GABEL
HAIR RESTORATION

Dear Patient,

Welcome to Gabel Hair Restoration and my practice! I would like to thank you in advance for reviewing and completing these forms. There is lot of information here. I fully understand that these forms will take 30-60 minutes to read and complete but can't emphasize enough just how helpful this information is to me. It's probably the most important document we'll have in your file to help me diagnose and treat your hair loss. I have included a lot of material here and it has been refined over the years. The questionnaire picks up areas that could easily be overlooked in a typical consultation. This will also allow me to understand your goals and expectations with treatment planning.

Prior to your appointment, I will review your responses very carefully and this form will become part of your medical file. Your information is transmitted and stored in a secure encrypted manner using SSL in our electronic medical record.

I recommend using Adobe Acrobat Reader to fill out this form. Here is a link to download Adobe Acrobat Reader. I recommend that you complete this form in one sitting rather then coming back to it.

Please bring your driver's license or photo ID with you to your appointment.

Please also send in any pertinent biopsy reports or blood tests prior to your appointment. A secure link is provided at the end of this document.

Patient satisfaction is our number one priority. Again, I appreciate you taking the time to complete this form and look forward to speaking with you soon.

Steven Gabel, MD, FACS, FISHRS
President & Medical Director
Gabel Hair Restoration Center

Version 8: 4.16.2024

GABEL
HAIR RESTORATION

PATIENT REGISTRATION (Please print)

First and Last Name: _____ **Date:** _____

Preferred First Name: _____ **Date of Birth:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Preferred Pharmacy (Required):

Pharmacy Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

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

☐ Home Phone: _____

☐ Cell Phone: _____

☐ E-mail Address: _____

Leaving a message on the phone:

☐ May leave a voicemail.

☐ May leave a voicemail with another person.

In Case of Emergency

Full Name: _____Relationship: _____

Emergency contact Phone Number: _____

_____ Initial here to authorize us to freely discuss/disclose your care with your Emergency Contact

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

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

GABEL
HAIR RESTORATION

PATIENT HISTORY

Patient Name: _____ **Today's Date**: _____

Date of Birth _____ **Age** _____ **Height** _____**Weight** _____

Sex assigned at birth: ☐ Male ☐ Female ☐ Intersex ☐ Decline to answer

Gender: ☐ Man ☐ Woman ☐ Transgender ☐ Non-binary/non-conforming ☐ Decline to answer

Pronouns: ☐ He/Him. ☐ She/Her. ☐ They/Them. ☐ Other: _____

Would you like a summary of this visit sent to your doctor?

☐ No

☐ Yes Please provide the following information about your doctor.
Please understand that it will take 2 - 3 weeks for the letter to be transcribed, verified, and sent out.

Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

Please check all referrals that apply.

☐ Internet (specific site) _____

☐ Google Reviews _____

☐ Friend/Patient_____

☐ Physician _____

☐ Other _____

Patient Name: _____ **Date of Birth: _____**

Age of onset of hair loss: _____ **Age: _____**

Where on your scalp or face have you lost hair?

☐ Frontal hairline	☐ Temples	☐ Sideburn
☐ Front half of the scalp	☐ Entire scalp	☐ Mustache
☐ Middle of the scalp	☐ Eyebrows	☐ Beard
☐ Back of the scalp (crown)	☐ Eyelashes	☐ Loss of body hair

Please provide any additional concerns or information about your hair loss.
Please state your goals and objectives with your treatment. This is very important.

Patient Name: _____ Date of Birth: _____

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):

☐ No I never had a hair transplant in the past

☐ Yes If yes, for each session, please provide the dates, they type of procedure (FUE or linear strip), the number of grafts, and the name of the surgeon in the space below:

Has your hair loss changed in the last 6 months to 1 year?

☐ No

☐ Yes If yes, please provide more information below

Did you ever have a SCALP BIOPSY (most people have not)?

☐ No

☐ Yes

If yes, what year did you have the scalp biopsy? _____

What were the results? _____

*****Your scalp biopsy results are critically important to Dr. Gabel.**
Please send a copy of the actual pathology report to Dr. Gabel's office prior to your visit.

Patient Name: _____ Date of Birth: _____

Have you been given any of the following diagnoses for your hair loss?

