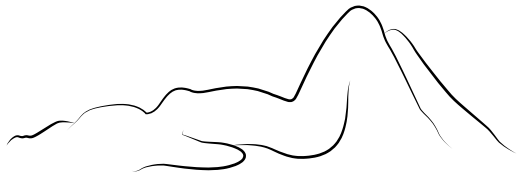


AESTHETIC SURGERY ASSOCIATES

History Intake Form

To assist our doctor's and staff in delivering the highest quality of care possible, we need information that will help us assess your overall health status and conditions that may affect your care

Name:_____ Birth Date:_____

Age: _____ Height_____ft. _____inches Weight _____ lbs

Primary Care Doctor:_____

Exactly why are you here to see our Doctor (Chief Complaint)?

_____

Do you have any allergies to drugs or medications? Yes ○ No ○ If yes, please list them below

_____

Do you use: Aspirin, Motrin, Naprosyn, or other Anti-inflammatory medicines: Yes ○ No ○

Have you ever had surgery? Yes No If yes, please list them below

_____

Have you ever had trouble with any anesthetic? Yes ○ No ○
If so, please explain _____

Do you have any illnesses? Please list them below

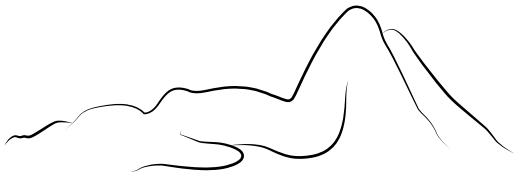
_____

Do you take any medications? Yes ○ No ○ If yes, please list them below

_____

Do you take any dietary supplements, vitamins, or herbal preparations? Yes ○ No ○

What are they? _____



AESTHETIC SURGERY ASSOCIATES

Patient Photographic Authorization and Release

I, _____authorize Dr. Day and/or Aesthetic Surgery Associates, to take photographs, slides or videotapes of me or parts of my body for my procedure(s) and for medical purposes to be used for my care, medical presentations and/or articles.

In addition, I authorize the use of these images, without compensation to me, for the following specific purposes: (Please initial in the boxes marked Yes or No for each item)

Yes	No	Medium
		in the office photo album for prospective patients.
		in office seminars for prospective patients.
		on our website for prospective patients.
		in print or online advertisements
		on any other forms of media (Facebook, radio, etc.)

I understand that:

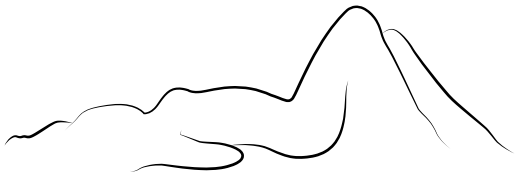
1. Such photographs, slides or videotapes may be published by Dr. Day and/or Aesthetic Surgery Associates in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that such uses may also include marketing on behalf of Dr. Day, for which Dr. Day may be receive direct or indirect remuneration.

2. I will not be identified by name in any of the media described above; however, I also understand that in some circumstances the photographs, slides, or videotapes may display features that identify me.

3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to Aesthetic Surgery Associates at 800 W. Central Texas Expwy Suite 100, Harker Heights, TX, 76548-1990 A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Day and/or Aesthetic Surgery Associates.

4. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.

5. A copy of this Authorization is valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.



AESTHETIC SURGERY ASSOCIATES

Patient Photographic Authorization and Release

I release and discharge Dr. Day and/or Aesthetic Surgery Associates from all liability, including liability for negligence that in any way arises out of:

1. Any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization; and

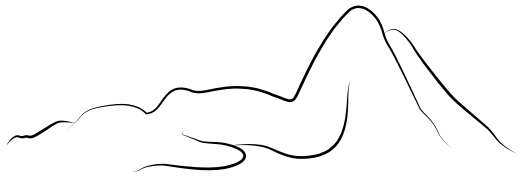
2. Any claim that I may have or may have had relating to such use and disclosure of those photographs, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public education and certifies that I have read this Authorization and Release carefully and fully understand its terms.

