

**Frank L. Stile, MD, PC**  
**Plastic & Reconstructive Surgery**

NAME (Last, First, M.I.) \_\_\_\_\_

DATE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

AGE \_\_\_\_\_ SEX: M / F CELL# \_\_\_\_\_ HOME# \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

MARTIAL STATUS: SINGLE MARRIED SEPARATED WIDOWED (CIRCLE ONE)

EMAIL ADDRESS: \_\_\_\_\_

PATIENT EMPLOYER: \_\_\_\_\_

EMPLOYERS ADDRESS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

EMPLOYERS PHONE NUMBER: \_\_\_\_\_

RESPONSIBLE PARTY/EMERGENCY CONTACT: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

PHONE NUMBER (S): \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

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PROCEDURES /TREATMENTS **THAT YOU PLAN ON DISCUSSING TODAY:**

BREAST AUGMENTATION	TUMMY TUCK	BREAST REVISION
EYELID SURGERY	BREAST LIFT	IMPLANT EXCHANGE
FACELIFT	BREAST REDUCTION	JUVEDERM
NECK LIFT	LABIAPLASTY	RESTYLANE
LIPOSUCTION	EARLOBE REPAIR	TCA PEEL
BROW LIFT	EAR CORRECTION	BOTOX
RHINOPLASTY	GYNECOMASTIA	CHIN AUGMENTATION

IF LIPOSUCTION WAS CIRCLED ABOVE, PLEASE LIST DESIRED AREAS:

\_\_\_\_\_

OTHER PROCEDURE NOT LISTED: \_\_\_\_\_

## ***Patient Health Disclosure***

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

Are you under a doctor's care? \_\_\_\_\_ Reason: \_\_\_\_\_

List any serious chronic illnesses (past or present): \_\_\_\_\_

Operations (specify and list approx. dates): \_\_\_\_\_

**Habits:** Alcohol - Yes \_\_\_\_\_ No \_\_\_\_\_ If yes: Daily \_\_\_\_\_ Occasionally \_\_\_\_\_ Never \_\_\_\_\_

Tobacco - Yes \_\_\_\_\_ No \_\_\_\_\_ If yes: Daily \_\_\_\_\_ Socially \_\_\_\_\_ Never \_\_\_\_\_

If daily, how many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Exercise & Activity: Frequent \_\_\_\_\_ Occasionally \_\_\_\_\_ Never \_\_\_\_\_

Type of exercise (if applicable): \_\_\_\_\_

Pregnancies: \_\_\_\_\_ Births: \_\_\_\_\_ Are you currently breastfeeding? \_\_\_\_\_

Do you have: Dentures \_\_\_\_\_ Chipped Teeth \_\_\_\_\_ Bridges \_\_\_\_\_ Loose Teeth \_\_\_\_\_ Diseased Gums \_\_\_\_\_

Other Dental Problems \_\_\_\_\_

Do you wear: Glasses \_\_\_\_\_ Contact Lenses \_\_\_\_\_ Prosthetic Device \_\_\_\_\_

### **Allergies And Sensitivities:**

YES	NO		YES	NO	
		Penicillin			Iodine
		Antibiotics			Betadine
		Sulfates			Chlorhexadrine Phisophex
		Morphine			Tetanus
		Codeine			Latex
		Demerol			Tincture of Benzoin
		Narcotics			Skin Adhesive/Tape
		Novacaine			Dairy Products
		Lidocaine			Other

**Specify Other If Checked:** \_\_\_\_\_

**Have you taken any of the following medications in the last 6 months?**

Yes	No	Medication	Yes	No	Medication
		Cortisone			Blood Pressure Medication
		Prednisone			Steroids
		Steroids			Migraine Medication
		ACTH			Seizure Medication
		Diuretics			Antibiotics
		Water Pills			Insulin
		Heart Medication			Orinase
		Digitalis			Anticoagulants/Blood Thinners
		Lamoxin			Pain Medication
		Nitroglycerine			Stimulants
		Appetite Suppressants			Homeopathic/Herbal Medication
		Birth Control Pills			Antipsychotic Medication
		Phen-Phen/Redux			Asthma Med./Inhaler
		Allergy Medication			Recreational or Illegal Drugs

**Please circle any of the following medications that you have taken in the last 2 weeks:**

Aspirin                      Ibuprofen (Motrin, Advil, Nuprin)                      Vitamin E                      Anti-Inflammatory Med

