Migraine Headache Questionnaire

Print Name: ____________________________ Date of Birth: ________________

Part I
Do you have migraine headaches as a diagnosed chronic medical condition for which you are seeing a physician, such as family practice, internist or neurologist?

☐ Yes. Please proceed to Part II.
☐ No. Stop. You do not need to answer Part II.

Part II
1.) How many migraine headaches did you have in the last month? ____________________________
2.) How many regular headaches did you have in the last month? ____________________________
3.) From where do your migraine headaches typically start from? What location? ____________________________
4.) How long do the migraine headaches last on average? Check best answer.
   ☐ < 2 hrs.  ☐ 3-4 hrs.  ☐ 5-12 hrs.  ☐ 12-24 hrs.  ☐ several days  ☐ >1 week
5.) How painful are your migraine headaches on average? (circle best answer)
   1  2  3  4  5  6  7  8  9  10
   (mild)------------------------------------------------------------------------(severe)
6.) Have there been any recent changes to the character or location of your migraine headaches?
   ☐ Yes ☐ No
7.) If you are female, are your migraine headaches during the time of your menstrual cycle?
   ☐ Yes ☐ No ☐ Not applicable
8.) Do your migraine headaches interfere with normal activities?
   ☐ Yes ☐ No
9.) Have you lost time from work due to your migraine headaches?
   ☐ Yes ☐ No  If yes, how many days?
10.) From what location do your migraine headaches usually start? Check all that apply. Under frequency, try to identify the number of headaches you have in this site out of the total number of headaches you have per month.

<table>
<thead>
<tr>
<th>Location</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behind right eye</td>
<td>Right temple</td>
</tr>
<tr>
<td>Behind left eye</td>
<td>Left temple</td>
</tr>
<tr>
<td>Above right eyebrow</td>
<td>Above left eyebrow</td>
</tr>
<tr>
<td>Above both eyebrows</td>
<td>Both temples</td>
</tr>
<tr>
<td>Back of right head</td>
<td>Back of left head</td>
</tr>
<tr>
<td>Back of both eyes</td>
<td>Above both eyebrows</td>
</tr>
<tr>
<td>Back of head</td>
<td>Both temples</td>
</tr>
<tr>
<td>Back of head</td>
<td>Back of head</td>
</tr>
</tbody>
</table>
11.) Check any of the following that occur before or during your migraine headaches.

- Nausea
- Bothered by light
- Blurred double vision
- Loss of vision
- Numbness / tingling
- Loss of consciousness / poor concentration
- Vomiting
- Bothered by noise
- Eyelids are puffy
- Light headedness
- Weakness of arm / leg
- Seeing lights
- Diarrhea
- Droopy eyelids
- Runny nose
- Other

12.) Check any of the following that bring on your migraine headaches, or make them worse.

- Stress
- Bright light
- Air travel
- Missed meals
- Straining
- Other
- "Letdowns"
- Loud noise
- Fatigue
- Sexual activity
- Bending over
- Weather change
- Heavy lifting
- Smells / perfume
- Coughing
- Certain foods

13.) Do any of the following make your migraine headaches better?

- Rest
- Exercise
- Quiet / darkness
- Hot compress
- Massage
- Warm shower
- Cold compress
- Pressure over migraine headache area

14.) Did / Do you take any prescription medications to treat your migraine headaches?

- No
- Yes. What medications/how often?

15.) Did / Do you take any over-the-counter medications to treat your migraine headaches?

- No
- Yes. What medications/how often?

16.) Did / Do you need any treatment, other than medications, to relieve your migraine?

- No
- Yes. Please describe.

17.) How would you rate your general health in the last month?

- Excellent
- Good
- Fair
- Poor

18.) Check off any of the following treatments that you have tried:

- Chiropractor
- Acupuncture
- Physical Therapy
- Biofeedback
- Botox or nerve block injection therapy

19.) To what extent do migraines affect the quality of your life?

________________________________________

Signature: _______________________________  Date: _______________________________
# Migraine Diary

Diaries can be useful to identify triggers, to keep track of your headaches, and to help your health care provider better understand your headaches. The headache diary also helps monitor changes in headache frequency and severity.

