DIEHL PLASTIC SURGERY
Cynthia Diehl M.D.
10208 Cerny Street; Suite 204
Raleigh, NC 27617

INFORMACIÓN DEL PACIENTE

NOMBRE: _____
APELLIDOS NOMBRE

DIRECCIÓN: _____
CALLE CIUDAD ESTADO ZIP

Casa TELÉFONO: _____ FECHA DE NACIMIENTO_____/_____/_____ AGE_____

Celular TELÉFONO: _____ SEXO_____

ESTADO CIVIL_____

Raza: Blanca Afro-Americana Hispana Asiatica Otro: _____

EMAIL: _____

Modo preferido de contactarnos con Ud: _____ Dejar mensaje? Si / No

Por favor, indique si quiere recibir nueva información Si / No

Por que medio se entero de nuestro consultorio?

☐ Internet ☐ La refirio otro doctor, un aviso _____ ☐ Amigo/familiar _____
☐ Otro _____

Contacto de Emergencia Nombre: _____ Telefono: _____ Relacion: _____

1. Razon principal por la cual ha venido a nuestro consultorio?_____

   _____

2. Que procedimientos esteticos ha tenido Ud. En el pasado? _____

   _____

3. Si ha tenido alguno, esta Ud. Satisfecho/Satisfecha con los resultados? Si / No

4. Tiene alguna pregunta o preocupacion respecto a algun tratamiento o procedimiento estetico? Si / No
   Si tien alguno, puede identificarl el que la preocupa? _____

_____ _____
Firma del Paciente Feca Fecha

CYNTHIA DIEHL, MD
DIEHL PLASTIC SURGERY, PLLC

NOMBRE:_____ **FICHA #:**_____
APELLIDOS NOMBRE

FECHA DE NACIMIENTO _____/_____/_____

ALTURA_____

FECHA DE ÚLTIMO EXAMEN FÍSICO_____ **PESO**_____

ENUMERE ALERGIAS A ALIMENTOS Y A MEDICAMENTOS_____

ES UD. ALÉRGICO O SENSIBLE AL LATEX?_____

ENUMERE TODOS LOS MEDICAMENTOS (*INCLUYE MEDICAMENTOS SIN PRESCRIPCIÓN MÉDICAY MEDICINAS HOMEOPÁTICAS*)

	MEDICINA	DOSIS	FRECUENCIA
1.			
2.			
3.			
4.			
5.			

CUÁL ES SU PROMEDIO DE CONSUMO DE **TIENE SOSPECHAS DE ESTAR EMBARAZADA?**_____

TABACO_____paquetes diarios **ALCOHOL**_____ **FECHA DE ÚLTIMA MAMOGRAFÍA**_____

ENUMERE TODAS LAS INTERVENCIONES QUIRÚRGICAS QUE HAYA TENIDO

	INTERVENCIÓN	AÑO	MÉDICO CIRUJANO
1.			
2.			
3.			
4.			

HA SIDO UD. HOSPITALIZADA POR ALGÚN MOTIVO APARTE DE UN PARTO?_____

TIENE UD. O ALGÚN PARIENTE PROBLEMAS CON LA ANESTESIA?_____

TIENE O HA TENIDO ALGUNA VEZ ALGÚN PROBLEMA CON:

_____ 1. Problemas cardíacos, Presión alta
_____ 2. Asma, Problemas de Pulmones, Falta de aliento
_____ 3. Diabetes
_____ 4. Ictericia, Hepatitis, Problemas de Hígado
_____ 5. Dolores de cabeza crónicos
_____ 6. Dolores de Pierna, Espalda, o Cuello
_____ 7. Problemas de Mamas
_____ 8. Desmayos
_____ 9. Glaucoma
_____ 10. Cáncer
_____ 11. Hemorragias
_____ 12. Convulsiones
_____ 13. Problemas de Riñones
_____ 14. Problemas de Piel
_____ 15. Fiebre Escarlatina / Reumática
_____ 16. Cicatriz Queloide
_____ 17. Cuágulos
_____ 18. Estómago / Intestino
_____ 19. Problemas Emocionales / Psiquiátricos

ENUMERE LA HISTORIA FAMILIAR DE ENFERMEDADES SIGNIFICATIVAS (*cuágulos, diabetes, problemas cardíacos, melanoma ,Hipertermia Maligna*)

_____

POR FAVOR DESCRIBA CUALQUIER INFORMACIÓN MEDICA QUE NOS PUEDA SER ÚTIL

_____

FIRMA_____ **FECHA**_____

Rev. 2/8/2011

Reviewed by: _____

Raleigh Face & Body

Diehl Plastic Surgery, PLLC

Cynthia Diehl, M.D.

