YMD
EYE & FACE
LASER AND PLASTIC SURGERY
RUTH HILL YEILDING, MD

Welcome to YMD Eye & Face!

Patient Name: _____

Please circle what you would like to discuss with Dr. Yeilding today:

SURGICAL	**NON-SURGICAL:**
Extra skin on upper eyelids	Wrinkles and fine lines
Bagging and wrinkling on lower lids	Lines around the mouth
Skin wrinkling and/or hyperpigmentation	Volume loss in face
Jowling and excess skin and/or fat in neck area	Hollow areas under the eyes
Droopy eyebrows	Loss of volume in lips
Other concern (write in):	Chin profile
	Vascular/red vessels on the face
	Skincare Needs
	Facials and/or Peels
	Lash thinning
	Body fat reduction(areas):
	Other concern (write in):

NEW PATIENT INFORMATION FORM

First Name: _____ M.I : _____ Last Name: _____

D.O.B (mm/dd/yyyy): _____ Age: _____ Sex ○ Male ○ Female

Address: _____ City: _____ State: _____ Zip: _____

Preferred Phone: _____ ☐ Cell ☐ Work ☐ Home

Other Phone number: _____ ☐ Cell ☐ Work ☐ Home

Preferred Pharmacy: _____ Phone Number: _____

☐ Patient allows YMD to send patient Protected Health Information (PHI) to patient Email address

Email: _____ How did you hear about us? _____

Emergency Contact Information

Name: _____ Phone: _____ Relationship: _____

Responsibility Party: (if different from patient)

Name: _____ Phone: _____ Relationship: _____

The US Government asks that we collect this information to help detect medical conditions that may be present in certain populations.

Race: _____ Hispanic or Latino (Yes/No): _____ Preferred Language:_____

I certify to the best of my knowledge that the above information is complete and correct. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to this office for any service furnished to me by the provider. I authorize the release to Medicare or any other insurance carrier and/or their agents any information necessary to determine benefits payable.

I accept full responsibility to understand my insurance policy and obligations for payment of my bill including any deductibles, co-payments, non-covered services or in the event of default, any reasonable attorney's fees and cost of collection. I will be responsible for obtaining any referral which my insurance may require from my Primary care physician prior to being seen in this office. If seen without a referral, I will be responsible for any services rendered.

I hereby authorize the physicians and staff of YMD Eye and Face to perform such evaluations and treatments to me as prescribed during any and all of my visits to YMD Eye and Face.

Signature of Patient or Responsible Party: _____ Date:_____

YMD Eye & Face
Yeilding MD LLC
Ruth Hill Yeilding M.D.
HEALTHCARE PROVIDER - PATIENT
BINDING ARBITRATION AGREEMENT

Patient Name: _____

Article 1: Agreement to Binding Arbitration. It is agreed and understood that any dispute as to medical negligence, or any controversy which arises out of or in any way relates to the diagnosis, treatment, or care of the patient by the undersigned healthcare provider, its physicians, or any member of the healthcare provider's staff will be resolved by arbitration as described in this Agreement.

Article 2: Waiver of Jury Trial. BY ENTERING INTO THIS AGREEMENT, THE PARTIES UNDERSTAND THAT THEY ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY CLAIM OR DISPUTE BETWEEN THEM DECIDED IN A COURT OF LAW BEFORE A JURY. The parties agree that by entering into this Agreement, they voluntarily waive this right for any and all present and future disputes and claims that arise between them.

Article 3: All Claims Must Be Arbitrated. It is the intention of the parties that this Agreement binds all parties whose claims may arise out of or are related to the diagnosis, care, treatment, or services provided by the undersigned healthcare provider, its physicians, or any member of the undersigned healthcare provider's staff, including, but not limited to claims of the patient, the patient's estate, the patient's spouse and any children, whether born or unborn, the childrens' biological father, and any other heirs of the patient, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

By signing this Agreement, the parties consent to the participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action if they had been involved in any way in the care of the patient. This may include claims of the patient against another physician, nurse or medical professional, or a hospital or other facility. Additionally, this Agreement is intended to resolve all claims for vicarious liability of the aforementioned individuals and/or entities.

The parties agree that all claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. All claims for monetary damages made against the undersigned healthcare provider, and the undersigned healthcare provider's partners, associates, professional association, corporation or partnership, and employees, agents and estates, related to the diagnosis, care, and/or treatment of the patient must be arbitrated, including, without limitation, claims for personal injury, loss of consortium, wrongful death, emotional distress, or and/or punitive damages.

