Denny Eye & Laser Center

Kevin Denny, M.D. B. James Haidler, O.D.

PATIENT REGISTRATION

NAME: _____
LAST FIRST MIDDLE INITIAL

ADDRESS: _____
NO. AND STREET CITY STATE ZIP

(____) _____ (____) _____ (____) _____ _____
HOME PHONE ☐ **WORK PHONE** ☐ **CELL PHONE** ☐ **EMAIL ADDRESS**

Check the box next to the phone numbers where we may leave a voice mail message in regards to your medical care.

SEX: ☐male ☐ female _____ _____ _____
SOCIAL SECURITY # **BIRTHDATE** (MM/DD/YY) **AGE**

OCCUPATION: _____ **EMPLOYER:** _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

EMERGENCY/MEDICAL CONTACT: _____
NAME NUMBER RELATIONSHIP

PRIMARY HEALTH INSURANCE

_____
COMPANY AUTHORIZATION NEEDED? MEDICAL GROUP COPAY

If you are covered on this insurance through someone else (e.g. spouse, parent), please provide that person's:

_____
NAME SOCIAL SECURITY NUMBER BIRTHDATE RELATIONSHIP

SECONDARY HEALTH INSURANCE

_____
COMPANY AUTHORIZATION NEEDED? MEDICAL GROUP COPAY

If you are covered on this insurance through someone else (e.g. spouse, parent), please provide that person's:

_____
NAME SOCIAL SECURITY NUMBER BIRTHDATE RELATIONSHIP

VISION INSURANCE i.e. VSP (Vision Service Plan) or EyeMed or MES (Medical Eye Services)

_____
COMPANY AUTHORIZATION NEEDED? MEDICAL GROUP COPAY

If you are covered on this insurance through someone else (e.g. spouse, parent), please provide that person's:

_____
NAME SOCIAL SECURITY NUMBER BIRTHDATE RELATIONSHIP

INSURANCE ASSIGNMENT AND FINANCIAL RESPONSIBILITY STATEMENT

By signing below, I give lifetime authorization for Medicare and/or Insurers to pay Denny Eye and Laser Center on my behalf for services provided to me by Kevin Denny, M.D. or any other person acting as an employee or agent of Dr. Denny. I understand that, regardless of my insurance status, I am ultimately responsible for fees for professional services provided as well as for products furnished through the Denny Eye and Laser Center, particularly for commonly non-covered services such as refraction. I will be responsible for deductibles and copayments. I authorize Denny Eye and Laser Center to release all information necessary to secure payments of benefits. I also agree to pay fees for late-cancelled or missed appointments. I further agree that a photocopy of this agreement shall be as valid as the original.

I ACKNOWLEDGE THAT THIS OFFICE HAS PROVIDED ME WITH NOTICE OF THEIR PRIVACY PRACTICES POLICY

X _____ DATE: _____ X _____
Signature of patient or person responsible for payment**/ DATE** **Signature** of Patient

Denny Eye & Laser Center
BOTOX MEDICAL HISTORY

PATIENT: _____

Please list ALL medications, including aspirin (or other blood thinners), Motrin/Advil, herbs, and vitamins, which you are taking: _____

_____

Are you on antibiotics at this time? ____ **NO** ____ **YES**

What medications are you ALLERGIC to? *(Please circle and list)*

No known allergies Penicillin sulfa codeine _____ _____

Circle any of the following illnesses you have or have ever had in the past:

No health problems

Myasthenia Gravis	Hepatitis	Other: *Please List*
Eye Disease or Vision Problems	Muscle Weakness	_____
Autoimmune Disease	Numbness	_____
Parkinson's Disease	Multiple Sclerosis	_____
Amyotrophic Lateral Sclerosis (ALS)	Neurological Disorders	_____
Lambert Eaton Syndrome	Ptosis (droopy eyelids)	

- **WOMEN: Are you Pregnant, trying to get pregnant or nursing? ___ YES ___ NO**
- **Have you had Plastic Surgery or other surgery to your face/neck area? ___ YES ___ NO**
  If Yes, please specify?: _____
- **Have you had Botox injections before? ___ YES ___ NO**
  If Yes, when was last treatment: _____ ***What area(s)?:*** _____
- **Happy with the previous Botox treatment(s):? ___ YES ___ NO**
  If No, please explain: _____
- **Ever had eyelid/eyebrow drooping after a Botox treatment?: ___ YES ___ NO**
  If Yes, please explain: _____