If I have questions about the use or disclosure of my photographs, slides, or videotapes, I can contact Aesthetic Surgery Associates at (254) 526-5106

Signature_____ Date_____

Witness_____



AESTHETIC SURGERY ASSOCIATES

Family History/Past History/Systems Review

Family History

Has any blood relative ever had the following?

	Yes	No		Yes	No		Yes	No
Breast Cancer	○	○	High Blood Pressure	○	○	Kidney Disease	○	○
Other Cancers	○	○	Heart Disease	○	○	Liver Disease	○	○
Melanoma	○	○	Stroke	○	○	Bleeding disorder	○	○
Depression	○	○	Congenital Deformity	○	○	Diabetes	○	○

Past Medical History

Have you ever had the following?

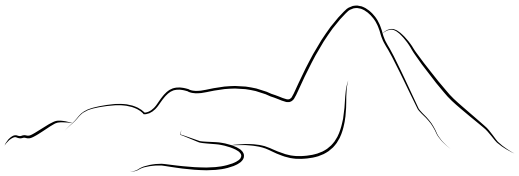
	Yes	No		Yes	No		Yes	No
Breast Cancer	○	○	High Blood Pressure	○	○	Kidney Disease	○	○
Other Cancers	○	○	Heart Disease	○	○	Liver Disease	○	○
Melanoma	○	○	Stroke	○	○	Bleeding disorder	○	○
Depression	○	○	Congenital Deformity	○	○	Mitral Valve prolapse	○	○
Stomach Ulcer	○	○	Thyroid Disease	○	○	Diabetes	○	○
AIDS or HIV+	○	○	Hepatitis	○	○	Anemia	○	○
Tuberculosis	○	○	Asthma	○	○	Glaucoma	○	○
Arthritis	○	○	Rheumatic Fever	○	○	Contact lenses	○	○
Eating Disorders	○	○	Migraine Headaches	○	○		○	○

Any other medical problem not listed? If so, please write it down on page 1.

Review of Systems

Do you have now or have you had within the past year?

	Yes	No		Yes	No		Yes	No
Weight Change	○	○	Swollen feet or ankles	○	○	Seizures	○	○
Dry Eyes	○	○	Skin Rash	○	○	Joint or Muscle Pain	○	○
Chronic Cough	○	○	Chest Pain	○	○	Swollen lymph nodes	○	○
Rapid Heart Beat	○	○	Irregular Heart Beat	○	○	Easy Bruising	○	○
Depression	○	○	Chronic Diarrhea	○	○	Easy Bleeding	○	○
Severe Infections	○	○	Jaundice	○	○	Numbness in hands or feet	○	○
Visual changes	○	○	Shortness of Breath	○	○	Breast masses or lumps	○	○
Urinary Burning	○	○	Urinary incontinence	○	○	Heat or cold intolerance	○	○
Blood Clots/DVT	○	○						



AESTHETIC SURGERY ASSOCIATES

Family History/Past History/Systems Review

Women Only

Are you pregnant now? Yes ○ No ○

Age period began_____

Did You Breast Feed? Yes ○ No ○

Are you planning additional pregnancies? Yes ○ No ○

Number of pregnancies 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ More ○

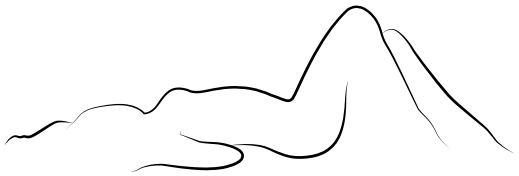
Number of Children 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ More ○

Date of last mammogram_____ Where was it done?_____

Do you do regular breast self-examinations? Yes ○ No ○ How Often? _____

I VERIFY THAT THE PRECEEDING INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

