REGENCY MEDICAL GROUP, PLLC
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MyStarDr.com

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we have shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we have shared information

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1 and/or page 5.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research. **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when a person dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

ADDITIONAL INFORMATION

- We Never market or sell personal information!
- We do not create or manage a hospital directory; do not create or maintain psychotherapy notes; and do not create and will not share substance abuse treatment records without your written permission, unless required by law to do so.

- EFFECTIVE DATE OF NOTICE: June 1, 2015. This Notice replaces any prior versions of our Notice of Privacy Practices.
- OUR PRIVACY OFFICIAL (contact with any questions, problems, or complaints):
  Janice Norville, MSN, MSBA, RN
  Phone: (248) 735-3800
  Email: Janice@MyStarDr.com

* * * * * * * * * * * * * * *

Acknowledgement of Receipt:

Please sign below to acknowledge receipt of a copy of this Notice of Privacy Practices. Your signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature: _____ Date_____

Rev: 4/14/22

Medical History Screening (Patient to complete)

Name: _____ Date: _____

Age: _____ Date of birth: _____ ☐ Male ☐ Female ☐ Non-Binary

List all medications that you take including supplements and herbs:

_____ _____

_____ _____

_____ _____

_____ _____

List all medication allergies and what reaction you had: _____

_____

Do you have, or have you ever had, any of the following medical problems?

	yes	no	Comments
High blood pressure	☐	☐	
Heart problems	☐	☐	
Lung problems (ie asthma, emphysema)	☐	☐	
Diabetes or blood sugar problems.	☐	☐	
Anemia or low blood count	☐	☐	
Kidney problems	☐	☐	
Blood clots or bleeding problems	☐	☐	
Liver problems	☐	☐	
Stomach problems	☐	☐	
Chest pain	☐	☐	
Seizures	☐	☐	
Cancer	☐	☐	
Depression or anxiety	☐	☐	
Have you ever had a problem with anesthesia?	☐	☐	
Do you smoke/vape?	☐	☐	
Do you drink alcohol?	☐	☐	
Do you use Marijana or street drugs?	☐	☐	
Family history of breast cancer	☐	☐	

List all previous surgeries you've had: _____

_____

List your medical doctors name and phone number: _____

Who will assist you with your care after surgery? Name, relationship, phone number:

_____

_____

Patient Signature: _____ Date: _____

Star
PLASTIC SURGERY

WHAT TYPES OF PROCEDURES ARE YOU CONSIDERING?

Liposuction:
- ☐ Abdomen
- ☐ Arms
- ☐ Back
- ☐ Chin / Neck
- ☐ Legs / Hips

Breast Procedure(s):
- ☐ Breast Reduction
- ☐ Breast Lift
- ☐ Breast Augmentation

Face:
- ☐ Full Face
- ☐ Forehead
- ☐ Neck
- ☐ Nose Reshaping
- ☐ Eyelids
- ☐ Chin

Body:
- ☐ Tummy Tuck
- ☐ Brazilian Butt Lift
- ☐ Labiaplasty

☐ **Botox / Fillers**

YOUR EMPLOYMENT

Are you currently employed? ☐ Yes ☐ No

Employer: _____City: _____

What type of work do you do? _____

Have you planned for time off from your job/profession for your surgery and recovery? ☐ Yes ☐ No

When do you plan to have your surgery? Month:_____ Year:_____

I plan to pay for my surgery with: ☐ Cash ☐ Credit Card ☐ Financing ☐ Other _____

COST OF COSMETIC SURGERY

Each patient fee is based upon you, individually. No two patients are alike- even twins. The same rule applies to plastic surgeons. The education, skill and ability of your surgeon should be of utmost importance to you when considering cosmetic surgery.

QUESTIONS YOU HAVE FOR YOUR CONSULTATION:

_____

_____

_____

_____

Signature _____ *Date:* _____

Star
PLASTIC SURGERY

WE DO NOT ACCEPT INSURANCE FOR SURGERY

Name: _____ Date of Birth: _____

Home Address: _____ City:_____ State: _____

Zip Code: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Would you like to receive text message appointment reminders? ☐ Yes ☐ No

Best phone number for us to text or leave a message: _____

Ethnicity: _____ Language: _____

If you do not speak English, who is your interpreter? _____

Gender: ☐ Male ☐ Female ☐ Other Height: _____ Weight:_____

HOW WERE YOU REFERRED TO STAR PLASTIC SURGERY?