Nombre: _____ Fecha De Nacimiento: _____

Procedimiento de lista de intereses

Háganos saber si podemos proporcionar más información sobre cualquiera de los siguientes tratamientos y / o procedimientos que proporcionamos en nuestra oficina:

- ☐ Liposuccion
- ☐ Botox / Dysport
- ☐ Reduccion de busto
- ☐ Labioplastia
- ☐ Rellenos dérmicos
- ☐ miraDry (sudor/olor en las axilas)
- ☐ CoolSculpting
- ☐ Agrandamiento de labios
- ☐ Incontinencia urinario
- ☐ Smart Lipo MPX (liposuccion laser)
- ☐ Reparación del lóbulo de la oreja
- ☐ Rejuvenecimiento vaginal (ThermiVa)
- ☐ Liposuccion Submental (cuello)
- ☐ Cellfina (tratamiento de celulitis)
- ☐ SkinPen / Microneedling
- ☐ SmartByte (control de peso)
- ☐ Estiramiento facial
- ☐ Levantamiento de cejas
- ☐ Elevación del cuello
- ☐ Cirugía de párpado
- ☐ Cirugía de nariz (Rinoplastia)
- ☐ Cirugía de orejas (otoplastia)
- ☐ Abdominoplastia
- ☐ Injerto de grasa
- ☐ Cirugía facial de revisión
- ☐ Implante de mentón (barbilla)
- ☐ exfoliación química para la cara
- ☐ Productos Avanzado para la piel
- ☐ Rejuvenecimiento de piel
- ☐ Dermaplaning / Dermablading
- ☐ Restauración Capilar

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Nombre_____ **Fecha de Nacimiento** _____

RECIBO DE AVISO DE LA PRIVACIDAD DEL PACIENTE

Yo dejo constancia que he recibido una copia de aviso de confidencialidad del paciente de Diehl Plastic Surgery. Este aviso describe cómo Diehl Plastic Surgery puede usar y/o divulgar mi estado de salud, así como las restricciones de uso de dicha información y los derechos que yo pueda tener sobre la confidencialidad de la información de mi salud.

_____ _____
Firma del paciente o representante Fecha

_____
Relación con el paciente

TARJETA DE CRÉDITO- HIPAA

DIEHL PLASTIC SURGERY REQUIRE UN PERMISO FIRMADO POR EL PACIENTE CUANDO SE USA LA TARJETA DE CRÉDITO PARA UN PROCEDIMIENTO O INTERVENCION EN ESTA OFICINA. SI HAY UNA DISPUTA CON LA COMPAÑÍA DE CRÉDITO DEBIDO A UN PROCEDIMIENTO RELACIONADO CON ESTA OFICINA, TENEMOS QUE TENER LA AUTORIZACIÓN DEL PACIENTE PARA RESPONDER ADECUADAMENTE A LA INFORMACIÓN REQUERIDA POR EL BANCO O CUALQUIER OTRA ORGANIZACIÓN RELACIONADA CON ESA TRANSACCIÓN.

VALORAMOS SU PRIVACIDAD Y PROMETEMOS QUE EL PERSONAL DE DIEHL PLASTIC SURGERY NO DIVULGARÁ INFORMACIÓN SALVO QUE SEA NECESARIO PARA RESOLVER LA DISPUTA.

GRACIAS POR SU COOPERACIÓN

_____ _____
Firma Fecha

COVID-19 RISK INFORMED CONSENT

I _____ (patient name) understand that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that Dr. Cynthia Diehl or Dr. Shruti Tannan and all the staff at Diehl Plastic Surgery and Tannan Plastic Surgery are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for Dr. Cynthia Diehl or Dr. Shruti Tannan and all the staff at Diehl Plastic Surgery and Tannan Plastic Surgery to proceed with the same.

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.

I have been given the option to defer my treatment/procedure/surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery.

