

## COSMETIC INTEREST QUESTIONNAIRE

Health issues of interest to you (please check all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> BOTOX <sup>®</sup> Cosmetic (Botulinum Toxin Type A) | <input type="checkbox"/> Avage <sup>™</sup> (Tazarotene) |
| <input type="checkbox"/> AHA and glycolic peels                               | <input type="checkbox"/> Skin care advice                |
| <input type="checkbox"/> Collagen therapy                                     | <input type="checkbox"/> Skin care products              |
| <input type="checkbox"/> Skin rejuvenation                                    | <input type="checkbox"/> Birthmarks                      |
| <input type="checkbox"/> Retin-A <sup>®</sup> or Renova <sup>®</sup>          | <input type="checkbox"/> Liver spots/age spots           |
| <input type="checkbox"/> Micro-dermabrasion                                   | <input type="checkbox"/> Sunscreen advice                |
| <input type="checkbox"/> Acne   | <input type="checkbox"/> Removing leg veins              |
| <input type="checkbox"/> Chemical peels                                       | <input type="checkbox"/> Facials and eye treatments      |
| <input type="checkbox"/> Laser resurfacing                                    | <input type="checkbox"/> Hair removal                    |
| <input type="checkbox"/> Laser treatments                                     | <input type="checkbox"/> Spider vein treatments          |
| <input type="checkbox"/> Other, please specify: _____                         | <input type="checkbox"/> Removing facial veins           |

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number:

- When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

<b>Younger Than</b>		<b>True Age</b>		<b>Older Than</b>
1	2	3	4	5

- When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

<b>Not Concerned</b>		<b>Somewhat Concerned</b>		<b>Very Concerned</b>
1	2	3	4	5

How did you hear about us?

- My physician (full name) \_\_\_\_\_
- My insurance company provider \_\_\_\_\_
- The yellow pages (specify advertisement) \_\_\_\_\_
- A friend or family member (name) \_\_\_\_\_
- Another person not listed above (name) \_\_\_\_\_

(continued next page)

## COSMETIC INTEREST QUESTIONNAIRE (continued)

Please provide the name and address of the person who referred you so we can thank them:

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An article or advertisement in \_\_\_\_\_

Internet

A seminar where I saw the doctor. The event took place on (date): \_\_\_\_\_

at (location): \_\_\_\_\_

### Patient Information

Name \_\_\_\_\_

Address \_\_\_\_\_

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Phone \_\_\_\_\_

Email \_\_\_\_\_

Would you like to be contacted via email for special events and  
cosmetic specials? \_\_\_\_\_Y \_\_\_\_\_N

Thank you



Let's do something beautiful

# Artisan Cosmetic Surgery

**Manish R Gupta, MD**

1050 Isaac Streets Drive • Suite 136 • Oregon OH 43616 • 419 696 5656  
3438 Granite Circle • Toledo OH • 43617 • 419 841 2303

Name \_\_\_\_\_ Date \_\_\_\_\_

                    Last                                      First                                      Middle                                      State      Zip  
Address \_\_\_\_\_ City \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Wk Phone \_\_\_\_\_

Date of birth \_\_\_\_\_ SSN# \_\_\_\_\_ email address \_\_\_\_\_

Reason for appointment \_\_\_\_\_

How did you hear about Dr Gupta/Artisan Cosmetic Surgery? \_\_\_\_\_

TV • Web site • Newspaper • Yellow Pages • Referral • Other

Can we leave a message for you at home? Yes No      Cell Phone? Yes No      At Work? Yes No

Can we send e-mails to the address you provided? Yes No      Can we send info to your home? Yes No

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_  
  Name                                      Address                                      Phone

Referring Physician: \_\_\_\_\_  
  Name                                      Address                                      Phone

Name of Primary Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ (If other than patient) Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Group Number \_\_\_\_\_ Policy ID Number \_\_\_\_\_

► Signature/Date of Patient or Responsible Party: \_\_\_\_\_  
  Name                                      Date