- ☐ No, I have never been given a diagnosis.
- ☐ Male Pattern Baldness (androgenetic alopecia)
- ☐ Female Pattern Baldness
- ☐ Alopecia Areata
- ☐ Dissecting Cellulitis
- ☐ Hair shedding (Telogen Effluvium)
- ☐ Lichen planopilaris (LPP)
- ☐ Folliculitis Decalvans
- ☐ Frontal Fibrosing Alopecia (FFA)
- ☐ Discoid Lupus (DLE)
- ☐ Pseudopelade of Brocq
- ☐ Trichotillomania
- ☐ Acne keloidalis
- ☐ Dandruff
- ☐ Seborrheic dermatitis
- ☐ Erosive Pustular Dermatosis
- ☐ Central centrifugal cicatricial alopecia (CCCA)
- ☐ Traction alopecia
- ☐ Chemical burn

Have you experienced the following conditions?

	In the past	Currently
Scalp tenderness/burning	☐	☐
Scalp tingling	☐	☐
Scalp itching	☐	☐
Scalp dandruff/flaking	☐	☐
Pimples on the scalp	☐	☐
Scalp Redness	☐	☐

Does your scalp feel "dry" "oily" or normal?

☐ My scalp feels dry ☐ My scalp feels oily ☐ My scalp feels normal (neither dry nor oily)

<u>Women Only</u>:

Are you pregnant? ☐ Yes ☐ No Are you breast feeding? ☐ Yes ☐ No

Have you started Menopause? ☐ Yes ☐ No

Are you on Hormone Replacement Therapy? ☐ Yes ☐ No

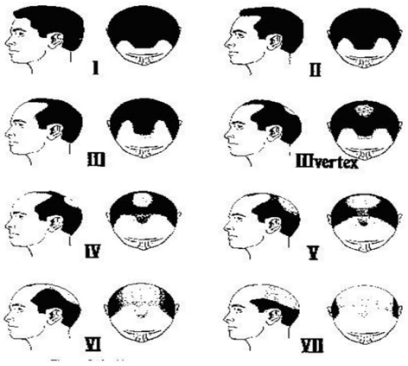
If yes, what medication(s): _____

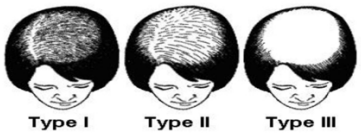
Patient Name: _____ Date of Birth: _____

Do you experience any of the following (which can sometimes occur from altered hormone levels)? Please check ALL that apply.

☐	None listed	☐	Irritability	☐	Vaginal dryness
		☐	Fatigue	☐	Sexual problems
☐	Hot flashes	☐	Anxiety	☐	Urinary symptoms
☐	Insomnia	☐	Memory Loss	☐	Bone pain
☐	Depressed mood	☐	Headaches	☐	Bone loss

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





☐	I	☐	IV	☐	Type I
☐	II	☐	V	☐	Type II
☐	III	☐	VI	☐	Type III
☐	III Vertex	☐	VII		

☐ My hair loss does not fit in any of those pattens.

CURRENT AND PAST TREATMENTS FOR YOUR HAIR LOSS

Minoxidil:	Never tried	In the past	Currently
	☐	☐	☐

If currently using **minoxidil**, what strength (%) and how often: _____

When did you start **minoxidil**_____

If you stopped using **minoxidil** in the past, when and why did you stop it? _____

_____

Patient Name: _____ Date of Birth: _____

Finasteride (Propecia): Never tried ☐ In the past ☐ Currently ☐

If currently using **finasteride**, is it a pill form or topical? _____

How many milligrams a day are you using? _____

When did you start **finasteride**_____

If you stopped using **finasteride** in the past, when and why did you stop it? _____

Are you experiencing any of the following <u>while taking</u> using finasteride?

- ☐ Decreased sex drive (libido)
- ☐ Impotence/ executive dysfunction
- ☐ Problems with ejaculation
- ☐ Breast enlargement
- ☐ Brain fog (clouded thinking)
- ☐ Penile shrinkage
- ☐ Mood changes (depression)
- ☐ No, I'm not experiencing any of these side effects.

Other: _____

<u>If you stopped</u> using finasteride in the past, what was the reason?

