REGISTRATION PACKET

Cleveland
COSMETIC SURGERY
where science meets beauty

PATIENT INFORMATION PACKET

Boutique Care

When you select Cleveland Cosmetic Surgery, you benefit from our surgical and aesthetic excellence, just as important and often lost in today's medicine, you benefit from our compassionate care and 'boutique' service. The Staff is an integral part of our 'boutique' care. 'We love what we do'- and it shows.

When you trust Dr. Diamantis with your physical appearance, you get a specialist who has the best credentials and the most experience. And you want an expert with the artistic ability to achieve

And it Shows.

We love what

Welcome to Our Family
Cleveland Cosmetic Surgery

Congratulations on taking the first step towards regaining your confidence. You are not alone on this journey. To date, more than 35 million Americans have scheduled for cosmetic surgery. Over the last two decades, thousands of women and men have placed their trust in Dr. Diamantis. Although many of our patients differ in age, occupations and lifestyles, they have one thing in common; treatment with us changed their lives by restoring their self-confidence. Many patients tell us the most exciting aspect of plastic surgery is the overwhelming new sense of freedom they feel.

What to Expect at Cleveland Cosmetic Surgery

Meet Dr. Diamantis and Staff; Cultivate a relationship with us; Develop a customized plan.

Answer new questions; Fine tune treatment options; Finalize treatment plan; Pick a surgery date.

Pick a pleasant dream; Review and confirm treatment plan; Meet Anesthesiologist; Wake up and it is done.

Plastic/Cosmetic Surgery Questionnaire

Patient Name:_____ Date: _____

A. Please indicate the following services, products, procedures and/or health issues of interest to you**.** Dr. Diamantis will be glad to review these particular interests with you**. (Please check all the boxes that apply).**

1. Facial Plastic Surgery:

- □ **Eyelid surgery**--- Blepharoplasty will help rejuvenate tired, puffy/sagging eyes
- □ **Cosmetic Nose Surgery**---Rhinoplasty, to help shape your nose into a more elegant shape
- □ **Facial Implants**---To permanently enhance facial disharmony with cheek/chin implants
- □ **Brow Lift**---To permanently soften forehead wrinkles and lift eyebrow position
- □ ***Weekend*LIFT™** ---An innovative procedure to rejuvenate the face with minimal surgery
- □ **Face and Neck lift**---Rhytidectomy is traditional surgery to rejuvenate the face and neck
- □ **Ear Surgery**---Otoplasty is designed to improve prominent large ears
- □ **Earlobe Repair**---Repair damaged or split ear lobe.
- □ **Double Chin Correction**---Several simple options are available (i.e. submental liposculpture)
- □ **Scar Revision**---Several plastic techniques to improve large unsightly scars

2. Non-Surgical Facial Rejuvenation:

- □ **Wrinkle Correction w/muscle relaxation**--- Botox®, Dysport®, Juvaeu® ,Xeomin®
- □ **Laugh & Marionette Wrinkle Correction**--- Juvederm®, Restylane®, Radiasse®, Sculptura®
- □ **Mid Face Lift**--- Voluma® /Lyft® is a long-lasting option to rejuvenate age related volume loss
- □ **Double Chin Correction**--- Kybella® is an FDA approved treatment to shrink unwanted fat
- □ **Fat/ Stem Cell Transfer**--- Your fat/ stem cells are prepared and used as a permanent filler

3. Lip Augmentation:

- □ **Lip Lift**--- A permanent procedure to enhance the volume and shape of the lips & mouth
- □ **Lip Implants**--- A soft naturally shaped implant to permanently enhance the lips
- □ **Fat/ Stem Cell Transfer**--- Native stem cells is transferred to the lips to improve lip size
- □ **Lip Enhancement**--- Juvederm®, Voluma®, Restylane® temporarily improve lip volume and shape

