MANINGAS
COSMETIC SURGERY

New Patient Information

Date _____

Full Name _____

(as it appears on legal documents / driver's license)

Address _____

City _____ State _____ Zip _____

Email address _____ SS# _____

Home phone _____ Business phone/cell_____

May we contact you at home or work? _____ May we leave a message? _____

Date of Birth _____ Age_____ Male ___ Female ___Marital Status_____

Height _____ Weight (lbs) _____ Number of Children _____

Race: Caucasian____ African American____ Hispanic____ Asian____ Other_____

Emergency Contact: Name_____

Phone_____ Relationship _____

How did you hear of our office?

Friend ____ (Friend's Name_____)

TV ____ (Station_____) Radio ____ (Station_____)

Website____ (Which Website? _____)

Newspaper___ (Which Paper?_____)

Magazine ___ (Which Magazine? _____) Yellow Pages ___

Other____ (If other, explain _____)

☐ I authorize the following person(s) to have access to my information including appointments, health history, consultation notes, procedure information and/or day of surgery notes, medications prescribed, or any other information provided to Maningas Cosmetic Surgery. If you do not wish to authorize anyone to have access to your information, leave this section blank.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish. There is room to explain your answers more completely on the back of the second page. **Please Type or Print.**

NAME: _____ **DATE OF BIRTH**:_____
Last First M

ADDRESS (CITY,ST) _____ **OCCUPATION** _____

PHARMACY PREFERENCE (LOCATION):_____ **PHONE**_____

PURPOSE FOR VISIT: What is the main reason you are seeing the doctor today?

_____

_____

MEDICATIONS

Please list any medications ***including aspirin, vitamins, over-the-counter, or herbal medication***?

Medication Name	***Dose***	***How Often Taken***

ALLERGIES

Medication Name	***Type of Reaction***

Do you have environmental Allergies?	**Yes No**	Please list:
Do you have food Allergies?	**Yes No**	Please list:
Do you have a known allergy to Latex?	**Yes No**	

PAST MEDICAL HISTORY ***Have you ever been DIAGNOSED with any of the following problems?***

	Yes	No	Year	Comment
CANCER (please list type):	❒	❒		
Cardiovascular				
Do you have a pacemaker	❒	❒		
High/Elevated Cholesterol	❒	❒		
High Blood Pressure	❒	❒		
Other Heart Problems	❒	❒		
Respiratory				
Asthma	❒	❒		
COPD	❒	❒		
Tuberculosis	❒	❒		
Gastrointestinal				
Hepatitis	❒	❒		
Reflux	❒	❒		
Stomach ulcers	❒	❒		
Kidney				
Renal Failure	❒	❒		
Mental and Emotional				
Depression (requiring treatment)	❒	❒		
Anxiety (requiring treatment)	❒	❒		
Hematologic/Immunity				
Anemia	❒	❒		
HIV/AIDS	❒	❒		
Mononucleosis	❒	❒		
Bleeding after surgery	❒	❒		
Blood transfusion	❒	❒		
Other Not Listed Above				
Problem:	❒	❒		

PAST SURGICAL HISTORY

Year	Procedure	Surgeon

SOCIAL HISTORY

Have you ever smoked? Do you smoke now?	**Yes** **Yes**	**No** **No**	Comments (indicate amount per day):
Do you drink alcohol?	**Yes**	**No**	Comments (indicate amount per week):
Do you use any recreational drugs?	**Yes**	**No**	Comments (indicate frequency):