- ☐ Decreased sex drive (libido)
- ☐ Impotence/ executive dysfunction
- ☐ Problems with ejaculation
- ☐ Breast enlargement
- ☐ Brain fog (clouded thinking)
- ☐ Penile shrinkage
- ☐ Mood changes (depression)
- ☐ No, I had not experienced any of these side effects.

Other: _____

Have you ever had steroid injections into your scalp?

☐ No

☐ Yes If yes, when was your last injection? _____

If yes, did they help with the hair loss? _____

Platelet Rich Plasma (PRP)

☐ No

☐ Yes If yes, how many treatments have you had? _____

If yes, when was your last treatment? _____

Patient Name: _____ Date of Birth: _____

Low Light Laser Treatment

☐ No

☐ Yes If yes, what type of device? _____

☐ Yes If yes, how often do you use it, and do you use it consistently? _____

Viviscal/Nutrafol

☐ No

☐ Yes

Have you ever used the medication ACCUTANE (also called ISOTRETINOIN) in the past for any reason including the treatment of acne?

☐ No, I have never used this medication.

☐ Yes, I have used this medication.

If yes, what year or years did you use isotretinoin (ACCUTANE)? _____

If yes, do you recall the HIGHEST dose of isotretinoin you were on?
(10 mg, 20 mg, 40 mg, 60 mg 80 mg)? _____

Please list any other treatment(s) you have had for your hair loss?

Patient Name: _____ Date of Birth: _____

How often do you shampoo your hair?

☐ A few times a day
☐ Usually once a day
☐ Every other day
☐ Every third day
☐ Usually once a week
☐ 1 time per week

Which of your family members have/had hair loss? If yes, please indicate the severity of hair loss.

	No Loss	Mild	Moderate	Significant
Mother	☐	☐	☐	☐
Mother's Father	☐	☐	☐	☐
Mother's Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Father's Father	☐	☐	☐	☐
Father's Mother	☐	☐	☐	☐
Brother(s)	☐	☐	☐	☐
Sister(s)	☐	☐	☐	☐

☐ I am adopted and do not know this information.

Please list any other family history of hair loss and how severe was their hair loss?

Patient Name: _____ Date of Birth: _____

PAST MEDICAL HISTORY: Please check YES or NO for every condition listed below:

YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Lung Disease
☐	☐	Low Iron	☐	☐	Stroke/TIA
☐	☐	High Cholesterol	☐	☐	Kidney Problems
☐	☐	Thyroid Problems	☐	☐	Diabetes
☐	☐	Polycystic Ovarian Syndrome	☐	☐	Cancer
☐	☐	Past MRSA / Staph infection	☐	☐	Asthma
☐	☐	Keloid Formation	☐	☐	History of Rheumatic Fever
☐	☐	Scarring	☐	☐	Mental Illness
☐	☐	Bleeding Disorder	☐	☐	Depression
☐	☐	HIV	☐	☐	Anxiety
☐	☐	Hepatitis	☐	☐	Implants
☐	☐	Irregular Heartbeat	☐	☐	Prosthetic Joints
☐	☐	Coronary Heart Disease	☐	☐	Substance Abuse
☐	☐	Heart Murmur	☐	☐	Problems with local anesthesia
☐	☐	Dry eyes	☐	☐	Chest pain
☐	☐	Colitis (bowel disease)	☐	☐	Dry Mouth
☐	☐	Stiff Joints	☐	☐	Reynaud's Disease
☐	☐	Osteoporosis	☐	☐	Osteopenia (low bone density)
☐	☐	Lupus	☐	☐	Bone Pain
☐	☐	Insomnia	☐	☐	Headaches
☐	☐	Hot Flashes			

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

Patient Name: _____ Date of Birth: _____

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

CURRENT MEDICATIONS

Please list **ALL** medications including over the counter medications; for example, aspirin or other blood thinners, vitamins, herbs, or supplements:

Name	Dose	Reason for taking it

Patient Name: _____ Date of Birth: _____

ALLERGIES TO MEDICATIONS:

☐ I do not have any allergies to medications that I am aware of

☐ If yes: Please list the medication(s) you have allergies to:

Medication Allergy	**Reaction**

Others:

Allergies to Latex: ☐ No ☐ Yes Allergies to Iodine: ☐ No ☐ Yes

Allergies to Adhesive: ☐ No ☐ Yes Allergies to Food: ☐ No ☐ Yes

SOCIAL HISTORY:

Current Occupation: _____

Smoking: ☐ Never smoked

☐ Previous smoker (When did you quit? _____)

☐ Currently smoke _____ packs/day for _____ years

Alcohol: ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never

Exercise: How much exercise do you do?