<table>
<thead>
<tr>
<th>HEADACHE</th>
<th>Time Started:</th>
<th>Time Ended:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Warning Signs:</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PAIN</th>
<th>Date:</th>
<th>Time Started:</th>
<th>Time Ended:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Pain: (e.g. piercing, throbbing, etc.)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Intensity of Pain: (circle one) (low) 1 2 3 4 5 6 7 8 9 (high)</td>
<td></td>
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<tr>
<td>Location: (between eyes, back of head, etc.)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>TREATMENT</th>
<th>Date:</th>
<th>Time Started:</th>
<th>Time Ended:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment or Medication Taken:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effect of Treatment:</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CIRCUMSTANCES</th>
<th>Date:</th>
<th>Time Started:</th>
<th>Time Ended:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours of Sleep:</td>
<td></td>
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<tr>
<td>What I ate today:</td>
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<tr>
<td>Events prior to headache: (strenuous activity, elevated stress, etc.)</td>
<td></td>
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Comments:
Patient Information Form

Patient Name: ____________________________ Preferred Language: ____________________________
Address: ________________________________ City: ___________ State: ___________ Zip: ___________
Home Phone: ____________________________ Cell Phone: ____________________________ Carrier: ___________
DOB & Age: ____________________________ Race: ____________________________ Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Sex: ___________ SSN: ____________________________ Email Address: ____________________________
Employer Name: ____________________________ Address: ____________________________
Occupation: ____________________________ Work Phone: ____________________________
Who is your primary care physician? ____________________________
How did you hear about our practice? ☐ Patient Referral: ____________________________ ☐ Dr. Referral: ____________________________
☐ Friend: ____________________________ ☐ Google ☐ Other: ____________________________
What is the nature of your visit? ____________________________
Is this an accident or work injury? ☐ Yes ☐ No Please provide insurance information: ____________________________

Emergency Contact

Name: ____________________________ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: ____________________________
Home Phone: ____________________________ Cell Phone: ____________________________ Work Phone: ____________________________

Primary Insurance

Name: ____________________________ Policy #: ____________________________ Group ID: ____________________________
Address: ____________________________ City: ____________________________ State: ___________ Zip: ___________

Insurance Card Holder Name: ____________________________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Dependent Card Holder’s Date of Birth ____________________________

Secondary Insurance


Name: _______________________________  Policy #: _______________________________  Group ID: _______________________________

Address: _______________________________  City: _______________________________  State: __________  Zip: __________

Insurance Card Holder Name: _______________________________  Relationship to Patient:  

[ ] Self  

[ ] Spouse  

[ ] Child  

[ ] Dependent  

Card Holder’s Date of Birth: _______________________________

Assignment and Release

I, _______________________________, have insurance coverage and assign directly all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_________________________________________  ____________________________________________
Signature of Insured / Guardian  Date

Medical History from ThedaCare

[ ] Yes  [ ] No

Are you a patient in the ThedaCare system? If “no”, proceed to the next section I - Surgery and Anesthesia History. If “yes”, please answer the next question.

[ ] Yes  [ ] No

FVPS can access your medical history from the ThedaCare system so that you do not have to fill out the following medical history. Do you consent to allowing us to access your medical history from ThedaCare? If you answer “yes”, you can skip the questions on the next two pages. Please initial here if yes.

Section I: Surgery and Anesthesia History

1. Have you ever had surgery?  [ ] No  [ ] Yes, please describe:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

2. Do you have a blood relative who had anesthesia complications of any kind?  [ ] No  [ ] Yes, please describe:

____________________________________________________________________________________
____________________________________________________________________________________

Section II: Specific Medical History

1. Are you pregnant?  [ ] No  [ ] Yes  Height: __________  Weight: __________

   Have you or do you still have:

   2. Anemia
   3. Asthma
   4. Emphysema
   5. Bleeding tendency
   6. Blood clots
   7. Cancer
   8. CHF
   9. COPD
   10. Diabetes

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Description</th>
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</table>
11. High Blood Pressure □ □
12. Heart disease □ □
13. Hepatitis □ □
14. Herpes/Cold Sores □ □
15. Kidney disease □ □
16. Melanoma □ □
17. Migraine headaches □ □
18. Stroke □ □
19. Thyroid disease □ □
20. Problem Scarring □ □
21. Have you been advised to or had psychiatric care? □ □
22. Vein problems, such as venous reflux disease □ □
23. Others Not Listed

Section III: Social History

Do you smoke? □ No □ Yes, how much?
1. Do you drink? □ No □ Yes, how much?
2. Do you have children? □ No □ Yes, how many?
3. Do you exercise? □ No □ Yes, how much?

