ASPEN
After Surgery Center

PATIENT INTAKE FORM

REFERRED BY: ______________________________________ FIRST VISIT: ___________

PATIENT NAME _________________________________ SS# ___________________________________

ADDRESS ____ CITY __________________STATE______

ZIP CODE_____________ HOME #_______________________WORK/CELL # ______________________

D.O.B. ______________E-MAIL ______________________________________

EMPLOYER ______________________________________ PH#_____________________

SPOUSE'S EMPLOYER_____________________________ PH# ______________________

DIAGNOSIS/CHIEF COMPLAINT ____

REFERRING PHYSICIAN _________________________ OFFICE # ________________________________

PRIMARY PHYSICIAN ___________________________ OFFICE # ________________________________

EMERGENCY NAME/NUMBER:____

Patient Name: ______________________________

Patient History Questionnaire (Capsular Contracture)

Date of your last surgery: ____________ How long after surgery did you notice a change/problem?__________

Onset date of your change/problem:___________ Have you had this problem before? Yes ☐ No ☐

What type of changes occurred? (please check all that apply to you):

Pain ☐ Scar ☐ Position ☐ Firmness ☐ Other ☐ If other, please explain____________________________

Patient's past medical history: Please check all that apply to you.

Diabetes	☐	Pacemaker/ implantable defibrillator?	☐
Cancer	☐	Hypertension/High Blood Pressure	☐
Heart Disease/Angina	☐	Shortness of Breath/ Asthma	☐
Allergies (Medication)	☐	Stroke	☐
Are you allergic to Latex?	☐	Osteoporosis/ Rib /Spine fractures in past	☐
Balance Disorders	☐	If applicable, are you pregnant?	☐

After / Before Surgery do/ did you?

Have excessive bruising / black and blue marks Yes ☐ No ☐ Smoke/Use Tobacco Yes ☐ No ☐

Become pregnant or breast feed Yes ☐ No ☐ Return to gym before 6 weeks Yes ☐ No ☐

Have infection in breast/ incision Yes ☐ No ☐ Have any dental cleaning/work Yes ☐ No ☐

Sustain trauma or injury to breast Yes ☐ No ☐ Have seroma or hematoma drained Yes ☐ No ☐

Type of implant: Silicone/ Saline/ Other:______ Implant Above/Below Muscle:______ Implant size :_______cc's

Other issues you feel relates to start of condition:____

What are your goals in coming to therapy? ____

How are you limited in your day-to-day activities? ____

Cultural/Religious- Any customs or religious beliefs or wishes that might affect care? __________________

Occupation: ____

Do you exercise regularly? Yes ☐ No ☐ If yes, how often? _____________ How long? ____________

What type of exercise do you do?____

Do you have difficulty sleeping because of your problem? Yes ☐ No ☐

How do you best learn? ☐ Pictures ☐ Reading ☐ Listening ☐ Demonstration

Patient Name: ______________________________

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Please list all medications you are currently taking:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Please list any surgeries you have had (chronological order) and the date(s) of that surgery below:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

1. On a scale from 0-10 (**10 being worst** hardness and **0 normal** softness) what number would you say your breast implant firmness is now? (Please Circle): 0 1 2 3 4 5 6 7 8 9 10

2. On a scale from 0-10 (**10 being worst** shape/position and **0 normal** shape/position) what degree would you say your breast(s) is now? (Please Circle): 0 1 2 3 4 5 6 7 8 9 10

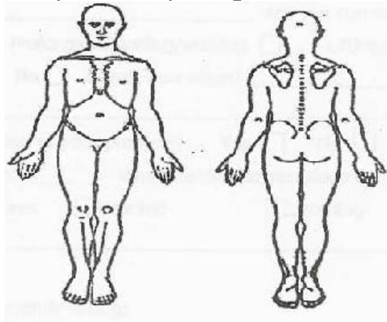
PAIN BEHAVIOR: Please **CHECK** any items below that apply to you.

Aching ☐	Throbbing ☐	Sharp ☐	Firmness ☐
Electric/Shooting ☐	Tightness ☐	On/Off ☐	

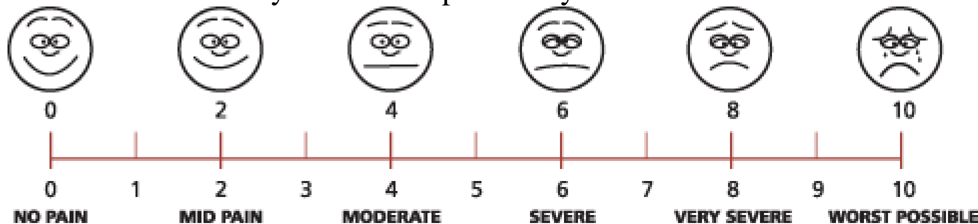
Your pain is worse: Please **CHECK** any items below that apply to you.

