SOLOMON S. BRICKMAN, M.D., P.A., F.R.C.P (C)

PATIENT INFORMATION

PATIENT: _____ DATE: _____
(FIRST) (MIDDLE) (LAST)

DOB: _____ SOCIAL SECURITY: _____ SEX: (M) OR (F)

(SINGLE) (MARRIED) (WIDOW) (DIVORCED)

WHO REFERRED YOU TO DR. BRICKMAN _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

OCCUPATION: _____ BUSINESS PHONE: _____

EMPLOYER: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SPOUSE NAME: _____ BUSINESS PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

POLICY HOLDER NAME: _____ DOB: _____ RELATIONSHIP _____

EMPLOYER: _____

SOCIAL SECURITY NUMBER OF POLICY HOLDER: _____

OUR OFFICE DOES NOT FILE WITH ANY SECONDARY INSURANCE.

PHARMACY INFORMATION

PHARMACY NAME: _____

PHARMACY NUMBER: _____

COSMETIC INTEREST QUESTIONNAIRE

Patient Name: _____ Date: _____

Health issues and procedures or products of interest to you (please check all that apply).

- ○ BOTOX® Cosmetic
- ○ Chemical Peels
- ○ Collagen Therapy
- ○ Skin Rejuvenation
- ○ Fine Lines: Tazorac & Retin- A
- ○ Microlaser Peel
- ○ Acne
- ○ Reduction of Acne Scars
- ○ Spider Vein Treatment
- ○ Scar Improvement
- ○ Cosmetic Fillers: Juvederm & Radiesse
- ○ Skin Care Products
- ○ Birthmarks
- ○ Liver Spot/Age Spots/Sun Spots
- ○ Sunscreen Advice
- ○ Removing Leg Veins
- ○ Reduction of Surgical Scars
- ○ Hair Removal
- ○ Removing Facial Veins
- ○ Wrinkle Improvement
- ○ Excessive Sweating of the Underarms, Palms of Hands and/or Sole of Feet

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older then my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

How did you hear about us?

- ○ My physician (full name) _____
- ○ My insurance company provider (name) _____
- ○ The yellow pages (specify advertisement) _____
- ○ A friend or family member (name) _____
- ○ Internet

Thank You Very Much!
Solomon Brickman, MD

Dermatology Medical History

Patient: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? □ YES □ NO If yes, list below:

1._____ 2._____

Have you ever had dental anesthesia (Novocain)? □YES □ NO Any bad reaction? □ YES □ NO

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

1._____ 3._____ 5._____

2._____ 4._____ 6._____

Do you have now, or ever had diseases or conditions of: (Please check **YES** or **NO**)

Lungs:	**YES**	**NO**
Bronchitis	□	□
Emphysema	□	□
Asthma	□	□
Chronic Cough	□	□
Morning Cough	□	□
Shortness of Breath	□	□
Wheezing	□	□
Cardiovascular:	**YES**	**NO**
High Blood Pressure	□	□
Chest Pain	□	□
Heart Attack	□	□
Heart Murmur	□	□
Irregular Heartbeat	□	□
Phlebitis	□	□
Inflammation of Vein	□	□
Blood clots	□	□
Pacemaker	□	□

Other Systemic:	**YES**	**NO**
Diabetes	□	□
Excessive thirst/hunger	□	□
Amputation	□	□
Thyroid	□	□
Kidney	□	□
Dialysis	□	□
Bladder	□	□
Frequency/burning	□	□
Gastrointestinal Stomach absorptive disorder	□	□
Nausea, vomiting, diarrhea when taking antibiotics	□	□
Yeast infection when taking antibiotics	□	□
Arthritis/Joint Deformity	□	□
Arthralgia	□	□
Limited motion	□	□
Artificial joint	□	□
Convulsions, Epilepsy or Seizures	□	□
Fainting	□	□

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin: Have you ever had skin cancer? □ YES □ NO

Has anyone in your family had skin cancer? □ YES □ NO

Do you have a history of any specific skin diseases? □ YES □ NO If yes, _____

Do you have problems with healing? □ YES □ NO

Do you develop keloids (scars) after surgery? □ YES □ NO

Do you bleed easily? □ YES □ NO

Do you develop skin rashes in reaction to □ Medications □ Food □ Environment □ Bandages □ Topical Neosporin □ Other _____

Social History:

Do you drink alcohol? □ YES □ NO If YES _____ drinks per day

Do you use IV drugs? □ YES □ NO If YES, What? _____ How often? _____

Do you smoke? □ YES □ NO if YES, how much per day: _____

Have you had or have been exposed to HIV (AIDS)? □ YES □ NO

Please answer the following questions:

(Women) Are you pregnant? □ YES □ NO Due Date: _____

What is you occupation? _____ Hobbies? _____

Completed by: □ Patient □Medical Assistant _____ _____ _____

Initials Signed by Patient Date

Patient Name: _____ DATE: _____

IS THERE ANY ONE IN YOUR FAMILY WITH THE FOLLOWING DISEASES?
INCLUDE GRANDPARENTS, PARENTS, SIBLINGS, AUNTS, UNCLES, AND COUSINS.

DIABETES	YES	NO	IF YES, WHOM_____
STROKE	YES	NO	IF YES, WHOM_____
HEART TROUBLE	YES	NO	IF YES, WHOM_____
TUBERCLUOSIS	YES	NO	IF YES, WHOM_____
CANCER	YES	NO	IF YES, WHOM_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I AUTORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN THE PLACE OF THE ORIGINAL.

DATE: _____ SIGNATURE: _____

I HEREBY AUTHORIZE SOLOMON S. BRICKMAN, MD. TO APPLY BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED BY HIM OR BY HIS ORDER. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO DR. SOLOMON S. BRICKMAN.

DATE: _____ SIGNATURE: _____

I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT.

I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORGINAL. THIS AUTHORIZATION MAYBE REVOKED BY EITHER ME OR MY INSURANCE COMPANY AT ANY TIME IN WRITING.

DATE: _____ SIGNATURE: _____

IF MY INSURANCE COMPANY CONSIDERS A PROCEDURE, TEST, OR VISIT TO BE COSMETIC IN NATURE, OR REFUSES TO PAY FOR THE PROCEDURE OR VISIT, I UNDERSTAND THAT I THEREBY BECOME RESPONSIBLE FOR THE CHARGES.

DATE: _____ SIGNATURE: _____

HOUSTON LASER SKIN CENTER
SOLOMON S. BRICKMAN MD., PA
11730 FM 1960 RD W
HOUSTON, TX 77065

I, _____ have reviewed a copy of Solomon S. Brickman's Notice of Privacy Practices. I have also been given the opportunity to obtain my own personal copy.

I give permission for my records to only be released to:

_____ _____

Name Date Of Birth

_____ _____

SIGNATURE OF PATIENT DATE

Notice of Privacy Practices

(Specialty Physician)

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 practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This notice describes our privacy practices. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

A. Treatment, Payment, Health Care Operations

Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered.

B. Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

Public Health, Abuse or Neglect, and Health Oversight
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement
We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided:

- The information is released pursuant to legal process, such as a warrant or subpoena;
- The information pertains to a victim of crime and you are incapacitated;
- The information pertains to a person who has died under circumstances that may be related to criminal conduct;
- The information is about a victim of crime and we are unable to obtain the person's agreement;
- The information is released because of a crime that has occurred on these premises; or
- The information is released to locate a fugitive, missing person, or suspect.

We also may release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation
We may disclose your medical information as required by workers' compensation law.

Inmates
If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted

to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President
We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the president of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

Required by Law
We may release your medical information when the disclosure is required by law.

C. Your Rights Under Federal Law

The U. S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care.

To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e., on the use of information, disclosure of information, or both), and (c) to whom the limits apply. Please send the request to the address and person listed at the end of this document.

Receiving Confidential Communications by Alternative Means
You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your

correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information
You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document.

We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.

We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons:

- The information is psychotherapy notes.
- The information reveals the identity of a person who provided information under a promise of confidentiality.
- The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
- The information has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

Texas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost-based fee.

Amendment of Medical Information
You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

- The information wasn't created by this practice or the physicians in this practice.
- The information is not part of the designated record set.
- The information is not available for inspection because of an appropriate denial.
- The information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing.

If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures
HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person at the end of this document. Your first accounting of disclosures (within a 12-month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request *before* any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits

We may contact you by (telephone, mail, or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U. S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.

F. Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

G. Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Solomon Brickman MD
Houston Laser Skin Center
11730 FM 1960 W
Houston, TX 77065
281-955-2263

This notice is effective 06/01/2005.