GYNECOLOGIC HISTORY ***(Women, please complete the following)***

	Yes	No	Comment
Menses/Pregnancies/Births			
Could you be pregnant?	❒	❒	
Date of last menstrual period:	___/____/___		
How many pregnancies have you had?	#_____		
How many live births have you had?	#		
Nursing			
Are you nursing?	❒	❒	
How many months total have you nursed?	#	months	
Hormone Replacement			
Have you ever taken Estrogen?	❒	❒	
Number of years taking Estrogen?	#	years	
Breast Health – Have you ever had:			
bloody nipple discharge?	❒	❒	
Non-bloody nipple discharge?	❒	❒	
Injury to breasts?	❒	❒	
Breast infections?	❒	❒	
Pain in breasts?	❒	❒	
Breast biopsy?	❒	❒	
Breast Cancer Risk Profile:			
Do you consider yourself:			
• Caucasian/non-black	❒	❒	
• Hispanic	❒	❒	
• Black	❒	❒	
What is your current age?	_____		
Age of first menses?	_____		
Age at first live birth?	_____		
Number of mother/sisters/daughters with Breast cancer:	_#_____		
Number of previous breast biopsies:	_#_____		
Biopsy with atypical hyperplasia?	❒	❒	GAIL Model Score: 5 year _____ Lifetime: _____ *(High Risk = 5 yr risk >=1.7%)*

PAST HOSPITALIZATIONS

Have you ever been hospitalized for a medical problem before? **Yes No** Please list below:

Year	Reason for Admission	Date	Physician

ANESTHESIA HISTORY

Have you ever had any problems with anesthesia (being numbed or put to sleep)? **Yes No**	If yes, please indicate which type of anesthesia and check reaction(s) below:

	Reaction	
General Anesthesia	No Problems	Nausea Vomiting Slow Awakening Difficult Intubation Other
IV Sedation	No Problems	Nausea Vomiting Slow Awakening Other
Epidural/Spinal	No Problems	Nausea Vomiting Bleeding Headache Other
Regional Block	No Problems	Insufficient Prolonged Systemic Reaction Other
Local	No Problems	Insufficient Block Heart Palpitations Systemic Reaction Other

Comments:

FAMILY HISTORY ***Please mark all that apply:***

					Maternal		**Paternal**	
	Mother	**Father**	**Brother**	**Sister**	**Grandmother**	**Grandfather**	**Grandmother**	**Grandfather**
Specific Anesthesia problem	❒	❒	❒	❒	❒	❒	❒	❒
CANCER (please list type) under check mark	❒	❒	❒	❒	❒	❒	❒	❒
Cardiovascular:								
High Blood Pressure	❒	❒	❒	❒	❒	❒	❒	❒
Heart Problems	❒	❒	❒	❒	❒	❒	❒	❒
Respiratory:								
Asthma	❒	❒	❒	❒	❒	❒	❒	❒
Lung Cancer	❒	❒	❒	❒	❒	❒	❒	❒
Neurologic:								
Stroke	❒	❒	❒	❒	❒	❒	❒	❒
Hematologic								
Bleeding/clotting problem	❒	❒	❒	❒	❒	❒	❒	❒

REVIEW OF SYSTEMS ***Have you RECENTLY had any of the following problems?***

	Yes	**No**	**Comment**
General Health Problems:			
Fever	❒	❒	What is your current Height: _____ Weight: _____
Chills	❒	❒	
Night Sweats	❒	❒	Current Bra Size (if discussing Breast Surgery): _____
Weight Loss/Gain > 10 lbs/1 month	❒	❒	
Fatigue	❒	❒	Desired Bra Size (if discussing Breast Surgery): _____
Head/Neck Problems:			
New Headache	❒	❒	
Vision/Eye problems	❒	❒	
Earache, loss of hearing	❒	❒	
Chronic sinus infections	❒	❒	
Cardiovascular Problems:			
Blacking out/Fainting	❒	❒	
Bluish discoloration of lips/fingernails	❒	❒	
Chest pain	❒	❒	
Irregular heartbeat/palpitations	❒	❒	
Swelling of ankles	❒	❒	