4. Skin Rejuvenation and Health:

- □ **Acne Treatment**--- Several medical options are available (i.e. Clenziderm®, Photo Facials)
- □ **Facial Wrinkles & Skin Tightening**--- Photo Facials, Pixel Perfect® Laser & Chemical Peels
- □ **Skin Tone and Texture**--- Harmony 360®, Pixel Perfect®, & Sclerotherapy for vein treatment
- □ **Dark Circles Under Eyes**--- Treatment with proprietary phenol peel to lighten & smooth
- □ **Acne Scar/ Pox Scar Correction**--- Several medical options are available (i.e. Dermabrasion)
- □ **Skin Care Program**--- A medically prescribed skin care regimen (i.e. Obagi®, PCA®)

5. Miscellaneous Cosmetic Procedures:

- ☐ **Hyperhidrosis (excessive sweating)**--- A common social concern treated with Botox®
- ☐ **Eyelash Enhancement/Latisse®**--- Is formulated to thicken, darken & elongate eyelashes
- ☐ **Hair Removal**--- Hair removal of the face, bikini, under arms, back & legs with Laser Therapy
- ☐ **Spider Vein Therapy**--- Removal of unsightly red spots with laser &/or sclerotherapy
- ☐ **Thinning Hair and Hair Loss**--- Medical hair restoration is a permanent solution
- ☐ **Nutrition and** Diet--- Medical weight loss program

6. Body Cosmetic Surgery Procedures

- ☐ **Vaser® Liposculpture of trunk, legs and** arms--- Several innovative techniques are available
- ☐ **Gynecomastia /Male Breast** Surgey--- Several procedures to remove male breast tissue
- ☐ **Non-invasive body contouring**--- Zerona®, Cool Sculpting® and Smart Lipo®

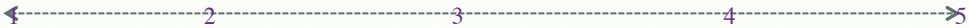
B. Please answer the following questions on a scale of 1 through 5 by circling the number you feel is most appropriate. The larger the number the older you feel and the more concerned you are.

1. When looking in the mirror, I believe I look younger, the same as, or older than my true age.

1 2 3 4 5

2. When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about my facial appearance.

1 2 3 4 5



C. How did you hear of our practice? A referral from a previous patient is the highest honor you can bestow on us. Please provide their full surname & email so we may formally thank them.

- ☐ Healthcare provider (full name) :_____
- ☐ Previous patient of Cleveland Cosmetic Surgery (full name) :_____
- ☐ A friend or family member (full name) :_____
- ☐ Another person not listed above (full name) : _____
- ☐ Internet search / social media / website /Twitter / Facebook / Instagram: (circle the appropriate one)
- ☐ A seminar / lecture given by Dr. Diamantis: (circle if it applies)
- ☐ Television / radio interview: (circle if it applies)
- ☐ Advertisement (i.e. print, radio and/or television)

Patient Registration Form

Name: _____ Date: _____

Cell Phone: (_____) _____ Home: (_____) _____

Email Address: _____

May we periodically send you SMS text messages and/or emails about appointments, products, services and promotions? YES NO

