Scott A. Spiro, MD, FACS **Alexis L. Parcells, MD**

CoolSculpting Intake

Patient Information

Today's Date _____

□ Mr. □ Miss □ Dr.
□ Mrs. □ Ms. □ Other Patient's Name _____
Home Address_____

City, State, Zip Code _____

Social Security # _____/_____/_____ Marital Status: Married _____ Single _____ Others_____

Date of birth _____/_____/_____ Age _____ Home Phone _____

Email Address _____ Cell Phone _____

□ I consent to being contacted by e-mail regarding promotions/ special events within the office services

□ I consent to being contacted by text message regarding upcoming appointments, office promotions and rating

Patient's Occupation _____ Employer _____

Business Address, City, Zip Code _____

Business Phone _____

Significant Other's Name _____ Significant Other's Occupation _____

Internist/ Medical Doctor _____ Phone _____

Medical Doctor Address _____

Purpose of Initial Consultation

Please check the procedure you are interested in:

_____ Brow Lift
_____ Face Lift
_____ Eyelid Surgery
_____ Rhinoplasty
_____ Fat Grafting
_____ Botox
_____ Laser Treatments
_____ Liposuction
_____ Tummy Tuck
_____ Gynecomastia
_____ Ear Surgery
_____ Breast Lift
_____ Facial Fillers (Juvéderm)
_____ Breast Reconstruction
_____ Breast Reduction
_____ Breast Augmentation
_____ Vaginoplasty
_____ Other Body Contouring
_____ CoolSculpting

Has this office treated any member of your family? Yes____ No ___ If yes, whom? _____

Emergency Contact

Name _____ Relationship _____

Home Phone _____ Phone _____

How Did You Hear About Us?

Please take a moment to tell us where you heard about our office

Check all that apply. Please remember all information is confidential.

Online Review Sites

☐ Yelp! ☐ Google. ☐ Realself ☐ American Society Plastic Surgeons Other: _____

Practice sites online

☐ Drspiro.com

☐ Instagram @SpiroPlasticSurgery, @ScottSpiroTheArtist, @AlexisParcellsMD

☐ Twitter @DrScottSpiro

☐ Facebook Spiro Plastic Surgery, LLC.

Print Media, Advertisements, Articles and/or Interviews:

☐ Suburban Essex ☐ Vicinity Magazine ☐ Bergen Health & Life ☐ NJ Top Docs

☐ NJ Monthly ☐ Morris Essex Health & Life ☐ Montclair Magazine ☐ Other: _____

☐ Physician Referral: _____

☐ Patient Referral: _____

☐ Friend of a Friend: _____

☐ Other Source (Please Specify): _____

Which referral / advertisement helped most in making your decision to visit our office?

_____

Patient Name: _____

Medical History

Height: _____ Weight: _____ Weight change in the past year: _____ Loss/Gain

Date of last physical _____/_____/_____ Location of last physical_____

Did your last physical include any of the following (please circle): EKG/ Blood work/ Chest X-Ray/ Stress Test/ Other

MEDICATIONS: Please list all medications, vitamins, supplements, and herbals that you take daily and as needed**:

Medication Name	**Dosage**	**How Often Taken**	**Reason for Taking**	**Prescriber (physician)**

**Please attach a separate sheet of paper with additional medications, supplements, vitamins, and herbals as needed.

ALLERGIES: Please list all allergies to any drugs, foods, environmental factors, or others with reactions below:

_____

☐ No Known Allergies

MEDICAL CONDITIONS/ILLNESSES: Have you ever been diagnosed with or had the following (please circle and explain):

