PATIENT MEDICAL HISTORY FORM

Last Name:_____ First Name:_____ Sex: F M
Address:_____ City:_____ State: ____ Zip:_____
Home Phone:_____ Cellular:_____ Email:_____
Birthdate: _____ Age:_____ Height:_____ Weight:_____ Waist: _____ Pant size _____ Shirt_____
Person to Contact in Case of Emergency and Telephone Number:_____
Family Physician:_____ Phone:_____
Ocupation:_____
Please answer the following by Circling YES or NO:

High Blood Pressure : YES NO
Bleeding Disorder : YES NO
Anemia: YES NO
Liver Disease: YES NO
Heart Disease: YES NO
Psychiatric illness : YES NO
HIV: YES NO
Herpes I or II: YES NO
Blood Clots : YES NO
History of Seizure: YES NO
Asthma: YES NO

Skin Disease: YES NO
Thyroid Disease: YES NO
Lung Disease: YES NO
Tuberculosis: YES NO
Hepatitis: YES NO
Diabetes: YES NO
Shortness of Breath: YES NO
Keloid Scarring: YES NO
Kidney Disease: YES NO
Dizziness or Fainting: YES NO
Vascular Disease: YES NO

Hernia/Umbilical:I currently have one/have history of having one: YES NO
Have you ever lost over 50lbs? YES/NO What Area:_____Month/Year_____
Please list any other medical history the doctor should be aware of:_____
Have you ever had an HIV test? YES/NO If YES then When:_____Results:_____
Have you recently been under the care of a physician for any reason? YES NO
If "YES"Please explain:
(for Women)Are you or could you be pregnant? YES/NO Last Menstrual Period: / /
MEDICATION:
Please list medications you currently take, Including appetite suppressants, vitamins, herbal supplements, or any homeopathic medication:
_____
Have you taken Accutane or Anticoagulants in the last 6 months? YES NO
Do you have any ALLERGIES and/or SENSITIVITIES? (Please indicate by circling YES or NO):

Penicillin: YES NO Aspirin: YES NO Lidocaine: YES NO Novocaine: YES NO
Sulfa: YES NO Xylocaine: YES NO Codeine: YES NO
Latex: YES NO Shellfish: YES NO Valium: YES NO
Any Other:: _____
Cigarette Smoking: YES NO How long since last use and how many?_____
Alcohol Use: YES NO How much?_____
Do you take Vitamin E: YES NO Drug Use: YES NO
Please list all previous surgeries, as well as Cosmetic:_____
_____Date:_____
_____Date:_____
Any complications or problems during or following the above procedure: YES NO
Which body area/areas would you like treated:_____
What are your expectations for liposuction?_____
Have you ever had Liposuction? YES/NO What Area:_____Month/Year_____
Have you has Gastric Bypass, Sleeve, Lapband, or other Weight Loss Surgeries:Y/N Month/Year_____
Have you had any Laser Treatment, Coolsculpting in the past?_____Month/Year_____

Signature_____ Date:_____

Downsize

Notice of Privacy Practices

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

Downsize is required by law to maintain the privacy of Protected Health Information ("PHI") and to provide you with notice of our legal duties and privacy practices with respect to PH I. PH I is 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. This Notice of Privacy Practices ("Notice") describes how we may use and disclose PHI to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to your PHI. We are required to provide this notice to you by the Health Insurance Portability and Accountability Act ("HIPAA").

Downsize is required to follow the terms of this Notice. We will not use or disclose your PHI without your written authorization, except as described or otherwise permitted by this Notice. We reserve the right to change our practices and this Notice and to make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised Notice to you.

Examples of How We Use and Disclose Protected Health Information About You

Treatment. We may use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment. We may use your health information for various payment purposes. Example: We may contact your insurer or other health care payer to determine whether it will pay for your medications.