_____

Are you currently:

☐ Single ☐ Divorced

☐ Married ☐ Separated

☐ Partnered

Patient Name: _____ Date of Birth: _____

Date:

Would you rate the following statement as TRUE or FALSE? Here is the statement: "In the months leading up to my hair loss, I probably had some of the most intense stress of my life."

☐ TRUE - Yes, I'd say that statement is true.

☐ FALSE - No, I don't think that statement is accurate.

PREVIOUS BLOOD TESTS

Please provide Dr. Gabel with any blood work results you have for the past 2 years.

ATTESTATION

By typing my name and date below as my Electronic Signature, I attest that the above information is true and correct to the best of my knowledge.

I understand that Dr. Gabel's clinic is a private clinic, and he does not participate in any insurance health plans unless otherwise noted. If you are trying to have your insurance company pay for your visit or surgical procedure, we will provide you with an invoice for the services rendered. All professional services are charged to the patient. Unless otherwise noted, no insurance or Medicare coverages apply. You will need to work directly with your insurance provider for reimbursement. I understand there are fees for blood tests and biopsies done through this clinic and that there are fees for both initial consultations and all follow up consultations.

I, the undersigned, do hereby give my consent for Steven P Gabel, MD, PC, Gabel Hair Restoration Center (Gabel Center) to furnish treatment considered necessary, and proper, in diagnosing and/or treating my physical and cosmetic condition.

Resuscitation Policy: It is the policy of the Gabel Center to perform full resuscitation on any patient.

Patient's Name and Date: _____

Example: John Doe, April 10, 2024

GABEL
HAIR RESTORATION

REQUEST FOR CONFIDENTIAL COMMUNICATIONS VIA EMAIL/TEXT MESSAGE

Patient Name: _____ Date of Birth: _____

"Practice" shall be understood to mean Steven Gabel, M.D., 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
- Answers to your questions or questions from Dr. Gabel which may include your hair loss history, examination, and treatment recommendations.
- Summary of your visits to the clinic or virtual teleconversations
- 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.

By typing my name below as my electronic signature, I have read this document and agree to be bound by its terms.

Patient's Signature: _____ Date: _____

GABEL
HAIR RESTORATION

Patient Name: _____ **Date of Birth**:_____

MEDICATION PRESCRIPTION POLICY

Dr. Gabel and the Gabel Hair Restoration Center strive to provide quality care in the most efficient manner possible. In an effort to safely manage refill requests, and follow standard medical practice guidelines, it is necessary for our clinic to implement a new medication refill policy. We understand that this is a change for both you and us. We hope to work together to deliver high quality medical care by keeping you informed of the policy change.
Please note the following:

1. Prescription refills require close monitoring by Dr. Gabel to ensure its safety, effectiveness, and safe continuation at the appropriate dose, frequency and term of the medication.
2. It is the responsibility of the patient to notify Dr. Gabel of any problems, issues, side effects, or allergies of the medications prescribed or asked to be refilled.
3. It is the responsibility of the patient to notify Dr. Gabel of any allergies to medications.
4. It is the responsibility of the patient to notify the office in a timely manner when refills are necessary. Approval of the refill may take up to (1) week after all the necessary paperwork has been received. Please do not wait until you are out of medication to begin the process for a medication refill.
5. All medications are to be taken as prescribed. If a patient takes a medication in excess of what is prescribed and runs out of the medication early (prior to the refill date), the refill will not be authorized early.
6. Dr. Gabel may require blood tests to have a medication refilled. If required, we will not refill the prescription until the results have been received.
7. Please do not have your pharmacy fax a refill request. Please email your request to scheduling@gabelcenter.com or call in your request to the office.
8. Dr. Gabel and the Gabel Center do not have contracts with insurance companies and will not do any preauthorizations for new medications or medications refills.
9. Refills will only be provided on medications that Dr. Gabel has prescribed in the past. New medications will not be refilled without a consultation.
10. The following documents must be filled out and returned to the office before any refill is approved and sent to the pharmacy:
    a. This Medication and Prescription Refill Policy must be read and signed,
    b. A medical history form must be filled out completely. Any changes in your health must be noted on the form. We will require this on a yearly basis. If we do not have an updated medical history form within a year, it will need to be updated.
    c. Medications such as finasteride, dutasteride, and minoxidil will have an additional form to complete.

