Anh Vu, M.D.
BOARD CERTIFIED PLASTIC SURGEON

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Marital Status: _____ SSN: _____

Home Address: _____ Sex: Male ☐ Female ☐

_____ Zip

Home Phone: _____

Cell Phone: _____

Email: _____

Referred by: _____

Primary Care Physician: _____ Phone Number: (____) ____ - _____

Cardiologist: _____ Phone Number: (____) ____ - _____

Emergency Contact: _____ Phone Number: (____) ____ - _____

Employer Information: _____ Work Number: (____) ____ - _____

Work Address: _____

Job Title: _____

If patient is under the age of 18, please complete this section:

Primary Guardian: _____ Date of Birth: _____

Home/Cell Phone: _____ SSN: _____

Secondary Guardian: _____ Date of Birth: _____

Home/Cell Phone: _____ SSN: _____

Patient/Guardian Signature: _____ Date: _____

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Anh Vu, M.D.
BOARD CERTIFIED PLASTIC SURGEON

INSURANCE POLICY

Primary Insurance: _____ Insured's Name: _____

Policy Number: _____ Group Number: _____

Secondary Insurance: _____ Insured's Name: _____

Policy Number: _____ Group Number: _____

Please understand that payment of your bill is considered a part of your treatment. Therefore, we require you to read and sign our Financial Policy as well as complete our Patient Information and Insurance form before receiving any services.

By signing below, you acknowledge that you understand and accept our Financial Policy. Your signature also authorizes us to file claims on your behalf to your insurance company when applicable, Medicare or Medicaid (whichever appropriate) and for those benefits to be made payable to Harmony Medical on your behalf.

REGARDING INSURANCE (TO INCLUDE MEDICARE AND MEDICAID)

All co-payment and deductibles are due prior to treatment. Our office will file your claims with your insurance as a courtesy to you and will assist you as much as possible with this process. However, we ask that you cooperate with us by making sure that you provide us with the correct information regarding your insurance policy and inform us of any changes to this information as they occur. **Although we will be filing your claims, you need to realize that the insurance agreement is between you and your insurance company and we are not a party to that contract. Our bill for services is an agreement between you and the physician and/or surgery center.**

You should also be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. As such, if for some reason your insurance company has not paid your account within 45 days of our filing, the balance will be automatically transferred to your responsibility. We will expect payment within 30 days of you receiving a statement from us.

Your insurance company may require a referral from your primary care physician. If this is the case, it is your responsibility to obtain this prior to your initial visit and for each visit thereafter. Failure to do this may result in your being responsible for payment of the entire consultation and/or surgical fee at the time of each visit.

REGARDING MEDICAL RECORDS

I authorize the release of my medical records to my physicians, attorneys and/or anyone related to my medical care. If applicable, I understand records may be emailed, mailed or faxed. I understand I am to provide Harmony Medical with all necessary and current insurance information and that I am financially responsible for any charges incurred not covered by my insurance. I understand that if I fail to keep any financial agreement I make with this practice and my account must be sent to a collection or legal agency, I will be responsible for all collection costs and legal fees incurred.

I grant permission for the use of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc. I agree that Dr. Vu and/or designated representatives or the practice may take and use preoperative and postoperative photographs of my person for confidential clinical record purposes and to aide in the course of my treatment. Such photographs shall remain the property of Dr. Vu and Harmony Medical.

Patient/Guardian Signature: _____ Date: _____

Anh Vu, M.D.
BOARD CERTIFIED PLASTIC SURGEON

FINANCIAL POLICY

By signing below, you acknowledge that you understand and accept our Financial Policy. Your signature also authorizes us to file claims on your behalf to your insurance company when applicable, Medicare or Medicaid (whichever appropriate) and for those benefits to be made payable to Harmony Medical on your behalf.

SURGERY SCHEDULING FEES

Reconstructive (Insurance) Patients:

- A $200 fee will be due at the time of scheduling your surgery with Dr. Vu in the OR of Flagler Hospital. This fee will be refunded to you at your one week follow-up from the date of surgery. If you need to reschedule your date of surgery, the $200 is nonrefundable and an additional $200 fee will be due at the time of scheduling your new surgery date and will be refunded to you at the one week follow-up of that date of surgery. Scheduling fees are in place to cover the costs of scheduling surgery and cut down on unnecessary rescheduling.
- A $100 fee will be due at the time of scheduling your in office excision with Dr. Vu in his office. This fee will be refunded to you when you show up for the scheduled in office surgery. If you need to reschedule your date of surgery, the $100 in nonrefundable and an additional $100 fee will be due at the time of scheduling your new surgery date and will be refunded to you when you arrive for that date of surgery. Scheduling fees are in place to cover the costs of scheduling surgery and cut down on unnecessary rescheduling.