INFORMED CONSENT FOR COVID-19 RISK

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

_____ _____

Patient or Person Authorized to Sign for Patient Date/Time

Witness _____ Date/Time _____

COVID-19 INFORMED CONSENT AGREEMENT

Please read this form, Write your initials in each box and sign at the bottom.

_____ I, the undersigned patient, consent to have my Doctor and/or his/her staff (hereinafter collectively "my Doctor") perform medical procedures, whether regarded as necessary, elective or aesthetic, during the time of the COVID-19 pandemic and after. I understand having my procedure performed at this time, despite my own efforts and those of my Doctor, may increase the risk of my exposure to COVID-19. I am aware that exposure to COVID-19 can result in severe illness, intensive therapies, extended intubation and/or ventilator support, life-altering changes to my health, and even death. I am also aware of the possibility that the procedure itself, whether performed in my Doctor's office or in a hospital, may result in a more severe case of COVID-19 than I might have had without the procedure.

_____ I also understand having my procedure performed at this time increases the risk of my transmission of COVID-19 to my Doctor. This virus has a long incubation period, there may be as yet unknown aspects of its transmission, and I realize that I may be contagious, whether or not I have been tested or have symptoms. To reduce the possibility of COVID-19 exposure or transmission at my Doctor's office, I accept that my Doctor will implement infection-control procedures with which I must comply, before, during and after my procedure, for my own protection as well as that of my Doctor. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures to be necessary.

_____ I have informed my Doctor of any COVID-19 testing I or any person living with me during the past 14 days has received, as well as the results of that testing, and if I am tested between now and the date of my procedure, I will immediately provide the results of that testing to my Doctor. I understand my Doctor may require that I be tested, possibly at my own expense and regardless of any prior testing, and that the results of that testing must be satisfactory to my Doctor, before I may receive my procedure.

_____ I confirm neither I nor any individual living with me has any of the COVID-19 symptoms listed by the Centers for Disease Control https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf, which website I have consulted; neither I nor any individual living with me during the past 14 days has experienced any such symptoms; and that I and all persons living with me for the past 14 days have practiced all personal hygiene, social distancing and other COVID-19 recommendations contained within all governmental orders issued by my city and state. I understand I must honestly disclose this information to avoid putting myself and others at risk.

_____ All topics above have been discussed with me, and all my questions have been answered to my satisfaction. Being fully informed, I accept the risk of COVID-19 exposure and I will bear the cost of any COVID-19 treatments required. I have been given the opportunity to postpone my procedure until the COVID-19 pandemic is less prevalent, but I choose to have my procedure performed now. If I am the parent, guardian or conservator of the patient, I hold his/her health care power of attorney. I have read this COVID-19 Informed Consent Agreement and am authorized to consent on the patient's behalf.

_____ _____ _____

Patient/Authorized Representative Signature and Initials Print Name & Date

The Aesthetic Society

Notice and Disclaimer. Medical information changes constantly. This COVID-19 Informed Consent Agreement sets forth the current recommendations of The Aesthetic Society, is provided for informational purposes only, and does not establish a new standard of care. April 25, 2020

Diehl Plastic Surgery
10208 Cerny Street; Suite 204, Raleigh, NC 27617

Notice of Privacy Practices
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.

About Us
In this Notice, we use terms like "we," "us" or "our" to refer to Diehl Plastic Surgery, its physicians, employees, staff and other personnel. All of the sites and locations of Diehl Plastic Surgery follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes as described in this Notice.

Purpose of this Notice
This Notice describes how we may use and disclose your health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibilities
We are required by law to maintain the privacy of your health information and provide you notice of our legal duties and privacy practices with respect to your health information. We will abide by the terms of this Notice.

How We May Use or Disclose Your Health Information
The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use your health information to provide you with medical treatment or services. For example, your health information will be disclosed to the oncology nurses who participate in your care. We may disclose your health information to your physician or another healthcare provider to be sure those parties have all the information necessary to diagnose and treat you.

For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

We may share your health information with pharmaceutical company patient assistance programs and patient support organizations in order to assist you in obtaining payment for your care or payment for certain parts of your care.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities.

We may ask you to sign your name to a sign-in sheet at the registration desk and we may call your name in the waiting room when we call you for your appointment.

