GABEL
HAIR RESTORATION

NAME First Last

DOB

PATIENT HISTORY FORM

The following information is important to your health. Please take the time to accurately and completely fill this out.

DEMOGRAPHIC INFORMATION

Age: ☐

Sex:

- ☐ Male
- ☐ Female
- ☐ Intersex

Gender:

- ☐ Man
- ☐ Woman
- ☐ Transgender
- ☐ Non-binary/non-conforming

Pronouns:

- ☐ He / Him
- ☐ She / Her
- ☐ They / Them
- ☐ Other:

Please check all referrals that apply.

- ☐ Internet - Specific site:
- ☐ Physician:
- ☐ Friend/Patient:
- ☐ Other:

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HAIR LOSS HISTORY

Age of onset of hair loss:

Where on your scalp or face have you lost hair?

- ☐ Frontal hairline
- ☐ Front half of the scalp
- ☐ Middle of the scalp
- ☐ Back of the scalp (crown)
- ☐ Temples
- ☐ Entire scalp
- ☐ Other:
- ☐ Eyebrows
- ☐ Eyelashes
- ☐ Sideburn
- ☐ Mustache
- ☐ Beard

Have you experienced the following conditions?

	In the past	Currently
Scalp tenderness/burning	☐	☐
Scalp itching	☐	☐
Pimples on the scalp	☐	☐

Explain:

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Have you used any of the following?

	In the past - When stopped?		Currently
Minoxidil (Rogaine®) treatment	☐		☐
Finasteride (Propecia®) treatment	☐		☐
Platelet Rich Plasma (PRP)	☐		☐
Low Light Laser Therapy	☐		☐
Hair Loss Shampoos	☐		☐
Viviscal	☐		☐

Other / Explain:

Which of your family members have/had hair loss?

- ☐ Mother
- ☐ Mother's Father
- ☐ Mother's Mother
- ☐ Father
- ☐ Father's Father
- ☐ Father's Mother
- ☐ Brother(s)
- ☐ Sister(s)
- ☐ Other / Explain:

Anyone else on your mother's side of the family with hairloss?

Anyone else on your father's side of the family with hairloss?

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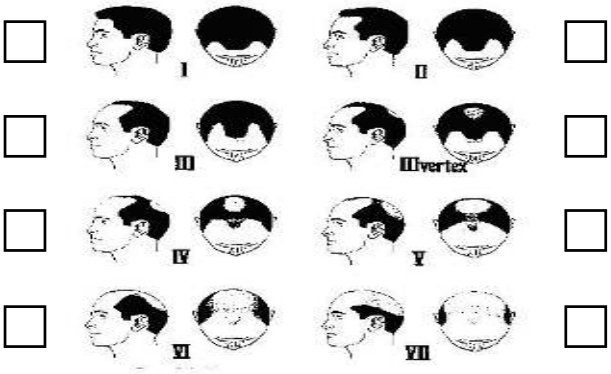
Please select the diagram which you feel most closely matches your hair loss pattern.



Please state your goals and objectives:

Have you ever had any hair restoration procedures in the past? If yes, please indicate date(s), area(s) transplanted, and number of grafts placed.

☐ I have never had a hair transplant in the past.

Details of prior hair transplant(s):

Is the following statement true or false? "In the months leading up to my hair loss, I probably had some of the most intense stress of my life."

☐ True

☐ False

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PAST MEDICAL HISTORY

Please check YES or NO for every condition listed below.

YES	NO		YES	NO	
☐	☐	History of Alopecia Areata	☐	☐	History of Rheumatic Fever
☐	☐	Lung Disease	☐	☐	Scarring
☐	☐	Low Iron	☐	☐	Mental Illness
☐	☐	Stroke/TIA	☐	☐	Bleeding Disorder
☐	☐	Lupus	☐	☐	Depression/Anxiety
☐	☐	Kidney Problems	☐	☐	HIV/Hepatitis
☐	☐	Hair Pulling	☐	☐	Implants
☐	☐	Diabetes	☐	☐	High Blood Pressure
☐	☐	Thyroid Disease	☐	☐	Prosthetic Joints
☐	☐	Cancer	☐	☐	Irregular Heart Beat
☐	☐	Polycystic Ovarian Syndrome	☐	☐	Substance Abuse
☐	☐	Asthma	☐	☐	Coronary Heart Disease
☐	☐	Past MRSA / Staph infection	☐	☐	Problems with local anesthesia
☐	☐	Rheumatic Heart Disease	☐	☐	Heart Murmur
☐	☐	Keloid Formation			

Do you have any medical conditions that are not listed above?

