

ONLINE CONSULTATION



ANGELA KEEN, M.D.
Plastic Surgery & Skin Care

CONTACT INFORMATION

Name	Date Of Birth	Age	Sex
Address	City	State	Zip
Preferred Phone #	Alternate Phone		
Email Address	Preferred Contact Method		
Reason For Consult	How Did You Hear About Our Practice?		
Hobbies/Work	Does Anyone Live With You? If So, Who?		
Insurance Company	Insurance Id #		
Emergency Contact	Emergency Contact Phone #		

RESPONSIBLE PARTY IF UNDER 18...

Name	Relation		
Address (if different from above)	City	State	Zip
Preferred Phone	Alternate Phone		

GENERAL PERMIT FOR PROFESSIONAL CARE AND PHOTOGRAPHS: I hereby give permission to Dr. Angela Keen, MD and associates to render treatment as she/he sees fit upon myself or my dependent and to call any consultant or anesthesiologist, laboratory, personnel, etc., as is deemed advisable in the care of this case. I also agree to be responsible for their charges, as well as the surgeon's, hospital's and/or surgical centers' charges. I understand that photographs before and after surgery are standard of care and I agree to complete this process. I understand photographs may be used for patient education as well as quality assurance purposes. I am advised that though good results are expected, they are not guaranteed.

Patient's or Parent's Signature: _____ **Date:** _____

PATIENT INFORMATION



ANGELA KEEN, M.D.
Plastic Surgery & Skin Care

Name: _____ **Date:** _____

SKIN	YES	NO	GENERAL	YES	NO	HEAD AND NECK	YES	NO
NEW OR CHANGING LESIONS			UNEXPLAINED WEIGHT CHANGE			DIFFICULT BREATHING THROUGH NOSE		
HISTORY OF SKIN CANCER			FATIGUE			EYE PAIN		
HEMATOLOGIC	YES	NO	PERSONAL HISTORY OF CANCER			GLAUCOMA		
ABNORMAL BLEEDING/BRUISING			DIABETES			EXCESSIVE TEARING		
ANEMIA			LIVER DISEASE OR HEPATITIS			DRY EYES		
IMMUNOLOGIC	YES	NO	CARDIOVASCULAR	YES	NO	PULMONARY	YES	NO
HIV			HIGH BLOOD PRESSURE			ASTHMA		
LUPUS			CHEST PAIN			CHRONIC RESPIRATORY PROBLEMS		
OTHER AUTOIMMUNE DISEASE			SHORTNESS OF BREATHE			ENDOCRINE	YES	NO
PSYCHIATRIC	YES	NO	IRREGULAR HEARTBEAT			DIABETES		
DEPRESSION			HISTORY OF HEART DISEASE			THYROID ABNORMALITIES		
ANXIETY			HISTORY OF BLOOD CLOT			NEUROLOGICAL	YES	NO
						SEIZURES		
						STROKE		

PLEASE DETAIL ANY "YES" ANSWERS ABOVE AND LIST ANY ADDITIONAL PROBLEMS OR CONCERNS:

Do you have any allergies or reactions to medications? Yes _____ No _____ If yes, please list: _____

Number of child births? _____ Last Mammogram? _____ Do you smoke? Yes _____ No _____

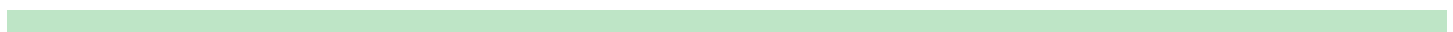
Please list any prescription medications currently being taken: _____

Please list any herbs and/or vitamins currently being taken: _____

Please list all prior surgeries including cosmetic procedures: _____

Please list your top 3 priorities for Dr. Keen to discuss with you: _____

Notes



TELEHEALTH AUTHORIZATION AND RELEASE



I hereby consent to communicating online with Dr. Keen and his/her staff and personnel (hereinafter referred to collectively as “my Doctor”) so as to conduct virtual consultations, telemedicine/telehealth, and any other purpose deemed by my Doctor to be appropriate while I am receiving medical and aesthetic services.

As announced by the US Department of Health & Human Services (“HHS”) on March 17, 2020, I understand my Doctor is now authorized to use non-public facing audio and/or video communication technology to provide telehealth, whether or not related to COVID-19, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, but my Doctor is not authorized to use public facing technology, such as Facebook Live, Twitch or TikTok.

I accept that even authorized non-public facing third-party applications potentially introduce privacy risks, but my Doctor will enable all available encryption and privacy modes when using these applications.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. Unless and until I revoke this authorization, it will exist in perpetuity from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from my Doctor.

I release and discharge my Doctor and all parties acting under my Doctor’s license and authority from any telehealth medical privacy claims I might otherwise have had prior to HHS’s March 17, 2020 notification. I certify that I have read this Authorization and Release and fully understand its terms.

Patient Signature

Witness/Physician/Staff

Patient Name

Date

I have read the above Authorization and Release. I am the parent, guardian or conservator of the patient, a minor. I am authorized to sign this consent on the patient’s behalf.

Parent/Guardian/Conservator Signature

Date

Parent/Guardian/Conservator Name