Patient Name: _____ Date of Birth: _____

11. Please provide the practice with the pharmacy you want us to send the prescription to. We will only send the refill request to one pharmacy. If a prescription has been sent, and you would like it transferred to another pharmacy, please contact the pharmacy directly to have it transferred.

12. We are seeing an increase in "mail order" pharmacies. If that is the case, we need to be provided the exact name, address, phone number, and fax number of the pharmacy. If that particular pharmacy is not in our electronic medical record pharmacy database, we will hand write a prescription and mail it to the patient's house. The patient can then send it to their pharmacy of choice. Please confirm that your current address is on file as that is where the prescription will be sent.

13. Dr. Gabel will send electronic prescriptions to Oregon and Washington. There are several states that do not allow physicians to prescribe medications if they are not licensed in that particular state. In that case, you will need someone to pick up your prescription and send it to you.

14. Please do your best to coordinate the timing of your refill requests. If you have more than one medication, and the timing is not the same, this process will need to be repeated and there will be a separate charge.

15. Refills will be provided at no charge for our surgical patients for a period of (2) two years after ahair restoration procedure. After two years, each prescription refill request will be $100. If the request is urgent, then the charge will be $150. Payments will only be accepted by credit card. You may call the office or have the office send you a secure link for payment.

16. All the documents requested and payment must be received before the prescription is sent.

17. Dr. Gabel participates in the Oregon Prescription Monitoring Program.

18. This policy is subject to change.

19. I had all my questions answered concerning this policy.I had all my questions answered concerning this policy.

By typing my name below as my Electronic Signature, I have read this Medication Prescription Policy and agree to be bound by its terms.

Patient's Name: _____ Date: _____

GABEL
HAIR RESTORATION

TELEHEALTH CONVERSATION INFORMED CONSENT

Patient Name: _____ 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. Health information is exchanged interactively from one site to another through electronic communications. Telephone conversations, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services. Dr. Gabel is only licensed in Oregon. Therefore, telehealth conversations with Dr. Gabel are not considered medical advice: they should be treated as a teaching or strategizing conversation to help you understand hair loss and treatment options. It is important for our patients to understand these issues so they can make a decision to proceed or not proceed.

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. Dr. Gabel is unable to make any diagnosis based on photos submitted or videos submitted. They will be used for teaching purposes and not medical advice.
- The patient's scalp cannot be seen up close which may affect the discussion.
- Procedures such as a biopsy cannot 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 conversation is to have a conversation about hair loss 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 which may not be secure or HIPAA compliant. We currently use Zoom and Google Meets, both of which are HIPAA compliant.
3. I understand that my participation in a tele conversation or follow up is voluntary. I have the right to refuse to proceed with the telemedicine conversation. This includes the right to refuse beginning a conversation, the right to terminate the conversation early, and the right to refuse additional

telemedicine conversations 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.

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, and that the session may be recorded by Dr. Gabel.
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. I understand that I have a responsibility to verify the identity and credentials of the Dr. Gabel.
11. **I understand and agree that a medical evaluation via telehealth limits is not possible for Dr. Gabel's to diagnose my hair loss or make medical or surgical recommendations - it is strictly teaching and strategizing. I accept the limitations of telemedicine and understand that Dr. Gabel may change the strategy for medications, surgical planning, the type of donor harvesting method, the number of grafts, the number of procedures to reach goals, and may ultimately discuss that I do not have surgery.**
12. 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.).
13. 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.
14. 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.
15. 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.
16. 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.

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

I certify that I have read and understand all 17 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 conversations in the future as well. If I do not agree with the above 17 points, then I will not sign this form, and schedule an in-office consultation with Dr. Gabel.

By typing my name below as my Electronic Signature, I have read this Telehealth Conversation Informed Consent and agree to be bound by its terms.