Acid Reflux	Bowel Obstruction	High Blood Pressure	Other Skin Disorders
Adhesive Allergy	Brain/Neurologic Disorder	High Cholesterol	Pneumonia
Anemias	Breast Biopsies	Hormonal Imbalance	Psoriasis or Eczema
Anxiety	Cancer	Kidney problems	Radiation
Arthritis	Chemotherapy	Large Scars or Keloids	Raynaud's
Asthma	Dental problems	Latex Allergy	Reactions to Anesthetics
Attention Deficit Disorder	Depression	Learning Disorder	Reproductive Problems
Back Problems	Diabetes	Liver Disease	Seizures
Bipolar Disorder	Dry Eye	Lung Problems	Sinus Problems
Bleeding Disorder	Facial Surgery	Mental Illness	Stroke
Blood Clots	Frequent infections	Metabolic Issues	Thyroid Issue
Body Dysmorphic Disorder	Heart Arrhythmia	Motion Sickness	Ulcers
Bone or Joint Disease	Heart Attack	MRSA or VRE	Urinary Problems
Bowel Intestinal Disorders	Hernia	Other Heart Condition	Vascular Disease

Please Explain: _____

Pertinent Family History: _____

PRIOR SURGERIES AND HOSPITALIZATIONS (please list all, including cosmetic procedures):

DATE	SURGERY OR ILLNESS	HOSPITAL AND PHYSICIAN

Have you ever had a reaction or adverse event related to anesthesia? Yes_____ No_____

If yes, please explain: _____

Have you or a member of your family ever had a history of malignant hypothermia? Yes_____ No_____

Our office is proud to offer CoolSculpting®!

coolsculpting

Discover how to freeze away fat with the world's #1 non-invasive fat reduction procedure*:

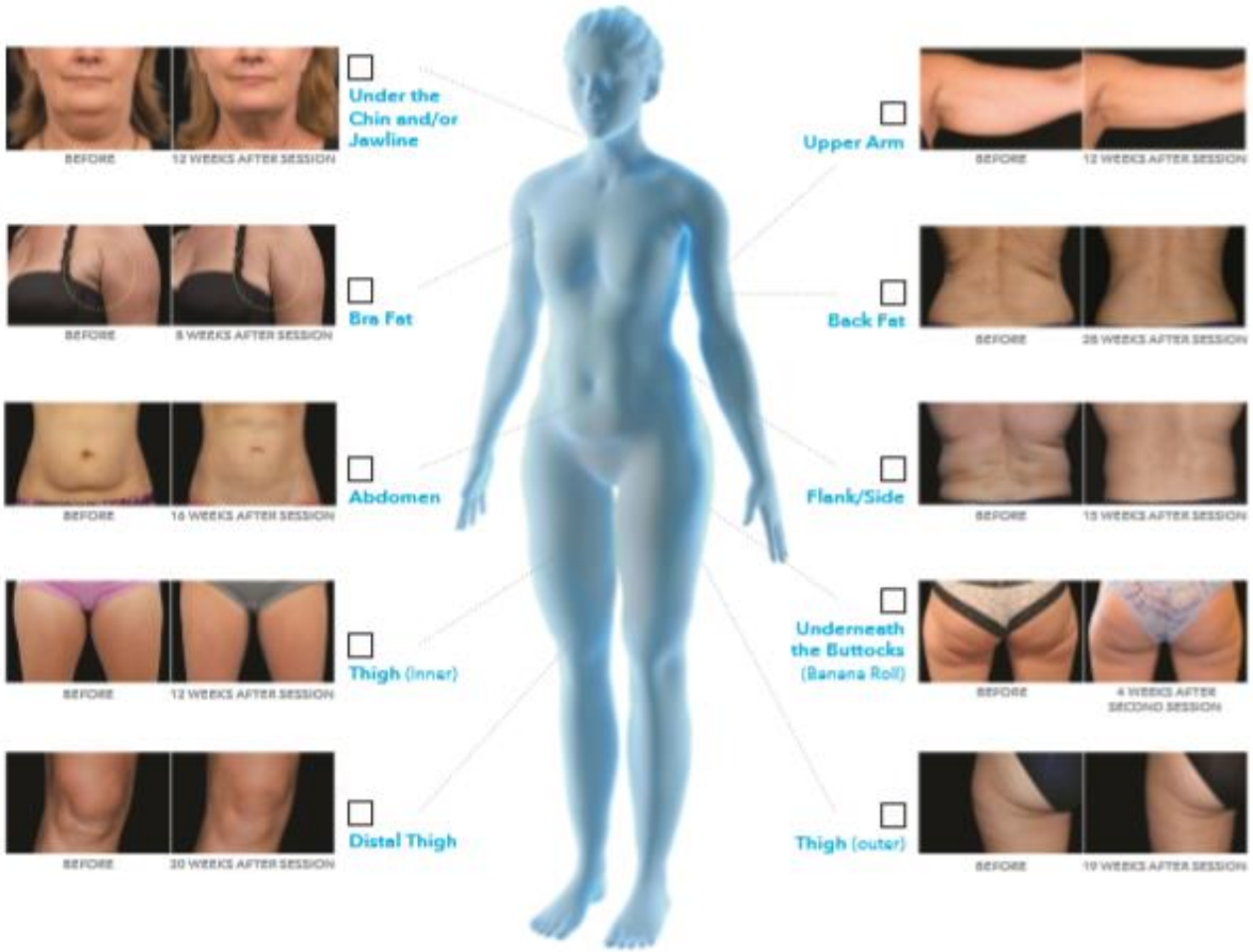
- Visible results without surgery and little to no downtime
- Millions of treatments performed worldwide
- FDA-cleared, safe, and effective

