1307 South International Pkwy
Suite 2091
Lake Mary, FL 32746

NEW PATIENT BODY CONTOURING FORM

First Name: _____ Last Name: _____ Today's Date: _____

Birthdate: _____ Male: Female: Email Address: _____

Home Address: _____

Phone Number: _____ Instagram: _____

Emergency Contact Person: _____ Phone Number: _____

How did you hear about us: _____

Areas of Concern: _____

Procedures of Interest:

EMFACE	☐
EMSCULPT NEO	☐
EMSELLA	☐
Botox	☐
Dysport	☐
Juvéderm	☐
Radiesse	☐
Acoustic Pressure wave therapy	☐
Sculptra	☐
Restylane	☐
Restylane Contour	☐
Restylane Define	☐
Restylane Kysse	☐
Cellulite Treatments	☐
Colombian Liposculpture	☐
Colombian Butt Lift	☐
DOT Laser Therapy	☐
Erectile Dysfunction	☐
Fat Storage	☐
Myers Cocktail	☐
Female Enhancement	☐
Lipodissolve	☐
Liposuction	☐
Liposculpture	☐
Nano Fat Transfer to the Face	☐

Neograft Hair Restoration	☐
Hair Transplant	☐
Perfecto PDO Threads	☐
Platelet Rich Plasma (PRP)	☐
PRP for Hair Restoration	☐
Renuvion Skin Tightening	☐
Weight loss/ Nutrition	☐
IV Therapies	☐
Age Management	☐
Hormone Replacement Therapies	☐
Post Lipo Treatments	☐
Lymphatic Drainage Massages	☐
Facials, Peelings, Skincare Regimen	☐
PRP Joint Injections	☐
PRP for Cosmetic Rejuvenation	☐
Testosterone Pellets	☐
Erectus Shot	☐
Femme Shot	☐
Other:	

Have you had liposuction before?	N ☐ Y ☐
If yes, what parts of your body?	
Do you have any allergies to medicines?	N ☐ Y ☐
If yes, list:	
Are you pregnant?	N ☐ Y ☐
Do you smoke?	N ☐ Y ☐
Do you have heart disease?	N ☐ Y ☐
Do you have blood clotting disorders	N ☐ Y ☐
Do you have a history of heavy bleeding during or after surgery or dental work?	N ☐ Y ☐
Do you have a history of blood clots in your legs?	N ☐ Y ☐
Do you have hepatitis or HIV?	N ☐ Y ☐
Have you had surgery in the area(s) for which you are seeking treatment?	N ☐ Y ☐
Are you taking Coumadin, aspirin or other blood-thinning agents?	N ☐ Y ☐
Any Complications with previous surgeries?	N ☐ Y ☐
Abdominal or Inguinal Hernias?	N ☐ Y ☐
Asthma or Lung problems?	N ☐ Y ☐
Previous Back Injury or nerve injuries?	N ☐ Y ☐
History of a Chronic viral infection	N ☐ Y ☐
History of seizures, neurologic or psychiatric problems?	N ☐ Y ☐
Diabetes or a Kidney infection?	N ☐ Y ☐

LAST MENSTRUAL PERIOD: _____

Are you taking Birth control pills? **YES ☐** **NO ☐**
Are you pregnant? **YES ☐** **NO ☐**

	YES	**NO**	**How much?**
SMOKE	☐	☐	
ALCOHOL	☐	☐	
LIVES ALONE	☐	☐	
SINGLE	☐	☐	
MARRIED	☐	☐	
DIVORCED	☐	☐	

LIST ALL YOUR CURRENT MEDICATIONS with DOSAGES:

MEDICATION	**DOSAGE**	**FREQUENCY**

ANY ALLERGIES: Patient is allergic to No Known Drug Allergies (NKDA).
ANY ALLERGIES TO LIDOCAINE? Example dental block at the dentist? _____

HEALTH MAINTENANCE:

PROCEDURE	DATE	Not Applicable	RESULTS
MAMMOGRAM		☐	
PAP TEST		☐	
COLONOSCOPY		☐	
RECTAL EXAM		☐	
PELVIC EXAM		☐	
FLU VACCINE		☐	
PNEUMONIA VACCINE		☐	
DEXA SCAN		☐	

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Office use Only

PHYSICAL EXAM:

VITAL SIGNS:

LMP:

A:

AREAS FOR LIPO_____

				FAT TRANSFER	
Outer Legs	☐	Lower Abdomen	☐	Buttocks	☐
Inner Legs	☐	Upper Abdomen	☐	Face	☐
Chin	☐	Love Handles	☐	Hands	☐
Sacrum	☐	Back Rolls	☐	Breast	☐
Arms	☐			None	☐

POST- LIPO PROGRAM:

P:

Advise to follow-up in:

OPIOID RISK TOOL (ORT) FOR NARCOTIC ABUSE

Please place an "X" to indicate your selection for the following statements.