Health Care Operations. We may use your health information for certain operational, administrative and quality assurance activities. This information will be used in an effort to continually improve the quality and effectiveness of service we provide.

Special Uses. We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We are permitted to use or disclose your PHI for the following purposes. However, Downsiz may never have reason to make some of these disclosures. To Communicate with Individuals Involved in:

Your Care or Payment for Your Care. We may disclose to a family member, other relative, close personal friend or any other person you identify, PHI directly relevant to that person's involvement in your care or payment related to your care.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public Health. As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement. We may disclose your PHI for law enforcement purposes as required by law or in response to a subpoena or court order. We may also disclose your PHI when required to do so by federal, state, or local law.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI for approved medical research.

Notification. We may use or disclose your PHI to notify or assist in notifying a family member, personal representative, or another person responsible for your care, regarding your location and general condition.

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions. If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority and to correctional institutions or for national security purposes.

Other Uses and Disclosures of PHI.
We will obtain your written authorization before using or disclosing your PHI for purposes other than those provided for above (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Obtain a paper copy of the Notice upon request. You may request a copy of our current Notice at any time. Even if you have agreed to receive the Notice electronically, you are still entitled to a paper copy.

Request a restriction on certain uses and disclosures of PHI. You have the right to request additional restrictions on our use or disclosure of your PHI by sending a written request. We are not required to agree to those restrictions. We cannot agree to restrictions on uses or disclosures that are legally required, or which are necessary to administer our business.

Inspect and obtain a copy of PHI. In most cases, you have the right to access and copy the PHI that we maintain about you. To inspect or copy your PHI, you must send a written request. We may charge you a fee for the costs of copying, mailing and supplies that are necessary. We may deny your request to inspect and copy in certain limited circumstances.

Request an amendment of PHI. If you feel that PHI we maintain about you is incomplete or incorrect, you may request that we amend it. To request an amendment, you must send a written request. You must include a reason that supports your request. In certain cases, we may deny your request for amendment.

Accounting of disclosures. You have the right to receive an accounting of the disclosures we have made of your PHI for reasons other than treatment, payment, or health care operations.

For More Information or To Report a Problem
If you have questions, requests or complaints, or are concerned that we have violated your privacy rights please contact:

Director of Patient Operations
7515 South Main St. Houston
TX,77030. Suite #780

If you believe your privacy rights have been violated, you can file a complaint with the Secretary of Health and Human Services.

I_____
_____
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed_____

Date_____

If not signed, reason why acknowledgement was not obtained_____
_____

Staff Witness seeking acknowledgement:

_____Date_____

DOWNSIZE!

CONSENT FOR TUMESCENT LIPO SURGERY

I authorize **Dr. Hennessy** to perform tumescent lipo on me to facilitate the removal of unwanted fat and/or provide body contouring. Tumescent lipo is a body contouring and sculpting technique. It is a means of reducing localized fat deposits that are difficult or impossible to remove with diet or exercise. I understand that the procedure is elective, and not having this procedure is an option. Just as there may be benefits to the procedure(s) proposed, I also understand that the procedure involves risks.

I clearly understand and accept the following:

1) The goal of tumescent lipo surgery, as in any cosmetic procedure, is improvement – not perfection.

2) The final result may not be apparent for 3 to 6 months post-operatively.

3) Tumescent lipo surgery is a contouring/sculpting procedure and is **not** performed for purposes of weight reduction, nor as a substitute for healthy diet and exercise.

4) Strict adherence to the post-operative regimen and instructions is necessary in order to achieve the best possible results.

5) I have not taken any aspirin or aspirin-containing products for a minimum of one (1) week prior to my surgery.

6) There is **no guarantee**, expressed or implied, that the expected or anticipated results will be achieved, and I understand that this is not a technique for treating obesity.

7) Rarely, in order to achieve the best possible results, a "touch-up" procedure may be done for an additional fee.

