

The Hunstad Center for Cosmetic Plastic Surgery, P.A.  
8605 Cliff Cameron Drive, Suite 100  
Charlotte, North Carolina 28269

New Patient Information & History

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

How would you like us to address you?  First Name  Nickname  Other \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

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

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Pager # \_\_\_\_\_ Fax # \_\_\_\_\_ Alternate Phone # \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Marital Status:  Married  Single  Separated  Divorced  Widowed

Sex:(Check one)  M  F Email address: \_\_\_\_\_

Emergency Contact Information

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Contact Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Employment Information

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

History

Primary Care Physician \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight gain or loss within past year \_\_\_\_\_ lbs.

Previous Surgeries (Please list ALL surgeries and dates)

Procedure \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

Procedure \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

Procedure \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

Procedure \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

Procedure \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

Procedure \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

Have you or any family members had any of the following illnesses?

	No	Yes	Relationship
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV/Aids	<input type="checkbox"/>	<input type="checkbox"/>	_____

New Patient Information, continued

	No	Yes	
Do you smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how many per day? _____
Do you consume alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how many ounces per day? _____
Do you use cocaine?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, frequency of use? _____
Do you use any other mind altering drugs?	<input type="checkbox"/>	<input type="checkbox"/>	Please list _____

\*\*\* **ALLERGIES:**

Are you allergic or sensitive to Penicillin? No Yes  
If yes, please describe \_\_\_\_\_

Do you experience nausea or vomiting with codeine? No Yes  
If yes, please describe \_\_\_\_\_

Please list ALL allergies to ANY medications \_\_\_\_\_  
\_\_\_\_\_

If yes, please explain:

Have you ever reacted to anesthesia? No Yes \_\_\_\_\_

Do you typically require large amounts of anesthesia? No Yes \_\_\_\_\_

Are you sensitive to adhesive tape? No Yes \_\_\_\_\_

Are you sensitive to latex? No Yes \_\_\_\_\_

Are you sensitive to suture materials ("catgut")? No Yes \_\_\_\_\_

Have you ever had Scarlet or Rheumatic fever? No Yes \_\_\_\_\_

Do you consider yourself a poor healer? No Yes \_\_\_\_\_

Do you bleed or bruise easily? No Yes \_\_\_\_\_

Do you form large scars or keloids? No Yes \_\_\_\_\_

Do you have any skin disorders such as eczema, boils, rashes, etc? No Yes \_\_\_\_\_

Are you currently under care for a psychiatric or emotional disorder? No Yes \_\_\_\_\_

Have you ever taken Phen-fen or any other diet medication? No Yes \_\_\_\_\_

Do you have motion sickness? No Yes \_\_\_\_\_

Do you have shortness of breath or difficulty breathing? No Yes \_\_\_\_\_

Do you have a hiatal hernia, heartburn, or indigestion? No Yes \_\_\_\_\_

Please list ALL other medical problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Name of Parent/Guardian (Please print) \_\_\_\_\_

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8605 Cliff Cameron Drive, Suite 100  
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**Notice of Privacy Practices**

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.

This Notice of Privacy Practices describes how **The Hunstad Center for Cosmetic Plastic Surgery, P.A.** may use and disclose your "protected health information" (PHI), to carry out treatment, payment and/or healthcare operations and for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related healthcare services.

We are required to maintain the privacy of your health information and to provide you with a notice as to our legal duties and privacy practices with respect to information collected and maintained about you. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. Any new notice will be given to you upon your request and will be effective for all PHI we maintain at that time.

**HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION:**

The following categories describe ways we may use or disclose your protected health information. There are explanations of what we mean for each category of uses and disclosures.

**Treatment, payment and healthcare operations:**

Federal law permits **The Hunstad Center for Cosmetic Plastic Surgery, P.A.** to use and disclose your PHI without your authorization or consent for the purposes of treatment, payment and healthcare operations.

• **Treatment**

We may disclose PHI to other healthcare providers who are responsible for your medical treatment. For example, we may provide other physicians, upon request, copies of various information to assist him/her in treating you.