Patient Name: _____

Date: _____

CoolSculpting® can target stubborn fat in the areas that bother you the most.

Indicate below which problem areas would you be interested in treating: (Check all that apply)



*CoolSculpting® is the treatment doctors use most for non-invasive fat removal.

Individual results and patient experience may vary.

Before and After photos courtesy of (in order of appearance): A. Jay Burns, MD; Jason Rivers, MD; Christine Dierickx, MD; Brian Hass, MD; Grant Stevens, MD; Scott Gerrish, MD; Amy Brenner, MD; Mark Beaty, MD; Innovation Research Center; Premier Plastic Surgery.

Uses

The CoolSculpting® procedure is FDA-cleared for the treatment of visible fat bulges in the submental (under the chin) and submandibular (under the jawline) areas, thigh, abdomen and flank, along with bra fat, back fat, underneath the buttocks (also known as banana roll) and upper arm. It is also FDA-cleared to affect the appearance of lax tissue with submental area treatments. The CoolSculpting® procedure is not a treatment for weight loss.

Important Safety Information

The CoolSculpting® procedure is not for everyone. You should not have the CoolSculpting® procedure if you suffer from cryoglobulinemia, cold agglutinin disease, or paroxysmal cold hemoglobinuria.

Important Safety Information (Continued)

Tell your doctor if you have any medical conditions including recent surgery, pre-existing hernia, and any known sensitivities or allergies.

During the procedure you may experience sensations of pulling, tugging, mild pinching, intense cold, tingling, stinging, aching, and cramping at the treatment site. These sensations subside as the area becomes numb. Following the procedure, typical side effects include temporary redness, swelling, blanching, bruising, firmness, tingling, stinging, tenderness, cramping, aching, itching, or skin sensitivity, and sensation of fullness in the back of the throat after submental or submandibular area treatment.

Rare side effects may also occur. CoolSculpting® may cause a visible enlargement in the treated area which may develop two to five months after treatment and requires surgical intervention for correction.

Please visit coolsculpting.com for full Important Safety Information.

