PATIENT INFORMATION: Date:_____

Patient Name_____ Date of Birth:_____Age:_____

Home Address:_____

City, State, Zip Code:_____ Social Security Number:_____

Home Phone:_____Cell Phone:_____E-mail:_____

Occupation:_____Employer:_____Business Phone:_____

Primary Care Provider (PCP):_____PCP Phone:_____

PCP Address:_____

Has this office ever treated any member of your family? Yes_____No_____

If yes, whom?_____

How did you hear about our office?_____

Emergency Contact Name:_____ Phone:_____Relation:_____

PLEASE CHECK OFF YOUR AREAS OF CONCERN:

- ☐ Forehead lines
- ☐ Frown lines between eyebrows
- ☐ Crow's Feet
- ☐ Lines around mouth
- ☐ Thin lips
- ☐ Sun damage/hyperpigmentation/melasma
- ☐ Eyes appearing tired
- ☐ Hollows beneath eyes
- ☐ Hollows at temples
- ☐ Skin texture
- ☐ Thinning hair
- ☐ Appearance of neck
- ☐ Sunken cheeks

PLEASE LIST CURRENT PRODUCTS:

Cleanser:_____

Toner:_____

Serum(s):_____

Moisturizer:_____

Eye Cream:_____

SPF (strength?):_____

Retinol/Retinoid:_____

Other:_____

Other:_____

Have you had any Botox, Fillers, or any other injectables, lasers, facials, chemical peels, or other cosmetic treatments in the last two weeks? If yes, please explain:_____

_____

_____

Patient Name_____ Date of Birth:_____

Fitzpatrick Skin Typing Worksheet

Circle the answer that best describes you:

	0	1	2	3	4
What is your natural eye color?	Light blue or gray	Blue, Gray, or Green	Hazel, Light brown	Dark brown	Brownish black
What is your natural hair color (prior to gray or white)?	Red, Sandy red	Blonde	Dark blonde, Chestnut brown	Dark brown	Black
What is the color of your unexposed skin (i.e. stomach, thighs)?	Reddish	Very pale	Pale with beige tint	Light brown, Olive	Dark brown
Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
What happens when you stay in the sun too long?	Painful redness, blisters, peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had burns
To what degree do you tan or turn brown?	Hardly any or not at all	Light color tan	Reasonable/ moderate tan	Tan very easily	Turn dark brown quickly
Do you turn brown or tan several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
When did you last expose your skin to the sun, tanning bed, or self-tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
Do you expose the area to be treated to the sun (tanning bed, self-tanner, sun-bathing, exercising outside)?	Never	Hardly ever	Sometimes	Often	Always
Add Above for Total Score: ☐					
Match your score to the corresponding Fitzpatrick Skin Type: 0-7 = I 8-16= II 17-25 = III 26-30 = IV Over 30 = V-VI					
Skin Type I: Fair skin, red or blonde hair, blue/green eyes, never tans, always burns					
Skin Type II: Fair skin, sandy- light brown hair, green or brown eyes, occasionally tans, usually burns					
Skin Type III: Medium skin, brown hair, brown eyes, often tans, sometimes burns					
Skin Type IV: Olive skin, brown/black hair, brown/black eyes, always tans, never burns					
Skin Type V: Dark skin, black hair, black eyes, never burns					
Skin Type VI: Black skin, black hair, black eyes, never burns					

Patient Name_____ Date of Birth:_____

Medical History:

Height_____Weight_____ Pharmacy Name and Location:_____

Do you now or have you ever smoked cigarettes, used any type of vape, or any other nicotine products? Yes_____ No_____ Quit Date:_____

Do you smoke or vape marijuana or THC, or use marijuana or THC edibles? Yes_____ No_____

Do you use any other recreational drugs? Yes_____ No_____ If yes, what kind and how often? _____

Number of alcoholic beverages consumed per week and what kind? _____

Have you ever had any psychiatric or psychological care (including therapy) Yes_____ No_____

If yes, please explain: _____

Do you have any significant emotional problems? _____

Do you suntan/use tanning beds? Yes_____ No_____

Have you used Accutane in the last year? Yes_____ No_____ If yes, when did you stop? _____

Do you use sunscreen daily? Yes_____ No_____ If yes, what strength SPF? _____

Have you ever used Hydroquinone or other skin lighteners/brighteners? Yes_____ No_____

Have you had any radiation therapy/chemotherapy in the past year? Yes_____ No_____

Are you prone to Herpes, cold sores, hives, blisters, and/or keloids? Yes_____ No_____