• **Payment**

We may use or disclose information about you to determine coverage eligibility for insurance plan benefits, obtains co-payment/coinsurance amounts and to facilitate payment for the treatment/services you receive from our healthcare providers.

• **Healthcare Operations**

Healthcare operations refer to business functions undertaken by **The Hunstad Center for Cosmetic Plastic Surgery, P.A.** Operations may include referral/specialist appointment schedule/reminders, recommending treatment alternatives and/or providing information regarding services that may be of interest to the individual. Information may be disclosed for purposes of medical review, legal services, audit services, and fraud and abuse detection programs. We will share your protected health information for purposes of claim administration on behalf of your medical insurance plan.

**Other uses and disclosures permitted without authorization:**

Federal law allows **The Hunstad Center for Cosmetic Plastic Surgery, P.A.** to disclose PHI without your authorization or consent in the following ways:

- To you or a personal representative designated by you or designated by law to act for you.
  - To the Secretary of Health and Human Services or any employee of HHS as part of an investigation to determine our compliance with Federal Privacy laws.
- To the State Medical Review Board to respond to inquires/investigations of our practice or requests for audit.
  - In response to court order, subpoena, discovery request or other lawful judicial or administrative proceeding.
- As required for law enforcement purposes. For example, to notify authorities of a criminal act.
- As required by law.
- As required to comply with Worker's Compensation and/or other similar programs established by law.

**YOUR RIGHTS IN RELATION TO PROTECTED HEALTH INFORMATION**

**Right to Request Restrictions on Uses and Disclosures:**

You have the right to request **The Hunstad Center for Cosmetic Plastic Surgery, P.A.** to limit its uses and disclosures of PHI in relation to treatment, payment or healthcare operations. You also have the right to restrict the disclosure of PHI to family members or personal representatives. Any such request must be made in writing and must state the specific restriction and to whom it applies.

**Right to Access Your Protected Health Information:**

You have the right to copies of your PHI following the procedures of **The Hunstad Center for Cosmetic Plastic Surgery, P.A.** Federal law prohibits you from having access to psychotherapy notes, information for use in a civil, criminal or administrative action or proceeding. If your request for access is denied you may file a written complaint to:

US Department of Health and Human Services  
200 Independence Ave. SW  
Washington, DC 20201

Federal law indicates you read and sign this Notice as notification of your right to an accounting and disclosure rights pertaining to Private Health Information after April 14, 2003.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian for Minor

\_\_\_\_\_  
Date

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**Photograph Consent**

**The Hunstad Center for Cosmetic Plastic Surgery, P.A.** believes that medical photographs are a necessary aspect of your treatment and medical record. Photographs are used for planning your surgery, comparing "before" and "after" results, insurance company, determination of benefits, and medical/legal matters.

In connection with the medical services which I am receiving from **The Hunstad Center for Cosmetic Plastic Surgery, P.A.**, I consent that all clinical photographs may be taken of me and/or parts of my body, under the following conditions:

- The photographs may be taken only with the consent of Dr. Hunstad and under such conditions and at such times that are approved by him.
- The photographs shall be taken by Dr. Hunstad or by a staff member approved by Dr. Hunstad.
- The photographs shall be used for medical purposes only and shall remain the sole property of Dr. Hunstad.
- The photographs shall be used for medical purposes only and, if deemed appropriate by Dr. Hunstad for medical research, education, or science. The photographs of my face and/or body, and information relating to my case, may be published and republished, either separately or in connection with each other, professionally for medical purposes or used for any other purpose which Dr. Hunstad deems proper in the interest of medical education, knowledge, or research. However, provided that it is specifically understood that in any such publications for use, I shall not be identified by name.

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

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**The Hunstad Center for Cosmetic Plastic Surgery, P.A.**  
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**Charlotte, North Carolina 28269**  
**704.549.0500**

**Surgery Booking & Financial Policies**

In order for **The Hunstad Center for Cosmetic Plastic Surgery, P.A.** to provide continued quality care to our patients, payment for services rendered must be received. Please read and sign this financial policy statement.