Patient's Name: _____ Date: _____

GABEL
HAIR RESTORATION

Patient Name: _____ Date of Birth: _____

PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I consent to photographs and/or video to be taken of me by Steven P Gabel, MD, PC, Steven Gabel MD, and/or his designated representative. ("Gabel"). These may include photographs and or videos preoperatively, during the actual surgical procedure(s), and/or postoperatively. This consent authorizes Gabel for today's appointment and all future appointments. The photographs and videos will become the property of Steven P 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. I hereby release, discharge, and agree to hold harmless Gabel and its affiliates and their respective representatives, assigns, and employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and name and the reproduction thereof as state above, including any claim for payment in connection with distribution or publication of the photographs and/or videos.

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.

I hereby warrant that I am over twenty-one years of age, and competent to contract in my own name insofar as the above is concerned.

I have been provided the opportunity to ask questions concerning the above. By typing my name below as my Electronic Signature, I certify that I have read the above Photographic Authorization and Release and enter into it knowingly and voluntarily and agree to be bound by its terms.

Patient's Name: _____ Date: _____

GABEL
HAIR RESTORATION

NOTICE OF PRIVACY PRACTICES
PATIENT RIGHTS AND RESPONSIBILITIES

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of and agree to the *Notice of Privacy Practices* of Steven P Gabel MD, PC. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to review it carefully.

Our *Notice of Privacy Practices* is subject to change. If we change our Notice, you may obtain a copy of the revised Notice on request from the Gabel Center

.

By typing my name below as my Electronic Signature, I acknowledge receipt of and agree to the *Notice of Privacy Practices* and *Patient Rights and Responsibilities* of Steven Gabel MD, PC.

Patient Name: _____ **Date of Birth: _____**

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

To be completed only if no signature is obtained:

If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of provider representative: _____ Date: _____

Reasons why the acknowledgement was not obtained:

☐ Patient refused to sign

☐ Other or comments: _____

GABEL
HAIR RESTORATION

Patient Rights and Responsibilities

This facility presents these Patient Rights and Patient Responsibilities to reflect the commitment to providing quality patient care, facilitating dialogue between patients, their physicians, and the facility management, and promoting satisfaction among the patients and their designated support person(s), physicians, and health professionals who collaborate in the provision of care. This facility recognizes that a personal relationship between the physician and the patient is an essential component for the provision of proper medical care. When the medical care is rendered within an organizational structure, the facility itself has a responsibility to the patient to advocate for expanded personal relationships and open communications between patients and their designated support persons, physicians, and the organization's staff members. This facility has many functions to perform, including but not limited to, preventing, and treating medical conditions, providing education to health professionals and patients, and conducting clinical research. All these activities must be conducted with an overriding concern for the patient and above all the recognition of his or her dignity as a human being. Although no catalogue of rights can provide a guarantee that the patient will receive the kind of treatment, he or she has a right to expect, these patient rights are affirmed and actively incorporated into the care provided in this facility.

1. The patient has the right to receive considerate and respectful care in a safe setting.
2. The patient has the right to know the name of the physician responsible for coordinating his/her care.
3. The patient has the right to obtain information from his or her physician in terms that can be reasonably understood. Information may include, but is not limited to his or her diagnosis, treatment, prognosis, and medically significant alternatives for care or treatment that may be available. When it is not medically advisable to share specific information with the patient, the information should be made available to an appropriate person in his or her behalf. When medical alternatives are to be incorporated into the plan of care, the patient has the right to know the name of the person(s) responsible for the procedures and/or treatments.
4. The patient has the right to obtain the necessary information from his or her physician to give informed consent before the start of any procedure and/or treatment. Necessary information includes, but is not limited to, the specific procedure and/or treatment, the probable duration of incapacitation, the medically significant risks involved, and provisions for emergency care.
5. The patient has the right to expect this accredited ambulatory surgery facility will provide evaluation, services and/or referrals as indicated for urgent situations. When medically permissible, the patient or designated support person(s) will receive complete information and explanation about the need for and alternatives to transferring to another facility. The facility to which the patient is to be transferred must first have accepted the patient for transfer.
6. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his or her action.
7. The patient has the right to obtain information about any financial and/or professional relationship that exists between this facility and other health care and educational institutions insofar as his or her care is concerned. The patient has the right to obtain information about any professional relationships that exist among individuals who are involved in his or her procedure or treatment.
8. The patient has a right to be advised if this accredited ambulatory surgery facility proposes to engage in or perform human experimentation affecting his or her care or treatment. The patient has the right to refuse to participate in research projects.
9. The patient has the right to every consideration for privacy throughout his or her medical care experience, including but not limited to, the following. Confidentiality and discreet conduct during case discussions, consultations, examinations, and treatments. Those not directly involved in his or her care must have the

permission of the patient to be present. All communications and records pertaining to the patient's care will be treated as confidential.