STATEMENT	YES	NO
Between ages 16-45	☐	☐
History of preadolescent sexual abuse	☐	☐
History of depression	☐	☐
History of ADD, OCD, bipolar disorder, or schizophrenia	☐	☐
Personal history of alcohol abuse	☐	☐
Personal history of illegal drug abuse	☐	☐
Personal history of prescription drug abuse	☐	☐
Family history of alcohol abuse	☐	☐
Family history of illegal drug abuse	☐	☐
Family history of prescription drug abuse	☐	☐

CAGE QUESTIONAIRE

Please place an "X" to indicate your selection for the following questions.

QUESTION	YES	NO
Have you ever felt you needed to cut down on your drinking?	☐	☐
Have people annoyed you by criticizing your drinking?	☐	☐
Have you ever felt guilty about drinking?	☐	☐
Have you ever felt you needed a drink first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

AGREEMENT AS TO THE RESOLUTION OF CONCERNS

"I, Patient/Guardian" shall be understood to mean _____
"Physician" shall be understood to mean Drs. De La Vega and Mercado of Eterna MD Medical Rejuvenation Center.

I understand that I am entering into a contractual relationship with the physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect on 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 a 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 Board of Family Medicine.

I agree the expert will be obligated to adhere to the guidelines or code of conduct defined by the American Board of Family Medicine.

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 precisely 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.

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

_____ _____
Patient Signature Date

_____
Patient Print Name

_____ _____
Witness Signature Date

_____ _____
Physician Signature Date

Consent to Photograph for Medical Documentation

I hereby authorize the above named physician to photograph or permit others to photograph _____ while under the care of the above physician, and agree that he will use the prints prepared there from for such purpose and in such as may be deemed necessary for medical documentation.

_____ _____
Patient Signature Date

_____
Patient Print Name

_____ _____
Witness Signature Date

Consent to Photograph for Marketing/Public Relations

I hereby authorize the above-named physician to photograph or permit other persons to photograph and record videos. (Photos will be anonymous)

_____ _____
Patient Signature Date

_____
Patient Print Name

_____ _____
Witness Signature Date

ETERNA MD CANCELLATION, NO-SHOW, AND REFUND POLICY

TREATMENTS: All treatments, procedures, deposits, products, and pre-paid packages are non-refundable. Packages are non-transferable and must be used within one year from the date of purchase. Credit/Deposits from pre-paid treatments, procedures and packages may be applied to other treatment(s) or product(s) only at management's discretion.
NO REFUNDS, EXCHANGES ONLY.

CANCELLATIONS and No-Shows: We understand that emergencies do arise; however, we do request at least 24 hours' notice for rescheduling or canceling all consultations. Failure to do so will result in a $50 charge to your account, and all New Patients will need to secure their procedure/treatment appointment with a credit card number. All procedures/treatments that require an hour of appointment will also be secured with a credit card.

ARRIVALS: Please arrive for your appointment at least 15 minutes earlier or on time. Arriving on time will ensure that you will receive the required amount of time you deserve for your treatment and helps us not to intrude on the following patient's reserved time.

CONSENT FOR EVALUATION AND COMMUNICATION

I hereby give my consent to ETERNA MD and their physicians to perform this evaluation that might include medical history, physical examination, lifestyle questions and others that are pertinent to my consultation. I understand they will be assisted by other health professionals, as necessary, and agree to their participation in my evaluation day. I certify that I am under the regular care of another physician for all other medical conditions. I will consult my physician(s) for any other medical services I may require. I understand that ETERNA MD is a specialized practice dealing exclusively in Age Management Medicine and Aesthetic procedures. I also understand that I will continue under the care of my other physician(s) for any on-going medical condition as well as for any medical consultation that I may need. Also I give permission to communicate after the consultation with me either via e-mail to send patient care plans with pictures of myself, before and after pictures or other pertinent information such as articles that are educational and provide information regarding my requested services. Also my physician might communicate with me after my consultation via phone, text messages, mail, electronic communications (e-mails) fax as well as his personnel to follow-up appointments, follow-up consultations, quotes or other information related to the services consulted.

By signing below, I agree to EternaMD's company terms and conditions.
To attest to my consent to this evaluation, I hereby affix my signature to this authorization to evaluation.

_____ _____
Patient Signature Date

_____
Patient Print Name

_____ _____
Witness Signature Date

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice of Privacy Practices describes the practices for safeguarding your personal health information. The term of this Notice applies to patients and dependents for medical treatment.

We are required by law to maintain the privacy of our patient's personal health information and to provide the notice of our legal duties and privacy practices with respect to personal health information (PHI). We are required to abide by the terms of this notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary as rules of law dictate and to make the new Notice effective for all personal health information (PHI) maintained. Copies of the revised Notices will be mailed to our patients. You have a right to request a copy of the Notice.

