Petroff Center
17720 Jean Way, Suite 100
Lake Oswego, OR 97035
(503) 635-4886

Date: _____

Completion of this information in its entirety is required at time of visit

☐Mr. ☐Mrs. ☐Ms. ☐Dr.	NAME:	PREFERRED NAME:	
ADDRESS: ☐ NO MAIL		CITY:	STATE:
ZIP:	SOCIAL SECURITY NUMBER:	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER	
DATE OF BIRTH: / /	SEX: ☐M ☐F	PREFERRED CONTACT NUMBER: ☐HOME ☐WORK ☐CELL	
Phone: ( ) ☐HOME ☐WORK ☐CELL ☐ O.K. TO LEAVE A MESSAGE WITH DETAILED INFORMATION ☐ LEAVE A MESSAGE WITH CALL-BACK NUMBER ONLY		Alt. Phone: ( ) ☐HOME ☐WORK ☐CELL ☐ O.K. TO LEAVE A MESSAGE WITH DETAILED INFORMATION ☐ LEAVE A MESSAGE WITH CALL-BACK NUMBER ONLY	

EMAIL ADDRESS: _____

**By providing my email address I authorize you to send me appointment reminders, patient information, newsletters and promotional emails about specials and events. I understand that I may unsubscribe at any time, and that you will never sell or share my email with any external entity.

REFERRAL SOURCE: ☐DOCTOR ☐ESTABLISHED PATIENT ☐INTERNET ☐NEWSPAPER ☐WORD OF MOUTH ☐ OTHER_____(PLEASE LIST)	**REFERRING PHYSICIAN:** _____ TYPE OF VISIT: ☐INSURANCE ☐COSMETIC ☐SECOND OPINION ☐LEGAL	
☐ STAFF MAY SPEAK WITH: NAME: _____ RELATIONSHIP: _____	☐ I WOULD LIKE TO REQUEST THAT ALL MAIL BE SENT TO AN ALTERNATE ADDRESS: _____ _____	
****REQUIRED**** EMERGENCY CONTACT :	RELATION:	PHONE: ( )

EMPLOYMENT: ☐FULL TIME ☐PART TIME ☐FULL TIME STUDENT ☐PART TIME STUDENT ☐RETIRED ☐UNEMPLOYED	
OCCUPATION:	EMPLOYER/SCHOOL:

PETROFF CENTER NOTICE OF PRIVACY PRACTICES CONSENT

Recipient Authorization to Use or Disclose Protected Health Information

PATIENT RECORDS OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right on uses 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.

The privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

I have read/received the notice of Privacy Practices Acknowledgment and have been provided the opportunity to review it as well as request a copy for my personal reference.

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

PETROFF CENTER
Plastic Surgery & Medi-Spa

PAYMENT POLICY

Payment is due in full at the time of service for all office visits, ancillary services and product. We accept cash, check, VISA, MasterCard, American Express and Discover for your convenience. Financing is available through CareCredit.

The Petroff Center has a 30-day exchange policy for all product purchases.

Cancellation Policy

Life happens…should you experience a change in your availability, we are requesting that you notify our office before noon on the business day prior to your scheduled appointment. We would be happy to assist you with rescheduling. Your prompt notification helps to ensure that every patient has fair access to schedule a timely appointment.

Should you fail to show for your scheduled appointment or notify our offices of your cancellation, we reserve the right to charge the following:

Mark A. Petroff, MD		Spa Services	
New Patient Consultations:	$100	Spa Consultations:	$50
Injectable Appointment:	$340	Facial and/or Laser Services	50% of scheduled service

Insurance

Mark A. Petroff, MD PC and/or the Petroff Center are contracted to participate directly with the Medicare program only. Effective 9/30/11, we have elected to terminate our participation with our remaining insurance contracts. Our decision does not affect our ability to treat you for your condition. Our decision allows us to take a patient-centered approach and provide excellent patient care. We recommend that you contact your insurance plan for a complete description of your out-of-network plan benefits.

Late Fees

After 90 days from the date of service, all accounts are subject to a Finance Charge of 1.5% per month, which is 18% per annum.

Canceled Checks

A $35.00 NSF charge will be applied to my account for any checks returned for insufficient funds.

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. All accounts assigned to collections will be charged a $150.00 collection fee. I hereby authorize the doctor to release information necessary to secure the payment of benefits. I authorize payment of insurance benefits directly to the Petroff Center. I authorize the use of this signature on all insurance submissions.

_____
Signature of Patient (for patients over the age of 18)

_____ _____
Date Signature of Guarantor or Legal Guardian (for patients under the age of 26)

PETROFF CENTER
Health Questionnaire

Mark A. Petroff, M.D. FACS

In order for us to fully understand your needs, we greatly appreciate you taking a moment to answer the following questions about your health and habits. Please answer each question to the best of your knowledge.

All information will be held in the strictest confidence.

Date: _____

Name: _____ Age: _____ Height: _____ Weight: _____

What is your occupation? _____

1. Please list any operations that you have had including minor or cosmetic surgery: ☐None ☐Yes

List:_____

_____

2. Any reactions to anesthesia: ☐ YES ☐NO: Explain: _____

3. List all drug/food allergies and **reactions**: ☐None _____

_____

4. Are you being treated for any medical illnesses, please list? ☐ YES ☐NO_____

_____

_____

5. Please list any medications (**with dosages**) you are taking (Including: aspirin, vitamins and herbal preparations): ☐None
List: _____

_____

6. Have you been treated for any of the following: ☐**YES or** ☐**NO Check ALL that apply:**

☐Asthma ☐High Blood Pressure ☐Heart Disease and/or abnormalities ☐ Pace Maker
☐Blood Clot ☐Bleeding Disorder/Bruises easily ☐Diabetes ☐HIV Infection
☐MRSA/Staph Infection ☐Hepatitis ☐Eye Problems ☐ Cold Sores
☐Scarring (Keloid-raised scars or hypertrophic-widened scars)

Continued on back…

7. Do you have any current infection(s) or complication(s) for which you are being treated for as a result of one of these medical conditions? **YES or ☐NO**

Describe:_____

8. Do you smoke? ☐Yes ☐No How many cigarettes per day? _____

9. Do you drink alcohol? ☐Yes ☐No How many glasses per day? _____

10. Have you used Accutane for the treatment of acne? ☐Yes ☐No

11. Do you routinely apply Glycolics or Retin-A to your face? ☐Yes ☐No
If so, when was the last time you used one or both of these?_____

12. Do you use sunscreen? ☐Yes ☐No If so, what SPF (sun protection factor) do you use?_____

13. When was the last time you exposed your face to the sun, including a tanning booth? :

WHEN: _____

14. Do you routinely use a self-tanning product or spray tan? ☐Yes ☐No

15. Have you had any of the following treatments in the past 2-4 weeks on your face or where the treatment is to be performed? If so, please check the treatment you received and give the approximate date this was performed:

☐Microdermabrasion ☐Chemical Peel ☐Laser Procedure ☐Other

Please give details:_____

Please describe your daily skin care regimen: _____

_____

I am interested in learning about:

- ☐ Facial Skin Rejuvenation
- ☐ Facial Wrinkles / Laser Treatment
- ☐ Botox Cosmetic
- ☐ Injectable facial fillers
- ☐ Other:_____
- ☐ Aging Face / Face, Neck & Brow Lifting
- ☐ Aging Eyes / Eyelid Surgery
- ☐ Nasal Surgery
- ☐ Facial implants
- ☐ Scar Revision

Comments: _____

_____

Patient Signature: _____ **Date:** _____