If yes, please explain: _____

How would you characterize your skin? (circle) Sensitive Dry Normal/Dry Normal/Oily Acne Prone

Women Only: What was the date of the first day of your last menstrual cycle? _____

Women Only: Are you currently breastfeeding? Yes_____ No_____

<u>Please list all prior surgeries and/or hospitalizations:</u>

DATE	SURGERY OR ILLNESS	HOSPITAL & PHYSICIAN

Patient Name_____ Date of Birth:_____

Please circle all current and previous medical conditions/illnesses and explain below:

Acid Reflux	Bowel/Intestinal Disorders	Facial Surgery	Kidney Problems	Seizures
Anemia	Body Dysmorphic Disorder	Frequent Infections	Liver Disease	Sinus Problems
Anxiety	Brain/Neurological Disorder	Glaucoma	Learning Disorder	Skin Disorder
Arthritis	Cancer	Heart Arrhythmia	Lung Problems	Stroke
Asthma	Chemotherapy	Heart Attack	Mental Illness	Thyroid Disorder
ADD/ADHD	Congestive Heart Failure	Heart Condition	Metabolic Issues	Ulcers
Autoimmune Disorder	COPD/Emphysema	Hernia	MRSA or VRE	Vascular Disease
Bipolar Disorder	Diabetes	High Blood Pressure	Pacemaker	Varicose Veins
Bleeding Disorder	Dental Problems	High Cholesterol	Pneumonia	Vision Problems
Blood Clots	Depression	Hormonal Imbalance	Radiation	
Bowel Obstruction	Bone/Joint Disease	Immunotherapy	Reproductive Problems	

Please explain:_____

Please list all medications, vitamins, supplements, and herbal medications that you take daily and as needed:

MEDICATION	DOSAGE	HOW OFTEN?	WHY YOU TAKE IT?	PRESCRIBER

Please list any allergies to any drugs, foods, environmental factors, or others with reactions below:

_____

_____

_____

☐ No Known Allergies

Patient Name_____ Date of Birth:_____

Coagulation Questionnaire:

1)	Do you currently have swollen legs?	Y / N
2)	Have you been diagnosed with Sepsis in the last 6 months?	Y / N
3)	Do you have a central venous access port?	Y / N
4)	Do you have a history of deep vein thrombosis (DVT) or pulmonary embolism (PE), or blood clots?	Y / N
5)	Do you have a family history of DVT, PE, or any other clotting issues including excessive bleeding?	Y / N
6)	Have you ever been diagnosed with any of the following:	
	Factor V Leiden	Y / N
	Prothrombin 20210A	Y / N
	Elevated cardiolipin antibodies	Y / N
	Heparin induced thrombocytopenia (HIT)	Y / N
	Elevated serum homocysteine levels	Y / N
	Positive lupus anticoagulant	Y / N
	Congenital or acquired thrombophilia	Y / N
	Any other type of abnormal clotting?	Y / N
7)	Have you had a stroke or transient ischemic attack within the last month?	Y / N
8)	Are you currently taking medications that are blood thinners (aspirin, NSAIDS, anti-platelet medications,	
	warfarin, Pradaxa, Aggrenox, Plavix, Pletal, Vitamin E, herbals, or homeopathic substances?	Y / N

All of the information provided within this history is accurate and complete to the best of my knowledge.

Patient Name Patient or Legal Guardian Signature Date

Authorization to Disclose Protected Health Information (PHI)

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is also called "protected health information" (PHI) under HIPAA's Privacy Rule. I understand that if the person or entity receiving this information is not a health plan or health care provider covered by the federal privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

Name of Individual or Company to Whom Disclosures May Be Made To:

1) Name: _____Relationship: _____

   Financial Information (circle): Yes No PHI (circle): Yes No

2) Name: _____Relationship: _____

   Financial Information (circle): Yes No PHI (circle): Yes No

3) Name: _____Relationship: _____

   Financial Information (circle): Yes No PHI (circle): Yes No

Limitations of Disclosure: Please describe any limitations that you would like on the disclosure of your PHI and/or Financial Information:

_____

I understand that I may revoke this permission, in writing, at any time. Revoking permission, however, does not affect previous disclosures that were made with my consent.

Print Name: Signature: Date:

Authorization to be Contacted Through Alternate Means

I hereby request to be contacted through alternate means. I understand that in the course of doing so, my PHI may be viewed by individuals I did not intend. I understand that I may revoke this request in writing, at any time. *Please list any alternate addresses, phone numbers, e-mail addresses, etc. that you would prefer to be contacted at:*

_____

Print Name: Signature: Date:

Authorization to be Contacted by Text Messaging (data rates may apply) and E-Mail

- ☐ I consent to be contacted by e-mail regarding notifications that documents have been uploaded to my patient portal and for promotions/special events within the office.
- ☐ I consent to be contacted by text messaging regarding upcoming appointments and rating services.

