DR. BRIAN BUINEWICZ, MD, PC
Plastic Surgery · Cosmetic Medicine · Le MedSpa

Patient Name: _____
First Middle Last

Address: _____
Street & Apartment # City State Zip

Age: _____ **DOB:** _____ **Gender:** _____ **Marital Status:** _____

Home Phone: _____ **Cell Phone:** _____

Other phone: _____ **Email:** _____

Any restrictions for contacting you? YES NO Contact restrictions (if any): _____

I consent to receive a message via text, answering machine, voicemail or for the office to leave a message with spouse, parent or other household member. (Circle one) YES NO

I consent to receive test results on my answering machine, by text, voicemail or for the office to leave a message with a spouse, parent or other household member. (Circle one) YES NO

Primary Doctor: (Name) _____ **Phone:** _____

Pharmacy (Name and phone number): _____

How did you hear about Dr. Buinewicz? (Circle all that apply)

TV Magazine Newsletter Seminar Salon Internet Advertisement

Doctor: _____ **Friend/Relative:** _____

Photo Authorization

I consent to the taking of photos and/or videos as me or parts of my body associate with the plastic surgery procedure(s) to be performed by Dr. Buinewicz and his staff. Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the images my portray features that will make my identity recognizable.

Photos and videos will ONLY be used for:

- **Educational or insurance purposes within the office** _____ **(please initial)**
- **In office seminars or for prospective patients** _____ **(please initial)**
- **On our website for prospective patients** _____ **(please initial)**
-

I have read the above Authorization, I am the parent, guardian, or conservator of _____**, aminor. I am authorized to sign the form on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.**

Signature: _____ **Date:** _____

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MEDICAL HISTORY FORM

Name: Date:

Date of Birth: Age:

1. Please list all food and drug allergies.

2. Please list all medications you now take (including over the counter meds, i.e. aspirin).

3. Please list all operations you have had.

4. Please list your medical problems.

5. Please list your present height and weight.

CHECK YES IF YOU HAVE EVER HAD:	YES	NO	COMMENTS
1. A heart attack	☐	☐	
2. Heart disease	☐	☐	
3. A heart murmur	☐	☐	
4. Chest pain or angina	☐	☐	
5. High blood pressure	☐	☐	
6. A stroke/mini stroke/TIA			
7. Fainting episodes	☐	☐	
8. Epilepsy/seizures/falling out	☐	☐	
9. Shortness of breath when resting	☐	☐	
10. Shortness of breath when climbing stairs or walking	☐	☐	
11. Shortness of breath at night	☐	☐	
12. Asthma/emphysema/COPD-chronic obstructive pulmonary disease	☐	☐	
13. Chronic bronchitis	☐	☐	
14. Tuberculosis	☐	☐	
15. An abnormal chest x-ray (specify)	☐	☐	
16. Diabetes/trouble with your blood sugar	☐	☐	
17. Kidney problems	☐	☐	
18. Arthritis/joint problems	☐	☐	
19. Heartburn/ulcer/hiatal hernia	☐	☐	
20. Cancer (specify)	☐	☐	
21. Chemotherapy (specify)	☐	☐	
22. Liver problems/jaundice/hepatitis	☐	☐	
23. Anemia/iron poor blood/low blood count	☐	☐	
24. Bleeding tendencies	☐	☐	
25. Thyroid problems	☐	☐	

CHECK YES OR NO TO INDICATE
WHETHER YOU CURRENTLY:

	YES	NO	COMMENTS
26. A significant weight loss without trying to diet	☐	☐	
27. Mental/emotional/nervous disorders	☐	☐	
28. Eye problems	☐	☐	
29. Frequent headaches/migraines	☐	☐	
30. A problem with anesthesia	☐	☐	
31. Hepatitis	☐	☐	
32. HIV	☐	☐	
32. Smoke cigarettes (specify number of packs per day)	☐	☐	
33. Drink alcohol	☐	☐	
34. Could be pregnant	☐	☐	
35. Have a cold or cough	☐	☐	
36. Have bridgework, dentures, chipped Or loose teeth, caps, braces	☐	☐	
37. Have any physical disabilities	☐	☐	

I certify that the above information is true and correct to the best of my knowledge.

_____ _____

Patient/guardian **Date**

_____ _____

Reviewed by **Date**

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APPOINTMENT NO SHOW/CANCELLATION POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel you appointment, you provide at least 24-hours notice.

