorized by law.
- when required by the Secretary of Health and the Department of Health and Human Services for the purposes of investigating or determining compliance with the privacy law.
- to a health oversight agencies for activities, authorized by law, for the government and certain private health oversight agencies to monitor the healthcare system, government programs and compliance with civil rights.
- to law enforcement officials, if required by law, or where permitted by law, or in response to a valid subpoena to a court or administrative agency when a judge or agency orders us to do so and in legal proceedings, such as in a response to a discovery request, subpoena, court order, etc.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information (PHI), which you can exercise by presenting a written request to our Privacy Officer:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI from us by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of PHI.
- The right to obtain and we have the obligation to receive written acknowledgement that you have read a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

This notice is effective as of January 1, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PHI that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Service, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Privacy Officer
Look Natural Hair Restoration
535 Sycamore Avenue
Shrewsbury, NJ 07702
(732)977-0301

For more information about HIPAA or to file a complaint:

The U.S. Department of Health &
Human Services of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202)619-0257 Toll Free: 1-877-696-6775

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(To be filed in patient's medical record)

I have been presented with a copy of Look Natural Hair Restoration's Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

_____
PATIENT'S NAME (Print)

_____
PATIENT OR LEGAL GUARDIAN SIGNATURE

_____
RELATIONSHIP TO PATIENT: (if other than self)

_____
DATE SIGNED

I wish to place the following restrictions on disclosure of my health information:

_____

Internal Use Only
If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____

FINANCIAL POLICY& PATIENT RESPONSIBILITY- HAIR RESTORATION

Welcome to our office:

Look Natural Hair Restoration ("LNHR") is dedicated to providing the highest level of care. This financial policy has been prepared to make your visit pleasant and informative, as well as to inform you of your financial responsibility to LNHR. Please read carefully, insert your initials at the end of each advisory indicating you have read this information and agree to it, then sign and date at the bottom of the page.

- Payment for your visit is due at the time service is rendered. **(Initial:_____)**
- A deposit for cosmetic surgery is required at time of scheduling. The balance must be paid in full three weeks prior to surgery. All deposits and payments are non-refundable. Please be aware that the surgeon's fee does not include lab fees, the anesthesiology fees, pathology charges, hospital charges or ambulatory surgery center charges (also known as facility fees). **(Initial:_____)**
- For your convenience, we accept cash, checks, American Express, Visa, MasterCard and Discover. **(Initial:_____)**
- You understand that Insurance companies do not pay for cosmetic procedures, including hair restoration procedures. **(Initial:_____)**
- I have received a copy of this Financial Policy & Patient Responsibility, understand the terms stated herein and have voluntarily executed this agreement. **(Initial:_____)**

Should you have any questions or concerns regarding this policy, please feel free to discuss this with your patient coordinator. No changes to the terms set forth in this agreement are binding upon LNHR unless written below and signed separately by both you and an authorized representative of LNHR.

Signature of Patient or Legal Representative: _____

If signed by a Legal Representative, relationship to Patient: _____

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A PATIENT'S BILL OF RIGHTS ACT

YOU have the right to be treated respectfully.

YOU have the right to be informed about your diagnosis, to know what your treatment options are, and to know what the potential outcomes of each treatment may be.

YOU have the right to know the names of those treating you.

YOU have the right to refuse treatment, as permitted by law. You can refuse treatment and still receive alternative care.

YOU have the right to privacy. No medical practitioner should ever release information about your condition or treatment to anyone, unless you give express consent to release such information.

YOU have a right to review your medical records, and if necessary have the information explained to you.

YOU have the right to know what your anticipated cost of treatment may cost you.

YOU are responsible for providing all information about your current condition, prior procedures, illnesses and medications. This info is necessary to determine the best treatment for you.

YOU are responsible for being considerate of the needs of others in the office.

YOU are responsible for providing all insurance information when requested, and following the requirements for your individual insurance plan for seeking treatment with the doctor.

Signed:_____ Date: _____

Print Patient's Name: _____

(To be placed in patient's permanent file)