## Patient History Questionnaire

**Print Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Sex:** \_\_\_\_\_

What is the reason for your visit? \_\_\_\_\_

**Medications:** Prescriptions and non-prescriptions, vitamins, home remedies and herbs:

Medication	Dose	Per day

Medication	Dose	Per day

**Allergies or Reactions to Medicines/ Foods/ Other Agents:**

Medication/Foods	Reaction or Side Effect

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

**List any Surgeries:** \_\_\_\_\_

**Are you under a Physician's Care?**     **Yes**     **No**

If yes, for what? \_\_\_\_\_

**Personal Past History: Circle any of the following you have or have had.**

- |                        |                         |                       |
|------------------------|-------------------------|-----------------------|
| Anemia                 | Cosmetic Surgery        | Kidney Trouble        |
| Anesthesia Problems    | Diabetes                | Liver Disease         |
| Artificial Heart Valve | Emphysema               | Nosebleeds            |
| Asthma                 | Frequent Colds          | Psychiatric Treatment |
| Bleeding Problems      | Heart Disease or Attack | Skin Disease          |
| Blood Transfusion      | Heart Pacemaker         | Stroke                |
| Cancer                 | Hepatitis B(Serum)      | Thyroid Disease       |
| Chemotherapy           | Hepatitis B(Infectious) | Tuberculosis          |
| Concussion/Head Injury | High/Low Blood Pressure | Ulcers                |

Do you have any diseases, conditions, or problems not listed? \_\_\_\_\_

**Family History:** Please indicate if any family members have had any of the following conditions:

**Anesthesia Problems** \_\_\_\_\_

**Breast Cancer** \_\_\_\_\_

**Epilepsy** \_\_\_\_\_

Do you smoke? \_\_\_\_\_

If yes how much? \_\_\_\_\_

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health, or in my medications, I will inform the doctor.

\_\_\_\_\_

**Signature**

\_\_\_\_\_

**Date**

**PLEASE READ CAREFULLY**

**HIPPA NOTICE OF PRIVACY POLICY ACKNOWLEDGMENT**

I have been given the opportunity to review the HIPPA Privacy Policy of Artisan Cosmetic Surgery, and Dr. Manish Gupta. I was provided with ample opportunity to ask any questions regarding the Privacy Policy and I understand that I may have the full Privacy policy in writing at my request.

\_\_\_\_\_  
Patient Signature

**AGREEMENT AS TO RESOLUTION OF CONCERNS**

“I”, “Patient/Guardian” shall be understood to mean \_\_\_\_\_.

“Physician” shall be understood to mean Manish Gupta MD, Artisan Cosmetic Surgery, and Manish Raj Gupta MD PC.

I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the Physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Society of Plastic Surgery.

I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the American Society of Plastic Surgery and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members. I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and Patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician’s reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Patient/Guardian

\_\_\_\_\_  
Effective from Date of Treatment:

\_\_\_\_\_  
Date of Signature

## MUTUAL AGREEMENT

Dr. Gupta and Artisan Cosmetic Surgery (collectively labeled “*Physician*”) agree to provide treatment to: \_\_\_\_\_ (“*Patient*”) The Physician takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician believes this is improper and may not be in the patients’ best interest. Accordingly, Physician agrees not to provide medical information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient’s consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of “rating sites” in cyberspace, many fail to provide useful information. Let’s get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Physician has invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about the Physician - his practice, expertise, and/or treatment - on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be in force and enforceable for a period of five years from Physician’s last date of service to Patient. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician’s patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship.

Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

SO AGREED THIS \_\_\_DAY OF \_\_\_\_\_, 200\_\_.

\_\_\_\_\_(PATIENT) \_\_\_\_\_ Manish Gupta MD, Artisan Cosmetic Surgery

### Photo Consent

Medical photographs/slides and videotapes may be taken before, during, or after a surgical procedure of treatment. Consent is required to take such images.

I hereby authorized Manish R. Gupta, MD and/or his associates or licensees to take pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes. I additionally consent to photographs, slides, and/or videotapes of my interview.

I hereby authorized Manish R Gupta, MD and/or his associates to licensees to use take pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks, for purposes of medical education, patient education, lay publication, or during lectures in medical lay groups.

I consent to the photographing or televising of the operation(s) or procedures(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, providing my identity is not revealed by the pictures.

Provided my identity is not revealed by the pictures, I understand that my photos may be used for the purposes of advertising, in print, video, or digital medium, including internet-based web-sites.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

**Yes, I have read the Photo Consent Form: I am in agreement and give my consent.**

\_\_\_\_\_(Patient) \_\_\_\_\_ (Date)

# PHI Authorization

## **Artisan Cosmetic Surgery**

### **Patient Authorization for Use and Disclosure of Protected Health Information**

By signing, I authorize Artisan Cosmetic Surgery to use and/or disclose certain protected health information (PHI) about me to \_\_\_\_\_.

This authorization permits Artisan Cosmetic Surgery to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose: \_\_\_\_\_

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on \_\_\_\_\_.

The Practice will \_\_\_ will not \_\_\_ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Artisan Cosmetic Surgery. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

**Artisan Cosmetic Surgery**  
**3438 Granite Circle**  
**Toledo, OH 43617**

Signed by:

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian, if applicable

**Artisan Cosmetic Surgery**  
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Patient Signature