Were you referred to us by a physician? ☐ Yes ☐ No Name of referring physician: _____

☐ Referred by friend/relative Name of referring friend/relative: _____

☐ TV/Streaming ☐ Radio ☐ Star Website ☐ Magazine ☐ Facebook ☐ Drive by ☐ Google

☐ Star Instagram ☐ Hydrafacial Instagram ☐ Emsculpt Instagram ☐ Sciton Instagram

Have you ever had cosmetic surgery? ☐ Yes ☐ No If YES, please complete the following information:

1. Type of cosmetic surgery: _____Date of surgery: _____/_____/_____

Physician name: _____

2. Type of cosmetic surgery: _____Date of surgery: _____/_____/_____

Physician name: _____

3. Type of cosmetic surgery: _____Date of surgery: _____/_____/_____

Physician name: _____

How long have you been thinking about having cosmetic surgery? ☐ 6 months ☐ 1 year ☐ 2+ years

Star
PLASTIC SURGERY

PRE-SKINCARE ASSESSMENT

Patient name:_____ Date:_____

Patient Information

_____

Address City State Zip

_____

Home Phone Work Phone Email

_____

How were you referred to us?

Describe your key skin concerns (select all that apply):

- ☐ Fine lines, frown lines, and wrinkles
- ☐ Uneven skin tone
- ☐ Skin texture or scars
- ☐ Dry, dull skin
- ☐ Acne
- ☐ Unwanted hair
- ☐ Brown spots or sun damage
- ☐ Skin laxity
- ☐ Other: _____

Primary reason for today's visit:

_____

Phase I: Patient Assessment

Check all that apply

☐ Are you currently under a physicians care?

For what?_____

☐ Previous facial surgery (what and when)

_____

☐ Have you recently used Accutane or topical medications? (include name and dosage)

_____

☐ Have you recently had laser treatments? (where)

_____

☐ I scar easily

☐ I take fish oils/flax seed oil

☐ I drink alcohol

☐ I smoke

Do you have any of the following:

- ☐ Rheumatoid arthritis
- ☐ Connective tissue disease
- ☐ Lupus or any autoimmune disease
- ☐ Ulcerative colitis (IBS)
- ☐ Multiple sclerosis
- ☐ Active acne or infection
- ☐ Open lesion or cold sore
- ☐ Active sunburn
- ☐ Skin conditions such as eczema, psoriasis, dermatitis, or rashes
- ☐ A viral concern such as HIV or hepatitis
- ☐ Anticoagulants Therapy
- ☐ Melanoma or lesions suspected of malignancy
- ☐ Pregnancy or lactation
- ☐ Neurological disorders such as epilepsy
- ☐ Infection in the urinary system
- ☐ Crohn's Disease (Lymphatic Drainage)
- ☐ Hyperthyroidism (Lymphatic drainage)
- ☐ Deep Venous Thrombosis (Lymphatic drainage)
- ☐ Lymphedema (Lymphatic drainage)
- ☐ Blood disorder or clotting issue
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Hormone imbalance
- ☐ Sensitive teeth
- ☐ Vision deficits

Please indicate how often you use the following:

- ☐ Blood thinners: _____
- ☐ Aspirin: _____
- ☐ Non-Steroidal (Aleve, Advil, Ibuprofen, Motrin, Celebrex): _____
- ☐ Multivitamins: _____
- ☐ Herbal supplements (Ginko, Ginseng, Garlic, Tumeric)

Medications:

☐ Current prescription medications (include name and dosage) including topicals:

_____

_____

Do you have any allergies to:

☐ Medications: _____

☐ Seasonal:_____

☐ Specific foods: _____

Questions about your skin:

1. Are your present skin concerns getting more pronounced? ☐ Yes ☐ No
2. Have you ever had laser/IPL hair removal? ☐ Yes ☐ No
3. Have you used the following hair removal methods in the past 6 weeks?

   ☐ shaving ☐ waxing ☐ electrolysis ☐ plucking/tweezing ☐ stringing ☐ depilatories
4. Have you ever had skin resurfacing or rejuvenation or chemical peels? ☐ Yes ☐ No
5. Do you form thick or raised scars from cuts or burns? ☐ Yes ☐ No
6. Do you experience hyperpigmentation (redness) from burns, cuts, or insect bites? ☐ Yes ☐ No
7. When were you last exposed to the sun or a tanning booth? _____
8. Are you planning a vacation in the sun? ☐ Yes ☐ No
9. Have you ever had treatment for pigmented lesions? ☐ Yes ☐ No

For female patients:

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No

Have you ever had:

Previous injections:

☐ Juvederm or Restylane:_____

☐ Sculptra, date of injection(s):_____

☐ Bellafill, date of injection(s):_____

☐ Radiesse, date of injection(s): _____

☐ Silicone, date of injection(s):_____

Previous reaction(s) to:

- ☐ Botox, Dysport, or Xeomin
- ☐ Dermal Fillers

Reactions include: bruising, swelling, infection/inflammation/discoloration of skin, hard knot around injection site, prolonged redness, poor healing or scabbed injection site(s)

Include specific description:_____

Do you have plans for:

- ☐ Air travel within 24 hours of dermal filler treatment planned
- ☐ Future social events planned within the next two weeks

I agree to inform the treatment provider at my next visit if I have any changes in my health or if my medications change.