Lifting arm ☐	Exercising ☐	Standing ☐	Lying on tummy ☐	Lying on side ☐
In AM ☐	As day progresses ☐	In PM ☐	At rest ☐	On the move ☐

Mark on the drawing below the areas where you feel your pain or where your problem area is .



Please circle the number that reflects your level of pain today.



Signature: ______________________________ Date: ____________________

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Broward County, Florida

CONSENT TO PHOTOGRAPH

The Undersigned does hereby authorize ASPEN REHABILITATION TECHNOLOGIES, LLC to photograph or permit other persons to photograph (**Print name**) ________________________ while a patient, and agrees that they may use or permit other persons to use the negatives or prints prepared there from for such purposes as evaluation of progress, treatment, research, and in such manner as may be deemed necessary. This consent is expressly intended to release from liability all of the above-named facility's personnel and consultants.

Photograph to be taken by Aspen Rehab Technologies, LLC Staff.

Purpose of photograph is for Research, Document Progress, and share with physician.

Signed ______________________________
Patient to be photographed

____
Witness

____
Date

____
Hour

PATIENT CONFIDENTIALITY, NON-DISCLOSURE, and NON-COMPETE AGREEMENT

The following is a CONFIDENTIALITY, NON-DISCLOSURE, and NON-COMPETE AGREEMENT with ASPEN REHAB TECHNOLOGIES, LLC (hereafter referred to as the 'Company'), and I (Print), ___________________________ (hereafter referred to as "Patient") this agreement is in consideration for providing treatment services as a patient I agree to the following.

I agree at all times during treatment, discussion, training, and as a patient with the Company, to hold in strictest confidence, and not to use, except for the benefit of the Company, or for the direct treatment of myself, the patient, to not disclose to any and all staff members of my referring physician, physician partners, other medical professionals, persons, firms, or corporations without written authorization from Tim Weyant, CEO Aspen Rehab Technologies, LLC, any Confidential Information of the Company.

I understand Confidential Information includes treatment techniques, manual therapy maneuvers, massage techniques, medical equipment treatment parameters or protocols including, but not limited to: Ultrasound usage or E-stim applications, and bandaging and compression garment techniques. I also agree not to compete or disclose to: referring physicians, referral sources, data, trade secrets, or knowledge, including but not limited to: research, product plans, products, services, customer lists and customers (including, but not limited to: customers of the Company on whom I called or with whom I became acquainted during the term of business), markets, software, developments, inventions, processes, formulas, technology, designs, drawings, engineering, hardware configuration information, marketing, finances, and other business information disclosed to me by the Company, either directly or indirectly in writing, orally, or by drawings or observation of parts or equipment.

I further understand that Confidential Information does not include any of the foregoing items if they have become publicly known and made generally available through no wrongful act of the Patient, or others who were under confidentiality obligations as to the material involved. This includes already established referral sources, physician's offices, and marketing programs, established by the Patient, prior to commencement of business with the Company.

I agree that I will not, during discussion, training, and treatment as a Patient, improperly use or disclose any proprietary information or trade secrets to any former or concurrent employer or business entity. This includes use or disclosure to any and all members of licensed and unlicensed staff, friends, or family members of the Patient. I will not bring onto the premises of the Company any unpublished document or proprietary information belonging to any such employer, person, or entity unless consented to in writing by such employer, person, or entity. I understand that the aforementioned proprietary information is held as patent protected within these United States and enforceable under United States Patent law.

I agree that during discussion, training, and treatment as a Patient, or should treatment be terminated by either party, I will deliver to the Company (and will not keep in my possession, recreate, or deliver to anyone else) any and all documentation, notes, items developed or supplied by the Company, and Tim Weyant, pursuant to discussion with the Company or otherwise belonging to the Company, its successors, or assigns.

At all times while this agreement is in force and after its expiration or termination, I agree to refrain from competing with, disclosing, or soliciting the Company's referring physicians, public markets including print, radio, or television, customer lists, trade secrets, or other confidential material. I agree to take reasonable security measures to prevent accidental disclosure and industrial espionage.

While this agreement is in force, I agree to use my best efforts at performing his/her job, and to abide by the non-disclosure and non-competition terms of this agreement.

