STEVEN B. HOPPING, M.D., F.A.C.S.

DATE_____

NAME_____

STREET
ADDRESS_____

CITY_____STATE_____ZIP_____

DATE OF BIRTH_____AGE_____ NAME OF SPOUSE/ PARTNER_____

EMPLOYER_____OCCUPATION _____

HOW DID YOU HEAR ABOUT US?
_____

WHO SHOULD WE NOTIFY IN THE EVENT OF AN EMERGENCY?
_____

RELATION_____
PHONE_____

PATIENT MEDICAL HISTORY

Height_____ Weight_____

Please list any medication that you are presently taking or have taken within the last 2 months:

MEDICATION NAME	DOSAGE	AMOUNT	FREQUENCY	ARE YOU TAKING THIS MEDICATION NOW?
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____

Do you have **allergies?**_____ Please list your drug allergy and reaction if you take them:_____
_____

Do you have sensitivity to Codeine?_____ Reaction:
_____

Have you ever been hospitalized?_____
When:_____

Do you drink alcohol? Yes_____ No_____ Socially_____ Regularly_____ Never_____

Have you ever used recreational drugs? Yes_____ No_____

Have you had any of the following medical conditions?

_____Bleeding _____Hepatitis _____Blood Transfusion _____Glaucoma _____Asthma
_____Bronchitis _____Depression_____Mental Illness _____Heart Disease _____Heart Burn
_____Diabetes _____Colitis _____High Blood Pressure _____Alcohol Addiction _____Drug Addiction
_____Prolonged Pain _____Other _____Sleep Apnea*

Have you ever had anesthesia?_____ When?_____
Complications?_____

List the surgeries you have had in the past, including cosmetic procedures (date, procedure)
_____
_____
_____
_____

Are you presently under the care of a physician? Yes_____ No_____

Date of your last EKG:_____

2311 M STREET, N.W., SUITE #503
WASHINGTON, D.C. 20037
TELEPHONE: (202) 785-3175
FAX: (202) 785-0763

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Physician Name:_____ Phone # _____

By signing this form, I assure the information provided is complete and accurate to the best of my knowledge. If any of the above information should change, I understand that it is my responsibility to inform the organization of such changes. I have reviewed and understand, and a copy of the following information has been made available to me should I request it: Information regarding the ownership of the practice, The Patient Grievance Process, the expertise of the physician(s), the Patient Rights and Responsibilities, DNR policy and Notice of Practice Privacy.

Patient Signature Date

FOR OFFICE USE ONLY

HEART:	ASTHMA:	BLEEDING DISORDERS:
KIDNEYS:	HEPATITIS:	SURGERY:
BLOOD PRESSURE:	TB:	ANESTHESIA:
THYROID:	SMOKER:	MEDICATION:
SLEEP APNEA*:	ALCOHOL:	RECREATIONAL DRUGS:

Areas of Interest

Name: _____ Date: _____

What type of treatment are you interested in: □ Surgical □ Non-Surgical □ Undecided

I am interested in: □ Immediate Results □ Gradual Results □ Open to both options

I am concerned about and/or interested in:

Wrinkles

- ☐ Around eyes
- ☐ Around mouth
- ☐ Forehead
- ☐ Between eyebrows
- ☐ Other: _____

Volume Loss

- ☐ Tired look under the eyes
- ☐ Jowls
- ☐ Flattening of the cheeks
- ☐ Lips appearing smaller
- ☐ Folds around and/or downward corners of the mouth

Excess Volume

- ☐ Abdomen
- ☐ Flanks (Love handles)
- ☐ Bra fat
- ☐ Upper arms
- ☐ Thighs (Saddle bags)

Miscellaneous

- ☐ Dark circles under eyes
- ☐ Puffy eyes
- ☐ Hair loss
- ☐ Microdermabrasion

Skin Care Regimen

- ☐ AM:_____ _____
- ☐ PM:_____ _____

Specific Services

Non-Surgical

- ☐ Botox/ Dysport
- ☐ Xeomin
- ☐ Restylane (Regular, Lyft, or Silk)
- ☐ Belotero
- ☐ Juvederm XC
- ☐ Radiesse
- ☐ Voluma XC
- ☐ Sculptra
- ☐ Bellafill
- ☐ Threading

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S T E V E N B. H O P P I N G, M. D., F. A. C. S.

- ☐ Eclipse PRP
- ☐ Thermage
- ☐ Clear & Brilliant
- ☐ Chemical Peel

Surgical

- ☐ Facelift
- ☐ S-Lift
- ☐ Neck Lift
- ☐ Temple Lift
- ☐ Brow Lift
- ☐ Eyelid Lift (Blepharoplasty)
- ☐ Nose (Septo/Rhinoplasty)
- ☐ Liposuction
- ☐ Fat Transfer
- ☐ Chin Augmentation (Mentoplasty)
- ☐ Cheek Augmentation (Malarplasty)
- ☐ Earlobe Repair/ Pinning (Otoplasty)
- ☐ Hair Transplant

Consent to Communicate

The HIPAA privacy rules grants our patients the right to request a restriction of use and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home or vice versa.

I wish to be contacted in the following manner (check all that apply):

Home Telephone: _____ □ Do not contact via this number
□ Ok to leave message with detailed information □ Leave message with call-back number only

Work Telephone: _____ □ Do not contact via this number
□ Ok to leave message with detailed information □ Leave message with call-back number only

Cell Phone: _____ □ Do not contact via this number
□ Ok to leave message and text with detailed information □ Leave message with call-back number only
□ **Ok to send Text Messages**

Email: _____ □ Do not contact via this address
□ **Yes, I would like to receive special offers and/or newsletters via email**
□ Ok to email detailed information

Text Message: _____ □ Do not contact via this address
□ **Yes, I would like to receive special offers and/or newsletters via email**
□ Ok to email detailed information

Written Communication □ Do not contact via this address
□ Ok to mail to my home address **Alternative Address: _____**
□ Send to alternative address _____

Best way to contact you: Home _____ Work _____ Cell _____ Email _____ Text _____

****Authorization to disclose your health information to: ****** □I do not authorize

Name Relationship
_____ _____

Name Relationship
_____ _____

The Privacy Rule requires healthcare providers to take the appropriate steps to limit the use or disclosure of, and requests for, PHI to the minimum information necessary to accomplish the intended task. The provisions do not apply to uses or disclosures

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made pursuant to an authorized request signed for by the individual. Uses and disclosures may be permitted without prior consent in the event of an emergency.

_____	_____
Patient Name	Date
_____	_____
Patient Signature	Date of Birth

HIPAA 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 we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control you 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 or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates: Required Uses and Disclosure: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

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You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to Steven B. Hopping M.D. or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying out privacy contact of your complaint. We will not retaliate against you for filing a complaint.

Red Flags Rule
It is the policy of Steven B. Hopping M.D. to follow all federal and state laws and reporting requirements regarding identity theft. A "red flag" defined by his policy includes a pattern, practice, or specific account or record activity that indicates possible theft.

This notice was published and becomes effect on/or before **April 14, 2003.**

By signing below, I hereby certify that I have been given information regarding the physician, his credentials, I have read and understand the HIPAA Notice of Privacy Practices and that I have disclosed to the best of my knowledge my medical history.

We require by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at **(202) 785-3175 Steven B. Hopping M.D., Center for Cosmetic Surgery.** You will be explained in detail of any changes that are due at today's visit.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

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