Patient Name: _____

TREATMENT CONSIDERATIONS AND CONSENT FORM

The CoolSculpting® procedure is a non-invasive procedure that is intended to change the appearance of the treatment area by delivering controlled cooling at the surface of the skin to break down fat cells that are just beneath the skin. This procedure is not a treatment for obesity or a weight-loss solution. The CoolSculpting procedure does not replace traditional methods such as diet, exercise or liposuction. **Initial:** ____

Clinical studies of a treatment site have shown that the CoolSculpting procedure can break down fat cells to change the appearance of visibly localized bulges of fat that is just beneath the skin on the abdomen, thighs, flanks and submental area. The submental area is the area under the chin. Following the procedure, the treated fat cells are naturally processed by the body. Visible results can vary from person to person. **Initial:** ____

WHAT YOU CAN EXPECT:

Temporary Sensations / Symptoms:

» The suction pressure of a vacuum applicator may cause sensations of deep pulling, tugging and pinching. A surface applicator may cause sensations of pressure. You may experience intense cold, stinging, tingling, aching or cramping as the treatment begins. These sensations generally subside during treatment as the area becomes numb. **Initial:** ____

» You may have dizziness, light-headedness, nausea, flushing, sweating, or fainting during or immediately after the treatment. **Initial:** ____

»The treated area may look or feel stiff after the procedure and transient blanching (temporary whitening of the skin) may occur. These are all normal reactions that typically resolve within a few minutes. **Initial:** ____

» Bruising, swelling, redness, cramping and pain can occur in the treated area and the treated area may appear red for one to two weeks after treatment. **Initial:** ____

» After submental area treatment, a feeling of fullness in the back of the throat may occur. Initial if the submental area is to be treated. If the area under the chin is not being treated, please write N/A. **Initial:** ____

» You may feel a dulling of sensation in the treated area that can last for several weeks after the procedure. Prolonged swelling, itching, tingling, numbness, tenderness to the touch, pain in the treated area, cramping, aching, bruising and/or skin sensitivity also have been reported. **Initial:** ____

Potential Side Effects / Risks

» Paradoxical Hyperplasia -- A small number of patients have experienced gradual development of a firmer enlargement, of varying size and shape, of the treatment area, known as “paradoxical hyperplasia”, in the months following the treatment. If such paradoxical hyperplasia occurs, it will be distinguishable from temporary swelling and will probably not resolve on its own. The enlargement/lump can be removed by means of a surgical procedure such as liposuction. **Initial**: ____

» Treatment area demarcation -- A small number of patients have experienced excessive fat removal in the treatment area, resulting in an unwanted indentation. The indentation may be improved through corrective procedures. **Initial**:____

» In rare cases, patients have reported the CoolSculpting treatment area to have darker skin color, hardness, discrete nodules, frostbite (local injury due to cold), hernia or worsening of existing hernia. Surgical intervention may be required to correct

hernia formation. **Initial**:____

Patient experiences may vary. Some patients may experience a delayed onset of the previously mentioned symptoms. Contact your physician immediately if any unusual side effects occur or if symptoms worsen over time. **Initial: ____**

» I understand that these and other unknown side effects may also occur. **Initial: ____**

Results

» You may start to see changes in as early as three weeks after your CoolSculpting procedure and will experience the most dramatic results after one to three months. Your body will continue to naturally process the injured fat cells from your body for approximately four months after your procedure. **Initial: ____**

» Results vary from person to person. You may decide that additional treatments are necessary to achieve your desired outcome. Although highly unlikely, it is possible that you will not experience any noticeable result from the procedure. **Initial: ____**

Do you currently have or have had any of the following?

» Cryoglobulinemia (a condition where abnormal level of proteins thicken the blood in cold temperatures), or paroxysmal cold haemoglobinuria or cold agglutinin disease (blood disorders where cold temperatures lead to red blood cell death). **Yes / No**

» Known sensitivity to cold such as cold urticaria (hives triggered by cold), Raynaud's disease (disorder in which cold leads to reduced blood flow in the fingers, which appear white, red, or blue), pernio or Chilblains (itchy and/or tender red or purple bumps that occur as a reaction to cold) **Yes / No**

» Poor blood flow in the area to be treated **Yes / No**

» Neuropathic (nerve) disorders such as post-herpetic neuralgia or diabetic neuropathy **Yes / No**