Cosmetic (Out of Pocket) Patients:

- A $500 NON REFUNDABLE Scheduling Fee is due at the time of scheduling your surgery with Dr. Vu in the OR of Flagler Hospital or in his office. This fee is nonrefundable for any reason. If a new date of surgery has to be chosen an additional $500 nonrefundable scheduling fee is required to secure your date of surgery. Cosmetic scheduling fees are in place to cover the costs of scheduling surgery. Cancellation of surgery, for any reason, within two weeks of surgery date will result in forfeiture of 50% of the surgery fees.

COSMETIC PATIENTS

A consultation fee of $50 will apply on your office visits and will be credited or applied to any future treatment or procedure (excludes retail products). These procedures are expected to be paid in full at the pre op appointment prior to surgery. However, follow-up cosmetic visits are at no charge for up to one year following a surgical procedure. Specific fees for cosmetic procedures will be discussed after you have completed your initial consultation. **Cosmetic surgeries, procedures and/or treatments will not filed with insurance, for any reason. Payment for cosmetic surgeries, procedures and/or treatments acknowledges and accepts this policy. Patient is responsible for full payment of services.**

CANCELLATION POLICY

We understand that circumstances may change suddenly or unexpectedly, leaving you in a position in which you are unable to keep your scheduled appointment. For this reason, our policy includes a 3 business day notice rescheduling policy. Scheduling an appointment confirms that you understand and agree to these terms. No-shows will result in forfeiture of the consultation fee. If an appointment is rescheduled less than 3 business days in advance of your scheduled appointment time, the consultation fee will be forfeited and no refund will be given.

MEDICAL ESTHETICIAN PATIENTS

To make a reservation for an appointment with our Medical Esthetician, patients must pay a $25 scheduling fee to hold the appointment date and time at the time of scheduling the appointment. If you cancel or reschedule your appointment within 72 hours leading up to the scheduled appointment, the $25 fee will be viewed as a cancellation fee.

USUAL AND CUSTOMARY RULES

Our Practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

PAYMENT METHODS

We accept check, cash, Visa, Master Card, Discover, American Express, Debit Cards and CareCredit Cards. Financing is available thru CareCredit for those who qualify and more information can be found at www.carecreditcom

DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR USE OF CREDIT CARDS, DEBIT CARDS, AND FINANCING

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment. Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services provided. By signing this form, you are irrevocably consenting to allow Harmony Medical to use and disclose your protected health information to any credit card entity, bank, or financing company when they request such information to process an account and assist with payment. You are irrevocably agreeing to not challenge such credit, debit or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that may arise.

Patient/Guardian Signature: _____ Date: _____

Anh Vu, M.D.
BOARD CERTIFIED PLASTIC SURGEON

VIDEOTAPE AND PHOTOGRAPHS RELEASE AND AUTHORIZATION

Patient Name (please print): _____ Date of Birth: _____

I hereby irrevocably consent to and authorize the use and reproduction by Harmony Medical, hereinafter referred to as ("practice"), or anyone authorized by any of them, of any and all photographs, electronic images, or video footage of me taken by the practice, or that the practice has in its possession, provided either by me or by a third party (collectively, Images) for the purpose of informing the medical profession and the general public about plastic surgery and plastic surgery procedures and techniques without compensation to me. Such use shall include, but not be limited to, distributing the Images via print, visual, and electronic media, specifically including the practice website and social media sites such as YouTube, Facebook, and Instagram. The Images (including any photographic negatives) shall be the sole property of the practice.

I understand that:

- Photographs are taken to capture treatment outcomes for surgical and nonsurgical procedures.
- I will not be identified by name in any of the published materials and photographs.
- My face will not be shown in any body photographs nor will they reveal my identity. For facial photographs, a black eye bar will be used to conceal identity, if possible, unless doing so will obscure treatment outcomes.
- I have the right to revoke this authorization in writing at any time through a written revocation to Harmony Medical.

I hereby waive any right to inspect or approve the finished product, photograph, video, DVD, CD-ROM, or matter that may be used in conjunction therewith or to the eventual use that it might be applied.