Respiratory Problems:		
Frequent non-productive cough	❒ ❒	
Frequent productive cough	❒ ❒	
Shortness of breath	❒ ❒	
Short of breath climbing 1 flight of stairs	❒ ❒	
Wheezing	❒ ❒	
Gastrointestinal Problems:		
Difficulty swallowing/food sticking in throat	❒ ❒	
Abdominal pain	❒ ❒	
Constipation	❒ ❒	
Diarrhea	❒ ❒	
Heartburn	❒ ❒	
Nausea	❒ ❒	
Vomiting	❒ ❒	
Blood in stools	❒ ❒	
Black, tar-like stools	❒ ❒	
Neurologic Problems:		
Numbness	❒ ❒	
Tingling	❒ ❒	
Seizures	❒ ❒	
Weakness	❒ ❒	
Urologic Problems:		
Blood in urine	❒ ❒	
Difficulty starting urine stream	❒ ❒	
Burning	❒ ❒	
Leaking of urine	❒ ❒	
Mental and Emotional Problems:		
Depression (requiring treatment)	❒ ❒	
Anxiety (requiring treatment)	❒ ❒	
Endocrine Problems:		
Feel cold all the time	❒ ❒	
Feel hot when others do not	❒ ❒	
Increased appetite	❒ ❒	
Diabetes	❒ ❒	
Thyroid deficiency	❒ ❒	
Thyroid excess	❒ ❒	
Hematologic Problems:		
Swollen Lymph Nodes	❒ ❒	
Bruising easily	❒ ❒	
Bleeding into joints	❒ ❒	
Skin Problems:		
Autoimmune Disorders	❒ ❒	
Itching	❒ ❒	
Rash	❒ ❒	
Burns	❒ ❒	

Signature: _____ Date:_____

PRIVACY NOTICE

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 Privacy Notice is being provided to you by Cosmetic Surgery Associates, LLC, d/b/a Maningas Cosmetic Surgery ("we", "us", or "our"), as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition. If you received this notice electronically, you are entitled to a paper copy of this Privacy Notice. If you received a copy of this notice in paper form, you can find it electronically at www.mcosmeticsurgery.com/resources/hippa-legal.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Maningas Cosmetic Surgery may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless Maningas Cosmetic Surgery has obtained your authorization or the use or disclosure is otherwise permitted by the HIPPA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

A. **TREATMENT.** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a laboratory, pharmacy or other treating physicians.

B. PAYMENT. Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurance company to get approval for the procedure that we have scheduled (i.e. pre-authorization or prior approval). We may also disclose protected health information to your health insurance company to determine your eligibility for benefits or whether a particular service is covered under your plan or to demonstrate medical necessity of the services or as required by your insurance company, for utilization review. We may also disclose protected health information to another provider involved in your case for the other provider's payment activities. This may include disclosure of demographic information to anesthesia care providers.

C. OPERATIONS. We may use or disclose your protected health information as necessary for our own health care operation, to facilitate the function of our surgical facilities, and to provide quality care to all patients. Health care operations include such activities as: quality assessment and administration improvement activities, employee review activities, post-operative patient assessments, training programs, including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensure, or credentialing activities, review and auditing, including compliance review, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities.

D. OTHER USES AND DISCLOSURES. As a part of your treatment, payments, and health care operations, we may also use or disclose your protected health information for the following purposes: to remind you of your surgery date, provide pre-operative instructions and discuss financial arrangements.

USES AND DISCLOSURES BEYOND TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS PERMITTED WITHOUT AUTHORIZATION OR OPPORTUNITY TO OBJECT

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. WHEN LEGALLY REQUIRED. We will disclose your protected health information when we are required to do so by any federal, state, or local law. For example, we may disclose medical information to federal, state, and local law enforcement officials; in response to a judicial order, subpoena, or other lawful process; and to address matters of public interest as required or permitted by law. For example, we are required to disclose medical information about you to the Secretary of the U.S. Department of Health and Human Services if the Secretary is investigating or determining compliance with HIPAA.

B. WHEN THERE ARE RISKS TO PUBLIC HEALTH. We may disclose your protected health information for the following public activities and purposes:

* To prevent, control, or report disease, injury or disability as permitted by law.
* To report vital events such as birth or death as permitted by or required by law.
* To conduct public health surveillance, investigations and interventions as permitted or required by law.
* To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance.
* To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
* To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

C. TO REPORT SUSPECTED ABUSE, NEGLECT, OR DOMESTIC VIOLENCE. We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence when specifically required or authorized by law or when the patient agrees to the disclosure.

D. TO CONDUCT HEALTH OVERSIGHT ACTIVITIES. We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of healthcare or public benefits.