» Impaired skin sensation **Yes / No**

» Open or infected wounds **Yes / No**

» Bleeding disorders or use of blood thinners **Yes / No**

» Recent surgery or scar tissue in the area to be treated **Yes / No**

» A hernia or history of hernia in the area to be treated or adjacent to treatment site **Yes / No**

» Skin conditions such as eczema, dermatitis, or rashes **Yes / No**

» Pregnancy or lactation (making breast milk or breast feeding) **Yes / No**

» Any active implanted devices such as pacemakers and defibrillators **Yes / No**

» Any major health problems such as liver disease **Yes / No**

» Any known sensitivity to isopropyl alcohol (rubbing alcohol) or propylene glycol **Yes / No**

As with most medical procedures, there are risks and side effects. These have been explained to me in detail. I have read the above information, and I give my consent to be treated with the CoolSculpting® procedure.

Print Name: _____

Signature:_____ Date: _____

Medical Record Photographic Consent

I understand that photographs and/or videos will be taken at the time of my consultation, as well as during and after my procedure. I understand that these photographs and/or videos will be **kept strictly confidential** and maintained as a part of **medical records**. No further use of my photographs and/or videos will be performed without my written consent.

_____ Patient Signature

_____ Witness Signature

_____ Date

Any questions or concerns regarding information contained in this document should be directed to:
Marybeth Gabriel, Privacy Officer
101 Old Short Hills Road, Suite 510
West Orange, NJ 07052
Telephone (973) 736-5907

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT RECEIPT

I acknowledge receipt of the Notice of Privacy Practices, amended July 1, 2018.

_____ _____ _____

Print Patient Name Signature of Patient/Legal Representative Date

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is also called "protected health information" under HIPAA's Privacy Rule. I understand that if the person or entity receiving this information is not a health plan or health care provider covered by the federal privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

Name of Individual/Company to Whom Disclosures May Be Made to (Name)	Relationship	Protected Health Information	Financial Information
_____		□	□
_____		□	□
_____		□	□

Limitations of Disclosure: Please describe below limitations you would like on the disclosure of your Protected Health Information and/or Financial Information _____

_____

I understand that I may revoke this permission, in writing, at any time. Revoking permission, however, does not affect previous disclosures that were made with my consent.

_____ _____ _____

Print Patient Name Signature of Patient/Legal Representative Date

AUTHORIZATION TO BE CONTACTED THROUGH ALTERNATE MEANS

I hereby request to be contacted through alternate means. I understand that in the course of doing so, my protected health information may be viewed by individuals I did not intend. I understand that I may revoke this request, in writing, at any time. Please describe below the specific means you would like employed, including alternate address, phone numbers, e-mail addresses, etc.

_____

_____ _____ _____

Print Patient Name Signature of Patient/Legal Representative Date

101 Old Short Hills Road • West Orange • New Jersey • 07052

Telephone (973) 736-5907 • Fax (973) 736-4987

Treatment Policies

We are committed to providing you with the best possible patient care and customer service. In order to achieve these goals, we need your assistance and your understanding of our financial policies.

1. Payment for services provided by our office are payable by cash, bank checks, money orders, Visa, MasterCard and American Express. Personal checks are only accepted three weeks prior to the date services are rendered. (Exceptions may be made at the discretion of the Practice Manager.) There is a fee of $30.00 for returned checks.

2. Please be aware that a deposit in the amount of $250 per treatment cycle is required in order to schedule your CoolSculpting treatment. The balance is due prior to your first treatment.

3. **Cancellations**- Any appointment cancelled or rescheduled with less than 24-hour notice will incur a cancellation fee of $250 per treatment cycle. The cancellation fee also applies to appointments for which patients do not arrive within 30 minutes of the scheduled time.