Who is your primary care physician? _____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health that I will report it to the office as soon as possible. I have read and understand the above medical history questions. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Patient signature: X_____ Date: _____

Patient Consent Form
Botox® Cosmetic

You have the right to be informed and educated about your treatment. You have the right to read this consent form, ask any questions, and have them answered to your satisfaction prior to receiving any treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

Please initial where indicated if you have read and understand each topic. Make sure all of your questions have been answered before you initial. There are three pages to this document.

General Information:

BOTOX® Cosmetic is a purified protein produced by the *Clostridium botulinum* bacterium, which is used to relax the muscles that cause those frown lines between the brows to form over time. BOTOX® works to block the release of acetylcholine and, as a result, the muscle doesn't receive the message to contract. This means that the muscle contractions are greatly reduced after using BOTOX®, providing diminished lines and wrinkles. Although Botox® was approved by the FDA for cosmetic use in 2002, the use of Botox® for wrinkles is not covered by insurance and must be paid for by the patient. In 2005, almost 3.3 million procedures were performed with FDA-approved BOTOX® Cosmetic.

Initials_____

Treatment for wrinkles:

Botox® therapy for wrinkles works best for "dynamic" lines and wrinkles, that means those lines that are directly associated with the muscle movement. Botox® therapy is less effective for fine textural changes on the skin surface, and for those lines present at rest. Botox® does not reduce facial lines of wrinkles caused by aging, heredity, gravity or sun damage.

Botox® therapy is temporary; meaning it will have to be repeated on a regular basis to remain effective. How long each treatment lasts will depend on many individual factors including the degree of skin sun damage present, the depth of the lines, the size of the muscles, the amount and strength of Botox® used, the frequency of re-treatment, and the speed of neuro-muscular repair. An average range of response is 3-6 months of diminished muscle contraction.

When Botox® therapy for wrinkles is performed, tiny amounts of the purified protein are injected into the facial muscles responsible for movement associated lines and wrinkles. This injection then weakens the muscle, thus reducing the associated lines and wrinkles.

After Botox® is placed into the targeted muscles, the weakening effect gradually begins over 3-5 days, and is not complete for 2 weeks. Therefore optimal results are not seen for at least two weeks, and sometimes longer. During this period, you may notice asymmetry, or unevenness, within the treated areas. This asymmetry will usually correct itself as the Botox® takes effect.

Also, for reasons not fully understood, some patients may be less sensitive or "resistant" to the effects of Botox®. In these patients, Botox® will not work as well or for as long as it should ordinarily be expected.

There are alternatives to Botox® therapy for wrinkles, including no treatment, topical cream treatments, chemical peels, laser peeling, surgical face lifting, and surgical destruction of the muscles involved in the formation of dynamic lines.

Initials_____

Aftercare:

For maximal results, it is recommended that after receiving Botox®, you maintain an upright posture for *at least 4 hours*. During this time it is also recommended that the treated area not be rubbed vigorously or massaged. You may wish to actively move the treated areas during this time, as this may help to increase the response of the Botox®-targeted muscles. I understand that I am at higher risk for side effects if I do not follow the aftercare instructions. I agree to follow up in 2-4 weeks after my first treatment if asked by my physician to do so.

Initials_____

Risks and Complications:

Side effects are always possible including the potential for unknown side effects. There is no known permanent side-effect of Botox® therapy for wrinkles. There are, however, several well known side effects that are temporary. The following side effects are rare but have been reported:

- Bruising:
  Usually at or near the injection site, may be increased with the use of aspirin or aspirin like products, including Vitamin E. This effect generally clears within 7-10 days.
- Headache:
  Related to the actual injections, is usually mild and transient lasting less than 24 hours. It may be relieved with Tylenol.
- Pain at the injection site:
  Similar to headache above, is usually mild, and relieved with Tylenol.
- Asymmetry:
  As described above, if present it is within the first two weeks of therapy. It may be corrected with "touch-up" injections, if necessary.
- Muscle twitching:
  Unusual, transient, and if persistent may corrected with "touch-up" injections.
- Numbness:
  A change in sensation in the treated areas, often described as a "dullness" has been noticed by some Botox® patients; it is usually only noticed for a few days after the injection. Treatment is not necessary.
- Eyebrow or eyelid ptosis (drooping) and double vision (diplopia):
  Seen in 1-2% of patients receiving Botox® therapy, is temporary lasting 2-4 weeks and usually mild. May be treated with special eye drops, or if necessary, patching of the affected eye.