10. The patient has the right to expect reasonable continuity of care, including, but not limited to the following. The right to know in advance what appointment times and physicians are available and where. The right to have access to information from his or her physician regarding continuing health care requirements following discharge. The number to call for questions or emergency care.
11. The patient has the right to access and examine an explanation of his or her bill regardless of the source of payment.
12. The patient and designated support person(s) have the right to know what facility rules and regulations apply to their conduct as a patient and guest during all phases of treatment.
13. The patient has the right to be free from all forms of abuse, neglect, or harassment.
14. The patient has the right to exercise his or her rights without being subjected to discrimination or reprisal.

Patient Responsibilities

1. It is the patient's responsibility to participate fully in decisions involving his or her own health care and to accept the consequences of these decisions if complications occur.
2. It is the patient's responsibility to follow up on his or her physician's instructions, take medications when prescribed, and ask questions that emerge concerning his or her own health care.

It is the patient's responsibility to provide name of support person in case of emergency and have this support person available when advised to do so.

Direct any care concerns or complaints to:

1. Steven Gabel, MD, Facility Director — Phone: (503) 693-1118
   Email: drgabel@gabelcenter.com
2. The Investigations Team at QUAD A — Phone: (888) 545-5222
   Email: investigations@quada.org
3. Oregon Health Authority — Phone: (971) 673-1222
   Email: oha.directorsoffice@oha.oregon.gov

NOTICE OF PRIVACY PRACTICES

Steven Gabel, MD, PC
Effective Date: **July 1, 2006.**
Revised March 15, 2024

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

WHO WILL FOLLOW THIS NOTICE
This Notice serves as Steven P Gabel, MD, PC's practices and that of:
- All health care professionals, colleagues, volunteers, students, observers, and staff of Steven P Gabel, MD, PC
- Any business associates with whom we share health information.

OUR PLEDGE TO YOU
We understand that health information about you is personal, and we are committed to protecting health information about you. We create a record of the care and services you receive at Steven Gabel, MD, PC to assure quality of care, billing, and to comply with legal requirements. This Notice applies to all of the records of your care generated by Steven Gabel, MD, PC. As required and when appropriate, we will ensure that only the minimum necessary information is released in the course of our duties.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations regarding the use and disclosure of medical information. We are required by law to:
- Keep health information about you private;
- Give you this Notice of our legal duties and
- privacy practices with respect to health information about you;
- Follow the terms of the notice of privacy practices that are currently in effect.

CHANGES TO THIS NOTICE
We may change this Notice at any time. Changes will apply to health information we already hold, as well as new information, after the change occurs. Before we make a significant change to our privacy practices, we will change this Notice and post the new Notice in the front entrances of our location.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION
The following areas describe different categories of uses and disclosures of your health information that we may make without your written authorization. For each category of uses or disclosures we will provide an example of use but have not listed every use or disclosure within that category. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment
Steven Gabel, MD, PC creates a record of treatment and services you receive. We may use your protected health information (PHI) to provide you with medical treatment or services. We may disclose your health information to your doctors, nurses, technicians/assistants or others involved in your health care to provide and manage your care.

For Payment
We may use and disclose your PHI in order to get paid for treatment and services we have provided you, as applicable.

For Health Care Operations
We may use and disclose your PHI to carry out necessary operations and ensure our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you.

Appointment Reminders
We may use and disclose your PHI to contact you as a reminder that you have an appointment for treatment or medical care at Steven P Gabel, MD, PC. We may send you emails if you list your email address to notify you of special offers.

Treatment Alternatives and Health-Related Products and Services
We may use and disclose your PHI to recommend possible treatment options or alternatives that may be of interest to you. Additionally, we may use and disclose PHI to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care
We may disclose your PHI to a friend or family member who is involved in your medical care or payment related to your health care, provided that you agree to this disclosure, or we give you an opportunity to object to this disclosure. However, if you are not available or are unable to agree or object, we will use our judgment to decide whether this disclosure is in your best interests.