Address: _____

City:_____ State:_____ Zip Code:_____

Gender:_____ Age:_____ Birthdate:____/____/____ Marital Status:_____

Employers Name:_____ Occupation:_____

Whom can we thank for referring you?_____

In case of emergency whom should we notify? _____ Their Phone: (_____)_____

Primary Medical Insurance

Person responsible for Account: _____

Relation to Patient: _____ Birthdate: ____/_____/___ S. S. # _____-_____-_____

Address (if different to patient's) _____

City: _____ State: _____ Zip Code: _____ Phone: (_____)_____

Person Responsible Employed By:_____ Business Phone: (_____)_____

Insurance Company Name: _____

Medical Questionnaire

Name:_____

Address:_____

Phone: _____ Age: _____

Height: _____ Weight: _____

Family Doctor/Phone: _____ (_____)_____

1. What brings you to our office today; How can we help you?

_____

2. Pre-operative **Medical History**: Please answer all questions by circling (yes) or (no)

A. **Do you have or ever had:**

1. Diabetes……..... yes no
2. Heart Disease…….. yes no
3. Heart Attack (MI)… yes no
4. Ankle Swelling…. yes no
5. Shortness of Breath yes no
6. Kidney Disease…… yes no
7. Rheumatic Fever…. yes no
8. Liver Disease…….. yes no
9. Anemia…… yes no
10. Abnormal Bleeding. yes no
11. Recent cold or flu… yes no
12. Glaucoma…… yes no
13. Mitral Valve Prolapse yes no
14. Heart Murmur…..... yes no
15. Thyroid Disease… yes no
16. Sleep Apnea……. yes no
17. Snoring……. yes no
18. Scarlet Fever…… yes no
19. Epilepsy/Seizures yes no
20. Lung Disease..... yes no
21. COPD..... yes no
22. Tuberculosis……. yes no
23. Asthma…… yes no
24. Venereal Disease.. yes no
25. High Blood Pressure yes no
26. GI Reflux…….. yes no
27. Ulcers…..…….. yes no
28. Pregnancy…… yes no
29. H.I.V/ A.I.D.S..…… yes no
30. Hepatitis A..... yes no
31. Hepatitis B..... yes no
32. Hepatitis C..... yes no
33. TMJ pain/clicking… yes no
34. Joint Replacement… yes no
35. Bleeding disorder.. yes no
36. Infection/MRSA.... yes no

3. 3. **Family History:** Please answer all questions by circling (yes) or (no)

A. Has any family member ever had:

1. Bleeding Disorder yes no
2. Deep Vein Thrombosis (DVT) yes no
3. Pulmonary Emboli yes no
4. Cancer yes no

3. **Family History** (continued): Please answer all questions by circling (yes) or (no)

A. **Has any family member ever had:**

8. Malignant Hyperthermia yes no
9. Autoimmune Disease yes no
10. Multiple Sclerosis yes no

i. If you answer 'yes' to any above questions? Please elaborate:

_____

4. Are you under a **physician's care**? yes no

Reason:_____

_____

5. List previous **hospitalization / operations**:

1. _____
2. _____
3. _____

6. Are you currently **pregnant**? yes no

7. Do you have an **allergy to Latex**? yes no

8. Do you have any **allergies to medications**? yes no

i. Explain the signs and symptoms:

_____

Medication Name	Dose	Frequency	Reason for taking

10. Have you ever had **radiation therapy** or **chemotherapy**? yes no

Explain:_____

11. Have you ever had **general anesthesia**? (i.e. sleep) yes no

Complications:_____

12. Have you ever had **local anesthesia?** (i.e. Novocain®) yes no

Complications:_____

13. Do you wear **contact lenses**? yes no

14. Have you ever used **Accutane**? yes no

Dates:_____

15. History **of Bells Palsy**? yes no

16. History of **dry eyes**? yes no

Last eye exam: _____

17. History of **Vitilego**? yes no

18. Do you **smoke** (please include vaping)? yes no

How many per day:_____

How many years:_____

19. Do you drink **alcohol**? yes no

How much per day: _____

How many years: _____

20. Do you use any **"street" drugs**: yes no

Cocaine, Heroin, Ecstasy or Marijuana (specify amount per day):

_____

_____

21. Have you had any past treatment for **chemical dependency**? yes no

22. Have/are you being treated for an **eating disorder**? yes no

23. With **previous surgeries**, have you experienced?

A. Abnormal bleeding? _____

B. Infection? _____

C. Delayed Healing?_____

24. Are you currently or have ever been treated for **depression/anxiety**? yes no

25. Are you currently/have ever been treated for a **psychological disorder**? If yes, explain :

_____

_____

26. Have you ever had complications from previous plastic surgery procedures? yes no

_____

_____

_____

27. List and date all the cosmetic/plastic surgery procedures you have had:

1. _____
2. _____
3. _____

28. Please describe below any **other pertinent** medical, psychological, or physical condition not mentioned above: Your thoroughness will assist Dr. Diamantis to develop the ideal treatment plan for you.

_____

_____

_____

29. Have you ever had diarrhea/ colitis caused by antibiotic therapy? yes no

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I understand the importance of a truthful and accurate health history to assist Dr. Diamantis in providing the safest and best care possible. I have answered the above questions truthfully and to the best of my knowledge.

