860.521.2200
West Hartford CT

Gary E. Russolillo, M.D.

Cosmetic and Reconstructive Plastic Surgery

413.568.2280
Westfield MA

Date ______________ **Email** (print) ______________________________

Patient's Name ______________________ Age ________ Date of Birth ______________

Home Address ______________________ City ______________ State ________ Zip ______________

Home Phone ______________________ Married Single Widow(er) Divorced Separated

Cell Phone ______________________ Patient's Occupation ______________________

Social Security # ______________________ Patient's Employer ______________________

Business Address ______________________ Business Phone ______________ Ext. ________

Family Internist/Pediatrician ______________________ Address ______________________

Patient Referred By ______________________ Address ______________________

Has this office previously treated any member of your family? Yes No If Yes, whom ______________

Name of Spouse/Parent ______________________ Spouse/Parent's Occupation ______________________

Spouse/Parent's Employer ______________________ Employer's Address ______________________

Business Phone ______________ Ext. ________ Social Security # ______________________

HEALTH INSURANCE (If applicable)

It is your responsibility to provide accurate and up to date insurance information.

Primary Health Insurance:

____
Name & address of insurance company

______________________ ______________________
Name of subscriber Social Security #

____
Policy Number

Secondary Health Insurance:

____
Name & address of insurance company

______________________ ______________________
Name of subscriber Policy #

MEDICAL HISTORY

Height_________ Weight__________ Any weight loss__________

Have you ever been pregnant? Yes No

If Yes, how many times?____________________ How many children do you have? _______________

Are you now pregnant?__________ Are you planning more children? Yes No Don't Know

Are you allergic to any pills, drugs, medicines? Yes No If Yes, comment ____________________

Have you ever had a bad reaction to a GENERAL anesthetic? Yes No ____________________

Have you ever had a bad reaction to a LOCAL anesthetic? Yes No ____________________

Do you have high blood pressure? Yes No ____________________

Do you bleed unusually easy (from cuts, surgery)? Yes No ____________________

Do you form large scars or keloids? Yes No ____________________

Do you have frequent infections or boils? Yes No ____________________

Have you ever had any significant emotional problems? Yes No ____________________

Have you ever had psychiatric care? Yes No ____________________

Have you ever been advised to see a psychiatrist? Yes No ____________________

Have you ever seen other plastic surgeons
about the SAME problem which brings you here? Yes No ____________________

Have you had any serious illnesses? Yes No ____________________

Do you have any chronic conditions? Yes No ____________________

Have you ever had the coronavirus in any form Yes No

What would you like to discuss

☐ cosmetic facial surgery ☐ body contouring ☐ breast enlargment/reduction/lift ☐ Liposuction
☐ fillers ☐botox/dysport ☐ skin care ☐ mole etc. removal

and/or Please describe

Previous surgery

type **year** **complications?**

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Serious Injuries

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Medications including supplements and herbal products

Please list ALL with dosage

___

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___

Authorization - insurance

- I hereby authorize payment directly to Gary E Russolillo, MD , PC for those surgical and/ or medical benefit: if any otherwise payable to me on the terms of my insurance
- I hereby agree to pay any and all charges that exceed or that are not covered by my insurance
- I agree to pay all reasonable attorney fees and collection fees in the event of default of payments of m charges
- I have read and fully understand the above finance responsibility and insurance authorization

Signature ___

- I hereby authorize Gary Russolillo, MD,PC to release any and all information required in the course of m examination or treatment
- I allow fax or electronic transmittal of my medical records if necessary
- This office is in compliance with the healthcare insurance portability and accountability act of 199 parentheses (HIPAA) – I may request a copy if desired

Signature ___

Gary E. Russolillo, M.D.

COVID-19 RISK INFORMED CONSENT

I ________________________________ (patient) understand that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that Dr.Gary Russolillo and all the staff at Gary Russolillo MD are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for Dr. Gary Russolillo and all the staff at Gary Russolillo MD to proceed with the same.

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.

I have been given the option to defer my treatment/procedure/surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery.

INFORMED CONSENT FOR COVID-19 RISK

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

____

_Patient or Person Authorized to **Sign** for Patient Date/Time

Gary E. Russolillo, M.D.

GARY E. RUSSOLILLO, M.D., P.C.
CONSENT AND ACKNOWLEDGMENT FORM

I, ______________________________(print patient's full name), consent to the use or disclosure of my protected health information by GARY E. RUSSOLILLO, M.D., P.C. to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by GARY E. RUSSOLILLO, M.D., P.C. may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how GARY E. RUSSOLILLO, M.D., P.C. will use and disclose my information can be found in GARY E. RUSSOLILLO, M.D., P.C.'s Notice of Privacy Practices. I understand that this consent is effective for as long as GARY E. RUSSOLILLO, M.D., P.C. maintains my protected health information.