Section IV: Family History

Have any blood relatives had any of the following? | No | Yes | Description |
---|---|---|---|
1. Asthma |
2. Bleeding Tendency |
3. Blood Clots |
4. Cancer |
5. Chronic Lung Disease |
6. Depression |
7. Diabetes |
8. Heart Disease |
9. High Blood Pressure |
10. Kidney Disease |
11. Melanoma |
12. Mental Illness |
13. Migraine Headaches |
14. Obesity |
15. Stroke |
16. Thyroid Trouble |

Section V: Medications
Are you taking any medications, vitamins or herbal supplements?  □ No  □ Yes, please list:

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Strength (mg)</th>
<th>How many times a day?</th>
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<tbody>
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Section VI: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia?  □ No  □ Yes, please list:

Section VII: Women Only

Date of last mammogram: __________________________  Number of pregnancies: __________________________

Do you do regular breast self-exams?  □ Yes  □ No
Do you breast feed?  □ Yes  □ No
Breast lump or discharge?  □ Yes  □ No

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: ___________________________________________  Date: ___________________________
Consent to Communicate

Patient: __________________________________________

Please mark the ways that you consent to us communicating with you:

<table>
<thead>
<tr>
<th>Method</th>
<th>Ok to Leave Voicemail</th>
<th>Ok to Leave Message with Another Person</th>
<th>Preferred Contact Method(s)</th>
<th>Best Time to Call*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call Work Phone</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call Cell Phone</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call Home Phone</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Send Email</td>
<td>-</td>
<td>-</td>
<td>□</td>
<td>-</td>
</tr>
<tr>
<td>Email Appointment Reminders</td>
<td></td>
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<tr>
<td>Email Office Specials</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Email Medical Info – Please keep in mind that communications via email over the internet are not secure and are not HIPAA compliant. Although it is unlikely, there is a possibility that information in an email can be intercepted and read by other parties besides the person to whom it is addressed.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Send Regular Mail</td>
<td>-</td>
<td>-</td>
<td>□</td>
<td>-</td>
</tr>
</tbody>
</table>

Mail to which Address: □ Home □ Other (please list):

Send Text Message. Carrier name: □

Text Appointment Reminders

Text Office Specials

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it’s ok to leave a message with another person, please list them:

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Relationship</th>
<th>OK to Release Results</th>
<th>Any Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Yes □ No</td>
<td></td>
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<td></td>
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<td></td>
<td>□ Yes □ No</td>
<td></td>
</tr>
</tbody>
</table>

Signature: __________________________________________ Date: ________________
NOTICE OF PRIVACY PRACTICES
This notice describes how Fox Valley Plastic Surgery may use and disclose your healthcare information and how you can obtain access to this information. Please review it carefully.

Fox Valley Plastic Surgery is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Fox Valley Plastic Surgery or received by Fox Valley Plastic Surgery from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Fox Valley Plastic Surgery will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.

Fox Valley Plastic Surgery reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not Requiring Your Consent

Fox Valley Plastic Surgery may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations.

Treatment may include:
• Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
• Consultations between healthcare providers concerning a patient;
• Referrals to other providers for treatment;
• Referrals to nursing homes, foster care homes, or home health agencies.

For example, Fox Valley Plastic Surgery may determine that you require the services of a specialist. In referring you to another doctor, Fox Valley Plastic Surgery may share or transfer your healthcare information to that doctor.

Payment activities may include:
• Activities undertaken by Fox Valley Plastic Surgery to obtain reimbursement for services provided to you;
• Determining your eligibility for benefits or health insurance coverage;
• Managing claims and contacting your insurance company regarding payment;
• Collection activities to obtain payment for services provided to you;
• Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
• Obtaining pre-certification and pre-authorization of services to be provided to you.

Fox example, Fox Valley Plastic Surgery will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include
• Contacting healthcare providers and patients with information about treatment alternatives;
• Conducting quality assessment and improvement activities;
• Conducting outcomes evaluation and development of clinical guidelines;
• Protocol development, case management, or care coordination;
• Disclosing Protected Health Information for accreditation purposes;
• Conducting or arranging for medical review, legal services, and auditing functions.

For example, Fox Valley Plastic Surgery may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

Fox Valley Plastic Surgery may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a patient, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient’s healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when Fox Valley Plastic Surgery is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

**As permitted or required by law.**

In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime.

**For public health activities.**

We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child. We may release healthcare records, to the Food and Drug Administration when required by federal law. We may disclose healthcare records for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

**For health oversight activities.**

We may disclose healthcare records in response to written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification.

**Judicial and Administrative Proceedings.**

Patient healthcare records may be disclosed pursuant to a lawsuit court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records.

**For activities related to death.**

We may disclose patient healthcare records to a coroner or medical examiner for purpose of completing a medical certificate or investigating a death.

