ALLURE ESTHETIC PLASTIC SURGERY | THE GALLERY OF COSMETIC SURGERY | SEATTLE PLASTIC SURGERY

Date:

PATIENT INFORMATION

Legal Name: _____

Preferred Name: _____

Mailing Address: _____

_____

City State

Date of Birth: _____ Age: _____

Current gender identity: _____

Sex assigned at birth: _____

Pronouns: _____

Occupation: _____

Hobbies _____

Marital Status: Single Married Widowed Divorced

Number of Children and Ages: _____

How did you hear about us? Google Yelp Referral

Other:

Have you been to our website?

_____

What are your goals?

_____

_____

CONTACT INFORMATION

Home: _____

Cell: _____

Email: _____

IN CASE OF EMERGENCY CONTACT:

Name: _____

Relationship: _____

Home: _____

Cell: _____

PROCEDURE OF INTEREST

FACIAL PROCEDURES:

- ❒ Brow/Forehead Lift
- ❒ Cheek Implant
- ❒ Chemical Peel
- ❒ Chin Implant
- ❒ Ear Surgery
- ❒ Facelift
- ❒ Neck Lift
- ❒ Eyelid – Asian
- ❒ Eyelid – Lower
- ❒ Eyelid – Upper
- ❒ Laser of Face
- ❒ Lip Augmentation
- ❒ Nose Reshaping
- ❒ Fat Transfer to Face

LIPOSUCTION:

- ❒ Abdomen
- ❒ Arms
- ❒ Back
- ❒ Buttocks
- ❒ Cheeks
- ❒ Chest (Men ONLY)
- ❒ Hips
- ❒ Knees
- ❒ Neck
- ❒ Thighs – Inner
- ❒ Thighs – Outer
- ❒ Waist

BODY PROCEDURES:

- ❒ Arm Lift
- ❒ Breast Augmentation
- ❒ Breast Lift
- ❒ Breast Implant Revision
- ❒ Breast Reduction
- ❒ Pectoral Implants
- ❒ FTM Top Surgery
- ❒ Brazilian Butt Lift
- ❒ Non-Surgical Brazilian Butt Lift
- ❒ Zombie Brazilian Butt Lift
- ❒ Thigh/Butt Lift
- ❒ Tummy Tuck
- ❒ Gluteal Implants

HAIR:

- ❒ Hair Restoration
  - FUE
  - FUT
- ❒ Scalp Reduction
- ❒ PRP
- ❒ A-CELL

OTHER PROCEDURES:

- ❒ Botox
- ❒ Dysport
- ❒ Fillers
- ❒ Microneedling
- ❒ Fraxel
- ❒ Laser Hair Removal
- ❒ Other:

_____

_____

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Medical History

_____(Initial) I understand that disclosing my complete medical history to the medical team prior to surgery is critical. I acknowledge that if I fail to inform Alderwood Surgical Center in writing of any disease, medical condition, surgery, hospitalization, allergy, procedure, medication, or other pertinent medical information at least 14 days prior to surgery, my surgery may be cancelled and I am subject to cancellation/rescheduling fees.

Referring Physician / Physician Information

Physician Name:	Is this the primary care provider? ❒ Yes ❒ No
Street Address:	If not, name of PCP:
City, State, Zip:	Telephone:

Patient Medical History *** please use back of form if more space is needed

ALLERGIES: (list all meds and reactions)

List all Present Illnesses/ Recent Diagnosis:

Past Medical History:

Past Surgical History:

CURRENT MEDICATIONS: (***list all medications including the dosage and frequency of use; include any vitamins/supplements/over the counter medication and herbals):

Do you take any of the following medications? Coumadin / Warfarin Plavix Aspirin NSAIDs Other:

Do you currently have or have had any of the following?