_____ _____

Patient Signature Date

_____ _____

Reviewed by (medical staff signature) Date

Please leave blank if you are not requesting anything done to your face.

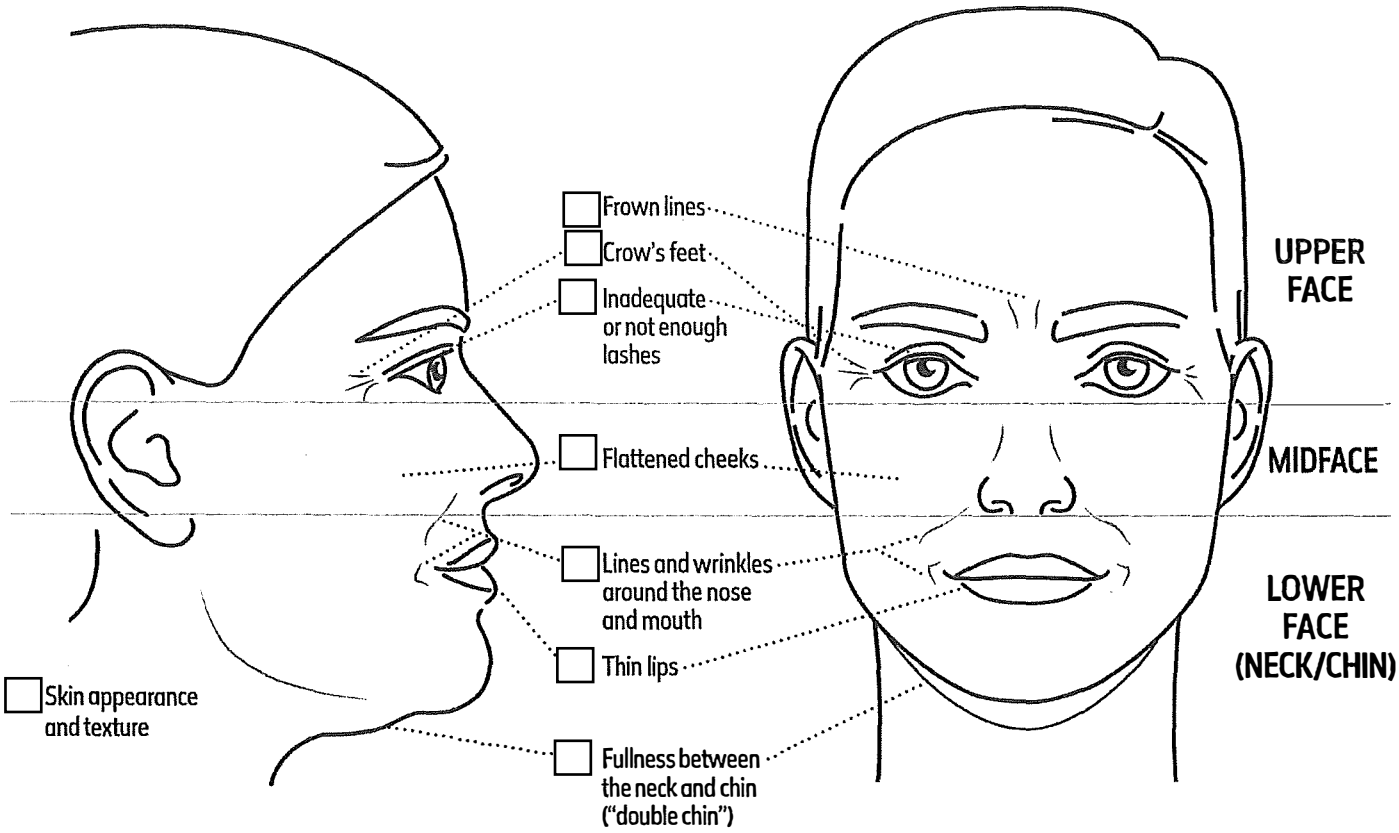
SELF-ASSESSMENT

NAME: _____ DATE OF BIRTH: _____ DATE: _____

What brings you in today? _____

Select which areas of the face concern you on the diagram below.

By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you.



Please complete and return this form to the front office before your consultation.