



Vargas Face and Skin Center
930 Carondelet
Building C, Suite 102
Kansas City, MO 64114

Notice of Privacy Practices Acknowledgement

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 ("HIPPA")**, I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and in-directly. Obtain payment from third-party payers. Conduct normal healthcare operations such as quality assessments and physical certifications.

Please refer to the VFSC Notice of Privacy Practices Health Information (privacy notice) for a more complete description of the uses and disclosures that our office/staff may use of your protected health information. I understand that Vargas Face and Skin Center has the right to change its Notice of Privacy Practices from time to time, and that I may contact Vargas Face and Skin Center at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that VFSC restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that VFSC is not required to agree to my requested restrictions, but if agreed to, then is bound to abide by such restrictions.

With my consent, VFSC may call the numbers I have provided in my personal information, contained within my medical chart, and leave a message on voicemail or with persons listed below in reference to any items that assist the practice in carrying out the TPO, such as appointments reminders, lab results and anything pertaining to my clinical care. VSFC may also mail correspondence to my address on file regarding the same, so long as it is marked as confidential.

VSFC has my permission to discuss my PHI and billing information with the following people:

_____	Relationship_____
_____	Relationship_____
_____	Relationship_____
_____	Relationship_____

I have the right to request that VFSC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement. I understand that VFSC may use or disclose my PHI in the following situations without my consent. These situations may include: As Required by Law, Public Health Issues, Communicable Diseases: Health Oversight, Abuse or Neglect, For and Drug Administration requirements, Legal Proceedings, Law Enforcement: Coroners, Funeral Director, and others.

By signing this form, I am consenting that VFSC may use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, VFSC may decline to provide treatment to me.

Signature of Patient (or Guardian)

Print Name of Patient

Date



Vargas Face and Skin Center

Dr. Hannah Vargas, M.D., F.A.C.S
930 Carondelet Drive, Bldg C, Suite 102
Kansas City, MO 64114

NEW PATIENT INFORMATION FORM

Patient _____ **Date:** _____

LAST NAME First Name Middle

Address _____

Street City State Zip

Contact #'s: _____

Home Mobile Work Other

Sex: Male Female **Birth Date:** _____ **Age:** _____

Marital Status: Single Married Divorced Separated Widowed

Patient's Employer: _____

Who is responsible for this account? _____ **Relationship to Patient:** _____

Patient's Primary Care Physician: _____ **Telephone #:** _____

Emergency Contact: _____ **Relationship:** _____ **Telephone #:** _____

Pharmacy Info: _____

How did you hear about Vargas Face and Skin Center / Dr. Vargas?

Friend / Family: _____ Name of who referred you: _____

Website: _____ Internet search: _____ Magazine: _____

Your Email Address (please print clearly):

Please send me emails from Vargas Face and Skin Center regarding promotions, newsletters, cosmetic surgery updates: Yes No

Reason for seeing the doctor today?

- Liposuction/Laser-Liposuction
- Tummy Tuck
- Eyelid Surgery
- Face Lift / Mini Face Lift
- Facial Laser Resurfacing
- Brow Lift
- Neck Lift
- Skin Care Products
- Nose - Cosmetic
- Nose - Breathing

- BOTOX®
- Facial Fillers
- Micro Dermabrasion
- Age spots/Liver Spots
- Spider Veins (face or legs)
- Laser Hair Removal
- Skin Rejuvenation
- Micro Laser Peel
- Tattoo Removal
- Second Opionion:

How long have you been considering cosmetic surgery/procedures? _____

Why did you choose Vargas Face and Skin Center for your visit today? _____

What information will be the most beneficial in your decision? _____

How soon would you like to have your surgery/procedure completed? _____



Personal / Family / Social History

Printed Name: _____ Date of Birth: _____ Age: _____

Do you have any allergies to medications or other? _____

Do you exercise? Yes No If so, how often? _____ Type: _____

Do you smoke? Yes No Cigarettes per day: _____ Cigars? _____ Pipe? _____

Chewing tobacco? Yes No How long have you been smoking/chewing? _____

Do you drink regularly? Yes No _____ Socially _____ Heavy _____ Prior Addiction

Have you ever had a drug dependency? _____ No _____ Never _____ Prior Addiction

Have you had any of the following? (Please mark each with Yes or No)