Other \_\_\_\_\_

**Have you ever received treatment for any of the following medical conditions?**

Yes	No	Condition	Yes	No	Condition
		Hepatitis, Jaundice, Cirrhosis, or Liver Disease			Stomach Ulcers
		Asthma, TB, Pneumonia, Emphysema, or Chest Disease			Blood Transfusion
		Heart Attack, Angina, Palpitations, Irregular Heart Beats			HIV or AIDS
		Shortness of Breath or Fainting Spells			Chronic or Recent Cough
		Stroke, Seizures, Bell's Palsy or Neurological Problems			Anorexia or Bulimia
		Abnormal or Excessive Bleeding			High Blood Pressure
		Rheumatic Fever or Congenital Heart Disease			Low Blood Pressure
		Sexually Transmitted Disease or Venereal Disease			Hives, Rash, Skin Disease
		Kidney Failure, Kidney or Prostate Problems			Diabetes, Abnormal Blood Sugar
		Migraines, Headaches, or Chronic Head Pain			Thyroid Problems
		Shingles, Cold Sores, Fever Blisters, Oral Herpes			Edema or Persistent Swelling
		Abnormal Healing or Poor Scar Formation			Anemia or Blood Disorder
		Anxiety, Depression, Psychological or Emotional Problems			Lupus or Arthritis
		Nervous Breakdown or Personality Disorder			Autoimmune Disease
		Phlebitis, Blood Clots, or Varicose Veins			X-Ray Treatment or Radiation

**I certify that the above is true and correct. I realize that withholding information about my medical history could result in serious injury to me or harm those involved in my care. I am aware that providing false or incomplete information about my medical and surgical history may result in the cancellation of my proposed surgery and forfeiture of my surgical fee.**

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Witness Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

*Dr. Frank L. Stile, M.D.  
Cosmetic Surgery Center and Spa  
8954 Spanish Ridge Ave.  
Las Vegas, NV 89148*

*I understand that Dr. Stiles charges a \$50.00 fee for a consultation with him. This fee is due before the consultation. I plan on paying with:*

*Credit/Debit Card \_\_\_\_\_ Cash \_\_\_\_\_ Already Paid \_\_\_\_\_  
(No checks accepted)*

*Signature: \_\_\_\_\_ Date: \_\_\_\_\_*

*Thank you,  
Clinique Plastique*

**Dr. Frank Stile  
Cosmetic Center and Spa  
Acknowledgement of Notice of Privacy Practices**

**Privacy Officer**

The Provider's Privacy Officer, Jessica, can be reach through the front office.

8954 Spanish Ridge Ave., Ste. #1, Las Vegas, NV 89148  
Phone:(702) 243-9555 / Fax: (702) 243-9856

**Acknowledgement**

I Hereby acknowledge receipt of this Notice of Privacy Practices.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

- OR -

**Acknowledgement Refused**

On this date, the undersigned patient refused or failed to acknowledge receipt of this Notice of Privacy Practices.

Name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for refusal/ failure: \_\_\_\_\_

Witness: \_\_\_\_\_

**ASSIGNMENT AND RELEASE**  
**(Please sign even if not applicable to you)**

I, the undersigned, understand that Dr. Stile does not take any insurance or supplement insurance, and assign directly to Dr. Stile all medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Person Authorized by Law

**MEDICARE AUTHORIZATION**  
**(Please sign even if not applicable to you)**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Frank Stile for any services rendered to me by Dr. Stile. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim form or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and for the deductible, coinsurance, and no covered service. Coinsurance and the deductible are based upon the charge determine of the Medicare carrier.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Person Authorized by Law

**Premium Surgical Services Center**

**MUTUAL BINDING ARBITRATION AGREEMENT**  
*Patient & Healthcare Provider*

**Patient's Name:** \_\_\_\_\_

This mutual Arbitration Agreement constitutes an integral part of a contract for medical services by and between the Healthcare Providers(s) who have or may agree to be bound hereunder and the Patient:

1. It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this Contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Nevada law, and not by a lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this Contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.
2. Such arbitration shall be in accordance with the current Medical Arbitration Rules of the Nevada Medical Association. This Mutual Arbitration Agreement shall apply to any legal claim or civil action in connection with this medical service against any healthcare provider who has agreed to be bound by this provision.
3. The execution of this Mutual Arbitration Agreement shall not be a precondition of the furnishing of service by the Healthcare provider, and this Mutual Arbitration Agreement may be rescinded by written notice from the Patient or Patient's representative to the Healthcare provider within 30 days of signature.
4. This Mutual Arbitration Agreement shall bind the parties hereto, including newborns, and the heirs, representatives, executors, administrators, successors, and assigns of such parties and newborns.