Article 4: Procedures and Applicable Law. Any and all present and future disputes and claims shall be resolved by the parties and/or claimants in accordance with the following:

a. **Presuit.** The parties and/or claimants shall have the benefit of presuit notice, investigation, and discovery as provided in Florida Statutes, Chapter 766. In the event the claim is not resolved as provided by 766.106 or 766.207, then any and all claims shall be resolved by arbitration pursuant to this Agreement. Nothing in this agreement shall be construed as preventing the parties from entering into a settlement agreement or participating in mediation prior to arbitration.

b. **Initiation of Arbitration Proceedings.** Written notice of the demand for arbitration shall be provided to the opposing party within 60 days from the termination of the presuit process, or within the remainder of the statute of limitations, whichever is greater. Written notice shall be sent certified mail, return receipt requested.

c. **Legal Representation.** The parties and/or claimants are entitled to be represented by legal counsel during any and all arbitration proceedings or hearings.

d. **Selection of the Arbitration Panel.** The arbitration will be conducted by three arbitrators who will hear the dispute and render a binding decision. Each party shall appoint one arbitrator who is an attorney with experience in medical malpractice alternative dispute resolution (hereinafter referred to as a "party arbitrator"), and one alternate arbitrator within thirty (30) days of the written demand for arbitration, and shall notify the other party of such appointment. In the event of multiple plaintiffs or multiple defendants, the arbitrator selected by the side with multiple parties shall be the choice of those parties. A neutral arbitrator shall be selected by the party arbitrators (excluding alternates), within thirty (30) days of their appointment. In the event of a party arbitrator's inability to complete the arbitration process, the alternate arbitrator

will be provided opportunity to review the proceedings to date, and will replace the departing arbitrator. The arbitrators shall appoint a time and place for the hearing, which shall be held within a reasonable time after the appointment of the neutral arbitrator, and which shall occur in Orange County, Florida.

e. **Applicable Law.** Except as provided herein, the parties agree that the arbitration shall be conducted in accordance with the Florida Arbitration Code, found in Florida Statutes, Chapter 682. Except as provided herein, the parties agree that Florida law applicable to medical malpractice claims and damages. The parties agree that the statute of limitation found in Florida Statutes, Chapter 95.11(4) (b) shall apply.

f. **Decision and Award of Arbitrators Final and Binding.** The parties to this Agreement hereby agree that the decision and award of the arbitrators is **final and binding** on both parties. The award rendered by the arbitrators may be entered in any court having jurisdiction thereof. The decision of the arbitrators only may be appealed in a limited amount of circumstances, which are those consistent with the provisions of the Florida Arbitration Code.

Article 5: Nature of the Proceedings. The parties agree that the arbitration proceedings are to be private. The privacy of the parties and of the arbitration proceedings shall be preserved and confidentiality shall be maintained.

Article 6: Arbitration Expenses. Expenses of the arbitration shall be shared equally by the parties to this Agreement, **except** that each party shall be responsible for the payment of his/her own legal counsel fees, witness fees, or other fees incurred by a party for his/her own benefit.

Article 7: Retroactive Effect. This Agreement is effective as of the first date medical services were rendered to the patient.

Article 8: Term and Termination. This Agreement shall be effective as of the date it is signed and shall remain in effect until terminated pursuant to the provisions herein. Any party may cancel the Agreement upon any anniversary date of this Agreement, provided that written notice is sent to the other party at the last known address no later than 60 days prior to such anniversary date. The patient understands that he or she will not receive further diagnosis, care, and/or treatment upon the termination of this Agreement. The patient also understands the Agreement will remain in effect for any diagnosis, care, and/or treatment rendered prior to the termination of the Agreement.

Article 9: Right to Refuse. The patient has the right to refuse to accept this Agreement, at which time a listing of available physicians in the same medical specialty will be provided to the patient. The patient understands he or she is not required to use the undersigned provider, and that there are numerous other providers who are qualified to diagnose, treat, and/or care for the patient.

Article 10: Severability. In the event that any one or more of the provisions contained herein shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision of this Agreement, but this Agreement shall be construed as if such invalid, illegal or unenforceable provision or provisions had never been contained herein unless the deletion of such provision or provisions would result in such a material change as to cause continued performance of this Agreement as contemplated herein to be unreasonable or materially and adversely frustrate the objectives of the parties as expressed in this Agreement.

Article 11: Translation. The English version of this agreement shall control over any Spanish version.

Article 12: Governing Law. This Agreement is governed by the laws of the State of Florida.

Article 13: Entire Agreement. This Agreement contains the entire agreement by and among the parties to date with respect to the subject matter hereof and supersedes any and all prior agreements and understandings, whether oral or written, with respect to such matters.

Article 14: Headings. The heading references herein are for convenience only, do not constitute a part of this Agreement, and shall not limit or affect any provision hereof.