After expiration or termination of this agreement, I agree not to compete with the Company and/or Tim Weyant unless express written authorization has been given by the Company.

IN WITNESS, a representative of the Company and I have signed this agreement.

Patient, Representative
Name:

Signature Date:

For The Company

Signature: Date:

AUTHORIZATION AND CONSENT FOR TREATMENT

1. I, the undersigned, acting on my behalf or as the legally authorized representative of patient stated below, do consent for treatment provided by SMART HEALTH SOLUTIONS, P.A. doing business as **Aspen Rehabilitation**. I agree to treatment by its employees, independent contractors, and business associates, which relate to care and treatment as designated. .

2. I understand and acknowledge that I am fully responsible for payment and any charges for care and services provided by Aspen Rehabilitation. If I am entitled to benefits or insurance of any kind from any policy of insurance, including, but not limited to: Medicare, Personal Injury Protection (PIP), or other auto and liability insurance covering me, or any party liable to me, I authorize payment of these benefits directly to Aspen Rehabilitation. I further understand and acknowledge that Aspen Rehabilitation will bill me for any co-payment and/or balance after my insurance carrier has paid or denied my claim, and will be responsible for any balance not paid. I further understand that Aspen Rehabilitation may send any outstanding unpaid balances to a collection agency to recover funds unpaid and that the cost of collections will be included in the outstanding balance owed. _______ (initials)

Initial Evaluation $160	Treatment	$1791	$2241
		UNILATERAL	BILATERAL

3. I understand that Aspen Rehabilitation may share my medical information, without my consent or express authorization, to my physician, providers, payers, business associates, and other entities for the purpose of treatment, payment, or healthcare services. My signature below authorizes this sharing of my information and that no information will be shared, used, disseminated, and collected for any other purposes than previously described.

4. I understand that Aspen Rehabilitation will provide therapy services that with diagnosis and treatment may involve risk and injury. I acknowledge that no guarantees have been made to me as a result of examination, care, or treatment. I acknowledge that I have the right to request an explanation of risks and benefits from services provided.

5. **I acknowledge that therapeutic treatment for post-cosmetic surgery may involve tissue manipulation of the affected areas, which may include breasts, buttocks, or abdominal region. I understand that all efforts will be made to ensure a female therapist will provide treatment; but that a male therapist may at times provide an initial evaluation and periodic follow-up treatment. I understand that in the event a male therapist is providing treatment, a female staff member will be present throughout the session.**

6. I understand that Aspen Rehabilitation is not legally responsible for the acts and omissions of its independent contractors.

7. I understand that Aspen Rehabilitation's Cancellation Policy requires 24 hours notice or a $40 charge may be imposed. This also applies when I arrive at least 15 minutes late to an appointment. I also understand that not showing for appointments without cancellation on two (2) or more occasions may result in being discharged from therapy services. _______ (initials)

8. I hereby acknowledge that I have received a copy of Aspen Rehabilitation's NOTICE OF PRIVACY PRACTICES for my review, prior to receiving initial services from Aspen Rehabilitation, either now or in the past.

SIGNED: ____ **DATE**: ______________________

Relationship to patient: ____

Patient unable to consent due to: ____

AESTHETIC SURGICAL MANAGEMENT
9900 W. Sample Rd., Suite 102
Coral Springs, FL 33065
Office: (954) 341-7875
Fax: (954) 341-7895

Authorization to Release Medical Information/HIPPA Compliance

Patient Name: ____________________________ Date of Birth: __________________

Address: ________________________________ Phone: ___________________

City: ______________________ State: _____________ Zip: ______________

I authorize the release of the following protected health information:

□ **Name of Plastic Surgeon** ____

□ Other: _________________ □ Paper Copy □ Electronic Copy

The purpose for this request to release medical information is:

□ **Treatment** □ Other (specify) _________________________

Send my medical information to: Name: ____

Address: _______________________________________

City, State, Zip: __________________________________

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for healthcare.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Aspen Rehabilitation shall not be held liable for any consequences resulting from re-disclosure.
- If the information to be release contains any information about HIV/AIDS and additional HIPPAA release of medical Information for will be requested.
- Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released
- A copy of this signed form will be provided to me.
- Aspen Rehabilitation may charge and administrative fee to cover cost of labor, copying, and postage. The physician's office will inform me of any charges and arrange for payment.
- This Authorization Expires on _____/____/____ (if date not completed/ one year after signed)

Patient/ Representative Signature _____________________ Date: ______________________