E. IN CONNECTION WITH JUDICIAL AND ADMINISTRATIVE PROCEEDINGS. We may disclose your health information in the course of any judicial or administrative proceedings in response to an order of a court of administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. FOR LAW ENFORCEMENT PURPOSES. We may disclose your health information to a law enforcement official for law enforcement purposes as follows:
* As required by law for reporting of certain types of wounds or other physical injuries.
* Pursuant to court order, court-ordered warrant, subpoena, summons or similar process.
* For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
* Under certain limited circumstances, when you are the victim of a crime.
* To a law enforcement official if we suspect that your health was the result of a crime.
* In an emergency to report a crime.

G. TO CORONER, FUNERAL DIRECTORS, AND ORGAN DONATION. We may disclose health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties.

H. FOR RESEARCH PURPOSES. We may use or disclose your health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

I. IN THE EVENT OF A SERIOUS THREAT TO HEALTH OR SAFETY. We may, consistent with applicable law and ethical standards of conduct, use or disclose your health information if we believe, in good faith that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health and safety or to the health and safety of the public.

J. FOR SPECIFIED GOVERNMENT FUNCTIONS. In certain circumstances, federal regulations authorize us to use or disclose your health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

K. FOR WORKER'S COMPENSATION. We may release your health information to comply with worker's compensation laws or similar programs.

L. TO BUSINESS ASSOCIATES. We may disclose your health information to our business associates (as defined under HIPAA) provided we enter into contracts with these persons requiring them to only use and disclose your health information as we are permitted to do so under HIPAA.

Uses and Disclosure Permitted without Authorization but with Opportunity to Object.

We may disclose your health information to your family member or a close family friend if it is directly relevant to the person's involvement in your surgery or payment related to your surgery. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your health information.

Uses and Disclosures which you Authorize.
Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have acted in reliance upon the authorization.

Your Rights.
You have the following rights regarding your health information:

A. THE RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION. You may inspect and obtain a copy of your health information that is contained in a designated record set for as long as we maintain the health information. A "designated record set" contains medical and billing records and any other records that your surgeon and we use for making decisions about you. Under the federal law, however, you may not inspect or copy the following records:

* Psychotherapy notes. Information compiled in reasonable anticipation, or for use in, a civil, criminal, or administrative action or proceeding; and health information that is subject to a law that prohibits access to health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed. We may deny your request to inspect or copy your health information, if in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced with the information. You have the right to request a review of this decision. To inspect and copy your medical information, you submit a written request to the Privacy Officer whose contact information is listed on the last page of this Privacy Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request. These costs will be made known to you at the time of your request.

B. THE RIGHT TO REQUEST A RESTRICTION ON USES AND DISCLOSURES OF YOUR HEALTH INFORMATION. You may ask us not to use or disclose certain parts of your health information for the purposes of treatment, payment or health care operations. You may also request that we do not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If we do agree to the requested restriction, we will not use or disclose your health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstance, we may terminate our agreement to a restriction.

C. THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION. You may have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request.

D. THE RIGHT TO REQUEST AMENDMENTS TO YOUR HEALTH INFORMATION. You may request an amendment of health information about you in a designated record set for you as long as we maintain this information. In certain cases, we may deny your request. If we deny your request, 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. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.

E. THE RIGHT TO RECEIVE AN ACCOUNTING. You may have the right to request an accounting of certain disclosures of your health information made by us. This right applies to disclosure for purposes other than treatment, payment or health care operations as described in the Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing and authorization form disclosures for our directory, to friends or family members involved in your care, or certain other disclosures we are permitted to

make without your authorization. The request must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. THE RIGHT TO OBTAIN A COPY OF THIS NOTICE. Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of this notice.

Our Duties.
Maningas Cosmetic Surgery is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future health information that we maintain. If the Maningas Cosmetic Surgery changes its Notice, we will provide a copy of the revised Notice by sending a copy of the revised Notice via regular mail or through in-person contact.