Article 15: Patient Acknowledgments. By signing this Agreement, the patient hereby acknowledges the foregoing:

a. **Right of Counsel.** By signing this Agreement, the patient acknowledges and understands that this Agreement is a legal document, and that he or she has the right to consult with an attorney of his or her choice prior to signing this Agreement, and to receive explanations or clarification of any of the terms of this Agreement.

b. **No Undue Influence.** The patient hereby acknowledges that he or she has not been pressured, induced, coerced, or intimidated in any way into signing this Agreement, and has signed this Agreement of his or her own free will and accord. The patient further acknowledges that he or she has not signed this Agreement under duress.

c. **Receipt of Copy of Arbitration Agreement.** The patient hereby acknowledges that he/she has received a copy of this Arbitration Agreement.

d. **The Patient's Understanding of the Terms of the Agreement:** By signing this Agreement, the patient hereby acknowledges that he/she has read this Agreement and understands and agrees to its terms. The patient acknowledges that he/she has been given every opportunity to ask questions and receive answers concerning the specifics and intent of this Agreement.

NOTICE

BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE RELATED TO YOUR MEDICAL DIAGNOSIS, CARE AND/OR TREATMENT DECIDED BY ARBITRATION. IN DOING SO, YOU ARE GIVING UP YOUR RIGHT TO A JURY TRIAL.

This Agreement shall be effective as of the date of the signature of the patient and/or the patient's representative below. Upon such signature, this Agreement shall be deemed to be fully executed and binding upon all parties.

Patient:

_____
Print Name

_____ _____
Patient Signature Date

Patient's Parent/Guardian (if applicable):

_____
Print Name

_____ _____
Patient's Parent/Guardian Signature Date

Healthcare Provider:

11/01/2017

_____ _____
Ruth Hill Yeilding, M.D. Date

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand YMD Eye & Face's Notice of Privacy Practices, revised September 23, 2013, containing a description of the uses and disclosures of my health information. I further understand that YMD Eye & Face may update its Notice of Privacy Practices at any time and that I may receive an updated copy of YMD Eye & Face's Notice of Privacy Practices by submitting a request in writing for a current copy of YMD Eye & Face's Notice of Privacy Practices.

_____
Printed Patient Name

_____ _____
Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

_____ _____
Printed Patient Personal Representative Name Relationship to Patient

_____ _____
Patient Personal Representative Signature Date

For YMD Eye & Face Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

YMD Eye & Face made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

- ☐ Patient or patient's personal representative refused to sign
- ☐ Patient or patient's personal representative unable to sign
- ☐ Other_____

_____
Employee Name (printed)

_____ _____
Employee Signature Date

YMD
EYE & FACE
LASER AND PLASTIC SURGERY
RUTH HILL YEILDING, MD

Photo Consent

Patient Name: _____

Your photo will be taken by YMD Eye & Face in conjunction with procedures performed at our facility or any facility used. They will be taken before and after any procedure completed to be used as a part your medical care and will be confidential.

Please select any additional ways that YMD Eye & Face may use your photos:

_____ Photos may be used for In-Office use, consisting of before and after booklets, etc.

_____ Photos may be used on our website and social media platforms.

_____Photos may be used for print media advertisements and articles.

Patient Signature: _____ Date:_____

YMD
EYE & FACE
LASER AND PLASTIC SURGERY
RUTH HILL YEILDING, MD

YMD Office Use Only
Item 1: Y / N
Item 2: _____

Medical History Information

Name: _____ Likes to go by: _____

Who is your Primary Care Physician? _____

Who is your Cardiologist (if you have one)? _____

Medical Conditions (Please circle all that apply):

Alcohol or Drug Disorder

Anxiety

Arthritis

Atrial Fibrillation

Autoimmune Disease (Lupus, Sjogren's Disease, Rheumatoid Arthritis)

Bipolar Disease

Bypass or Stent Placement

Cancer

Congestive Heart Failure

Depression

Diabetes

Glaucoma

High Blood Pressure

Kidney Problems

Other Psychiatric Illness (If so, please list below)

Thyroid Disease (Hypo- or Hyperthyroidism)

Are you currently experiencing? (Please circle all that apply)

Anxiety

Chills

Depression

Fatigue

Fever

Headache

Do any of the following apply to you? (Please circle all that apply)

Accutane Use

Cold Sores

Dry Eyes

Electrolysis to Face

Lasik/PRK

Pacemaker

Radiation to Face

Keloid Scar Formation (excessive scaring)

Do you have a Latex Allergy? Yes ____ No ____

If Yes, please list the reaction: _____

Are you <u>allergic</u> to any medications? Yes ____ No ____

If Yes, which medications, and what occurs when you take them?

_____

Are you a smoker? Yes ____ No _____

Please list <u>ALL PAST SURGERIES</u> and the date the procedure was performed:

Please list any other medical conditions that apply to you:

Please list <u>ALL MEDICATIONS</u> you are currently taking and the dosage:

Patient name: _____ Patient Sign:_____