Respiratory	Cardiovascular	Neuro / Muscular
____ Allergies / Hay Fever	____ Chest Pain	____ Bone / Joint Problems
____ Asthma / Wheezing Lung Trouble	____ Dizziness / Fainting Spells	____ Cataract / Glaucoma
____ Pneumonia	____ Heart Attack	____ Epilepsy/ Seizures
____ Shortness of Breath	____ Heart Murmur	____ Headaches
____ Snoring	____ High Blood Pressure Pulmonary Embolism	____ Head Injury
____ Tightness in Chest	____ Rheumatic Fever	____ Numbness in Limb
____ Sleep Apnea	____ Recent Stress Test	____ Rheumatism / Arthritis
If Yes, do you use CPAP	____ Swelling of Ankles / Feet	____ Ringing in Ears
❒ Yes ❒ No COPD	____ Heart Arrhythmia (abnormal heart rhythm)	____ Stroke/ TIA (Mini Stroke)
	____ CHF	____ Back Problems
		____ Gout

Hepato-Gastro-Intestinal	Hematology / Renal / Endocrine	Other
____ Change in Bowel Habits Bleeding or Constipation	____ Anemia	____ HIV
____ Indigestion/ Acid Reflux/ Hiatal Hernia Stomach	____ History of Bleeding Problems	____ Bariatric Patient
____ Ulcers	____ Blood Clots	____ Cancer
____ Hepatitis	____ Bladder Infection Chills,	____ Difficulty in Sleeping
____ Liver Disease / Jaundice	____ Fever or Sweats	____ Sexually Transmitted Disease
____ Loss of Appetite/ Nausea/ Vomiting Cirrhosis	____ Diabetes	____ Dry Eyes/Eye Injury
	____ Kidney Problems/Thyroid Trouble	____ History of Breast Lumps / Bumps

Do you smoke?	❒ Yes, how much? How long?	❒ No
Do you drink? If yes, frequency:	❒ Yes, last drink?	❒ No
Have you or any of your relatives ever had a bad reaction to anesthesia?	❒ Yes	❒ No
Do you wear contact lenses?	❒ Yes	❒ No
Do you wear dentures?	❒ Yes	❒ No
Do you have a history of chemical dependency?	❒ Yes	❒ No
Are you under treatment for anxiety or depression?	❒ Yes	❒ No
If female, are you pregnant?	❒ Yes ❒ No Date of last menstrual period:	

Signature of Patient Printed Name Date

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Acknowledgement of Receipt of Patient Rights & Privacy Practices

As a patient of you have the right to:

- Be treated with dignity & respect, in a safe & secure environment, free from all forms of discrimination, abuse, neglect, harassment and reprisal.
- Be provided with appropriate privacy in the performance of your medical care.
- Expect patient disclosures and records to be treated confidentially except when release is required by law.
- Be provided with complete information concerning your diagnosis, evaluation, treatment and prognosis in terms you can understand. You may select family members or others to represent you if you cannot make your own decisions or you may exclude family members from hearing this information. When it is medically inadvisable to give such information to you, the information will be provided to a person designated by you or to a legally authorized person.
- Information necessary to give informed consent before the start of any procedure, agree to your care, and be involved in care planning and treatment.
- Free communications unless restrictions are necessary for your care and safety and to have communication restrictions explained to you, family members, or others who represent you.
- Include family input in care decisions, in compliance with existing legal directives or court-issued legal orders.
- Refuse treatment and to be informed of the medical consequences of your refusal.
- Be informed of provisions for after-hour and emergency care if needed.
- Access information contained in your medical records within a reasonable timeframe, in accordance with state and federal regulations.
- Initiate review of any concern you may have about your care.
- Express spiritual beliefs and cultural practices as long as these do not harm others or interfere with treatment.
- Complain about care without fear of reprisal or denial of care. To have complaints resolved within 14 days and, if requested, to receive a written response from Allure Esthetic. Patients may take concerns to the Patient Care Coordinator at Ballard 206.209.0988 / Lynnwood 425.775.3561.
- Be notified of unanticipated outcomes as required by law.
- Be informed of any human experimentation or research projects affecting your care or treatment and of the right to refuse participation in such experimentation or research without hindering access to your care.
- Request access to protective services.

