NAYAK
PLASTIC SURGERY

PATIENT REGISTRATION (please print)

Patient Last Name _____ First Name _____ MI _____

Date of Birth _____ Age _____ Marital Status_____

Street Address _____ City _____

State _____ Zip _____ Email _____

Phone (H) _____ (C) _____ (W) _____

Emergency Contact Name _____ Phone Number _____

ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY SERVICE FEES.

ESTHETIC CLIENTS MUST GIVE 24 HOURS NOTICE TO CANCEL OR RESCHEDULE APPOINTMENTS. PATIENTS WHO CANCEL OR RESCHEDULE WITH LESS THAN 24 HOURS NOTICE 3 TIMES WILL BE REQUIRED TO PUT DOWN A DEPOSIT OF $75 FOR FUTURE APPOINTMENTS. SUCH FEE WILL BE FORFEITED IF THE APPOINTMENT IS CANCELED LESS THAN 24 HOURS IN ADVANCE.

IMPORTANT: AS OF 3/1/18, WE CAN NO LONGER ACCEPT CHECKS FOR PRODUCTS AND NONSURGICAL SERVICES. CASH AND ALL MAJOR CREDIT CARDS ACCEPTED. WE ALSO DO ACCEPT SOME CARE CREDIT PLANS. PLEASE CONTACT US FOR MORE INFORMATION.

Patient's Signature (If 18 years or older) _____ Date _____

Parent/Guardian's Signature (If under 18 years) _____ Date _____

NAYAK
PLASTIC SURGERY

NOTICE OF PRIVACY PRACTICES:
Acknowledgement of Receipt

By signing this form, you acknowledge receipt of and agree to the *Notice of Privacy Practices* of Nayak Plastic Surgery, PC. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to review it carefully.

Our *Notice of Privacy Practices* is subject to change. If we change our Notice, you may obtain a copy of the revised Notice on request from your health care team.

I acknowledge receipt of and agree to the *Notice of Privacy Practices* of Nayak Plastic Surgery, PC.

X Signature: _____ Date:_____
(patient/parent/conservator/guardian)

To be completed only if no signature is obtained:
If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of provider representative:_____ Date:_____
Reasons why the acknowledgement was not obtained:
□ Patient refused to sign.
□ Other or Comments:
_____
_____

RESUSCITATION POLICY
It is the policy of Nayak Plastic Surgery to perform full resuscitation, when appropriate, on any patient unless we have written receipt of notarized direction to the contrary.

NAYAK PLASTIC SURGERY, P.C.
ARBITRATION AGREEMENT

This Arbitration Agreement is executed by Dr. Laxmeesh Nayak and Nayak Plastic Surgery, P.C. (also d/b/a Avani Day Spa), individually and on behalf of its staff and employees (collectively, "NPS") and you ("Patient"). The parties to this Arbitration Agreement agree that any and all claims, disputes and controversies (collectively referred to as "claims") arising out of, or in connection with, or relating in any way to any diagnosis, treatment, medical service, or spa service received, or goods purchased from NPS or any of its employees will be resolved exclusively by binding arbitration. This includes, but is not limited to, claims for payment, nonpayment, refunds, breach of contract, breach of privacy, fraud or misrepresentation, negligence, malpractice, claims for equitable relief or claims based on tort, contract, statute, or warranty.

Should you initiate a claim, the parties agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Facial Plastic and Reconstructive Surgery. The parties agree that these physician experts will be obligated to adhere to the guidelines or code of conducted defined by the American Academy/Board of Facial Plastic and Reconstructive Surgery. The parties further agree to require any attorney hired by them to adhere to these provisions.

Any arbitration conducted pursuant to this Arbitration Agreement shall be conducted by JAMS, an independent and impartial entity regularly engaged in providing arbitration services, in accordance with the JAMS Comprehensive Arbitration Rules and Procedures, which can be found at http://www.jamsadr.com ("Rules"). In the event of any inconsistency between this agreement and the Rules, the arbitrator shall apply the terms of this agreement. The parties acknowledge that this provision alters the Rules. This agreement shall be governed by and interpreted under the Federal Arbitration Act, 9 U.S.C. Sections 1-16.

The parties agree that this Arbitration Agreement shall inure to the benefit of and binds the parties, their spouses, heirs, children, siblings, representatives, successors and assigns. The parties further intend that this agreement is to survive the lives or existence of the parties hereto.

All claims based in whole or part on the same incident, transaction or related care or service provided by NPS to you shall be arbitrated in one proceeding. A claim shall be waived and forever barred if it arose and should reasonably have been discovered prior to the date upon which notice of arbitration is given to NPS and such claim is not presented in the arbitration proceeding.