Initials_____

Contraindications to treatment with Botox®

There are certain conditions where treatment with Botox® is not recommended, including:

- If you are pregnant or breastfeeding. If you think you may be pregnant or are breastfeeding, please inform the provider prior to the injection.
- If you have a history of neurologic disease (myasthenia gravis, Lambert-Easton syndrome, ALS), especially if it is currently active, you may not be a good candidate.
- If you are currently taking aminoglycoside antibiotics or penicillamine, you may need to discuss further your ability to receive Botox® therapy with the doctor.
- If you are taking any drugs for heart arrhythmia (quinidine), you may not be a good candidate.
- If you are taking hydroxychloroquine (Plaquenil) for rheumatoid arthritis
- Although the risk for allergic reaction is low, Botox® is not recommended for patients with severe allergies or a history of anaphylaxis.
- If you have an allergy to eggs
- If you have a history of eyelid drooping or Bell's palsy
- If you have an infection at the injection site
- This risk of bruising or bleeding may be increased by medications with anticoagulant effects such as aspirin, NSAIDs such as Motrin or Celebrex, high doses of Vitamin E and certain herbs (Ginkgo Biloba, St John's Wort).

None of these conditions above apply to me: Initials: _____

Payment:

Because Botox® therapy for wrinkles is considered a cosmetic procedure, insurance does not pay for treatment. Payment at the time of service is required for all patients. We request a 24-hour notice of cancellation for all scheduled Botox® appointments. If less than 24 hours notice is given or you do not show up for a scheduled appointment, a cancellation fee of $100 will be charged.

Initials: _____

Photographs:

I understand and give permission for pictures to be taken of my Botox® therapy, both before and after treatment. I understand that I will not be identified by name and that appropriate measures shall be made to block visible and/or recognizable features to protect my identity. I understand I will not receive any compensation for the use of my photograph. I understand that these photographs will remain the property of Kevin Denny, MD and/or the Denny Eye and Laser Center, and that they will remain as part of my medical record.

Initials: _____

****

By signing below, I agree that I have read and understand the above information, and that my questions have been fully answered to my satisfaction. I authorize Kevin Denny, MD to treat my wrinkles and lines with Botox® therapy today as well as future treatments as needed. I understand that the practice of medicine and surgery is not an exact science and that no results are guaranteed, including Botox® therapy for wrinkles and lines. I hereby release the doctor and the facility from liability associated with this procedure.

Patient Name: _____

Patient Signature: _____

Date: _____

Cosmetic Financial Agreement

Providing quality care for our patients is our primary concern. The following is a summary of our financial policy for cosmetic treatments at Denny Eye & Laser Center. We would be happy to provide further clarification if necessary. We ask that you read and sign the following to acknowledge that you have been advised of your financial responsibility for cosmetic services provided here.

Prior to seeing Dr. Kevin Denny, a staff member will discuss with you the likely costs involved in your procedure(s) and review your financial responsibility.

BOTOX: Fees for Botox injections are based upon the number of areas treated. You and Dr. Denny will determine how many areas and how much is needed to achieve your desired outcome. Botox treatments are payable in full at the time of your appointment.

If you fail to show for your appointment or give less than twenty four (24) hours notice prior to your appointment time you will be charged $100.

We accept cash, checks, Master Card, Visa, American Express and Discover for all services. We do not bill any insurance carrier for any Botox Cosmetic service. The patient is responsible for full payment of all services.

A $25 service fee is assessed on all returned checks. Payment of this fee and all past due amounts must be received prior to receiving any additional cosmetic services from our office.

We ask that you provide a valid credit card at the time you schedule your treatment. If you do not have a credit card, you may send a check as prepayment of your fees to secure your appointment.