Uses and Disclosure of Your Personal Health Information (PHI)

Authorization: Except as explained below, we will not use or disclose your personal health information (PHI) for any purposes unless you have signed a form (Authorization Form) allowing a use of disclosure. Unless we have taken any action in reliance on the authorization, you have the right to revoke an authorization if the request for revocation is in writing and sent to our office of record.

Disclosures for Treatment: We may disclose your personal health information as necessary for your treatment. For example, a doctor or healthcare facility involved in your care from a referral may need your personal health information in our possession to provide care for you.

Uses and Disclosures for Payment: We will use and disclose your personal health information (PHI) as necessary for payment purposes. For example: We may use your personal health information (PHI) to process insurance claims, including Medicare and commercial carriers.

Uses and Disclosures for Health Care Operations: We will use and disclose your personal health information (PHI) as necessary for health care operations. For examples: we may use or disclose your personal health information (PHI) to healthcare facilities or for diagnostic testing, such as; MRI's, CT scans, radiology or laboratory testing.

Practices Uses and disclosures: We may contact you with reminders of an upcoming appointment, information about other treatment options, or health related products, programs or services that may be available to you.

Outside Business Consultants: Some aspects of our services are sometimes performed by persons outside of our organization and are here under contract or agreements. It may be necessary for us to disclose your personal health information to these outside contractors or organization that perform services for us. We require them to safeguard the privacy of your personal health information (PHI) and we require them to be HIPAA compliant.

Family, Friends and Personal Representatives: with your approval, we may disclose to family members, close personal friends or other persons that you may identify, your personal health information (PHI) relevant to their involvement with your care. If you are unavailable, incapacitated or involved in an emergency, and we determine that a limited disclosure is necessary to provide you care/treatment, we may disclose your personal health information (PHI) without your approval.

Other uses and Disclosures: We are permitted or required under HIPAA or State law to use or disclose your personal health information (PHI) without your Authorization, in the following situation:For any purpose required by Law. For public health requests: such as: Death, Injury, or suspected child abuse or neglect. To a government authority if we believe an individual is a victim of abuse, domestic violence, neglect or for health oversight actions (such as inspections, licensure actions, civil or administrative or criminal proceedings). For administrativeor judicial proceedings such as: Subpoena, court orders or a discovery request. For Law Enforcement purposes: such as: Reporting injuries, wounds, or for locating or identifying suspects, missing persons or witnesses. To medical

examiners, coroners and funeral directors. For procuring, banking or transplants of organs, eye or tissue donations. For certain research projects.To avoid a serious threat to health or safety under certain instances. For intelligence or national security issues, members of the armed forces for military activities, or information about an inmate or an individual being held at a correctional institution or a law enforcement agency having custody. To be compliant with workers compensation programs or requests. We will follow all state and federal laws or regulations that provide additional privacy protections. We will only release or disclose AIDS/HIV related information, any information relating to your mental status, genetic testing information or any substance abuse issues as permitted by state and federal law or regulations.

Your Rights:

Restrictions on Use and Disclosure of Your Personal Health Information (PHI). You have the right to request restrictions on how we use or disclose your personal health information (PHI) for treatment, healthcare operations or payment (Commercial Insurance Carriers and Medicare/Medicaid). You have the right to restrict disclosures to family members or others who are not involved in your care or who are not financially responsible for your care. To request restrictions on certain individuals, send a written request to our office to Attention: Privacy Officer. We are not required to always agree with your request for a restriction but, if we do grant your request, you will receive a written acceptance of your request.

Receipt of Confidential Communications of your personal health information (PHI). You have the right to request communications relating to your personal health information (PHI) by alternative means such as by: Fax (with a secure cover sheet) or at an alternative location. We will accommodate any reasonable requests. To request a confidential communication, please send a written request to our office: Attention: Privacy Officer.

Access to your Personal Health Information (PHI). You have the right to inspect and or obtain copies of your personal health information that we maintain in your designated personal records, with one or two exceptions. To request access to your information, you must send a written request to our office, Attention: Privacy Officer. A medical records release form can be obtained at our office.

Amendment of your Personal Health Information (PHI). You have the right to request an amendment to your personal health information (PHI) to correct any errors or omissions. To request an amendment to your personal health information, you must send a written request to our office: Attention: Privacy Officer. We are not required to grant the request in certain instances.

Accounting of Disclosures of your Personal Health Information (PHI). You have the right to receive an accounting of certain disclosures made by us of your personal health information. To request an accounting, you must send a written request. Attn: Privacy Officer.

Complaints: If you believe your privacy rights have been violated, you can send a written complaint to our office. Please send to the attention of: Privacy Officer.

If you have any questions or need any assistance regarding this Privacy Notice of your privacy rights, please contact our office.

I acknowledge that I have received a copy of the Privacy Practices for Protected Health Information effective today.

_____ _____

Patient Signature Date

_____

Patient Print Name

_____ _____

Witness Signature Date