You have the right to seek legal counsel concerning this Arbitration Agreement. Execution of this Arbitration Agreement is not a precondition to the furnishing of services to you. In the event a Court having jurisdiction finds any phrase, clause, sentence or provision of this Arbitration Agreement unenforceable, the remainder of the agreement shall be enforceable.

The parties acknowledge and understand that arbitration is a complete substitute for traditional litigation and by entering in to this agreement the parties are giving up and waiving their constitutional right to have any claim decided in a court of law before a judge and a jury, as well as any appeal from a decision or award of damages.

Patient certifies that he/she has read this Arbitration Agreement and understands its contents.

THIS CONTRACT CONTAINS A BINDING ARBITRATION PROVISION WHICH MAY BE ENFORCED BY THE PARTIES.

Patient's Signature _____ **Date**_____

Laxmeesh Nayak, M.D.'s Signature _____ **Date**_____

Nayak Plastic Surgery's Signature _____ **Date**_____

Nayak Plastic Surgery
Patient Health/Skin History Form

Name _____ Today's Date _____

Date of Birth _____ Age _____ Sex _____ Height _____ Weight _____

Primary Care Physician_____

How did you hear about us? _____

Procedures I would like to discuss *(Check all that apply)*:

Facial Rejuvenation:
- ☐ Necklift
- ☐ Facelift
- ☐ Eyelid Correction
- ☐ Forehead/Brow Lift
- ☐ Fat Transfer

Profile Surgery:
- ☐ Chin Implant
- ☐ Cheek Implant
- ☐ Facial/Neck Liposuction
- ☐ Nasal Surgery

Ear Surgery:
- ☐ Reduce Prominence
- ☐ Reduce Earlobe Size
- ☐ Repair Torn Earlobe

Skin Rejuvenation:
- ☐ Wrinkles
- ☐ Pigmentation/Age Spots
- ☐ Redness/Rosacea
- ☐ Roughness/Texture
- ☐ Scars/Acne Scarring
- ☐ Large pores
- ☐ Acne

Injectables:
- ☐ Botox/Dysport
- ☐ Juvederm
- ☐ Restylane
- ☐ Voluma
- ☐ Lip Augmentation
- ☐ FakeLift

Nonsurgical Procedures:
- ☐ Hair removal
- ☐ Laser Resurfacing
- ☐ Chemical Peels
- ☐ Photofacial/IPL
- ☐ CoolSculpting Fat Reduction
- ☐ Ultherapy facial tightening
- ☐ Microlaser Peel
- ☐ Cellfina – Permanent Cellulite Reduction
- ☐ Thermiva – Treatment for Leakage, Dryness & Sexual Function in Women

Please indicate in your own words what concerns you have:

_____

_____

Have you ever had or used:

yes	no	
☐	☐	Retin A
☐	☐	Chemical peels
☐	☐	Microdermabrasion
☐	☐	Laser, type _____
☐	☐	Botox
☐	☐	Restylane, Collagen, Juvederm, Fillers
☐	☐	Silicone, Sculptra, Artefill
☐	☐	Accutane
☐	☐	Herpes (or cold sore) medication
☐	☐	Oral contraceptives

Current skin care regimen:

Cleanser _____

Toner _____

Scrub _____

Exfoliator _____

Sunscreen _____

Moisturizer _____

Other _____

Sun exposure:
Past: ☐Little ☐Excessive

Tanning Beds:
Past: ☐Little ☐Excessive

Sunscreen:
☐Never ☐Occasional ☐Daily

Present: □Little □Excessive Present: □Little □Excessive

Review of Systems

Please circle any symptoms below that you feel are affecting your health:

General: Fatigue, unexplained weight gain/loss, fever, chills, night sweats, sleep problems, pain.

Skin: New or changing skin growth, unexplained rash.

Head: Headaches, recent trauma.

Eyes: Blurred/loss of vision, eye pain, discharge, glasses/contacts, **dryness, LASIK, glaucoma**

Ears: Excessive noise exposure (loud music), ear pain, loss of hearing, ringing in ears, drainage.

Nose: Frequent bloody nose, sinus pain, post nasal drainage, congestion.

Mouth: Tooth pain, oral sores, bleeding.

Throat: Hoarse voice, voice changes, pain or difficulty swallowing, frequent soreness or swelling.

Neck: Pain, stiffness, swelling.

Chest: Breast changes or lumps, nipple discharge, chest wall pain.

Lungs: Cough, shortness of breath, wheezing. **CPAP?**

Heart: Murmurs, palpitations, pain with exertion, passing out.

Stomach: Frequent nausea, vomiting, diarrhea, constipation, abdominal pain, bleeding, constipation.

Urinary Tract: Frequent urination, pain on urination, blood in urine.

Musculoskeletal: Joint pain, swelling, muscle pain, stiffness, restricted movement, swelling.

Nervous System: Loss of consciousness, dizziness, seizures, weakness or numbness in any body part, tremors, twitching.