Complaints.
You have the right to lodge complaints to Maningas Cosmetic Surgery and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to us by contacting the Privacy Officer verbally or in writing, using the information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person.
Our contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by us, you may submit a complaint to our Privacy Officer at:

Cosmetic Surgery Associates, LLC
d/b/a Maningas Cosmetic Surgery
620 West 32nd St. Suite B
ATTN: Privacy Officer
The Privacy Officer can be contacted by telephone at **417-437-0303**

PATIENT RIGHT AND RESPONSIBILITIES

PATIENT RIGHTS:

- You have the right to prompt and adequate response to reasonable request and needs for treatment or services, within our capacity.
- You have the right to choose a healthcare provider who can give you high quality health care when you need it or to refuse examination or care by a specific healthcare professional. You have the right to refuse to participate in experimental research.
- You have the right to accurate and easily understood information about your health plan, healthcare professionals, and health care facilities. If you speak another language, have a physical or mental disability, or just don't understand something, help will be provided so you can make informed health care decisions.
- You have the right to information regarding services available at Maningas Cosmetic Surgery and the cost of these services.
- You have the right to know your treatment options and to take part in decisions about your care. Parents, guardians, family members, or others that you select can represent you if you cannot make your own decisions.
- You have a right to considerate, respectful care from your doctors, health plan representatives, and other health care providers that does not discriminate against you.
- You have the right to talk privately with health care providers and to have your health care information protected. You also have the right to a copy your own medical record. You have the right to ask that your doctor document in your records any corrections to inaccurate, irrelevant, or incomplete information.
- You have a right to a fair, fast, and objective review of any complaint you have against your health plan, doctors, hospitals or other health care personnel. This includes complaints about waiting times, operating hours, the actions of health care personnel, and the adequacy of the health care facility.
- You have the right upon request to receive a copy of any itemized bill or statement of your charges.
- You have the right to after-hours contact numbers. You may contact a nurse after hours at 417-540-7880. If a medical emergency arises always dial 911
- You have a right to review our payment policy for all services rendered.
- You have a right to review all credentials for the facility and for healthcare professionals.

PATIENT RESPONSIBILITIES:

- You are responsible for providing complete and accurate information to the best of your ability about your health, any medications, including over the counter products and dietary supplements, present complaints, past illnesses, hospitalizations, advanced directives, power of attorney, or other directive that could affect your care, any allergies or sensitivities, and other matters relevant to health or care.
- You are responsible for keeping all appointments or contacting the office 24 hours prior to your appointment to cancel.
- You are responsible to inform Maningas Cosmetic Surgery promptly if you do not understand any matter relating to your care and treatment or instructions with which you cannot comply.
- You are responsible to follow the treatment plan prescribed by your provider.
- You are responsible to be considerate to other patients and to see that any person with you is considerate, particularly with reference to noise.
- You are responsible for providing a responsible driver to transport you home and remain with you for 24 hours if required by your physician.
- You are responsible to observe the smoke-free policy at our office.
- You must accept personal financial responsibility for any charges for services rendered at Maningas Cosmetic Surgery and for any charges not covered by insurance if insurance is filed.
- You are responsible to provide necessary information regarding coverage of your charges.
- You must be respectful to all the health care providers and staff.
- You are responsible for your actions if you refuse treatment or do not follow your provider's instructions.
- You are responsible for all products purchased at Maningas Cosmetic Surgery and understand that these may be prescription products, which are by state law nonrefundable.

PATIENT CONSENT FOR CONSULTATION

I authorize the performance of a consultation and/or examination on my person by or under the supervision of Dr. Talon Maningas. I understand that this consultation may be for evaluative purposes only and that Dr. Talon Maningas shall not be obligated to perform any treatment, cosmetic, or surgical services prior to my execution of a written consent for such procedures. I have read and understood the Privacy Notice and Patient Rights and Responsibility documents. I have been given the opportunity to ask questions and voice any concerns about such documents and all answers have been explained to me in detail. My signature attests my understanding and satisfaction with the answers that have been given and I desire to proceed with the consultation.

Patient Name (Printed): _____ Date: _____
Signature: _____

I am the parent or legal guardian of the above-named minor, and have authority to execute this Patient Consent for Consultation.

Name (Printed): _____ Relationship to Patient: _____
Signature: _____ Date: _____