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Please list ALL surgeries you have had including the date(s).

MEDICATIONS AND ALLERGIES

Current Medications: Please list all medications including over the counter medications; for example, aspirin or other blood thinners, vitamins, herbs, or supplements.

Allergies to Medications:

Additional Allergies:

Yes	No	
☐	☐	Latex Allergy
☐	☐	Iodine Allergy
☐	☐	Adhesive Allergy
☐	☐	Food Allergy - Explain:

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SOCIAL HISTORY

Current occupation:

Smoking:

- ☐ Never smoked
- ☐ Previous smoker - When did you quit?
- ☐ Currently smoke - How much / how often?

Alcohol:

- ☐ Daily
- ☐ Occasionally
- ☐ Rarely
- ☐ Never

COMMENTS

Any additional information you feel is relevant:

By signing below, I attest that the above information is true and correct to the best of my knowledge.

Patient's Signature: **Date:**

GABEL CENTER

HIPAA COMMUNICATION FORM

First Name:

Middle Initial:

Last Name:

Date of Birth:

Street Address:

City:

State:

Zip Code:

☐ **Please check here if you do <u>not</u> wish for mail to be sent to this address.**

Preferred Pharmacy (Required):

Pharmacy Name:

Address:

Phone Number:

I give permission for Dr. Gabel and/or his staff to contact me via:

☐ Home Phone:

☐ Cell Phone:

☐ E-mail Address:

Phone Carrier:

Leaving a message on the phone:

☐ May leave a voicemail

☐ May leave a voicemail with another person

In Case of Emergency

Name:

Phone:

Relationship:

Patient's Signature: **Date:**

GABEL
CENTER

ACKNOWLEDGMENT AND CONSENT

Patient Name: First Last **Date of Birth:**

I understand that Steven P. Gabel, MD, PC (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words or photographs, and may include information about my health history, health status, symptoms, examinations, test results, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of This Practice, and my rights regarding my health information.

I understand that the **Notice of Privacy Practices** may be revised from time to time, and that I am entitled to receive a copy of any revised **Notice of Privacy Practices**. I also understand that a copy of or a summary of the most current version of This Practice's **Notice of Privacy Practices** in effect will be posted in the waiting area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the **Notice of Privacy Practices**, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

Patient's Signature: **Date:**

GABEL CENTER

REQUEST FOR CONFIDENTIAL COMMUNICATIONS FORM VIA EMAIL/TEXT MESSAGE

Patient Name: First Last **Date of Birth:**

"Practice" shall be understood to mean Steven Gabel, MD, Steven Gabel, MD, PC, employees of Steven Gabel, MD, PC, Gabel Center, and Gabel Hair Restoration Center.

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with the Practice there is a reasonable chance that a third party may be able to intercept those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I consent to allow the Practice to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Appointment Reminders
- Health Related Information
- Marketing offers

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that message & data rates may apply. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Patient's Signature: **Date:**

GABEL CENTER

TELEHEALTH INFORMED CONSENT

Patient Name: First Last **Date of Birth:**

Telehealth or telemedicine is healthcare provided by any means other than a face-to-face visit. In other words, Dr. Gabel and the patient are in different physical locations. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services. Telehealth consultations have both benefits as well as potential risks. It is important for our patients to understand these issues so they can make a decision to proceed or not proceed with a consultation via telemedicine.

What are the benefits of telemedicine?

- Individuals with concerns about hair loss or hair problems in general may access the expertise of Dr. Gabel without the need to travel to Dr. Gabel's office.
- Patients who have had or are going to have surgery with Dr. Gabel may discuss questions they have or conduct follow up discussions without the need to travel to Dr. Gabel's office.

What are the main potential risks of telemedicine?

- Submitted images (photos) may be of poor quality and biased in how they are taken by the patient which ultimately affects interpretation of the patient's diagnosis and /or advice on the patient's treatment plan.
- The patient's scalp can not be seen up close which may affect some diagnoses.
- Procedures such as a biopsy can not be performed with telemedicine
- Some treatments such as steroid injections and PRP therapies cannot be performed through telemedicine.
- There may be a breach of security which leads to a breach of the patient's privacy of personal health information. It is possible that hacking or tapping into the video is possible by others even though Dr. Gabel is using a secure system to conduct the telemedicine sessions.