8) I understand that tumescent lipo surgery is contraindicated in certain patients (see below) and that I am not one of these patients:

   a) Women who are pregnant or believe they might be pregnant or are nursing
   b) Patients with active thrombophlebitis or active infection
   c) Patients with poor circulation or confined to bed
   d) Patients with a history of pulmonary embolism or blood clots in the lungs
   e) Patients with a history of severe or multiple allergic reactions
   f) Patients with uncontrolled diabetes mellitus or uncontrolled collagen vascular disease (e.g. Lupus, etc.)
   g) Patients with a history of uncontrolled bleeding
   h) Patients with positive blood tests for hepatitis, HIV, or AIDS

Although complications following tumescent lipo are infrequent, I understand that the following may occur:

1) Infection is rare, but should it occur, treatment with antibiotics and/or surgical drainage may be required.

2) Numbness or increased sensitivity of the skin over treated areas may persist for weeks or months. Rarely, it is possible that localized areas of numbness or increased sensitivity could be permanent.

3) Normal temporary side effects associated with tumescent lipo surgery include soreness, inflammation, bruising (usually resolves in about 3 weeks), swelling or edema, numbness, and minor irregularity of the skin. Some of these effects may persist for weeks or months after the tumescent lipo procedure. Discomfort may last, on average, from 4-6 weeks.

4) Skin irregularities, lumpiness, hardness, and dimpling may appear post-operatively. Most of these irregularities disappear with time and/or massage, but localized irregularities may persist permanently. Additional procedures or medical care may be needed. If loose skin is present in the treated area, it may or may not shrink to conform to the new contour.

Patient Initials

Objectionable scarring or pigment changes are unusual because of the small size of the incisions used, but scar formation, such as keloids, or permanent pigment changes are possible.

6) For patients with skin of color, hyperpigmented scars (dark to black scars) can occur at the incision sites and be permanent.

7) Dizziness may occur during the first 24 to 48 hours following tumescent lipo surgery, particularly upon rising from a lying or sitting position, or when removing compression garments. If this occurs, extreme caution must be taken while walking. Do not attempt to drive a car if dizziness is present.

8) Surgical bleeding is very rare using the tumescent technique of lipo surgery; however, it could theoretically require hospitalization.

9) Temporary accumulation of fluid under the skin (seroma) may occur, requiring possible surgical drainage.

10) Some rare but serious complications are possible: burns, infections, poor healing, blood clots, infection, scarring, surgical shock, pulmonary complications, skin loss, hematomas (collection of blood under the skin), abscess, skin necrosis (dead skin), necrotizing fasciitis (tissue damaged by bacteria), puncture wounds in an internal organ, injury to other internal structures including nerves, blood vessels, or muscles, allergic reaction to medication or material used during procedure, and anesthesia-related complications.

11) Fat tissue, which is removed during the procedure, contains a lot of fluid. Physicians may inject large amounts of fluid during the procedure. Either may result in a fluid imbalance which could cause serious conditions such as heart problems, excess fluid collecting in the lungs, or kidney problems.

12) In addition to these possible complications, I am aware of the general risks inherent in all surgical procedures and topical, local and/or tumescent anesthesia administration. Although rare with tumescent lipo unexpected severe complications can occur, including but not limited to: allergic reaction, paralysis, convulsions, blood clots, strokes, heart attack, brain damage, or even death. It is important to discuss with your physician any past history of blood clots or swollen legs that may contribute to these conditions. Seek emergency medical care immediately if you experience shortness of breath, difficulty breathing, agitation, delirium, chest pains, or unusual heart beats.

13) I have never experienced any adverse reaction to lidocaine, epinephrine, sodium bicarbonate or steroids. I consent to the administration of any anesthesia or sedation considered necessary or advisable for my procedure. All forms of anesthesia involve risk and the possibility of complications, injury, and in rare instances death.