4. **"Pop-Off's"-** Once the CoolSculpting applicator has been applied, patients must be extremely vigilant that they do not move and cause the applicator to become dislodged. This is referred to as a "pop off". If a "pop off" occurs within the first 50 minutes of a treatment hour, the treatment cycle is considered incomplete and must be repeated. Remember, once the procedure has begun, the handpiece cannot "pop off" on its own. Patients must remain as immobile as possible during their treatment to avoid "pop off's". A call button will be provided to summon a staff member to assist you. In the event of a "pop off", patients will be charged a fee of $250 ($350 for the CoolMax applicator).

If you have any questions about our treatment policies, please feel free to ask for additional clarification. We are here to assist you in any way possible. Thank you for choosing Spiro Plastic Surgery, LLC.

_____ _____

Patient/Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

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

Any questions or concerns regarding information contained in this document should be directed to:
Marybeth Gabriel, Privacy Officer
101 Old Short Hills Road, Suite 510
West Orange, NJ 07052
Telephone (973) 736-5907

We Have a Legal Duty to Safeguard Your Protected Health Information (PHI)
This includes information that can be used to identify you that we have created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We must provide you with this notice regarding our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use and disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice at any time. Any changes will apply to the PHI we already have. We will promptly post the revised policy in our office waiting room. You may also request a copy of this notice from the individual named above at any time.

How We May Use and Disclose Your Protected Health Information
We use and disclose health information for many reasons. Below we describe the different uses and disclosures.

Uses and disclosures which do <u>not</u> require your authorization:

- *Treatment* - We will use your health information for treatment. We may provide your information to hospitals, anesthesiologists, and other physicians involved in your care, nurses and technicians.
- *Payment* – We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. A bill may be sent to you, a third-party payer, or collection agency. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis and procedures.
- *Health Care Operations* – We may disclose your PHI in order to operate this practice. We may use your information in order to evaluate the quality of health care services our office provides. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make certain we are complying with laws that apply to our practice.
- *Federal, State, or Local Law, Judicial or Administrative Proceedings, or Law Enforcement* – We may disclose your information when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, domestic violence, or when ordered in a judicial or administrative proceeding.
- *Business Associates* - There are some services provided in our practice through contacts with business associates. Examples include radiology, anesthesiology, laboratory diagnostics, hospital and surgical facilities, etc. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer when necessary. So that your health information is protected, however, we require the business associate to appropriately safeguard your information.
- *Public Health Activities* – We may report information to government officials in charge of collecting information about various diseases, infections, and medical products. We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls. We may provide coroners, medical examiners, and funeral directors any necessary information.
- *Health Oversight Activities* – We will provide information to assist the government when it conducts an audit or investigation of a physician or medical practice.
- *Tissue/Organ Donation* – We may contact tissue procurement organizations to assist them in donations and transplants.
- *Research* - We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. <u>We will always ask for your specific written permission if the researcher will have access to any information that reveals who you are, such as your name, address or other patient identifying information.</u>
- *To Avoid Harm* - In order to avoid a serious threat to the health and safety or a person or the public, we may provide your information to law enforcement personnel or persons able to prevent or lessen such harm.
- *Specific Government Functions* – We may disclose information on military personnel or veterans in certain situations. We may disclose information for national security purposes or conducting intelligence operations.
- *Workers' Compensation* – We may provide information to comply with applicable workers' compensation laws.

- *Appointment Reminders and Health Related Benefits or Services* – We may use information to advise you of future appointments, treatment alternatives, or other health care services or benefits we offer.
- *Incidental Uses and Disclosures* – An incidental use and disclosure is a secondary use that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. Such uses are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your information than is necessary to accomplish the permitted disclosure.

Uses and disclosures where you have the opportunity to object:

- *Disclosures to Family, Friends, and Others* – Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. You may object in whole or in part to these disclosures.

Other uses and disclosures of medical information not covered by this policy or applicable laws will only be made with your prior written approval. You may revoke that permission, in writing, at any time. Revoking your permission does not require us to take back any disclosures we have previously made with your permission.