Print Name: Signature: Date:

Medical Record and Photographic Consent

I understand that photographs and/or videos will be taken at the time of my consultation, as well as during and after my procedure as part of my medical record. Photographs may be submitted to insurance carriers for the purpose of coverage determinations. I understand that photos sent to Spiro Plastic Surgery, LLC will be at my own will and discretion.

Print Name: Signature: Date:

Use of Medical Records

I acknowledge that Spiro Plastic Surgery, LLC can use information from my medical record, plan of care, and surgery outcome in future presentations to residents and regional and national meetings and presentations. Your name, Social Security number, and/or date of birth will never be used for presentations or meetings.

Print Name: Signature: Date:

Use of Medical Records

I consent to the use of pre- and post-operative photos for use in scientific meetings. Your name, Social Security number, and/or date of birth will never be used for presentations or meetings.

Print Name: Signature: Date:

Notice of Privacy Practices Acknowledgement Receipt

I acknowledge receipt of the Notice of Privacy Practices, amended June 24, 2025.

Print Name: Signature: Date:

Financial Policy Agreement for Spiro Plastic Surgery

CONSULTATION FEES: Patients who wish to discuss multiple surgical procedures and/or treatment of multiple body regions may be charged an additional fee. Consultations that are functional in nature may be submitted to insurance and subject to deductible, co-insurance, and co-pay. If consultations are both cosmetic and functional, they may be subject to both a self-pay/out-of-pocket consultation fee as well as a billable charge to your insurance carrier.

ACCEPTED METHODS OF PAYMENTS: For services provided by our office, we accept cash, bank checks, money orders, Visa, MasterCard, Discover, and American Express. Personal checks will not be accepted upon your first encounter. Payment for surgical procedures with personal checks will only be accepted up to three weeks prior to the services being rendered. Please be advised that the business reserves the right to use its own discretion when accepting forms of payment. There is a fee of $30.00 for returned checks.

OUT-OF-NETWORK/NON-PARTICIPATING: Spiro Plastic Surgery, LLC is a non-participating provider with all health insurance plans.

- ***Claims for services rendered in the office:*** Healthcare claims for any services rendered in the office will be processed under the out-of-network provisions of your policy.
- ***Claims for services rendered at facilities:*** Our providers operate at facilities that are in-network with all major insurance carriers which protects you from balancing billing under The No Surprises Act. Any approved surgeries performed at in-network facilities will be processed per your in-network benefits, and you will be responsible for any in-network co-pays, deductibles, and co-insurance per the terms of your plan.

COVERED SERVICES:

- ***Approved Surgeries:*** If you meet the criteria for coverage, we will initiate all pre-certifications/pre-determinations required for medically necessary procedures prior to your surgery and notify you of the outcome. Prior to your approved procedure, we will collect any applicable co-pays, deductibles, and co-insurance per the terms of your plan. We will submit all approved procedures to your insurance carrier on your behalf.

NON-COVERED SERVICES:

- ***Non-Covered Surgeries:*** If your procedure does not meet criteria for coverage under your plan provisions, we will collect 100% of the surgical fee in advance of your procedure, due three (3) weeks prior to surgery. Not all services rendered by Spiro Plastic Surgery, LLC that your provider may consider medically necessary are covered benefits under every insurance carrier. All procedures that are submitted to insurance and denied as a non-covered service will be your financial responsibility.

COSMETIC PROCEDURES: Procedures deemed cosmetic in nature will not be submitted for pre-certifications or pre-determinations to your insurance carrier.

MEDICARE: – Effective April 1, 2011, Dr. Spiro has "opted out" of the Medicare system and may enter into private contracts with Medicare beneficiaries. As such, patients must accept full

responsibility for payment of Dr. Spiro's fees for all services rendered. Medicare limiting charges do not apply to Dr. Spiro's services. Our office cannot submit claims to Medicare for services provided by Dr. Spiro. Similarly, Medigap plans and other supplemental plans will not make payment for services rendered by Dr. Spiro as he is opted out of Medicare.

MEDICAID – Spiro Plastic Surgery, LLC does not participate with Medicaid or any Medicaid plans administered through other carriers. Please advise our office if you have a primary or secondary Medicaid plan.

