

# history and physical



Name: \_\_\_\_\_

Date: \_\_\_\_\_

## social:

Age: \_\_\_\_\_ Sex:  M  F Married:  Yes  No Occupation: \_\_\_\_\_

Responsible adult available to assist during recovery period:  Yes  No Relationship: \_\_\_\_\_

## habits:

Smoke, Amount \_\_\_\_\_

Coffee/Tea/Cola, Amount \_\_\_\_\_

Alcohol, Amount \_\_\_\_\_

Daily Exercise, Amount \_\_\_\_\_

## medications:

### List dose or number of pills per day

Prescription Drugs

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Non Prescription (Vitamins; Herbs)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Regular Aspirin Use, Dosage & frequency \_\_\_\_\_

NSA (Advil, Motrin, Ibuprofen), Dosage & frequency \_\_\_\_\_

Cortisone Injections Past Year, Date(s) and injection location \_\_\_\_\_

Drug Allergy, List drug(s) and type of reaction \_\_\_\_\_

Latex Allergy

Tape Allergy

## family history:

Have any blood relatives ever had the following problems:

Abnormal Bleeding

Diabetes

Cancer

Tuberculosis

Coronary Surgery

Anesthetic Problems

Hypertension

Other Serious Illness

Abnormal Clotting

Heart Attack

Kidney Disease

Please describe questions with a checkmark \_\_\_\_\_

## women patients only:

Number of pregnancies \_\_\_\_\_ Number of children \_\_\_\_\_ Last menstrual period \_\_\_\_\_ Did you breast feed?  Y  N

Bra size \_\_\_\_\_ Last MMG \_\_\_\_\_ Results \_\_\_\_\_ Additional breast studies \_\_\_\_\_

## personal past history:

### Have you ever had:

- |   |   |                                       |   |
|---|---|---------------------------------------|---|
| <input type="checkbox"/> Abnormal Bleeding  | <input type="checkbox"/> Angina         | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Snoring                      |
| <input type="checkbox"/> Abnormal Clotting  | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Hepatitis    | <input type="checkbox"/> Weight Change past 12 months |
| <input type="checkbox"/> Acid Regurgitation | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other Serious illness        |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Fainting Spell | <input type="checkbox"/> Sleep Apnea  |   |

Please describe questions with a checkmark \_\_\_\_\_

Have you ever received a transfusion?  Yes  No If yes, what year? \_\_\_\_\_

Have you been tested for HIV?  Yes  No If yes, what year? \_\_\_\_\_ Result:  Positive  Negative

### Do you wear:

- |   |                                      |                                      |                                   |
|---|--------------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Contact lenses | <input type="checkbox"/> Eye glasses | <input type="checkbox"/> Hearing aid | <input type="checkbox"/> Dentures |
|---|--------------------------------------|--------------------------------------|-----------------------------------|

Previous Surgery, year and type of procedure \_\_\_\_\_

### Indicate the type(s) of anesthesia received in the past, list any complications / reactions you experienced:

- Local anesthesia - (complications/reactions): \_\_\_\_\_
- General anesthesia - (complications/reactions): \_\_\_\_\_
- Spinal / Epidural - (complications/reactions): \_\_\_\_\_

Date last seen by Primary Care Physician \_\_\_\_\_ Primary Care Physician (name) \_\_\_\_\_

Telephone ( \_\_\_\_\_ ) \_\_\_\_\_ Address \_\_\_\_\_

## review of systems:

- |  |  |   |                                    |
|--|--|---|------------------------------------|
| <input type="checkbox"/> Loose Dental Devices  | <input type="checkbox"/> Vomiting            | <input type="checkbox"/> Recent Upper Respiratory Infection | <input type="checkbox"/> Black Out |
| <input type="checkbox"/> Chest Pain            | <input type="checkbox"/> Cough               | <input type="checkbox"/> Current Pregnancy                  | <input type="checkbox"/> Stroke    |
| <input type="checkbox"/> Neck Mobility Problem | <input type="checkbox"/> Difficult Voiding   | <input type="checkbox"/> Normal Menstrual Period            | <input type="checkbox"/> Obesity   |
| <input type="checkbox"/> Irregular Heart Beat  | <input type="checkbox"/> Shortness of Breath |   |                                    |
| <input type="checkbox"/> Short Neck            | <input type="checkbox"/> Seizure             |   |                                    |

### Additional Form Comments:

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Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

# patient information



SS# \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( \_\_\_\_ ) \_\_\_\_\_

Work Phone ( \_\_\_\_ ) \_\_\_\_\_

E-mail address \_\_\_\_\_

Cell Phone ( \_\_\_\_ ) \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ Sex \_\_\_\_\_ Married  Yes  No

## Referring Source

Doctor \_\_\_\_\_

Patient \_\_\_\_\_

Other \_\_\_\_\_

Hospital \_\_\_\_\_

Employment Status  Yes  No

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Spouse Work Phone # ( \_\_\_\_ ) \_\_\_\_\_

## FINANCIAL POLICY:

All deductibles, co-payments and co-insurance will be collected after services are rendered.  
Cash, check or credit card payment will be accepted.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

# SEAN A. SIMON, M.D.

6200 SUNSET DRIVE, SUITE 501 305-668-0496



## NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES  
AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

I acknowledge that I was provided with a copy of the Sean A. Simon, M.D. Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. Provided that Sean A. Simon, M.D. continues in its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my health information for the purpose and the activities permitted under the federal privacy law, which are described in the Notice of Privacy Practices.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (305) 668-0496 or by requesting one at the office of Sean A. Simon, M.D.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
If personal representative, personal representative's relationship to patient

If you received this form electronically, please sign and date the form and return it to the office of Sean A. Simon, M.D. at 6200 Sunset Drive, Suite 501 Miami, FL 33143 or fax it to (305) 667-7459.