By signing below, I understand and acknowledge the following:

- I have read and understand this consent, and
- I have received GARY E. RUSSOLILLO, M.D., P.C.'s Notice of Privacy Practices currently in effect.

____
Print Name of Individual or Personal Representative for the above-named patient

______________________________ ____________
Signature of Individual or Personal Representative Date

If signed by the individual's representative, describe the legal authority of the representative to act on behalf of the individual: ______________________________

GARY E. RUSSOLILLO, M.D., P.C. is unable to obtain written consent and acknowledgment because:

☐ Individual refused

☐ Emergency treatment situation

☐ Individual not able to sign due to incompetence or other medical reason

Other:______________________________

970 Farmington Ave.
West Hartford, Connecticut 06107
860.521.2200 Fax 860.521.2605

www.germd.com

7 Court Street
Westfield, Massachusetts 01085
413.568.2280 Fax 413.564.6911

Gary E. Russolillo, M.D.

PERMISSION FOR PHOTOGRAPHY

I hear by voluntarily grant permission to Dr. Gary Russolillo and his designated representatives to take and use clinical photographs of my ________________

____

With the understanding that such photographs are for confidential, clinical record purposed and that all photographs remain the property of Dr. Gary Russolillo.

________________________________ ________________

Signature Date

____

Printed Name

Occasionally, such photographs are used for teaching purposes, research, medical publications as well as public education and for patient information and education.

I will / not permit the use of my photographs for such ethical professional purposes.

________________________________ ________________

Signature Date

________________________________ ________________

Witness Date

Cosmetic Plastic Surgery Clinical Skin Care

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Gary E. Russolillo, M.D.

RELEASE OF INFORMATION AUTHORIZATION FOR

Name____

The following is a list of Parties of whom Gary E. Russolillo MD or his designees may disclose health care Information during the course of my treatment.

☐ **All of any of the following** ☐ **No one**

☐ **Wife/Husband**	**Name______________________________**	**#______-______________________**
☐ **Mother**	**Name______________________________**	**#______-______________________**
☐ **Father**	**Name______________________________**	**#______-______________________**
☐ **Son**	**Name______________________________**	**#______-______________________**
☐ **Daughter**	**Name______________________________**	**#______-______________________**
☐ **Sister**	**Name______________________________**	**#______-______________________**
☐ **Brother**	**Name______________________________**	**#______-______________________**
☐ **Other**	**Name______________________________**	**#______-______________________**
☐ **Other**	**Name______________________________**	**#______-______________________**
☐ **Private MD**	**Name______________________________**	**#______-______________________**
☐ **Referring MD**	**Name______________________________**	**#______-______________________**

Signature____ Date__________________

Witness____ Date__________________

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Gary E. Russolillo, M.D. P.C.

Notice of Privacy Practices

Effective Date: April 14, 2003

Purpose of the Notice of Privacy Practices

This Notice of Privacy Practices (the "Notice") is meant to inform you of the uses and disclosures of protected health information that we may make. It also describes your rights to access and control your protected health information and certain obligations we have regarding the use and disclosure of your protected health information.

Your "protected health information" is information about you created and received by us, including demographic information, that may reasonably identify you and that relates to your past, present or future physical or mental health or condition, or payment for the provision of your health care.

We are required by law to maintain the privacy of your protected health information. We are also required by law to provide you with this Notice of our legal duties and privacy practices with respect to your protected health information and to abide by the terms of the Notice that is currently in effect. However, we may change our notice at any time. The new revised Notice will apply to all of your protected health information maintained by us. You will not automatically receive a revised Notice, but a copy will be provided to you at your next visit to our office.

How We May Use or Disclose Your Protected Health Information

We will ask you to sign a consent form that allows us to use and disclose your protected health information for treatment, payment and health care operations. You will also be asked to acknowledge receipt of this Notice.

The following categories describe some of the different ways that we may use or disclose your protected health information. Even if not specifically listed below, we may use and disclose your protected health information as permitted or required by law or as authorized by you. We will make reasonable efforts to limit access to your protected health information to those persons or classes of persons, as appropriate, in our workforce who need access to carry out their duties. In addition, if required, we will make reasonable efforts to limit the protected health information to the minimum amount necessary to accomplish the intended purpose of any use or disclosure and to the extent such use or disclosure is limited by law.