INSURANCE PAYMENTS: Our office may be notified by your insurance carrier that you have received an insurance check/ACH payment. Should you receive an insurance payment for services rendered by Spiro Plastic Surgery, LLC, you will be responsible for reimbursing our office within seven (7) days of receipt with a copy of the explanation of benefits. If you have not received any insurance correspondence, it is your responsibility to follow-up with the insurance carrier immediately. Non-payment to our practice may result in default of your account and subsequent placement with an attorney or bonded collection agency.

COLLECTIONS: In the event a patient balance exceeds 90 days, the undersigned authorizes Spiro Plastic Surgery, LLC and/or their authorized agent to verify any information provided to the practice, now or in the future, and/or obtain additional information by securing data from a credit reporting agency. In addition, the undersigned agrees to pay a thirty percent collection fee in the event of default on their account, if the account is placed with an attorney or bonded collection agency.

CREDIT CARD DISPUTES: If you engage your credit card company by disputing a charge, you are hereby authorizing Spiro Plastic Surgery, LLC to share details regarding appointments, treatments, and purchases with your credit card company, thereby relinquishing your HIPAA rights as it pertains to the financial dispute.

APPOINTMENT SCHEDULING FEES, LATE FEES, AND CANCELLATION FEES:

Spiro Plastic Surgery LLC collects fees for scheduling appointments**.** Scheduling fees are collected prior to scheduling the appointment and will be applied towards your consultation fee or service fee. Please read the following carefully.

- **CONSULTATION/SCHEDULING FEE FOR DR. SPIRO:**
    - The cosmetic consultation fee for Dr. Spiro is $500. This is prepaid and collected at the time of scheduling an appointment. This amount is retained as a cancellation fee for appointments that are cancelled or rescheduled within two business days of an appointment and "no shows."
    - Spiro Plastic Surgery is out-of-network with all carriers, opted out of Medicare, and we do not accept Medicaid. The consultation fee for patients seeking treatment for medically necessary or potentially medically necessary procedures with out-of-network plans, Medicare, or Medicaid is $200 and is prepaid and collected at the time of scheduling an appointment. This amount is retained as a cancellation fee for appointments that are cancelled or rescheduled within two business days of an appointment and "no shows."
        - If you have out-of-network benefits, your consultation fee will be submitted to your carrier on your behalf.
- **SCHEDULING FEE FOR COOLSCULPTING CONSULTATIONS, SKIN CARE SERVICES, AND INJECTABLES:**
    - The scheduling fee for CoolSculpting consultations, injectables, lasers, and all other skin care services is $100 which is prepaid and collected at the time of scheduling an appointment. This amount is retained as a cancellation fee

for appointments that are cancelled or rescheduled within two business days of an appointment and "no shows." The fee may be allocated towards services rendered for treatments performed within thirty days of the consultation.

- **SCHEDULING FEE FOR COOLSCULPTING:**
  - The scheduling fee for CoolSculpting treatments is $250 per treatment cycle. The balance for treatment cycles is due prior to treatment on the day of the appointment. The scheduling fee for CoolSculpting treatments will be assessed and retained as a cancellation fee for appointments that are cancelled or rescheduled within two business days of an appointment and "no shows."
- **LATE FEES AND CANCELLATION FEES**:
  - A late fee will be assessed for all appointments for patients who do not arrive on time. If you are late and we cannot accommodate you, your appointment will be subject to cancellation. The scheduling fee will be assessed and retained as your late fee charge.
  - If you are late and our office is able to accommodate you, the scheduling fee will be assessed and retained as a late fee charge and will not be applied towards the balance of your consultation or treatment. The full amount of the service will be due at the time of the appointment.

PRODUCT REFUND POLICY: If a patient has a documented skin reaction within three weeks of the purchase date of the product, a credit for the product may be issued. Credits may be used towards future products and/or services within Spiro Plastic Surgery, LLC. No credits will be issued after three weeks from the purchase date. All credits expire one year from the date issued.

By signing below, you are agreeing that you have read and understand our financial policy. If you have any questions about our financial policies, please feel free to ask for additional clarification from our Billing Manager. We are here to assist you in any way possible. Thank you for choosing Spiro Plastic Surgery, LLC.

Print Name: Signature: Date:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Any questions or concerns regarding information contained in this document should be directed to:

Privacy Officer, Spiro Plastic Surgery, LLC
101 Old Short Hills Road Suite 510
West Orange, NJ 07052
Telephone (973) 736-5907

We Have a Legal Duty to Safeguard Your Protected Health Information (PHI).