Name: _____Date:_____

(Patient Signature)

Name: _____Date:_____

(Doctor Signature)

Office Financial Policy

To give our patients the best care possible, it is important to help us maintain our records and keep our accounts current.

Fees and Deposits.

For elective cosmetic surgical procedures, we require a deposit of one-half (½) of the total fees to be paid at the time you schedule your surgery. The balance of the fees must be paid in full at the time of your pre-surgical consultation, which is scheduled two weeks prior to your surgery.

Insurance.

Cleveland Cosmetic Surgery does not accept insurance of any type as payment for surgical procedures. You are personally responsible for payment for your elective cosmetic surgery.

Payment Options.

For your convenience, we gladly accept MasterCard, Visa, American Express and Discover for payment. If you choose to pay by credit card, there will be a 3.5% convenience fee added to the amount of your charge. We will only accept personal checks up to 21 days prior to your scheduled surgery date. There will be a $50.00 fee for all checks returned to us. All delinquent accounts will be referred to collections and you will be responsible for additional fees.

Cleveland Cosmetic Surgery also has relationships with third party credit lenders such as Care Credit, and Lending Tree USA to assist you with payment options. Please ask for details.

Appointment and Cancellation Policy.

Your appointment time is reserved exclusively for you and we have scheduled medical staff to be available for your appointment time and location. We know your time is valuable, so please remember ours is too. If you must cancel a surgery date with less than 28 days notice, you will lose 50% of your proposed treatment plan and will also be charged an additional $500.00 fee for the cancelled anesthesia team. These cancellation fees are allocated for administrative, facility and medical purposes. Additionally, there will be no cash refunds for the balance of the fee, however, any credit balance may be used for future surgical procedures or purchase of products.

I acknowledge that I have read and understand the Financial Policy and agree to be bound by its terms.

Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 15, 2010 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of the Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide you.

HEALTHCARE OPERATIONS: We may use and disclose your health information on connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

NOTICE OF PRIVACY PRACTICES (continued)

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the patient rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment of your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your locating, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces Personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you .50 for each page, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

NOTICE OF PRIVACY PRACTICES (continued)

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other that treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 15, 2010. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

ALTERNATE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing.)** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under any circumstance.

ELECTRONIC NOTICE: If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made top amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Vas Diamantis
Telephone: 216-227-3333
Fax: 440-845-4556
Email: vsdiamantis@yahoo.com
Address: 14700 Detroit Avenue, Lakewood, Ohio 44107

Patient Name:_____ **Date:** _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD

I hereby request and authorize the release of all information, without limitations regarding any physical and mental condition, as revealed by your observation or treatment, past, present or future.

This includes medical, surgical and dental history, x-ray findings, diagnosis, prognosis and access to all hospital records and photocopies of the same.

I request that you release the above information to:

Dr. Nicholas C. Diamantis
Doctor's Name

14700 Detroit Avenue
Address

Lakewood, Ohio, 44107

Requesting Information: _____

_____

_____
Patients Name

_____
Patient's I.D. Number

_____
Patient's Birthday

_____
Patients Signature Date

_____
Witness' Signature Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY RIGHTS

Cleveland Cosmetic Surgery is required to provide you with a copy of the Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this Form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

Patient Name: _____

Additional information requested:

At which of the following number(s) do we have permission to contact or leave messages for you regarding your treatment, medication or financial/insurance information?

Home #____ - ____ - _____ Cell #____-____-_____ Work# ____ - ____ - _____

_

Other than your insurance carrier, who may we speak with about your healthcare information?

Spouse Name: _____ Phone # _____

Child Name: _____ Phone # _____

Parent Name: _____ Phone # _____

Other Name: _____ Phone # _____

I acknowledge that I have received a copy of this office's Notice of Privacy Practices and I have had an opportunity to review it.

_____ _____

Patient Signature **Date**

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

O The patient refused to sign.

O Due to an emergency situation it was not possible to obtain an acknowledgment.

O We are not able to communicate with the patient.

O Other (Please provide specific details): _____