Blood in Stool	Yes	No	Anxiety	Yes	No
Recent weight loss or gain	Yes	No	Ulcers	Yes	No
Teeth or gum problems	Yes	No	Gas	Yes	No
Eye Pain, redness	Yes	No	Jaundice	Yes	No
Hepatitis	Yes	No	Stomach pain	Yes	No
Vision problems	Yes	No	Kidney Disease	Yes	No
Bladder Infections	Yes	No	Hernia	Yes	No
Blood in urine	Yes	No	Stomach or duodenal ulcers	Yes	No
Any nose bleeds	Yes	No	Burning/itching w/urination	Yes	No
High blood pressure	Yes	No	Frequent urination	Yes	No
Heart attack or angina	Yes	No	Prostate problems	Yes	No
Chest pain or pressure	Yes	No	Diabetes	Yes	No
Heart palpitations	Yes	No	Thyroid Disease	Yes	No
Shortness of breath	Yes	No	Problems w/blood sugar	Yes	No
Stroke or mini-strokes	Yes	No	Cancer	Yes	No
Tremors or numbness	Yes	No	Coughing up blood	Yes	No
Loss of Consciousness	Yes	No	Hay Fever	Yes	No
Migraine Headaches	Yes	No	Wheezing	Yes	No
Emphysema	Yes	No	Gout	Yes	No
Asthma	Yes	No	Arthritis	Yes	No
Easy bruising or bleeding	Yes	No	Leg cramps or swelling	Yes	No
Swollen glands	Yes	No	Swollen joints	Yes	No
Concerning rashes	Yes	No	Depression	Yes	No
Changes in Moles	Yes	No	Panic	Yes	No
HIV/AIDS	Yes	No	Problems with Anesthesia	Yes	No

List all Current Medications: _____

Aspirin: Yes No **Vitamins:** Yes No **Herbals:** Yes No

List any medical problems: _____

List any surgeries / hospitalizations: _____

Family History:

Are there any medical conditions in your family that Dr. Vargas should be aware of:

History of family members bruising easily: Yes No

History of family members having problems with anesthesia: Yes No

By signing below, I attest that the information I have provided on this form is complete and true to the best of my knowledge.

Patient's Signature _____ **Date** _____

Date: _____; _____ Date: _____; _____ Date: _____; _____ Date: _____; _____ Date: _____; _____



Hannah Vargas, M.D., F.A.C.S.
Vargas Face and Skin Center

Photographic Release Form

RECORD OF AUTHORIZATION FOR TAKING AND PUBLICATION OF PHOTOGRAPHS

Permission to take Photos FOR PATIENT CHART

In connection with the medical services, which I am receiving from my physician, Dr Vargas, I consent that photographs may be taken of me or parts of my body under the following conditions.

- A. The photographs may be taken only with my consent to my physician and under such conditions and at such time as may be approved by her.
- B. The photographs shall be taken by my physician or by photographer approved by my physician.
- C. The photographs shall be used for the sole purpose of my medical records and will be retained in my medical chart.

Patient's Name:(print) _____

Patient's Signature: _____ Date: _____

If a minor or patient is unable to affix signature:

Proxy/Guardian's name (print): _____

Proxy/Guardian's Signature: _____ Relationship: _____

Permission to use Photographs and or Name

I, _____, hereby give my permission for HANNAH VARGAS, M.D. (Vargas Face and Skin Center, P.C.) to use my _____Photographs _____Name in their marketing or professional educational presentations, or until I submit in writing a request to cease the use of my name or photographs.

Patients Name: _____ Date: _____

Patient's Acceptance / Signature: _____

Witness: _____ Date: _____

I DO NOT give my permission for my photos or name to be used, and request my photos (if any) remain in my chart and not used for any other purpose other than by the physician for my care.

Patient Signature: _____ Date: _____