Patient Understanding and Agreement
I have read this financial policy and understand that I have financial responsibility for payment of cosmetic services provided by Denny Eye & Laser Center, and hereby assume and guarantee payment of all expenses incurred during my office visit. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees, should this be required.

_____ _____

Patient Name Date

_____

Patient Signature

Denny Eye & Laser Center
NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

Dear Patient:

As ever, our practice is dedicated to providing the highest quality medical care, which includes treating all patients with respect for their privacy. This notice describes how medical information about you may be used and disclosed and how you can get access to your medical information, as required by the Privacy Regulations created by the passage of the Health Insurance Portability and Accountability Act (HIPPA) of 1996. Please review this information carefully.

COLLECTION, USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

In the course of providing you with evaluation, treatment, and other services, this practice collects information about you and your health. This information is stored in paper and computer records, and constitutes your medical record. The medical record we create is the property of this practice, but the information it contains belongs to you. The law permits us to use or disclose your health information for the following purposes:

TREATMENT We use and disclose medical information about you to provide your medical care. We may disclose your name and diagnosis to employees of other locations where we may provide services, such as a hospital where Dr. Denny may perform surgery for you. We may share your medical information with other physicians or individuals who offer services that you seek and we do not provide, such as eye photography or pharmacy dispensing. We may also disclose information, under limited circumstances, to members of your family or others who can help you obtain treatment, make medical decisions, or maintain treatment regimens.

PAYMENT We use and disclose medical information about you to obtain payment for services provided to you. For example, we give your health insurer the information they require in order for them to pay us for services we provide you.

HEALTH CARE OPERATIONS We may use and disclose medical information about you to operate this medical practice, for example:

- reviewing and improving the quality of care we provide, evaluating and training of our staff
- obtaining authorizations or referrals through your insurer
- complying with medical reviews, certification, licensing or credentialing, legal services or audits
- submitting bills electronically
- leaving messages to remind you of your appointments

REQUIRED BY LAW We will disclose your health information when we are required to do so by law:

- to public health authorities or health oversight agencies authorized to collect such information
- when necessary to reduce a serious threat to health and safety
- to report suspected abuse, neglect, domestic violence or other suspected crimes
- as required by judicial or administrative proceedings
- as required by law enforcement officials, federal, military, or national security regulations
- to coroners or organizations involved in organ or tissue donation as necessary

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

For uses that are not required by law, or for treatment, payment, or health care operations, we will require your written authorization to release information. You may revoke your prior authorization in writing to our practice at any time.

You can request that our practice communicate with you in a certain manner or location (for example, only call you at home, not at work.)

You can make a written request for certain additional restrictions in our use or disclosure of your health information. We are not required to agree to your request, however, we will accommodate reasonable requests and will respect any agreements we make.

You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including medical and billing records. You must submit your signed, written request to: Privacy Officer, Denny Eye & Laser Center 2201 Webster Street, San Francisco, CA 94115 or fax to (415) 567-2973, along with any copying fees.

You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, submit your signed, written request to: Privacy Officer, Denny Eye & Laser Center, 2201 Webster Street, San Francisco, CA 94115 or fax to (415) 567-2973, along with a reason that supports your request for amendment.

Denny Eye & Laser Center does not sell any patient information or share your email address with any third parties. We may use your mailing address or email address to send you news or information about the Denny Eye & Laser Center only, i.e. trunk show events, new business announcements, or otherwise at your request (e.g. you request we send you an email reminder about your appointment). If you do not want Denny Eye & Laser Center to use your mailing address or email for the purpose of sending you news or information about the practice, please inform the front desk staff. Your request will be handled promptly but you may still receive marketing communications that were already in process prior to receipt of your request.

You have a right to a paper copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time.

You have the right to file a complaint if you believe your privacy rights have been violated. You will not be penalized for filing a complaint. File to:

Privacy Officer Denny Eye & Laser Center 2201 Webster Street San Francisco, CA 94115 or fax to (415) 567-2973	- or -	Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Room 509F HHH Building Washington, DC 20201

If you have any questions regarding this notice or our health information privacy policies, please contact us at 2201 Webster Street, San Francisco, CA, 94115, or via fax at (415) 567-2973 or by phone at (415) 567-8200.

Updated 5/29/2008