I hereby release, discharge, and agree to hold harmless the practice and its affiliates and their respective representatives, assigns, and employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and name and the reproduction thereof as stated above, including any claim for payment in connection with distribution or publication of the video and/or photographs.

I hereby warrant that I am over twenty-one years of age and competent to contract in my own name insofar as the above is concerned.

I have read and understand the foregoing release, authorization, and agreement, before signing my name below, and enter into it knowingly and voluntarily.

Patient/Guardian Signature: _____ Date: _____

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Anh Vu, M.D.
BOARD CERTIFIED PLASTIC SURGEON

PATIENT PRIVACY & CONSENT
FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby consent to the use or disclosure of my protected health information by Harmony Medical, hereinafter referred to as ("Practice"), for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by the Practice may be conditioned upon my consent as evidenced by my signature on this document.

I understand that payment for procedures that are aesthetic or cosmetic in nature are my sole responsibility and will not be billed to any third party. I understand that payment for such procedures may be requested in advance of any treatment. I understand there are no warrantees, implied or otherwise, to the outcomes of any treatments or procedure.

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other personnel who are involved in taking care of you at the practice or hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical and allied health students and other practice or hospital personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

This notice describes our practice's policies and procedures and that of any health care professional authorized to enter medical or personal information into your chart which also includes all practice or hospital personnel.

We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious risk or threat to public health or safety; for treatment alternatives; for organ and tissue donation; for health oversight activities; lawsuits and disputes; national security and intelligence activities; to protective services for the President and other government officials; and to worker's compensation staff if work related. Other uses and disclosures of your personal information could include disclosure to: coroners, medical examiners and funeral directors. Additional disclosures may be made to correctional institutions if you are an inmate and to law enforcement if you are involved in or being investigated for criminal activity.

NOTICE OF INDIVIDUAL RIGHTS
You have the rights to request an "accounting of disclosures". This is a list of the disclosures we made of medical information to you. To request this list or accounting of disclosures, you must submit your request in writing to the practice administrator.

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the practice administrator and you must provide a reason that supports your request. We may deny your request for an amendment. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. 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 to the practice administrator.

We reserve the right to change this notice.

If you believe your privacy rights have been violated, you may file a complaint with the practice administrator. To file a complaint with the practice administrator, contact Kelly Wilson at 904-245-1320. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our practice administrator.

I acknowledge by signing below that I have received and read Patient Privacy and Consent.

Patient/Guardian Signature: _____ Date: _____

Anh Vu, M.D.
BOARD CERTIFIED PLASTIC SURGEON

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

REASON FOR VISIT:

_____
_____
_____

HISTORY OF PROBLEM:

_____
_____
_____

OTHER MEDICAL PROBLEMS:

1. _____
2. _____
3. _____
4. _____

PREVIOUS OPERATIONS:

OPERATION	WHEN	WHERE	SURGEON

Do you smoke or use a tobacco replacement? Circle: Yes ☐ No ☐ How much?_____ How long? _____

Do you drink alcohol? Circle: Yes ☐ No ☐ How much?_____ How long? _____

Family History of Cancer: _____

Family History of Heart Disease: _____

Other Family History not listed: _____

DRUG ALLERGIES:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

CURRENT MEDICATIONS & DOSAGES:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Patient/Guardian Signature: _____ Date: _____

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Anh Vu, M.D.

BOARD CERTIFIED PLASTIC SURGEON

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE NOW OR HAVE HAD IN THE PAST:

CONDITION	YES	NO	COMMENT
WEIGHT GAIN			
WEIGHT LOSS			
NIGHT SWEATS			
NIGHT FEVERS			
CHANGES IN HEARING			
CHANGES IN VISION			
HEADACHES			
SORE THROAT			
SWOLLEN LYMPH NODES			
DIFFICULY SWALLOWING			
BREAST LUMPS/DISCHARGE			
CHANGES IN COLOR/SIZE OF BREASTS			
ASTHMA			
SHORTNESS OF BREATH			
DIFFICULTY BREATHING			
COUGH UP BLOOD			
HEART DISEASE			
HYPERTENSION			
HIGH CHOLESTEROL			
PERIPHERAL VASCULAR DISEASE			
HEART MURMUR			
ABDOMINAL PAIN			
NAUSEA			
VOMITING			
CONSTIPATION			
DIARRHEA			
BLOOD IN STOOL			
DIFFICULT URINATION			
PAINFUL URINATION			
BLOOD IN URINE			
DIABETES			
THYROID DISORDER			
OTHER METABOLIC DISORDER			
EASY BLEEDING/BRUISING			
ARTHRITIS			
BONE OR JOINT PROBLEMS			
SEIZURES			
EPILEPSY			
DEPRESSION			
ANXIETY			
MOOD DISORDERS			
HIV			
HEPATITIS A, B, or C			
YELLOW JAUNDICE			
SKIN RASH			
SKIN LESIONS			