X_____ Date: _____/_____/_____



AESTHETIC SURGERY ASSOCIATES

Registration Information

Patient Name:_____
Patient Address: _____
City: _____ State:_____ Zip: _____

Birth Date: _____/_____/_____ Age: _____

SSN#: _____-_____-_____ Driver's Lic: State: _____ #: _____

Patient Phone:
Home: (_____)_____ Cell: (_____)_____
Business: (_____)_____

E-mail: _____Occupation: _____

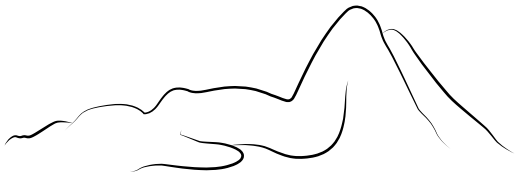
Patient / Spouse (circle one)

Emergency Contact: _____Relationship: Spouse Other_____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (_____)_____ Alternate Phone: (_____)_____

Referral Source: _____

Insurance Information (Please list all Insurances)

Insurance Company: _____
Insured Name: _____
Group #:_____ ID #: _____



AESTHETIC SURGERY ASSOCIATES

Registration Information

Assignment of Benefits

I hereby authorize direct payment of medical and/or surgical benefits to Aesthetic Surgery Associates for services rendered by its physicians in person or under their supervision. I understand that I am financially responsible for any balance not covered by any insurance.

I hereby authorize Aesthetic Surgery Associates to release any medical information that may be necessary for either medical care and/or in processing applications for financial benefits.
I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

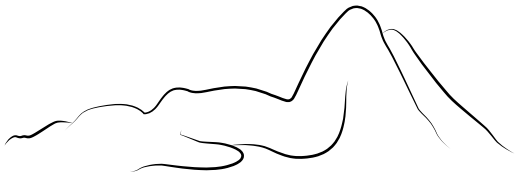
A photocopy of these assignments shall be valid as the original.

Signature: _____ Date: _____/_____/_____

Printed Name: _____

Responsible Person: _____ Date: _____/_____/_____

Relationship to Patient: _____



AESTHETIC SURGERY ASSOCIATES

Social History

Although some of the following questions may be highly personal in nature, they are intended to insure your safety during surgery and in the recovery period. Many supplements, drugs and medications can have serious interactions with anesthesia. In addition, living situations and the degree of support during recovery can have significant impact on how smoothly your post-operative course can be. We apologize for any feelings that the questions may raise regarding your privacy. Our only interest is in the safety and quality of your care. Rest assured, your answers to the questions will remain private unless you specifically agree to release the information in writing.

Are you: Married ○ Single ○ Divorced ○ Widowed ○ Separated ○

Do you live with: Alone ○ Family ○ Friend ○

Do you smoke? Yes ○ No ○ If so, how many packs a day? _____

For how long? _____

Do you take drugs? Yes ○ No ○ If so, what? _____

How often? _____

Do you drink alcohol? Yes ○ No ○ How many drinks in a week?_____

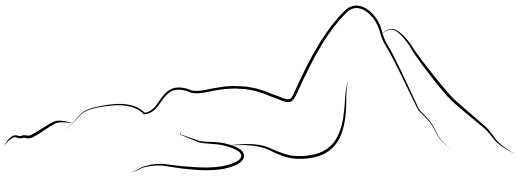
Do you exercise? Yes ○ No ○ How many times a week? 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○

Do you have significant fears or phobias related to medical care? Yes ○ No ○

If you have fears, what are they?

_____

Do you have hobbies? Yes ○ No ○ What are they? _____



AESTHETIC SURGERY ASSOCIATES

Patient Privacy Consent

The following is a consent that gives Aesthetic Surgery Associates, its staff, and Physicians permission to use or disclose Protected Health Information for treatment purposes, payment for medical services, or health care operations. These uses are described in the patient privacy statement, a copy of which has been supplied to you with this consent.

Although Protected Medical Information can be released to third-parties under current federal and state law without a specific consent being signed, we at Aesthetic Surgery Associates feel that it is important for every patient to understand the concept and use of their personal information as applies to our practice.