- **Consultation Visit:** Payment is expected on the day of your visit. Your initial consultation fee with Dr. Hunstad varies by procedure and you will be notified when you make your appointment. Please be prepared to pay this on the day of your visit. We accept Debit Cards/VISA/MC/Checks/Cash.
- **Insurance:** As a convenience to our patients, we will provide you with all of the necessary documentation to file a claim with your insurance company.
- **Financing Options:** Your bill is always your responsibility. Financing options are available through Advance Patient Financing ([www.advancedpatient.com](http://www.advancedpatient.com)), Care Credit ([www.carecredit.com](http://www.carecredit.com)) and Reliance Medical Finance Company ([www.reliancemedicalfinance.com](http://www.reliancemedicalfinance.com))
- **Surgery Deposit:** A **25%** deposit is required to book all surgeries.
- **Paying the deposit:** You may pay the deposit over the phone with a Master Card, Visa, or a bank debit card. If you are using a debit card, please call your bank in advance to authorize the transaction.
- **Cancellation List:** If you would like to be placed on our cancellation list, you must already be on our schedule.
- **Final payment:** Final payments for surgery and anesthesia fees are due **three weeks prior** to your surgery date. It is your responsibility to contact our Surgery Coordinator (704.549.0500) to make your payment by the due date. The Hunstad Center for Cosmetic Plastic Surgery will cancel your surgery if payment is not received by the due date. If payment is not received at least **three weeks prior** to your surgery, we will need to reschedule your surgery.
- **Anesthesia Fee:** The check for Anesthesia should be made payable to **Dr. Philip Walk** and mailed to our office at least **three weeks prior** to your surgery date.
- **Time of Surgery:** Please note that the time of your surgery is subject to change as our schedule mandates. We will confirm the time that you need to be at The Hunstad Center at least 3 days prior to your surgery date. Please understand that our schedule changes frequently.
- **Rescheduling Surgery:** Please notify our office at **least 4 weeks prior** to your surgery date should you need to reschedule your surgery.
- **Canceling Surgery:** If you choose to completely **cancel** your surgery, all but \$500 will be refunded within 30 days of your request.
- **Re-talks & Additional Procedures:** Should you consult with Dr. Hunstad and would like to add additional procedures to your already booked surgery, please note that we may need to completely reschedule your surgery date to accommodate the additional time needed for the additional procedures. **We can not always add time to an already booked surgery.**
- **Touch-ups and/or Re-do's:** All touch-ups and/or re-do's will be charged operating room fees and Anesthesia fees, which must be paid **in full** when you book your surgery.
- **Skin Care Services:** Skin Care packages can be purchased at a discount. However, should you not use the entire package and request a refund on any unused portion of the package, the refund will be based on the individual charge of the services.

All questions and/or concerns regarding your financial responsibilities should be directed to our Office Administrator at 704.549.0500. All charges are individualized with respect to the nature and complexity of your specific concerns.

I have read completely, understand, and agree to abide by the Financial Policy of  
**The Hunstad Center for Cosmetic Plastic Surgery, P.A.**

Signature of Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

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8605 Cliff Cameron Drive, Suite 100  
Charlotte, North Carolina 28269  
704.549.500 800.927.6594  
704.549.501

**What source of referral led you to become a patient at The Hunstad Center for Cosmetic Plastic Surgery? Please check all of the following that apply:**

- Previous patient of Dr. Hunstad's
- A friend referred me. Name of friend: \_\_\_\_\_
- My doctor referred me. Name of doctor: \_\_\_\_\_
- Yellow Pages
- Yellow Book
- Lake Norman Phone Directory
- Charlotte Woman Magazine
- University City Magazine
- Lake Norman Magazine
- Newspaper Advertising
- Our website: [www.hunstadcenter.com](http://www.hunstadcenter.com)
- Other Internet links? Which one: \_\_\_\_\_
- Radio Advertising
- The Hunstad Center newsletter

**We appreciate your feedback!**

**Thank you.**