I attest the above history is complete to the best of my knowledge and understand and accept my failure to disclose any other medical history in addition to the above information can adversely affect the course of treatment to meet my goals, my safety, or the outcome of any treatment I undergo with Dr. Vu and any member of his staff. The information provided by me will be used by Dr. Vu in his decisions regarding my care.

Patient/Guardian Signature: _____ Date: _____

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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. AnhVu and all the staff at Coastal Aesthetic Center, dba Harmony Medical 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. Anh Vu and all the staff at Coastal Aesthetic Center, dba Harmony Medical 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.

_____ **Patient Initials**

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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

I have been offered a copy of this consent form (patient's initials) _____

_____ **Patient Initials**

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INSTRUCTIONS

This document explains the purpose of telemedicine – also known as "telehealth" and referred herein, collectively, as "telemedicine" – and outlines the benefits and risks of telemedicine.

It is important that you read the whole document carefully. Please initial each page. Doing so means you have read the page. Signing the consent agreement means that you agree to a telemedicine session with your doctor or one of the doctor's assistants (i.e. nurse practitioner, physician assistant, etc.).

GENERAL INFORMATION

Telemedicine is the distribution of health-related services and information via electronic and telecommunication technologies, such as computers and mobile devices, to access and manage health care services remotely. Telemedicine may include technologies you use from home or that your doctor uses to improve or support health care services. Telemedicine allows out-of-office patient and clinician contact, care, advice, reminders, education, intervention, monitoring, and remote admissions. Examples of telemedicine include videoconferencing, teleconferencing, transmission of images, e-health including patient portals, and remote monitoring of vital signs.

ALTERNATIVE METHODS OF MEDICAL CARE BESIDES TELEMEDICINE

In-person care is an alternative method of medical care to telemedicine.

BENEFITS OF TELEMEDICINE

The benefits of telemedicine include the following:

- Make health care accessible to people who live in rural or isolated communities.
- Provide long distance clinical care.
- Make services more readily available or convenient for people with limited mobility, time or transportation options.
- Obtain expertise of specialists.
- Improve communication and coordination of care among members of a health care team and patient.
- Provide support for self-management of health care.
- Quick and efficient medical evaluation and management.

RISKS OF TELEMEDICINE

As with any medical care options, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and assistant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- Security protocols could fail, causing a potential breach of privacy and/or inadvertent disclosure of personal identifying information and/or protected health information;
- Lack of access to complete medical records may result in adverse drug interactions, allergic reactions or other judgment errors;
- Overuse of medical care;
- Unnecessary or overlapping care.

_____ Patient Initials

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CONSENT FOR THE USE OF TELEMEDICINE

1. I understand that the purpose of telemedicine is to provide health care services.
2. I permit my doctor and the doctor's assistants to use telemedicine in my care.
3. I understand that telemedicine means using phone and/or video to communicate with my health care team instead of seeing my team in person (face-to-face).
4. I understand that reasonable efforts will be made to protect my privacy, though there may be risk of inadvertent disclosure of my personal identifying information and/or protected health information.
5. I understand that I can ask questions and discontinue the use of telemedicine at any time I choose.
6. I understand that telemedicine does not replace other types of medical assessment and care. If I am not improving and have serious health concerns, I will seek immediate medical attention at an emergency facility.
7. ALL OF MY QUESTIONS REGARDING TELEMEDICINE WERE ANSWERED, AND THE FOLLOWING WAS EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
   a. THE CONCEPT OF TELEMEDICINE
   b. RISKS AND BENEFITS OF THE USE OF TELEMEDICINE
   c. ALTERNATIVE METHODS OF MEDICAL CARE

I CONSENT TO THE USE OF TELEMEDICINE IN MY MEDICAL CARE AND THE ITEMS THAT ARE LISTED ABOVE (1-7). I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS.

_____

Patient or Person Authorized to Sign for Patient Date/Time

Witness _____Date/Time_____

I have been offered a copy of this consent form (patient's initials) _____

_____ Patient Initials

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