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:_____

QUESTIONS TO ASK:

1. When was your last surgery? _____
2. How many surgeries have you had? _____
3. What CC symptoms are you experiencing? _____
4. When did you notice the s/s of contracture? _____
5. Is this as a result of mastectomy/breast cancer? _____

Patient Name: _____

ASPEN
After Surgery Center

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: _____

ASPEN After Surgery Center

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

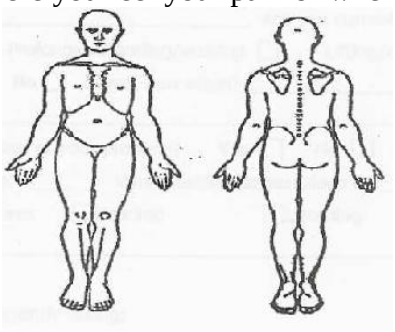
PAIN BEHAVIOR: Please **CHECK** any items below that apply to you.

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

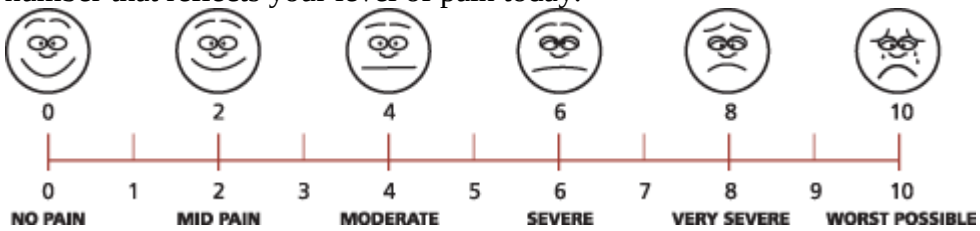
Your pain is worse: Please **CHECK** any items below that apply to you.

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: _____

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. This consent is expressly intended to release from liability all of the above-named facility's personnel and consultants.

1. Consent to take video/photo to clinically share data with surgeon (not for marketing use): _____(initials)

Surgeon's name _____

Patient's Signature _____

2. Consent to take/post video/photos to our web links to spread consumer awareness. **Name and face will be excluded If suggested.** _____(initials)

Patient's Signature _____

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

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

Signed _____

_____
Witness

_____
Date

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:

ANTIBIOTIC
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 ASPEN REHAB TECHNOLOGIES, LLC EIN# 30-0532407. 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 insurance benefits are not covered for cosmetic/reconstructive treatment and that insurance claims are not filed. I understand and acknowledge I am fully responsible for payment and any charges for care and services provided by Aspen Rehab Technologies, LLC. Any reversed credit card charges against Aspen Rehab Technologies, LLC will have a 40% additional fee added to the amount owed for legal services to collect. I understand and acknowledge that Treatments are NON- REFUNDABLE. The payment for treatment is due on the second visit in full. We accept Cash, Visa, Master Card, Discover, and Checks (return checks are subject to a fee of $35). _____ (initials)

   Initial Evaluation: $299 Treatment Package x4 visits: $1196

3. I understand that Aspen Rehab Technologies, LLC 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 Rehab Technologies, LLC 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 Rehab Technologies, LLC is not legally responsible for the acts and omissions of its independent contractors.

7. I understand that Aspen Rehab Technologies, LLC 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 Rehab Technologies, LLC NOTICE OF PRIVACY PRACTICES for my review, prior to receiving initial services from Aspen Rehab Technologies, LLC, either now or in the past.

Patient Print Name: _____ Date: _____

SIGNED: _____ Date: _____

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

ASPEN
After Surgery Center

Authorization to Release Medical Information/HIPAA Compliance

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

I authorize to release/request of my protected health information to/from:

□ Physician/Plastic Surgeon: _____

□ Family Member: _____ Relationship to Patient: _____

□ Diagnostic Testing Center: _____

□ Other: _____

My information may be released in the form of: □ Paper Copy □ Electronic Copy

The purpose for this request is to release medical information for:

□ Medical Care / Treatment □ Other (Specify): _____

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 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 Rehab Tech, LLC shall not be held liable for any consequences resulting from re-disclosure.
- If the information to be released contains any information about HIV/AIDS an additional HIPAA release of medical Information form 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 may be provided to me if I request it.
- Aspen Rehab Tech, LLC may charge an administrative fee to cover cost of labor, copying, and postage for any and all medical records. 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: _____