Protected Health Information is specific information that our practice has compiled as part of your medical record. It includes information such as: past medical history, history of present illness, review of systems, physical exam, diagnosis, procedure or operative reports, laboratory results, clinical photographs, x-ray results, pathology results, and information regarding medically implanted devices. Personal information such as your name, address, insurance information, social security number, and other items are included in the definition.

Under certain conditions or circumstances, treatment may be conditional upon signing this consent. These circumstances involve concerns we may have that restrictions will compromise the quality or appropriateness of your care.

Your Rights

You have the right to review our Privacy Policy Statement before signing this consent, and we encourage you to do so. If you have any questions about this consent, or our Privacy policy, please bring it to the attention of our staff and we will be more than happy to clarify them for you.

You have the right to submit a request in writing at any time in the future to restrict this consent, or revoke it. Your request to revoke or restrict Protected Health Information will not affect information that has already been disclosed prior to your request.

Consent

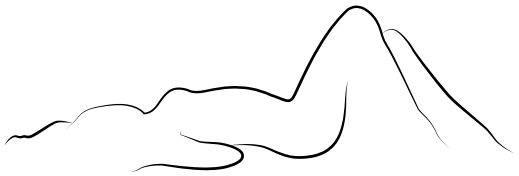
I hereby give permission for Aesthetic Surgery Associates to use or disclose my Protected Health Information for Treatment Purposes, Medical Services, or Health Care Operations. This authorization includes release of any medical information that may be necessary for either medical care or processing applications for financial benefits.

Signature: _____ Date: _____/_____/_____

Printed Name: _____

Authorized Representative: _____

Relationship: _____ Date: _____/_____/_____



AESTHETIC SURGERY ASSOCIATES

Patient Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFLLY.

Your privacy and safeguarding your medical information are critical concerns to us here at Aesthetic Surgery Associates. The Federal Government's Health Information Portability and Accountability Act (HIPAA) requires that every patient receives notification about how the details of your current or past health condition (Protected Health Information or PHI) are disclosed to those outside our practice. We agree with this policy, and will do our utmost to protect personal information about you that our practice may have in your record. Although our policy is to disclose information only after receiving a written release from you, or from someone legally responsible for you, we will disclose information to persons and organizations outside the practice under certain conditions. These conditions involve filing insurance claims, communicating with other doctors or organizations (hospitals, labs, health care agencies and governmental agencies), or performing those tasks necessary to conduct your medical care.

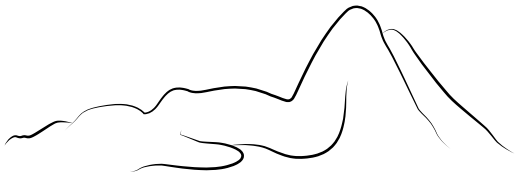
Given the complexity of modern medicine, and the insurance industry, there are a number of appropriate circumstances in which we will need to disclose or use your Protected Medical Information without your specific written consent. These uses are best described in terms of the following categories:

For Treatment: In order to undertake, coordinate, or complete a patient's treatment we may need to disclose Protected Health Information to nurses, pharmacists, doctors, lab technicians, X-ray technicians and other individuals involved in your care.

For Health Care Operations: We may use or disclose your Protected Health Information to others in connection with reviews of our practice carried out as part of a quality assurance program or records review conducted by outside insurance agencies or governmental agencies responsible for regulation medical practices or insuring compliance with existing regulations. If these reviews are conducted, we will make every attempt to protect your identity and comply with the review while protecting the anonymity of our patients. However, sufficient material may need to be disclosed that could possibly reveal your Protected Medical Information.

Appointment Reminders or Verification: We may need to disclose Protected Health Information about you in connection with appointment reminders by phone or by mail. Simply by identifying ourselves as a caller, other persons may learn that you are under treatment by us. We will make every effort to be discreet, but your information may need to be used to remind you or an appointment, or verify to others that you have an appointment.

Individuals Involved in Care of Payment of Care: Our practice may disclose Protected Health Information to friends or family members who are involved in our patient's care. Information will be disclosed with the intent of insuring the accurate conduct of care, or to answer questions about appropriate delivery of care.



