JEFFREY S. EPSTEIN, M.D., F.A.C.S., P.A.

Mr/ Mrs/Ms.Miss/Dr Name ______________________________ **Date** __________

Address (Permanent) ____
City/State **Zip code**

Address (Local) ____
City/State **Zip code**

Social Security No. __________________ **Date Of Birth** ____________ **Age** ____

Referred By _________________________ **Name of Spouse/Partner** ______________

Home Phone __________________ **Cell Phone** ______________________________

E-mail __________________________________ **Ethnicity** _____________________

****

Occupation _____________________ **Employed By** _________________________

Business Address ____
City/State **Zip Code**

Bus. Phone ________________________

****

If Minor, Person Who Is Legally Responsible _________________________________

As you know, some types of surgery are not covered by insurance. However, the following information is important to have on file.

Name of Insurance ____

Address ____
City/State **Zip code**

Phone _____________________ **Effective Date** ___________________________

I.D. No. _____________________ **Group No.** _______________________

Name of Personal Physician _______________________________________

****

Reason for Your Visit ____

Preferred Method of Payment (please circle):

Credit Card **Cash** **Check** **Insurance (if applies)** **Financing Plan**

MEDICAL HISTORY

Allergies To Medications ______________________________

Allergies/Sensitivities To Latex, Tape, Iodine, Etc. ______________________________

Current Medications ______________________________

Current Vitamins, Holistic Medications ______________________________

Past Surgeries, Including Plastic Surgery (include location, approximate dates)

____

____

History Of Any Serious Illness Or Accidents ______________________________

____

Have You Ever Had Any Of The Following Problems? (Please circle if yes)

Anemia   Bleeding   Complications with Anesthesia

Diabetes   Easy Bruising   High Blood Pressure

Jaundice/Hepatitis   Mitral Valve Prolapse

Poor Healing/Scarring   Psychological (consulting a professional)

Respiratory/Asthma   Substance Abuse

If You Circled Any Of The Above, Please Describe ______________________________

____

Do You Have Any Of The Following Habits?

Cigarette/Cigar Smoking ____________ Frequency ____________

Alcohol ____________ Frequency ____________

Have You Been Told You Need Antibiotics Prior To Surgery? ____________

Patient's Signature   Date   Doctor's Signature   Date

FOUNDATION FOR HAIR RESTORATION
JEFFREY S. EPSTEIN, M.D., F.A.C.S., P.A.

Making the decision to do something about one's hair loss is a very important one. In order to help us to best educate you, and to provide us with all the information that we need, please take the time to fill out this form.

HAIR LOSS HISTORY

Age Of Onset Of Hair Loss ______________

How Fast Does Hair Loss Seem To Be Progressing Currently? ________________

Medications Taken For Hair Loss (please provide dates as well as effectiveness)

- **Rogaine® (minoxidil) 2%** ____________________
- **Rogaine® (minoxidil) 5%** ____________________
- **Minoxidil plus Retin-A** ____________________
- **Propecia® (finasteride) 1 mg.** __________________
- **Proscar® (finasteride) 5 mg.** __________________
- **Other** ____________________________________

Please Circle Which Members Of Family Have/Had Significant Hair Loss

Father **Brothers** **Maternal Uncle** **Paternal Uncle**

Maternal Grandfather **Paternal Grandfather** **Mother**

Others ____

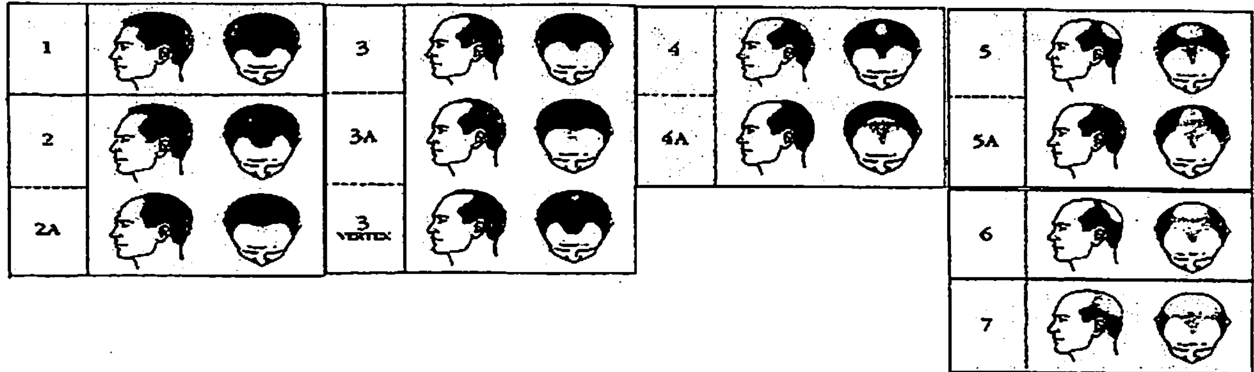
Please Circle The Description That Best Describes Your Current Hair Condition For Each Area Of The Scalp

Hairline:	*Normal*	*Thinning*	*Very Thin*	*Bald*
Frontal Recessions:	*Normal*	*Thinning*	*Very Thin*	*Bald*
Frontal Area:	*Normal*	*Thinning*	*Very Thin*	*Bald*
Mid Scalp:	*Normal*	*Thinning*	*Very Thin*	*Bald*
Crown/Back:	*Normal*	*Thinning*	*Very Thin*	*Bald*

For The Above Areas, Please Circle All That Are Of Concern

Using The Diagram (The Norwood Classification Of Hair Loss) Please Mark:

- With A *Circle* Which Hair Loss Pattern You Have Now
- With A *Square* To Which Hair Loss Pattern You May Progress In The Future