**For research.**

Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

**To avoid a serious threat to health or safety.**
We may report a patient’s name and other relevant data to the Department of Transportation if it is believed the patient’s vision or physical or mental condition affects the patient’s ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

For Workers Compensation.
We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

Fox Valley Plastic Surgery will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that Fox Valley Plastic Surgery has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Fox Valley Plastic Surgery to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would no apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Fox Valley Plastic Surgery may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Fox Valley Plastic Surgery send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Fox Valley Plastic Surgery not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Fox Valley Plastic Surgery amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Fox Valley Plastic Surgery for the six years prior to the date of the request, beginning with disclosures made after April 14th, 2003. We are not required, however, to record disclosures we make pursuant to signed consent or authorization.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with Fox Valley Plastic Surgery and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Fox Valley Plastic Surgery, please contact the Privacy Officer at Fox Valley Plastic Surgery.

It is the policy of Fox Valley Plastic Surgery that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.
I, ____________________________________________________________, have been given the opportunity to read, review, obtain a hard copy and ask questions about Fox Valley Plastic Surgery's Notice of Privacy Practices, and how Fox Valley Plastic Surgery uses and discloses my information and my rights concerning my information.

Patient or Personal Representative Signature: ____________________________________________ Date: ______________

If Personal Rep, describe relationship ____________________________________________

☐ The patient’s condition prohibits the individual from signing an acknowledgement at the time. It will be obtained as reasonably practicable after the patient’s condition improves.

☐ Acknowledgment was unable to be obtained. Reason:

________________________________________________________________________

________________________________________________________________________
FINANCIAL POLICY

Thank you for choosing us as your health provider. We are committed to your successful treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment. If at any time you have questions regarding any treatment, fee, or service, please discuss them with us promptly. We will make every effort to avoid a misunderstanding.

ALLOWABLE FORMS OF PAYMENT

The patient or his/her legal representative is ultimately responsible for all charges incurred. Our office accepts payment by cash, check and credit cards from Visa, Mastercard, Discover and American Express.) We also offer patient financing through Care Credit.

INSURANCE/CO-PAYS/DEDUCTIBLES

As a courtesy to you, we will file your insurance claims for you. Our office accepts assignment of benefits for many insurance companies. However, we are not participating providers with all of them, so please inquire as to whether we are with your plan. We will verify your coverage and will estimate what your patient responsibility will be through co-pays, deductibles and co-insurance. You are responsible for paying these out of pocket expenses before any surgery or office procedure is done. Your health care policy is a contract between you and your insurance company. It is ultimately your responsibility to pay for all services provided by Fox Valley Plastic Surgery.

INJURIES/ACCIDENTS

If your injury or accident involves litigation, a letter of protection needs to be obtained from the attorney involved.

BILLING

Statements are mailed monthly and expected to be paid in full within 60 days after your insurance has paid unless other arrangements have been made with our Financial Supervisor. If payment is not received in 90 days, your account will be turned over to a collection agency.

Thank you for understanding our Financial Policy. If you should have questions or problems, please let us know and we will be happy to assist you in every way possible.

I have read the above Financial Policy. I understand and agree to this.

<table>
<thead>
<tr>
<th>Patient’s or Responsible Party’s Signature</th>
<th>Date</th>
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</table>

I consent to having before and after photographs taken of me or parts of my body. These will be used for office and insurance prior authorizations purposes only.

<table>
<thead>
<tr>
<th>Patient’s or Responsible Party’s Signature</th>
<th>Date</th>
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I hereby authorize my insurance benefits to be paid directly to FVPS realizing I am responsible to pay any and all charges that exceed or that is not covered by insurance. I authorize the release of pertinent medical information to insurance and workers comp carriers.

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<th>Patient’s or Responsible Party’s Signature</th>
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I hereby consent to and authorize the use and reproduction by Fox Valley Plastic Surgery, or anyone authorized by them, of any and all photographs, electronic images or video footage of me taken by FVPS, or that FVPS 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 FVPS website and social media sites such as YouTube, Facebook and Twitter. The Images (including any photographic negatives) shall be the sole property of FVPS.

I understand that the Images will not be identified by my name, but that such Images may reveal my identity. I understand and accept these terms.

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 FVPS 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 the reproduction thereof as stated above, including any claim for payment in connection with distribution or publication of the video and/or photographs.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Fox Valley Plastic Surgery.

I hereby warrant that I am at least eighteen years old, and competent to contract in my own name insofar as the above is concerned.

The purpose of this form is to obtain my prior written consent so that Fox Valley Plastic Surgery may photograph or film me for one or more of the following purposes listed below for which I do hereby consent. Initial all that apply:

________ Medical Use: Use or disclosure of image for medical specialty board in formulating its examination of applicant physicians, or in a professional presentation or journal publication

________ Office Use: Use or disclosure of image for marketing or advertising purposes and patient education within the office

________ Internet Use: Use or disclosure of image for marketing or advertising purposes and patient education via print, visual and electronic media

Photo Limitations: ________________________________________________________________

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

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