Your Rights Regarding Your Protected Health Information

Although your health record is the physical property of the healthcare practitioner, the information belongs to you. You have the right to:

- Obtain a copy of the Notice of Privacy Practices upon request
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522. This request must be made in writing to the attention of the Privacy Officer and must include what information that patient wants to limit and to whom the limits apply. We will consider your request but are not legally required to accept it.
- Inspect and copy your health record as provided for in 45 CFR 164.524. This request must be made in writing to the attention of the Privacy Officer. We will respond to you within 30 days of receiving your written notice. We may charge a fee for the costs of copying, mailing, faxing, reproducing photographs, or other expenses associated with a patient's request.
- Choose how we send health information to you. You may request that we send information to you at an alternative address or by alternate means.
- Request an amendment of your health record if you feel the information we have is incomplete or incorrect as provided in 45 CFR 164.528. Requests must be made in writing to the attention of the Privacy Officer and must include a valid reason to support the request. We will respond within 60 days of receiving your written request.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528. This list will not include disclosures you have already consented to such as those made for treatment, payment, or health care operations, or disclosures made prior to the effective date of this policy. This request must be made in writing and must state a period of no longer than six years. We will respond within 60 days of receiving your written request.

For More Information or to Report a Problem

If you have any questions or would like additional information, you may contact Marybeth Gabriel, Privacy Officer at (973) 736-5907. If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint. All complaints must be made in writing.

Revisions of Privacy Policy

We reserve the right to change our Privacy Practices at any time and to make the new provisions effective for all protected health information we maintain. You may request a copy of any revisions made to our Notice of Privacy Practices either by mail, telephone, or in person.

Policy Effective Date: July 1, 2018

101 Old Short Hills Road, Suite 510
West Orange, New Jersey 07052
Telephone (973) 736-5907 • Fax (973) 736-4987

From Route 280 West
- Take Exit 6A – Laurel Avenue South
- Within half a mile, you will reach a fork in the road. Stay left.
- This road changes times several times (Shrewsbury Dr, East Cedar St)
- At the 5th traffic light, our building is the large 5 story office building on the left hand side, directly across from Saint Barnabas Medical Center
- Our building is called the Atkins Kent Building.

From Route 280 East
- Take Exit 6 – Laurel Avenue
- Turn right at the end of the exit ramp onto Laurel Avenue South
- Within half a mile, you will reach a fork in the road. Stay left.
- This road changes times several times (Shrewsbury Dr, East Cedar St)
- At the 5th traffic light, our building is the large 5 story office building on the left hand side, directly across from Saint Barnabas Medical Center
- Our building is called the Atkins Kent Building

From the Garden State Parkway
- Garden State Parkway to Exit 145
- Stay Left and follow signs for Route 280 West
- Follow directions for Route 280 West

From the George Washington Bridge
- Route 80 West to the Garden State Parkway South
- Follow directions above from the Garden State Parkway

From the New Jersey Turnpike
- Take Exit 15W
- Follow signs for Route 280 West
- Follow directions for Route 280 West

From Route 287 North or South
- Exit at Route 10, take Route 10 East
- At the Livingston Traffic Circle, follow signs for Northfield Road
- At the third traffic light, make a right turn onto Shrewsbury Road.
- At the top of the hill, Shrewsbury Road merges with Old Short Hills Road.
- At the 3rd traffic light, our building is the large 5 story office building on the left hand side, directly across from Saint Barnabas Medical Center
- Our building is called the Atkins Kent Building.

From Route 78 East or West
- Take exit 48
- Take Route 24 West
- Exit at JFK Parkway, follow signs for Livingston
- In approximately 2 miles, you will come to a traffic light at South Orange Avenue. Make a right.
- At the 2nd traffic light, make a left on Old Short Hills Road
- Our building is on the right at the 1st traffic light. It is called the Atkins Kent Building.