Office appointments which are cancelled in less that 24-hours notification are subject to a $50.00 cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as a NO SHOW. These patients are subject to a $50.00 fee as well.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

NOTICE OF NO REFUND POLICY

Please note that our office has a strict NO REFUND policy. Procedures, products, treatments and other appointments cannot be refunded.

Also, ANY revisions or touch-ups of surgical procedures, injections or treatments will be at a MINIMUM of 50% of the original cost.

Please sign below to acknowledge the receipt of our policies:

Signature: _____ **Date:** _____

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TO ALL PATIENTS

PLEASE RED COMPLETELY AND SIGN

I understand that charges for services are payable on the day it is rendered. I authorize Dr. Buinewicz to bill my insurance company for medically necessary services if applicable under my specific health insurance plan. I am responsible for all bills being paid in full whether or not my health insurance company agrees to pay you. I understand that my contract is between Brian R. Buinewicz MC, PC and myself.

I hereby authorize direct payment of medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, Private insurance, and any other health plan to Brian R. Buinewicz, MD, PC.

In compliance with Medicare regulations we are required to ask the following questions:

Do you or your spouse work for a company that provides you with health insurance? Yes _____ No _____

Are you entitled to Medicare because of a disability or End Stage Renal Disease? Yes _____ No _____

Is the illness or injury the result of an automobile accident or other injury? Yes _____ No _____

Has treatment for the accident or illness been authorized by the Veteran's Admin? Yes _____ No _____

Are you entitled to any benefits under the Federal Black Lung Program? Yes _____ No _____

I certify that this information is true and complete to the best of my knowledge.

_____ _____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT

TO USE AND DISCLOSE HEALTH INFORMATION

This acknowledgement of notice of consent authorizes LeMedSpa to use and disclose health information about you for treatment, payment and health care operation purposes.

Notice of Privacy Practices. LeMedSpa has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to: Brian R. Buinewicz, MD, PC, 3655 Route 202, Suite 225, Georgetown Crossing, Doylestown, PA 18902.

_____ _____

Signature Date

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Address to LeMedSpa at Buckingham: 3655 Route 202 Georgetown Crossing
Doylestown, PA 18902 Suites 225-230

Telephone: 215-230-4013
Facsimile: 215-230-4143
Attention: Privacy Officer, Brian R.Buinewicz, M.D.

I have received the Notice of Privacy Practices for LeMedSpa at Buckingham. LeMedSpa at Buckingham is authorized to use and disclose health information about _____
Patient's Name
for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

Signature of patient: _____
(or patient's personal representative)

Date: _____

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COSMETIC INTEREST QUESTIONNAIRE

Our goal is to respond to all of our patient's needs and to provide the highest quality care. In order to provide the information and services you desire on the health and appearance of your skin and body, we invite you to complete the following questionnaire:

Please check all that apply:

( ) Wrinkle Reduction
( ) AHA and Glycolic Peels
( ) Injectable Dermal Fillers
( ) Skin Rejuvination
( ) Skin Texture
( ) Microdermabrasion
( ) Acne
( ) Chemical Peels
( ) Facials/Eye Treatments
( ) Hair Removal
( ) Anti-Aging/Antioxidant Treatments
( ) Botox Cosmetic
( ) Photo-rejuvenation
( ) Hair Waxing
( ) Tempsure
( ) Breast Enlargement
( ) Liposuction
( ) Neck Lift
( ) Brow Lift
( ) Abdominoplasty
( ) Hair Follicle Transplant
( ) Cellupulse for Cellulite Reduction
( ) Hyperhidrosis (excessive sweating)
( ) Skin Care Advice
( ) Skin Care Products
( ) Birthmarks
( ) Liver Spots/Age Spots
( ) Sunscreen Advice
( ) Pore Size
( ) Laser Treatments
( ) Spider Vein Treatments
( ) Removing Facial Veins
( ) Thermage
( ) Ulthera skin tightening
( ) Coolscuplting
( ) Emsculpt
( ) Breast Reduction
( ) Thigh Lift
( ) Face Lift
( ) Eyelid Surgery
( ) Buttock Contouring
( ) Genetic Testing for
( ) Breast Cancer
(_) Labiaplasty

( ) Other – Please Specify: _____

I WOULD LIKE TO BE CONTACTED FOR FURTHER INFORMATION, EVENTS AND PROMOTIONS. THE BEST WAY TO CONTACT ME IS:

Name: _____

Cell phone (text/call): _____

Email: _____

For more information, please visit our website, Facebook and Instagram page. #buinewiczplasticsurgery