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Please Circle All The Characteristics Of Your Hair

Hair Color: *Black* *Brown* *Gray* *Blonde* *Red* *Salt & Pepper*

Hair Curl: *Straight* *Slightly Wavy* *Wavy* *Curly*

Hair Thickness: *Fine* *Medium* *Medium Coarse* *Coarse*

****

Past Hair Surgery History (please include dates, physician/clinic, graft number)

____

____

****

What Are Your Goals? ____

____

____

Which Of The Following Would You Be Most Helpful (please circle all that apply):
In-Depth Consult *Talking To Patients* *Meeting Patients* *Viewing A Procedure*

HIPAA Notice of Privacy Practices

Jeffrey S. Epstein, M.D., F.A.C.S.
6280 Sunset Drive, Ste 504, Miami, FL 33143
telephone (305) 666-1774

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 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 or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

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 school 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 Disclosures: 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 an 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.

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 operations. 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 us 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 our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

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

We are required 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 our Main Phone Number.

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

Print Name:________________________ Signature____________________Date______

Dear Patient:

We take great pride in our reputation for providing the highest levels of quality medical care to our patients. It has always been our commitment to make all of our patients happy. Dr. Epstein stands by his work and seeks 100% satisfaction from each and every one of them. We can confidently say that we consistently receive an extremely high rate of patient satisfaction and we enjoy the kind words of appreciation and praise we receive on a daily basis from our patients.

However, we realize there are times when the rare patient will not be satisfied with his/her outcome of treatment, and respect every patient's right to pursue whatever remedies if he/she feels to have not received the appropriate level of care. Unfortunately, in this country there are many frivolous legal claims filed that drive up insurance rates and cause much distress to physicians. To help cut down on these frivolous claims, it makes sense that the mutual use of only board-certified experts can help expedite resolution of concerns.

We are requesting that you review and sign the attached two (2) documents concerning both of our conduct and obligations after you have provided our office with your personal information and/or received medical care from our office.

Agreement as to Resolution of Concerns:

OUR COMMITMENT TO YOU

We commit to using only American Board of Medical Specialties (ABMS) board-certified expert medical witness(es) in any legal situation, who follow the code of ethics of our national specialty society. These steps ensure that expert medical witnesses we use have passed examinations, demonstrated expertise in their field and adhere to a solid code of ethics.

We demonstrate this commitment to you with our signature on this form.

WHAT WE ARE ASKING YOU TO DO

We are asking you, or any representative of yours, to commit to this process also, by using only board-certified physicians expert medical witness(es) if you decide to take legal action.

Mutual Agreement to Maintain Privacy:

We take privacy laws and matters very seriously. We respect our patients' privacy, even beyond what is required by Federal and State law. In return, we are asking that our patients refrain from publishing or airing commentary upon Dr. Epstein and his practice, expertise and/or treatment, without prior written consent. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage a physician's reputation and practice. Similarly, Dr. Epstein respects the privacy of his patients and will refrain from any such activity regarding his patients without their prior written consent.

We hope, and believe, you will never have to consider these matters again. But if you do, we will honor our commitments to you.

MUTUAL AGREEMENT TO MAINTAIN PRIVACY

Dr. Jeffrey Epstein, M.D., and Jeffrey Epstein, M.D., P.A., (individually and/or collectively "*Physician*") agree to maintain Privacy of ____________ ("*Patient*") as outlined in the HIPAA form. The Physician takes pride in being able to extend a greater degree of privacy than is required by HIPAA, state confidentiality mandates, and common law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, HIPAA forbids physicians from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician believes this is improper and may not be in the patients' best interest. Accordingly, Physician agrees not to provide any list for marketing or be paid for selling patient lists or protected health information to any party for the purpose of marketing directly to patients. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

In consideration for treatment and the above noted patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Physician and his practice, expertise and/or treatment unless explicitly mandated by law. Publishing is intended to include attribution by name, by pseudonym, or anonymously. Physician has invested significant financial and marketing resources in developing the practice. In addition, Patient will not denigrate, defame, disparage, or cast aspersions upon the Physician; and (ii) will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in any such activity. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage Physician's practice.

Physician feels strongly about Patients' privacy as well as the practices' right to control its public image and privacy. Both Physician and Patient will work to prevent the publishing or airing of commentary about the other party from being accessed via Internet, blogs, or other electronic, print, or broadcast media without prior written consent. Finally, this Agreement shall be in force and enforceable (and fully survive) for a period of the longer of (a) five years from Physician's last date of service to Patient; or (b) three years beyond any termination of the Physician-Patient relationship. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients.

Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

SO AGREED THIS ___DAY OF __________, 2009.

_____________________________ _____________________________

Patient Physician

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean ______________________.
(insert name of patient or guardian)

"Physician" shall be understood to mean **Jeffrey S. Epstein, M.D., F.A.C.S.; and/or Jeffrey S. Epstein, M.D., P.A.**

I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are certified by either (a) the American Board of Facial Plastic and Reconstructive Surgery; or (b) the American Board of Hair Restoration Surgery, as applicable in light of the subject procedure. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses, if certified by the American Board of Facial Plastic and Reconstructive Surgery will also be members in good standing of the American Academy of Facial Plastic and Reconstructive Surgery.

I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the American Academy of Facial Plastic and Reconstructive Surgery or the American Board of Hair Restoration Surgery, as applicable in light of the subject procedure, and that the expert(s) will be obligated to fully consent to formal review of conduct by such organization.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions. In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

______________________	______________________
Physician	Patient/Guardian
______________________	______________________
Effective from Date of Treatment:	Date of Signature