We may disclose your health information to a third party that performs services, such as billing and collections, on our behalf. In these cases, we will enter into a written agreement with the third party to ensure they protect the privacy of your health information.

Appointment Reminders: We may use and disclose your health information in order to contact you and remind you of an upcoming appointment for treatment or health care services.

Treatment Alternatives and Health-Related Benefits and Services: We may use your health information to inform you of services or programs that we believe would be beneficial to you. We may call, mail or email you information about these services or goods. For example, we may contact you to make you aware of new products, supply product information, or new patient assistance programs that may be available to you.

Individuals Involved in Your Care or Payment for Your Care: We may release your health information, including information about your conditions, to a family member or friend who is involved in your medical care or who helps pay for your care. If you would like us to refrain from releasing your health information to a family member or friend, please notify Diehl Plastic Surgery. We may also disclose your health information to disaster-relief organizations so that your family can be notified about your condition, status or location.

We are also allowed by law to use and disclose your health information without your authorization for the following purposes:

As Required by Law: We may use and disclose your health information when required to do so by federal, state or local law.

Judicial and Administrative Proceedings: If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the healthcare system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

Law Enforcement: We may disclose your health information, within limitations, to law enforcement officials for several different purposes:
- To comply with a court order, warrant, subpoena, summons, or other similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime, if unable to obtain the victim's agreement;
- About a death we suspect may have resulted from criminal conduct;
- About criminal conduct we believe in good faith to have occurred on our premises; and
- To report a crime, the location of a crime, and the identity, description and location of the individual who committed the crime, in an emergency situation.

Public Health Activities: We may use and disclose your health information for public health activities, including the following:
- To prevent or control disease, injury, or disability;
- To report births or deaths;
- To report child abuse or neglect;
- To report adverse events, product defects or problems;
- To track FDA-regulated products;
- To notify people and enable product recalls; and
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition.

Serious Threat to Health or Safety: If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information to someone able to help prevent the threat.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank.

Coroners, Medical Examiners, and Funeral Directors: We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

Workers' Compensation: We may disclose your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose your health information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Military and Veterans Activities: If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose your health information to authorized federal officials so they may provide protective services for the President and others, including foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing you health care, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.

Research: We may use and disclose your health information for certain limited research purposes. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project, assesses a number of specific issues, and determines that appropriate privacy safeguards are in place to allow the use of health information in the research project. We may, however, disclose your health information to people preparing to conduct a research project; for example, to help them look for patients with specific medical needs, so long as the health information they review does not leave the practice.

Other Uses and Disclosures of Your Health Information: Other uses and disclosures of your health information not covered by this Notice or the laws that apply to us will be made only with your authorization. If you authorize us to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by the revoked authorization, except to the extent that we have taken action in reliance on your authorization.

Your Rights Regarding Your Health Information

Right to Request Restrictions: You have the right to request restrictions on how we use and disclose your health information for treatment, payment or healthcare operations. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing and submit it to Diehl Plastic Surgery, 10208 Cerny Street, Ste. 204, Raleigh NC 27617.

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail. To request confidential communications, you must make your request in writing and submit it to Diehl Plastic Surgery, 10208 Cerny Street, Ste 204, Raleigh NC 27617.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes or information that is compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceedings. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us and submitting it to Diehl Plastic Surgery, 10208 Cerny Street, Ste 204, Raleigh NC 27617. If you request a copy of your health information, we may charge a fee for the costs of copying, mailing or preparing the requested documents.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to Diehl Plastic Surgery, 10208 Cerny Street, Ste 204, Raleigh NC 27617. We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity to file a written statement of disagreement with us.

Right to an Accounting of Disclosures: You have the right to request an accounting of certain disclosures we make of your health information. Please note that certain disclosures, such as those made for treatment, payment or health care operations, need not be included in the accounting we provide to you.

To Request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by us and submitting it to Diehl Plastic Surgery, 10208 Cerny Street, Ste 204, Raleigh NC 27617. Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact Diehl Plastic Surgery, 10208 Cerny Street, Ste 204, Raleigh NC 27617.

Right to Complain: If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquires to Diehl Plastic Surgery, 10208 Cerny Street, Ste 204, Raleigh NC 27617. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against or penalized for filing a complaint.