This includes information that can be used to identify you that we have created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We must provide you with this notice regarding our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use and disclosure. We are legally required to follow the privacy practices that are described in this notice. However, we reserve the right to change the terms of this notice at any time. Any changes will apply to the PHI we already have. We will promptly post the revised policy in our office waiting room. You may also request a copy of this notice from the individual named above at any time.

How We May Use and Disclose Your Protected Health Information:
We use and disclose health information for many reasons. Below we describe the different uses and disclosures. Uses and disclosures which do not require your authorization:

- Treatment - We will use your health information for treatment. We may provide your information to hospitals, anesthesiologists, and other physicians involved in your care, nurses and technicians.
- Payment – We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. A bill may be sent to you, a third-party payer, or collection agency. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis and procedures.
- Health Care Operations – We may disclose your PHI in order to operate this practice. We may use your information in order to evaluate the quality of health care services our office provides. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make certain we are complying with laws that apply to our practice.
- Federal, State, or Local Law, Judicial or Administrative Proceedings, or Law Enforcement – We may disclose your information when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, domestic violence, or when ordered in a judicial or administrative proceeding.

- Business Associates - There are some services provided in our practice through contacts with business associates. Examples include radiology, anesthesiology, laboratory diagnostics, hospital and surgical facilities, etc. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer when necessary. So that your health information is protected, however, we require the business associate to appropriately safeguard your information.
- Public Health Activities – We may report information to government officials in charge of collecting information about various diseases, infections, and medical products. We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls. We may provide coroners, medical examiners, and funeral directors any necessary information.
- Health Oversight Activities – We will provide information to assist the government when it conducts an audit or investigation of a physician or medical practice.
- Tissue/Organ Donation – We may contact tissue procurement organizations to assist them in donations and transplants.
- Research - We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. We will always ask for your specific written permission if the researcher will have access to any information that reveals who you are, such as your name, address or other patient identifying information.
- To Avoid Harm - In order to avoid a serious threat to the health and safety or a person or the public, we may provide your information to law enforcement personnel or persons able to prevent or lessen such harm.
- Specific Government Functions – We may disclose information on military personnel or veterans in certain situations. We may disclose information for national security purposes or conducting intelligence operations.
- Workers' Compensation – We may provide information to comply with applicable workers' compensation laws.
- Appointment Reminders and Health Related Benefits or Services – We may use information to advise you of future appointments, treatment alternatives, or other health care services or benefits we offer.
- Incidental Uses and Disclosures – An incidental use and disclosure is a secondary use that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. Such uses are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your information than is necessary to accomplish the permitted disclosure.

<u>Uses and disclosures where you have the opportunity to object:</u>
Disclosures to Family, Friends, and Others – Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. You may object in whole or in part to these disclosures.

Other uses and disclosures of medical information not covered by this policy or applicable laws will only be made with your prior written approval. You may revoke that permission, in writing, at any time. Revoking your permission does not require us to take back any disclosures we have

previously made with your permission.

Your Rights Regarding Your Protected Health Information

Although your health record is the physical property of the healthcare practitioner, the information belongs to you. You have the right to:

- Obtain a copy of the Notice of Privacy Practices upon request.
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522. This request must be made in writing to the attention of the Privacy Officer and must include what information that patient wants to limit and to whom the limits apply. We will consider your request but are not legally required to accept it.
- Inspect and copy your health record as provided for in 45 CFR 164.524. This request must be made in writing to the attention of the Privacy Officer. We will respond to you within 30 days of receiving your written notice. We may charge a fee for the costs of copying, mailing, faxing, reproducing photographs, or other expenses associated with a patient's request.
- Choose how we send health information to you. You may request that we send information to you at an alternative address or by alternate means.
- Request an amendment of your health record if you feel the information, we have is incomplete or incorrect as provided in 45 CFR 164.528. Requests must be made in writing to the attention of the Privacy Officer and must include a valid reason to support the request. We will respond within 60 days of receiving your written request.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528. This list will not include disclosures you have already consented to such as those made for treatment, payment, or health care operations, or disclosures made prior to the effective date of this policy. This request must be made in writing and must state a period of no longer than six years. We will respond within 60 days of receiving your written request.

For More Information or to Report a Problem

If you have any questions or would like additional information, you may contact the Privacy Officer at (973) 736-5907. If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint. All complaints must be made in writing.

Revisions of Privacy Policy

We reserve the right to change our Privacy Practices at any time and to make the new provisions effective for all protected health information we maintain. You may request a copy of any revisions made to our Notice of Privacy Practices either by mail, telephone, or in person.

Policy Effective Date: June 24, 2025.