14) In the event of an emergency, I hereby give my consent to my transfer to a nearby hospital. I understand that I am responsible for any transportation expenses incurred for my care during the time I am in transit between institutions, as well as any hospital, physician, laboratory, or radiological expenses.

15) Before and after procedure instructions have been discussed with me. I certify that I have read this entire document and that this procedure, its potential benefits and risks, as well as alternate treatment options have been explained to my satisfaction. I have had all my questions answered, and I voluntarily authorize and freely consent to the proposed tumescent lipo treatment including the administration of medication, anesthesia, and sedation and disposal of tissue, by my physician and/or his/her associates assisted by personnel and other trained persons as well as the presence of observers.

16) I agree and understand that I will not drive myself home after having my tumescent lipo procedure. _____ is driving me home. Their telephone number is_____ and I have made arrangements to have _____ stay with me after the procedure, for the first 24 hours.

_____	_____	_____
Patient Name (Printed)	Patient Signature	Date/Time
_____	_____	_____
Witness Name (Printed)	Witness Signature	Date/Time

DOWNSIZE!

IMPORTANT INFORMATION ABOUT TUMESCENT LIPO

Risks of Tumescent Lipo Surgery: Any surgery involves the risk of infection, bleeding, scarring, or serious injury. However, tumescent lipo has an amazingly good safety record. One of the reasons that tumescent lipo is safer than other lipo techniques is that general anesthesia is not required. The greatest risks of lipo are those associated with general anesthesia. By eliminating general anesthesia, the risks of tumescent lipo are dramatically reduced.

Patients can minimize the risk of surgical complications by not taking medications or over-the-counter preparations that might adversely affect the surgery. Patients should inform the surgeon of any medications being taken regularly, or occasionally, including herbal remedies.

Cellulite: Tumescent lipo of the thighs, while improving the silhouette, does not necessarily eliminate the subtle "puckering" of the skin often called "cellulite." Cellulite results from the pull of fibrous tissue that connects skin to underlying muscle. While tumescent lipo may reduce the degree of cellulite, it is unlikely to eliminate it. Tumescent lipo should not worsen cellulite.

Tumescent Lipo and Obesity: Tumescent lipo is not an appropriate treatment for obesity. Tumescent lipo is not a substitute for a prudent diet, good nutrition, and regular exercise. Obese patients may be good candidates for limited tumescent lipo if their goal is simply to improve the shape of certain limited areas of the body.

Postoperative Healing: Normal healing after tumescent lipo involves a limited but definite degree of soreness, swelling, bruising, and lumpy firmness. A temporary mild numbness of the skin may persist for up to 4 months. Most patients can actually see some improvement of their silhouette within one week after surgery. However, because of the slow resolution of post-surgical swelling, the ultimate results following tumescent lipo usually require 12 to 24 weeks to be achieved.

Realistic Expectations: Although the results of tumescent lipo are often quite spectacular, it is not realistic to expect perfection. It is impossible to guarantee the precise amount of improvement that will result from tumescent lipo. Patients should not have unrealistic expectations. Although patients can usually expect to achieve at least a 50% improvement, it is unreasonable to expect 95% improvement or near perfection. For the perfectionist, or for tumescent lipo of a very large area, maximum improvement may require a second procedure for which an additional fee may apply.

Patients who would be satisfied with a 50% improvement would be reasonably good candidates for tumescent lipo. The "50% Improvement" is intentionally a vague measure. It indicates a definite perceptible improvement, but something short of perfection. If a 50% improvement would make a patient happy, then it is likely that these expectations will be met.

Longevity of Results: The fat cells that are removed by tumescent lipo do not grow back. If the patient later gains or loses weight, the change tends to be distributed proportionately over the entire body. Although one can expect some changes with aging, provided that the patient does not gain large amounts of weight, the new, more pleasing silhouette is relatively permanent.

Patient Name (Printed)	Patient Signature	Date/Time
Witness Name (Printed)	Witness Signature	Date/Time

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____