- **For Treatment** - We may use and disclose your protected health information to provide you with medical treatment and related services.
- **For Payment** - We may use and disclose your protected health information so that we can bill and receive payment for the treatment and related services your receive.
- **For Health Care Operations** - We may use and disclose your health information as necessary for quality assurance and improvement activities, medical review, legal services and auditing functions, and general administrative activities.
- **Business Associates** - There may be some services provided by our business associates, such as a billing service, transcription company or legal or accounting consultants. We may disclose your protected health information to our business associate so that they can perform the job we have asked them to do. To protect your health information, we require our business associates to enter into a written contract that requires them to appropriately safeguard your information.

- **Appointment Reminders** - We may use and disclose protected health information to contact you as a reminder that you have an appointment.
- **Treatment Alternatives and Other Health-Related Benefits and Services** - We may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives and to tell you about health related benefits, services, or medical education classes that may be of interest to you.
- **Health Oversight Activities** - We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, accreditation, licensure and disciplinary actions.
- **Judicial and Administrative Proceedings** - If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to your authorization or a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process if such disclosure is permitted by law.
- **Law Enforcement** - We may disclose your protected health information for certain law enforcement purposes if permitted or required by law.

When We May Not Use or Disclose Your Protected Health Information

Except as described in this Notice, or as permitted by Connecticut or Federal law, we will not use or disclose your protected health information without your written authorization.

Your written authorization will specify particular uses or disclosures that you choose to allow. If you do authorize us to use or disclose your protected health information for reasons other than treatment, payment or health care operations, you may revoke your authorization in writing at any time by contacting GER's Privacy Officer.

Marketing

A signed authorization is required for the use or disclosure of your protected health information for a purpose that encourages you to purchase or use a product or service except for certain limited circumstances such as when the marketing communication is face-to-face or when marketing includes the distribution of a promotional gift of nominal value provided by GER.

Your Health Information Rights

You have the following rights with respect to your protected health information. The following briefly describes how you may exercise these rights.

- **Right to Request Restrictions of Your Protected Health Information** - You have the right to request certain restrictions or limitations on the protected health information we use or disclose about you. You may request a restriction or revise a restriction on the use or disclosure of your protected health information by providing a written request stating the specific restriction requested. You can obtain a Request for Restriction form from our office. We are not required to agree to your requested restriction. If we do agree to accept your requested restriction, we will comply with your request except as needed to provide you with emergency treatment. If restricted protected health information is disclosed to a health care provider for emergency treatment, we will request that such health care provider not further use or disclose the information. In addition, you and GER may terminate the restriction if the other party is notified in writing of the termination. Unless you agree, the termination of the restriction is only effective with respect to protected health information created or received after we have informed you of the termination.

- **Right to Receive Confidential Communications** - You have the right to request a reasonable accommodation regarding how you receive communications of protected health information. You have the right to request an alternative means of communication or an alternative location where you would like to receive communications.
- **Right to Access, Inspect and Copy Your Protected Health Information** - You have the right to access, inspect and obtain a copy of your protected health information that is used to make decisions about your care for as long as the protected health information is maintained by our office. To access, inspect and copy your protected health information that may be used to make decisions about you, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of preparing, copying, mailing or other supplies associated with your request. We may deny, in whole or in part, your request to access, inspect and copy your request, we will provide you with a written explanation of the reason for the denial. You may have the right to have this denial reviewed by an independent health care professional designated by us to act as a reviewing official. This individual will not have participated in the original decision to deny your request. You may also have the right to request a review of our denial of access through a court of law. All requirements, court costs and attorney's fees associated with a review of denial by a court are your responsibility. You should seek legal advice if you are interested in pursuing such rights.
- **Right to Amend Your Protected Health Information** - You have the right to request an amendment to your protected health information for as long as the information is maintained by or for GER. Your request must be made in writing, and must state the reason for the requested amendment. You can obtain a Request for Amendment form from our office. If we deny your request for amendment, we will give you a written statement disagreeing with the denial. We may rebut your statement of disagreement. If you do not wish to submit a written statement disagreeing with the denial, you may request that your request for amendment and your denial be disclosed with any future disclosure of your relevant information.
- **Right to Receive An Accounting of Disclosures of Protected Health Information** - You have the right to request an accounting of certain disclosures of your protected health information by us or by others on our behalf. To request an accounting of dis closures, you must submit a request in writing, stating a time period beginning on or after April 14, 2003 that is within six (6) years from the date of your request. The first accounting provided within a twelve-month period will be free. We may charge you a reasonable, cost-based fee for each future request for an accounting within a single twelve-month period. However, you will be given the opportunity to withdraw or modify your request for an accounting of disclosures in order to avoid or reduce the fee.
- **Right to Obtain A Paper Copy of Notice** - You have the right to obtain a paper copy of this Notice.
- **Right to Complain** - You may file a complaint with us or 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 Officer of your complaint. You will not be penalized for filing a complaint and we will make every reasonable effort to resolve your complaint with you.

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