By signing this form, I understand and agree to the following:

1. I understand that the purpose of the telemedicine consultation or follow up is to help diagnose and/or treat my hair loss condition, or follow up on prior consultations and/or surgery.

2. I understand that telehealth involves the communication of my medical health information in an electronic or technology-assisted format.

3. I understand that my participation in a telemedicine consultation or follow up is voluntary. I have the right to refuse to proceed with the telemedicine consultation. This includes the right to refuse beginning a consultation, the right to terminate the consultation early during the course of the consultation before it is completed, and the right to refuse additional telemedicine consultations in the future. I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

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Patient Name: First Last **Date of Birth:**

4. I understand that telemedicine just like standard traditional office based visits do not come with a guarantee - my condition may or may not be improved and in some cases may even get worse.

5. I understand that if the connection with Dr. Gabel's video system is not working, I have the option of speaking with Dr. Gabel via a standard telephone call.

6. I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:
   - It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
   - Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
   - Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

7. I agree that information exchanged during my telehealth visit will be maintained by the Gabel Center, Dr. Steven Gabel, and the Gabel Center Staff.

8. I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

9. The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

10. I agree that I have verified to Dr. Gabel and his staff my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

11. I understand that I have a responsibility to verify the identity and credentials of the Dr. Gabel.

12. I understand that electronic communication cannot be used for emergencies or time sensitive matters.

13. **I understand and agree that a medical evaluation via telehealth limits Dr. Gabel's ability to fully diagnose my hair loss, or make medical or surgical recommendations. I understand that some or all of his recommendations may change when I have a face to face consultation. I accept the limitations of telemedicine and understand that Dr. Gabel may change the recommendations for medications, surgical planning, recommendations including the type of donor harvesting method, the number of grafts, the number of procedures to reach my goal, and may ultimately recommend that I do not have surgery.**

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Patient Name: First Last **Date of Birth:**

14. I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

15. I understand that Dr. Gabel may choose to forward my information to an authorized third party. Therefore, I have informed Dr. Gabel and the Gabel Center staff of any information I do not wish to be transmitted through electronic communications.

16. By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

17. I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

18. To the extent permitted by law, I agree to waive and release Dr. Gabel, the staff of the Gabel Center, and Steven P. Gabel, MD, PC, from all claims I may have about the telemedicine visit.

19. I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

By signing below, I certify that I have read and understand all 19 points of this agreement and that I had an opportunity to have questions answered to my satisfaction. I understand that there are benefits and risks associated with telemedicine as described above. I understand that this consent form will remain on file and will be used for additional telemedicine consultations in the future as well. If I do not agree with the above 19 points, then I will not sign this form, and will instead schedule an in-office consultation with Dr. Gabel.

Patient's Signature: **Date:**

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CENTER

PHOTOGRAPHIC AUTHORIZATION AND RELEASE

Patient Name: First Last **Date of Birth:**

I authorize photographs and/or video to be taken of me by Steven Gabel, MD or his designated representative. These may include photographs and or videos preoperatively, during the actual surgical procedure(s), and/or postoperatively. This consent authorizes Dr. Gabel for today's appointment and all future appointments. The photographs and videos will become the property of Steven Gabel, MD, PC.

I understand that photographs and/or videos will be taken before, during, and after my procedure(s) as a routine part of my medical care. **I further understand that these photographs and videos will be kept strictly confidential unless otherwise noted**. The undersigned further acknowledges that they relinquish all right, title, and interest in these photographs, or any profit or gain directly or indirectly realized through the use of the photographs.

This consent is in consideration of services performed and consultations conducted by the physician, and there have been no representations or inducements concerning this consent except as set forth herein.

The patient may request copies of the photographs and videos. The photographs and videos are stored in a secure, HIPAA compliant, cloud storage media. Steven Gabel, MD, PC uses BOX.COM as their storage provider. This may change at any time. A signed request form must be filled out, and the patient will be provided with a time-sensitive, secure link to their photographs and videos in BOX.COM. There will be a charge of $50 associated with providing the link.

I have been provided the opportunity to ask questions concerning medical photography. By signing below, I certify that I have read the above authorization and release and fully understand its terms intending to be legally bound hereby.

Patient's Signature: **Date:**