Disaster Relief Purposes
We may disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. We will give you the opportunity to agree to this disclosure or object to this disclosure, unless we decide that we need to disclose your PHI in order to respond to the emergency circumstances.

As Required By Law
We will disclose your PHI when required to do so by federal, state or local law.

To Avert a Serious Threat to Health and 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. Any disclosure, however, would be to someone able to help prevent the threat.

Workers' Compensation
We may release your PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose medical information about you for public health activities, such as those aimed at preventing or controlling disease, preventing injury or disability, and reporting the abuse or neglect of children, elders and dependent adults.

Military and Veterans
If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Health Oversight Activities
We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
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 your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

Law Enforcement
We may disclose PHI to government law enforcement agencies in response to a court order, warrant, subpoena, summons or similar process issued by a court.

Coroners, Medical Examiners and Funeral Directors
We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the facility to funeral directors as necessary to carry out their duties.

Specialized Government Functions
We may your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. We may disclose your PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state to conduct special investigations.

Inmates
If you are an inmate of a correctional institution, you lose the rights outlined in this Notice. Furthermore, if you are an inmate or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Other Uses of Your Medical Information
Other uses and disclosures of your PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by the authorization, except that, we are unable to take back any disclosures we have already made when the authorization was in effect, and we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your PHI in our records:

Right to Inspect and Copy
With certain exceptions, you have the right to inspect and copy your PHI from our records. To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing. A form will be provided to you for this request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances. If you are denied the right to inspect and copy your PHI in our records, you may request that the denial be reviewed. With the exception of a few circumstances that are not subject to review, another licensed health care professional within Steven P Gabel, MD, PC, who was not involved in the denial, will review the request and decision to deny access. We will comply with the outcome of the review.

Right to Request Amendment
If you feel that your PHI in our records is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the PHI. To request an amendment, you must submit your request in writing. A form will be provided to you for this request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend PHI that:

- Was not created by us, unless you can provide us with a reasonable basis to believe that the person or entity that created the PHI is no longer available to make the amendment;
- Is not part of the PHI kept by or for the facility;
- Is not part of the PHI which you would be permitted to inspect and copy; or
- Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a Statement of Disagreement, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want this form to be made part of your medical record, we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures
You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your PHI other than our own uses for treatment, payment and health care operations, (as those functions are described above) and with other exceptions pursuant to the law. To request this list or accounting of disclosures, you must submit your request in writing. A form will be provided to you for this request. Your request must state a time period that may not be longer than six years and may not include dates before September 1, 2010. The first list you request within a 12- month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request that we follow additional, special restrictions when using or disclosing your PHI for treatment, payment or health care operations. You also have the right to request that we follow additional, special restrictions when using or disclosing your PHI to someone who is involved in your care or the payment for your health care, like a family member or friend. For example, you could ask that we not use or disclose that you are receiving services at Steven P Gabel, MD, PC. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must submit your request in writing. A form will be provided to you for this request. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about your appointments or other matters related to your treatment in a specific way or at a specific location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must submit your request in writing. A form will be provided to you for this request. Your request must specify how or where you wish to be contacted. We will not ask you the reason for your request. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. To obtain a paper copy of this Notice, please contact a member of your health care team.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with Steven P Gabel, MD, PC or the Federal Government. All complaints must be submitted in writing. **You will not be penalized or retaliated against for filing a complaint.** To file a complaint with us, or if you have comments or questions regarding our privacy practices, contact:

Steven P Gabel, MD, PC
Privacy Officer
12115 SW 70th Ave, STE 200
Tigard, OR 97223
503-693-1118

To file a complaint with the Federal Government, contact:
Office of Civil Rights (Room 515 F)
US Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0805
(202) 619-0553

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Thank you for reviewing all the pages and forms. Once you completed the document, you may submit it to us in three ways:

1. Save the file as a PDF and either
   a. Upload the document to:
      Gabel Center Secure Document Upload Link

   b. Email the filled out PDF to us at
      Scheduling@gabelcenter.com

2. Save the file as a PDF, print it, and bring it to your appointment or send it by us by mail.

Again, thank you very much for your time and effort to complete these forms.

Steven Gabel, MD, FACS
Gabel Hair Restoration Center