ADVANCE DIRECTIVES

All patients have the right to participate in their own health care decisions and to make advance directives regarding such decisions. We respect and uphold those rights. However, unlike an acute care hospital, Allure Esthetic does not perform "high risk" procedures. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery and care after your surgery or procedure. It is our policy, regardless of the contents of any advance directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital. At the hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with the terms of any advance directive you may have. If you do not agree to this policy, we are pleased to assist you to reschedule the procedure elsewhere. If you present an advance directive at the time of admission this will be noted on your medical record and a copy will be delivered, along with a copy of your medical record, to the hospital if an adverse event necessitates a transfer as indicated above.

PRIVACY PRACTICES

I acknowledge that I have received and read a copy of the Statement of Privacy Practices and the Patient Bill of Rights for the offices of Allure Esthetic. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information (PHI) that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my PHI. The Statement of Privacy Practices is also posted in the facility.

Allure Esthetic reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

In general, the HIPAA privacy rule gives me the right to request a restriction on uses and disclosures of my PHI. I am also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to my office instead of my home. I wish to be contacted in the following manner (check all that apply):

	OK to leave detailed message	Leave call-back number only	Do NOT call
Telephone:	❒	❒	❒
Email: _____	❒	❒	❒

Please indicate the names and relation of people who we may communicate with regarding your appointments and/or medical information:_____

_____(initial) I do not wish to allow any of my information to be shared with anyone including my spouse, or any other family member and/or guardian.

Patient Name (Please Print) Patient Signature Date

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Financial Policies

General Financial Policy:
Surgical procedures, injections, esthetic treatments, and retail products must be paid for in full at the time of service or delivery of goods.

Payment Methods Policy:
Payments for injections, esthetic treatments, prescriptions or products can be made by cash or credit card. Payments for surgeries and related deposits can be made by cash, personal check, money order, ACH or Bank Transfer, Wire Transfer, Credit Card, or approved financial institution arrangements administered by third parties including Care Credit, Alphaeon Comenity Business Center, or United Medical Credit. Personal checks, ACH, or Wire Transfers will only be accepted up to 21 days prior to the scheduled surgery. An additional 5% processing fee will be charged when the payment method chosen is credit card, debit card or financing company.

Pricing and Treatment Policy:
The standard pricing of products and services is subject to change at any time without warning or notice. Treatment prices may vary from client to client based on individual programs or recommendations of products or services, tailored for client-specific needs. Treatment programs are non-transferable in part or whole to any other treatment or individual. All pre-payments for any esthetic treatments expire six months from the date of purchase, including treatments such as laser hair removal, Fraxel, IPL, and Microneedling. After the six-month period, unused treatments will be considered forfeited.

Product Sales Policy:
All product sales are final. In the case of a documented adverse reaction to any product, an exchange or credit may be issued within 10 days of the original purchase.

Surgical Date Policy:
In order to secure a date for any surgery procedure, a non-refundable $1,000 deposit must be paid in full. The remaining balance is due no later than three (3) weeks prior to surgery, typically at the pre-operative appointment. If the pre-operative appointment occurs within three (3) weeks of surgery, payment in full is due at the beginning of the appointment.

Cancellation and Reschedule Policy:
If surgery is cancelled or rescheduled at any time prior to 21 days before surgery, a non-refundable cancellation or rescheduling fee of $1,000 is applied and any remaining surgery deposit balance shall be refunded. If surgery is cancelled or rescheduled within 15-21 days before surgery, an amount equal to 50% of the total surgery fee will be retained by Alderwood Surgical Center. If surgery is cancelled or rescheduled within 14 days of surgery, an amount equal to 100% of the total surgery fee will be retained by Alderwood Surgical Center. If the surgery is rescheduled due to a documented medical emergency, any remaining surgical deposit less non-refundable cancellation fee stated above, shall be applied to a future mutually agreeable surgery date if documentation is approved by Alderwood Surgical Center.

Refund and Unclaimed Property Policy:
Alderwood Surgical Center LLC shall refund patients for any overpayments for surgical or cosmetic procedures within 60 days of the Company identifying the overpayment. Any overpayment resulting in a refund owed shall be refunded via the original method of payment, when available. A check will be issued when the original payment method is unavailable.