AESTHETIC SURGERY ASSOCIATES

Patient Privacy Notice

Research / Medical Literature: Our doctors participate in research which may involve collection and use of your Protected Medical Information in connection with a study, journal article, or educational program. Before using your information a valid authorization to do so will be specifically requested from you. You are under not obligation to participate in any research being conducted.

As Required by Law or to Avert a Serious Threat to Health or Safety: Protected Health Information may be disclosed or used when required by public law. An example of this is the requirement to release specific patient information when certain kinds of communicable disease is involved in your treatment.

For Payment: Our practice may use or disclose Protected Health Information to third-party payers (insurance companies or Government Agencies) so that we may receive payment for treating you.

Patient Rights

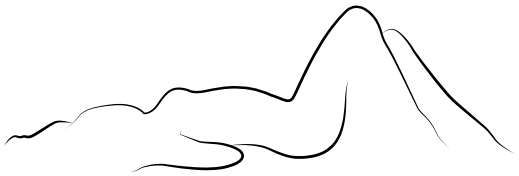
UNDER THE NEW HIPAA GUIDELINES, YOU HAVE SPECIFIC RIGHTS CONCERNING THE USE OF AND DISCLOSURE OF YOUR PROTECTED MEDICAL INFORMATION. PLEASE READ THE FOLLOWING CAREFULLY SO THAT YOU UNDERSTAND THOSE RIGHTS

Right to Request Restrictions: You have the right to request restrictions and limitations on how your Protected Medical Information is used or disclosed. This is done through a written request specifying the limitations that you wish to have placed. We will make every effort to agree to reasonable requests that do not complicate or compromise your care. If we agree to your requested restrictions, we will abide by them until such time as the patient removes them in writing. Aesthetic Surgery Associates may not be able to safely or thoroughly conduct your care with these restrictions, and is not required to agree to them.

Right to Inspect and Copy Your Information: You have the right to inspect and obtain a copy of Protected Medical Information that may be used to make treatment decisions in your care. Simply make the request in writing to our office for a copy of your information. A small fee may be charged for copies to defray the additional office expense.

Right to Amend: You have the right to make a written request to amend medical information that you believe is inaccurate or incomplete. We have every interest in maintaining highly accurate records about you and welcome the chance to further improve them. Please submit any changes to us in writing. However, Aesthetic Surgery Associates may deny the request if we feel that the original information in accurate or complete.

Right to Request Confidential Communications: You have the right to request that our practice, or its physicians, communicate with you in a certain manner (for example: e-mail, mail, cell phone etc.). This is to assure that you are able to select the method that most protects your privacy. Your request will need to be submitted in writing.



AESTHETIC SURGERY ASSOCIATES

Patient Privacy Notice

Right to an Accounting of Disclosures: You have the right to request an accounting of all disclosures our practice has made of your Protected Health Information over a reasonable period of time. You may be charged an administrative fee for each list requested.

Right to a copy of the Privacy Statement and Statement of Patient Rights: You will be furnished with a copy of this document when you first register with our practice. Additional copies will be provided on request. When and if the practice develops a web site, the document will be available as a download.

The Practice's Responsibilities

Aesthetic Surgery Associates and its Physicians are required by law to maintain the Patient Privacy Notice and abide by its terms from its effective date. If our privacy practices are modified in the future, and these modifications affect use and disclosure of previously obtained Protected Health Information, the modified policy can be obtained from our practice on demand. In the event that we change our policy, or if a change in the law affects the patient's rights or our responsibility, we will promptly amend our privacy policy and advise our patients of the change.

Point of Contact: If you have concerns about your Protected Medical Information, or need additional help in understanding how and under what circumstances it is used, please contact our office for more details.

Effetive Date of this Privacy Policy: September 6th, 2002

I have reviewed the Patient Privacy Notice and have received a copy.

Patient Signature: _____ Date: _____/_____/_____

Printed Name: _____(intiails)