### For Physician Office's use only:

Complete this section of the form if not signed and dated by the patient or patient's representative.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SS# \_\_\_\_\_ Phone Number: ( \_\_\_\_ ) \_\_\_\_\_

Address: \_\_\_\_\_ Date signature requested: \_\_\_\_\_

Reason that the signature and date not obtained: \_\_\_\_\_

# disclaimer



## IMPORTANT NOTICE UNDER FLORIDA STATUTE LAW 458320 PLEASE READ THIS IMPORTANT DOCUMENT AS THESE ARE YOUR RIGHTS UNDER FLORIDA STATUTE LAW 458.320

### Dear Patient:

Under Florida law Statute (458.320 F.S.), physicians are generally required to carry medical malpractice insurance or demonstrate financial responsibility to cover potential claims for medical malpractice. I HAVE DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law under certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant of Florida law statute (459.320 F.S.).

This document MUST BE SIGNED AND WITNESSED before you initiate or continue under the care of Sean A Simon, M.D.

Thank-you.

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Sean A. Simon, M.D.

Note: No treatment can be provided by Sean A Simon, M.D. unless this form has been read and signed. This form is provided to protect your rights under Florida Statute 458320.

I, \_\_\_\_\_, have read this document and acknowledge and understand its contents.

(PRINT FULL NAME HERE)

Signature: \_\_\_\_\_, Date: \_\_\_\_\_

Witness: \_\_\_\_\_, Date: \_\_\_\_\_

Copy received by patient: \_\_\_\_\_

COPY OF STATUE PROVIDED ON REQUEST OR SIGNS CONCERNING  
THE FLORIDA STATUTE LAW 458320 ARE POSTED IN OUR OFFICE

# physician-patient arbitration agreement



## **Preface:**

I, Dr. Sean Simon, have decided under Florida Law to practice without Malpractice Insurance. Under this practice, this Arbitration Agreement ("Agreement") should be read carefully and fully understood. If you have any questions before or after reading and signing this statement please ask the staff or my office manager. Please read this document clearly. Thank you for your consideration.

**Article 1: Agreement to Arbitrate:** It is understood that my dispute as to medical malpractice that is, as to whether any medical services rendered under this contract were unnecessary, authorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by the Florida Arbitration Code, Chapter 682, and not by a lawsuit except as Florida law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must be Arbitrated:** It is the intention of the parties that this Agreement bind all parties whose claims may arise out of or related to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of a pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties and must be made within the time frame set forth in F.S. 95.11 dealing with medical malpractice. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of demand for neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees to the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefits. Arbitration shall take place within 30 days after the completion of discovery as provided in the Florida Rules of Civil Procedure (Rules 1.280-1.390) and the decision of the arbitration panel shall be binding upon the parties for all purposes. The time for responding to discovery requests shall be 10 days. All discovery shall be completed within 2 months after the appointment of the panel of arbitrators, unless the time for discovery is extended for good cause by the panel. The arbitration panel shall decide any disputes regarding

discovery. The arbitration panel is expressly authorized to award all reasonable fees and costs, including attorney's fees, to the prevailing party against any party who has violated this Agreement. The parties agree that the arbitrators have the immunity of a judicial officer for civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law provisions.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be proper additional party in court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

**Article 4:**

General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable Florida statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for the arbitrators shall be governed by the Florida Rules of Civil Procedure provisions relation to arbitration.

**Article 5:**

Retroactive Effect: If patient intends this Agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below.

Effective as of the date of first medical services

\_\_\_\_\_ (Patient's or Patient's Representative's Initials)

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and effect and shall not be affected by the invalidity of any other provisions.

I understand that I have the right to receive a copy of this Arbitration Agreement.

# authorization for and release of medical photographs/slides and/or video footage



## authorization for release of patient image

Name: \_\_\_\_\_

Address: \_\_\_\_\_

(STREET ADDRESS, CITY, STATE AND ZIP CODE)

I consent to the taking of photos, sliders or video footage by Dr. Sean Simon or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Sean Simon. I further authorize Dr. Sean Simon or one of his/her associates to release to the American Society of Plastic Surgeons ("ASPS") such images.

I provide this authorization as a voluntary contribution in the interest of public education. I understand that such photographs shall become the property of ASPS and may be retained by ASPS or released by ASPS for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

I hereby grant permission for the use of my medical records including illustrations, photographs, or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by the American Board of Plastic Surgery, Inc.

Neither I nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the images may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, from Dr. Sean Simon.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire one year from the date written below.

I understand that the information disclosed, or some portion thereof may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPPA"). I further understand that because ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPPA the information described above may no longer be protected by HIPPA.

I release and discharge Dr. Sean Simon, ASPS, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

Signature: \_\_\_\_\_, Date: \_\_\_\_\_

I have read the above Authorization and Release, I am the parent, guardian, or conservator of \_\_\_\_\_, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

Signature: \_\_\_\_\_, Date: \_\_\_\_\_