Mental Health: Feelings of nervousness/anxiety/panic, crying spells, depression, confusion, problems concentrating.

Blood/Lymph: Anemia, bleeding tendency, easy bruising, swollen/painful lymph nodes.

Other:

_____

Personal/Family Medical History

Please check where you or members of your family, have had the following:

	Yourself	Father	Mother	Father's Side	Mother's Side	Brother(s)	Sister(s)
AIDS/HIV							
Alcoholism							
Anemia							
Anxiety							
Arthritis							
Asthma							
Bleeding Problem							
Cancer							
Cirrhosis							
Dementia							
Depression							
Diabetes Mellitus							
Eczema, Hives Rash							
Eye Problem/Glaucoma							
Heart Disease/Murmur							
Hemophilia							
High/Low Blood Pressure							
High Cholesterol							
Kidney/Bladder Problem							
Liver Disease/Jaundice							
Lung Disease							
Mental Illness							
Osteoporosis							
Parkinson's Disease							
Peptic Ulcer Disease							
Phlebitis/Blood Clot							
Rheumatic Fever							
Seizures/Epilepsy							
Sickle Cell Disease							
Stroke							
Thallasemia							
Thyroid Disease							
Tuberculosis							

Other: _____

_____

_____

Allergies:
□ None
□ Medication Allergies (& reaction caused)
_____

□ Other _____

Do you have a Latex allergy?: □ Yes □ No

General/Social Information:

Would you be able to lie on your back comfortably for 4 hours? □ No □ Yes

Any nicotine in the last 3 months? □ Yes □ No

□ Cigarettes □ Cigars □ Pipe □ Ecig □ Gum/patch

□ Other _____

If yes, how much/how long? _____

Are you a former smoker? □ Yes □ No

If yes, when did you quit? _____

Do you drink alcohol? □ Yes □ No

If yes, how much and how often do you drink?

_____

Exercise: How much/what kind?

_____

Have you ever used **(check one)**:

□ Cocaine
□ Methamphetamines
□ Intravenous drugs
□ Marijuana or other smoked drugs
□ Afrin or other nasal sprays for longer than 2-3 days?
□ None of the above

If yes, what, how long, and how recently?:

_____

Are you pregnant or nursing? □ No □ Yes

With whom do you live?

□ I live alone. □ I live with _____

Are you currently: (Please circle)

Single Married Partnered Widowed
Divorced Separated

Current occupation/employment: (Please circle)

Retired Disabled Working as _____

Emergency Contact?

_____ _____ _____
(Name) (relationship) (phone #)

Please list all current medications

Prescription Drugs:

Name	Dose	Reason for taking it
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Over the counter: (aspirin, Tylenol, antihistamines, herbals, vitamins, etc)

Name	Dose	Reason for taking it
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list current illnesses/health problems:

_____
_____
_____
_____

Please list surgeries and hospitalizations:

	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT; NO INSURANCE OR MEDICARE COVERAGES APPLY.I, THE UNDERSIGNED, DO HEREBY GIVE MY CONSENT FOR NAYAK PLASTIC SURGERY, PC, TO FURNISH TREATMENT CONSIDERED NECESSARY, AND PROPER IN DIAGNOSING AND/OR TREATING MY PHYSICAL AND COSMETIC CONDITION(S).

_____ _____
Patient Signature Physician Signature

Form completed by _____ _____
(If person other than patient) (Date)

NAYAK PLASTIC SURGERY

NOTICE
Completion of this form is entirely **OPTIONAL**.

Consent for Use of Photographs/Videos

I, _____, give my informed and voluntary consent to L. Mike Nayak, M.D. and/or his associates to take photographs and/or video of me pre-operatively, intra-operatively, and post-operatively. I understand that these photographs and/or videos will be utilized to show the transformation process to the general public which includes current and prospective patients. I understand entirely that this authorization is completely voluntary, and that people or automated online image recognition features may recognize/identify my face or my other identifying features. I understand that any disclosure of information has the potential of further, unauthorized disclosure that may affect my privacy in unforeseen ways.

Nayak Plastic Surgery & Avani Derm Spa has my permission to share my:

___Before & After Photos
___Video Testimonials
___Surgical/Treatment Photos/Video
___All of the Above

For…

___General Online/Digital Use *(includes all items below except print/billboards)*
___Specific Use:
___Snapchat Story
___Instagram Story
___Instagram
___Facebook
___Website *(nayakplasticsurgery.com/avanidermspa.com)*
___RealSelf
___YouTube
___In-Office Before & After Galleries

___Traditional Print Advertising
___Billboard Advertising *(Will be notified before use)*

Signature: _____ Date: _____

We greatly appreciate your cooperation. Thank you.

Sincerely,

L. Mike Nayak, MD