Alderwood Surgical Center LLC is responsible for compliance with Washington's Uniform Unclaimed Property Act and will report any abandoned property three years from the date such property came into the Company's possession. Alderwood Surgical Center complies with both federal and state law by providing notice to patients in writing of any overpayment and refunding any overpayment within 60 days of service.
Patients will be notified of any overpayment within 30 days so that the Company can confirm the method of payment. Any refunded amount will be re-issued through the original payment method. If the original payment method is unavailable, a check will be mailed. Every attempt will be made to refund the patient through the original form of payment. Gift cards or account credits may be offered at the discretion of the CEO/COO.

_____ **(Patient/Responsible Party Initials)**

If the money owed to the patient is not refunded within three years, it is considered "unclaimed property" under Washington State Law. Washington's Uniform Unclaimed Property Act applies to the following situations: (1) The Company is not able to contact the patient after good faith effort has been made to refund the amount overpaid; (2) The Company fails to issue a refund for any overpayment; or (3) A gift card or account credit is not used in part or in full. If any of these situations arise, Alderwood Surgical Center shall report the monies as unclaimed property to the Washington Department of Revenue according to their required deadline of three years from the date such property came into the Company's possession.

Delinquency Policy:
Payments for goods and services must be made in full at the time of service or delivery of goods. In the event payment is not made timely, any balance will be subject to a 3% monthly finance charge. Written notice will be provided to the mailing address on file after 60 days and 90 days of delinquency. After 90 days of written notice of delinquency, Alderwood Surgical Center shall take action to collect the debt owed, up to and including debt collections and legal action.

Quote and Fee Estimate Policy:
Dr. Javad Sajan, Dr. Craig Jonov and Dr. David Santos' quote is intended to provide an estimate only, and is subject to change at the discretion of Alderwood Surgical Center, LLC. The fees stated in the quote are estimated costs of any procedures listed on the quote. Any discounts given for the procedural plan are as listed, and any deviation from the original procedural plan may result in a loss of discount. This quote is valid for 90 days from the date received.
The doctor's quote is inclusive of the following expenses: operating room/facility fees, doctor's fees, anesthesia, implants (when applicable). Prices do not include costs associated with prescription drugs, necessary laboratory fees, preoperative appointment, PPE fee or additional surgical garments.

Any revisions or touch ups are subject to additional facility, doctor, and anesthesia fees. In the event that Lab Work/EKG/Medical Clearance is required prior to surgery, Alderwood Surgical Center must receive written documentation no later than two (2) weeks prior to the surgery.
Otherwise, Alderwood Surgical Center reserves the right to cancel the surgery; please refer to the cancellation policy for more information.

Surgery Cancellation Policy
Once you have paid the deposit and we have an agreed upon surgery date, our cancellation policy is as follows:
If surgery is cancelled at any time prior to 21 days before surgery, a non-refundable cancellation fee of $1,000 is applied and any remaining surgery deposit balance shall be refunded. If surgery is cancelled within 15-21 days before surgery, an amount equal to 50% of the total surgery fee will be retained by Alderwood Surgical Center and any remaining surgery deposit balance shall be refunded. If surgery is cancelled within 14 days of surgery, an amount equal to 100% of the total surgery fee will be retained by Alderwood Surgical Center. _____ **(Patient/Responsible Party Initials)**

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility.

Responsible Party (PRINT) Signature of Responsible Party Date

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Patient Name Relationship to Patient

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Customer Satisfaction Policy

We take great pride in our reputation for providing the highest level of quality medical care to our patients. However, we realize that there are times when some patients may not be satisfied with the outcome of their treatments. In such instances, we welcome the opportunity to address any issue or concern that may arise.

If you are concerned with the care or service provided by any of our locations (Gallery of Cosmetic Surgery, Allure Esthetic, or Seattle Plastic Surgery) please give us a call at (206) 209-0988 or (425) 775-3561 so we can attempt to resolve the issue. Due to health privacy laws, we do not respond to questions or concerns posted to online review platforms such as Google or Yelp.

We will make a good faith effort to resolve your concern in a timely manner.

By signing below you acknowledge that you received and reviewed our Customer Satisfaction Policy.

Patient Name (Please Print)	Patient Signature	Date
Witness Name (Please Print)	Witness Signature	Date