Family Medical Eye Center Dr. Robert Fox
2216 Buenaventura Blvd.
Redding, CA 96001
(530) 241-6550
www.eyedocfox.com

Marketing Consent for TempSure™ Wrinkle, Tissue Heating, and Cellulite Treatments

CLIENT INFORMATION CONSENT AND RELEASE

DATE:______________________

Cynosure, Inc. has requested permission to use information and images from your TempSure treatment procedure(s), which includes and is not limited to, my personal health information related to the procedure (e.g. age, gender, skin type, treatment regimen, etc.) as well as procedure and client descriptions (e.g. portrait, picture, likeness; and my voice). Any or all of which may be used in a recording, videotape, television production or reproduction, sound track recording, film strip, still photograph, medical research, product development, training or other written materials or articles for publication purposes, including use on website(s) supported by Cynosure, Inc. Such information and images will become a part of my personal health records and, under certain circumstances, may be shared or given to third parties as a part of my health records. I will have the ability to review and access such information and images as a part of my health records and provide corrections to errors I believe exist. Beyond this, I acknowledge that I have no rights, title or interest in the information and images, including claim of copyrights.

I consent to photographs and videos being taken only with the consent of my practitioner, and under such conditions and at such times as may be approved by my practitioner. I agree that the photographs and videos shall be taken by my practitioner or by a photographer approved by my practitioner.

I hereby grant to Cynosure, Inc., its successors, assigns, and anyone acting under its authority or permission, the right to make originals, copies or derivate works of the information and items referred to in this Consent Form, where appropriate and to use for any lawful purpose (including publicity and other trade purposes) throughout the world and reproduce at any time in any form or manner and to copyright any form or manner capturing the information and items referred to in this Consent Form.

I hereby release Cynosure, Inc. and its successors from any claim, which I might otherwise have as a result of any such use, copyright or publication.

Client name (please print): ____

Signature: ____

Date ____

MEDICAL HISTORY FORM

Family Medical Eye
Center Dr. Robert Fox
2216 Buenaventura Blvd.
Redding, CA 96001
(530) 241-6550
www.eyedocfox.com

Last Name: ________________________________ First Name: ____________________________

Address:____

City:______________________State:____________Zip Code: ____________

Telephone: Home:__________________ Work:_________________________Cell: ______________________

Date of Birth: _______________ Sex: Female ___ Male ____

Family Doctor:_________________________Phone: ________________

Pharmacy:_____________________________Phone: ________________

Emergency Contact:_______________________Phone: ______________

Which body area/areas would you like treated? ________________________

Please answer all of the following questions **YES NO**

1. Do you have **ANY** current or chronic medical illnesses? ☐ ☐

   Disclose any history of heat urticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness.

   Please List: ____

2. Do you have **ANY** current or chronic skin conditions? ☐ ☐

   Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition.

   Please List: ____

3. Are you currently under a doctor's care? If so, for what reason? ☐ ☐

   ____

		YES	NO
1.	Do you take/use **ANY** medications (prescriptions and non-prescriptions), vitamins, herbal or natural supplements, on a regular or daily basis?	☐	☐
	Please List: ______________________________		
5.	Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis?	☐	☐
	Please List: ______________________________		
6.	(For women) are you or could you be pregnant?	☐	☐
7.	Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)?	☐	☐
8.	Do you have **ANY** allergies to medications, foods, latex or other substances?	☐	☐
	Please List: ______________________________		
9.	Have you ever taken oral or injected gold therapy?	☐	☐
10.	Do you have a history of herpes I or II in the area to be treated?	☐	☐
11.	Do you have a history of keloid scarring or hypertrophic scar formation?	☐	☐
12	Do you have any open sores or lesions?	☐	☐
13.	Do you have any history of radiation therapy in the area to be treated?	☐	☐
14.	In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications?	☐	☐
	Please List product name and date last used: ______________________________		
15.	Do you have a history of surgery or other treatments, medical or cosmetic, in the area to be treated?	☐	☐
	If yes, please list______________________________		
16.	Do you have or have you ever had a hernia?	☐	☐
17.	Have you taken Accutane® (or products containing isotretinoin) in the last 12 months?	☐	☐
18.	Do you have a history of fainting or passing out?	☐	☐
19.	Do you consider yourself to have an anxious or nervous personality?	☐	☐
20.	Do you consider yourself claustrophobic or have issues with confinement?	☐	☐
21.	Have you had any unprotected sun exposure or used tanning beds or lamps in the last week?	☐	☐

Signature:______________________________Date:__________________

Reviewed by:____________________________Date:__________________

Family Medical Eye Center, Robert C. Fox MD

2216 Buenaventura Blvd Redding, CA 96003 530-241-6550

CONSENT TO OPERATION, ANESTHETICS AND OTHER MEDICAL SERVICES

Patient's Name:

Date of Birth:

Date:

I authorize Dr. Robert C. Fox and whomever he designates as his assistants, to perform the following surgery.

I consent to the administration of such anesthetics as may be considered necessary or advisable.

I agree that I have read and fully understand the above CONSENT TO OPERATION, ANESTHETICS AND OTHER MEDICAL SERVICES form, and that alternative modes of treatment were explained to me by my doctor.

I also agree that no guarantee or assurance has been made as to the results that may be obtained.

SIGNED:____

WITNESS: ______________________________________

PATIENT RIGHTS REGARDING PROTECTED HEALTH INFORMATION

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be

involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes that it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

You may revoke this authorization at any time, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contract of your complaint. We will not retaliate against you for filing a complaint. Please direct your complaints to the office manager.

This notice was published and becomes effective on or June 2003

Your signature below acknowledges that you have received and accept this notice of our privacy practices.

Patient Name: ______________________________ **DOB** ____________

Patient Signature: ______________________________ **Date:** ____________

PLEASE MARK ALL THAT APPLY:

2. Signature above is not the patient's signature. Please print signee's name and relationship to patient (i.e. Legal Guardian/Parent, POA, Caregiver, etc.)______________________________________

3. I authorize Dr. Fox and his staff members to leave messages on my home/cell/work number(s) regarding appointments and billing questions.

4. I authorize Dr. Fox and his staff members to discuss my protected health information with the following people:

Name: ______________________ **Relationship:** ______________________

Name: ______________________ **Relationship:** ______________________

HIPAA NOTICE OF PRIVACY PRACTICES FOR THE OFFICE OF
ROBERT C. FOX, MD, INC
2216 BUENAVENTURA BLVD
REDDING, CA 96001

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also

describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

DISCLOSURES FOR HEALTH TREATMENT

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

DISCLOSURES FOR HEALTHCARE OPERATIONS

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, speak with our office manager in person or by phone.

We reserve the right to change the terms of this notice and will inform you of any changes.

DISCLOSERS FOR PROVIDER COMPENSATION

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for the treatment.