An Enhanced You
COSMETIC SURGERY MEDICAL GROUP
Robert M. Lowen, M.D.
Diplomate, American Board of Plastic Surgery

Patient Questionnaire

Patient Name: _____ Date: _____
First, Middle, Last Name

Address: _____
Street, Apt # City State Zip Code

Cell Phone Number ( ) _____

Email Address: _____
To opt out of email notices of special offers, open house events and newsletters, please check this box. □
Check any contact restrictions: □ no cell phone □ no emails □ no regular mail □ no work □ no home

Age: _____ Birthdate: _____/_____/_____ □ Female □ Male

Height: ____'____" Weight: _____ lbs # of Children: _____

Marital Status: □ single □ married □ other: _____

Spouse's Name/ Emergency Contact Name & Phone #: _____

Patient's Employer: _____ Occupation: _____

How did you hear about Dr. Lowen? Please mark all that apply

□ Web Search: which site _____ □ Real-Self □ Google □ Yelp □ Patient: _____
□ Family/Friend □ Other: _____
If you were referred by a specific person, may we thank them? □ Yes □ No

Areas of Interest: Please mark all that apply

Facial Procedures
□ Botox
□ Blepharoplasty (Eyelid lift)
□ Brow or Forehead Lift
□ CO2 Laser Facial Rejuvenation
□ Earlobe Repair
□ Facial Lipo (Neck, Jowls)
□ Face or Neck Lift
□ Lip Enhancement
□ Otoplasty (Ear pinning)
□ Rhinoplasty (Nose reshaping)
□ Skin Resurfacing (Laser, Peels, etc)
□ Dermal Fillers
□ ThermiTight (skin tightening)
Arms Face/ Neck Abdomen Thighs
□ Other: _____

BBreast Procedures
□ Breast Augmentation
□ Breast Augmentation Revision
□ Breast Implants with Lift
□ Mastopexy (Breast Lift)
□ Breast Reduction
□ Gynecomastia

Body Procedures
□ Abdominoplasty (Tummy Tuck)
□ SmartLipo Areas: _____
□ Liposuction
□ Brazilian Butt Lift (Fat Transfer)
□ Thigh Lift
□ Brachioplasty (Arm Lift)
□ Lipoma Removal How many? _____

Medical Skin Care Spa
□ Botox or Dysport
□ Chemical Peels (pigment, acne)
□ Microneedling
□ PRP/ PRF Rejuvenation
□ Laser Hair Removal
□ Laser Scar Treatment
□ Laser Tattoo Removal
□ Photofacial/ IPL skin rejuvenation
□ Skin Care Regimen: ZO, Neocutis
□ Silhouette InstaLift/ Threadlift
□ Spider Veins (leg veins)
□ Stretch Mark Treatment
□ ThermiVa (Non-Invasive Feminine Rejuvenation)
□ SculpSure Non-Invasive Fat Melting

I understand that office visit charges are payable on the day of service is rendered. I authorize Dr. Lowen to bill my insurance company, if appropriate. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Lowen and myself. If insurance is used, I authorize my insurance company to pay medical benefits directly to Dr. Lowen. I authorize the release of any medical other information necessary to process my medical insurance claims. I have read and acknowledge the information I have filled out is to the best of my knowledge.

Patient Signature: _____ Date: _____

Getting to Know You as Our Patient

Patient Name: _____ Height: _____ Weight: _____ Age: _____

What procedure(s) are you seeing Dr. Lowen for in your consultation today?:

_____

How long have you considered the procedure(s)? _____

Have you had a consultation with a different physician for the same procedure(s)? □ yes □ no
If so, when was the consultation? _____ (approximate month and year)
Have you had multiple consultations for the same procedure(s)? □ yes □ no
If you were to have this surgery how would you describe a successful outcome?
_____
Have you ever had cosmetic surgery procedure before? _____
Was it a satisfactory experience? _____

What are your areas of major concern that need to be addressed in order to help you move forward with your decision to have surgery?

□ fees	□ child care	□ spouse/ significant other approval
□ financing my procedure	□ choosing the right size implants	□ before and after photos
□ trust in Dr. Lowen	□ recovery/ after-care help	□ reviews (RealSelf, Yelp, etc.)
□ scarring	□ surgery facility	□ time under anesthesia
□ c-section scar	□ time off of work	□ drainless tummy tuck

Other factors: _____

How have you planned on financing your procedure?

a. My personal credit card
b. I will need assistance with CareCredit or Alphaeon
c. I will pay with a personal check, cashier's check or money order

From a scale of 1 - 3, how motivated are you in having your procedure?

□ 1 - I have decided to have surgery within the next 3 to 6 months and my finances are in order
□ 2 - I am ready to move forward within 3 months, my finances are in order and I am ready to select my surgeon
□ 3 - I am ready to have surgery within the next month, my finances are in order and I am ready to select my surgeon

Thank you and welcome to our practice!

The Web is becoming a key way that patients learn about our practice. Do you participate in any of the following? (check all that apply)

Facebook_____

Twitter_____

Google+_____

RealSelf_____

Instagram_____

Yelp_____

Blogging? If yes, where can we see it? http://_____

What website(s) did you find helpful to use in researching our practice or the procedure?

www._____

www._____

www._____

NOTICE TO CONSUMERS: Dr. Lowen and all medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbc.ca.gov.
Robert M. Lowen, MD
Certified by the American Board of Plastic Surgery

_____Date:_____
Signature of patient

An Enhanced You Cosmetic Surgery

Robert M Lowen MD

Notice of Privacy Policy

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

As our patient, you have entrusted your medical information to our care. We know that your relationship with us is based on trust, and that you expect us to act in your best interest. As your personal medical history is your private information, we hold ourselves to the highest standards in its safekeeping.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. HIPAA provides penalties for covered entities that misuse personal health information. We are required by law to maintain the privacy of your protected healthcare information and to provide you with this notice of our legal duties and our privacy practices. HIPAA gives you, the patient the right to understand and control how your protected health information ("PHI") is used.

Under HIPAA regulations, we may use and disclose your Protected Health Information (PHI) without written consent for treatment, payment and health care operations (TPO).

• Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is communicating with your referring physician, pharmacy or laboratory.

• Payment means activities related to obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include verifying insurance coverage or sending you a billing statement.

• Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. Examples of this would be patient survey cards or contacting you by phone or in writing to remind you of an appointment.

• We may also be required or permitted to disclose your PHI for law enforcement, matters of public health and safety, and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We will not use your information for marketing or fundraising without your permission.

In compliance with federal and state privacy laws, **written authorization by the patient or legal guardian is required before we can release records for reasons other than treatment, payment and healthcare**

operations. If you give authorization to release your records, you may revoke such authorization in writing, and we will honor your request from the date we receive your written request forward.

You have the right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you.
• You can advise us of the best location to contact you to protect your private information.
• You can request a copy of medical record in writing.
• You can request an amendment of your PHI. This request must be done in writing and will be honored at our discretion.
• We keep a log of disclosures of your medical information for the past six years and you can request a copy
• We will notify you if a breach of your protected health information if it occurs.

Please let us know if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with our practice and with the Department of Health and Human Services, Office of Civil Rights.

By the Authority of: Robert M Lowen MD
Title: Medical Director, An Enhanced You Cosmetic Surgery
Email address: drlowen@enhanced-you.com
Date: effective February 20, 2019

By the Authority of: Robert M. Lowen, MD and/or staff members

I _____ have received a copy of The Practice's Notice of Privacy Practices.

Patient Name	
Date	
Signature	