This document is effective as of the date of first medical services. If any provision of this arbitration agreement is determined to be invalid or unenforceable, the remaining provisions shall remain in full force.

\*NOTICE: By signing this contract, you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. See Article 1 of this contract.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Patient/Parent/Conservator/Guardian)

**If signed by other than patient, indicate relationship:** \_\_\_\_\_

**Signature of Medical Professional:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Healthcare Provider or Authorized Representative)  
**Premium Surgical Services Center**

*Dr. Frank Stile*  
*Cosmetic Surgery Center*

8954 Spanish Ridge Ave., Ste. #1  
Las Vegas, NV 89148  
Phone: (702) 243-9555  
Fax: (702) 243-9854

**NOTICE OF PRIVACY PRACTICES**

The Effective Date of This Notice is January 2009

**\*PATIENT COPY – PLEASE KEEP\***

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.

These pages describe the type of information we gather about you, with whom that information may be shared and the safeguards we have in place to protect it. You have the right to the confidentiality of your medical information and the right to approve or refuse the release of specific information except when the release is required by law, or permitted by law without your authorization.

If you prefer additional limitations on the use of your medical information, you may request them by following the procedure below.

If you have any questions about this notice, please contact our Privacy Officer. This notice describes the Provider's practices regarding the use of your medical information and that of:

- Any health care professional employed by the Provider who is authorized to enter information into your medical record
- Any member of a volunteer group we allow to help you
- All employees, staff, and other personnel who may need access to your information
- If we have, or in the future will have, multiple sites or locations, all of them will adhere to the provision in this notice. Multiple sites and locations may share medical information with each other for treatment, payment or health care operations for purposes described in this notice.

**OUR PLEDGE REGARDING MEDICAL INFORMATION**

We understand that medical information about you and your health is personal. Protecting medical information about you is important to us. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Provider's employees.

**Appointment Reminders:** We may use disclosed medical information to contact you as a reminder that you have an appointment for treatment or medical care.

**Treatment Alterations:** We may use disclosed medical information to tell you about health related benefits, options or alternatives that may be of interest to you.

**Health-Related Benefits and Services:** We may use disclosed medical information to tell you about health-related benefits or services that may be of interest to you.

**Individual Involved in Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. We may give information to someone who helps pay for your care. If you are in a hospital, we may also tell your family your condition and that you are in a hospital. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

**Research:** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication or another. We may disclose medical information about you to people preparing to conduct a research project, to help them look for patients with specific needs, so long as the medical information they review does not leave the facility conducting the research.

**As Required By Law:** We will disclose medical information about you when required to do so by federal, state, or local law.

**To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Any disclosure, however, would only be to someone able to help prevent the threat.

**Protective Services for the President, National Security and Intelligence Activities:** We may release medical information about you to authorized Federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations, or intelligence, counterintelligence, and other national security authorized by law.

## **YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU**

You have the following rights regarding medical information we maintain about you:

**Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must submit a signed request in writing to our Privacy Officer at the address listed on this notice. If you request a copy of the information, we may charge a fee for the cost of copying. If you are denied access to medical information you may request that denial be reviewed. Another licensed health care professional chosen by the Provider will review your request and the denial. The person conducting the review will not be the person who denied your request. We comply with the outcome of the review.

**Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the information kept by the Provider
- Is not part of the information which you would be permitted to inspect and copy;  
or
- Is inaccurate or incomplete

**Right to an Accounting of Disclosures:** You have the right to request an “accounting of disclosures”. This is a list of the disclosures we made regarding medical information about you. This accounting will not include many disclosures, including those made to you or pursuant to your authorization, those made for treatment, payment and perorations purposes, national security and intelligence purposes, and those made to correctional institutions. To request this list or an accounting of disclosures, you must submit your request in writing to our Privacy Officer.

#### **OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made under your authorization. We are required to retain our records of the care that we provided to you for seven years.