Fleming Island Plastic Surgery

Date: / /

How did you hear about our office? _____

Patient Information

Age: _____ DOB: _____/_____/_____ ☐Male ☐Female

Patient's Name _____
Last First Middle

Mailing Address _____
Street Apt/Unit Number

_____
City State Zip Code

Home: _____ Mobile: _____ Work: _____

E-Mail: _____

Social Security #: _____ - _____ - _____ Driver License #: _____

Marital Status: ☐Single | ☐Married | ☐Divorced | ☐Widowed | ☐Domestic Partnership

Employer's Name _____ Occupation: _____

_____
Street City State Zip

Spouse Information

Spouse's Name _____
Last First Middle

Spouse's Employer _____

Spouse's Cell: _____ Spouse's Work: _____

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)
☐ Call Home Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐
☐ Call Cell Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐
☐ Call Work Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐
Ok to send e-mail?		Ok to send Text Messages?	
Email Appointment Reminders	☐ Yes ☐ No	Text Appointment Reminders	☐ Yes ☐ No
Email Medical/Schedule Info	☐ Yes ☐ No	Text Medical/Schedule Info Staff	☐ Yes ☐ No
Email Office Specials/News	☐ Yes ☐ No	Text Office Specials/News	☐ Yes ☐ No

Fleming Island
Plastic Surgery

Emergency Contact			
Name:	Phone:	Relationship to Patient:	

Please allow the front desk to make a copy of your insurance card.

Insurance Information

Primary Insurance Company Name: _____

Name of Policy Holder: _____

Policy Holder DOB: _____ Relation to Policy Holder: _____

Policy #: _____ Group #: _____

Secondary Insurance Company _____

Name of Policy Holder: _____

Policy Holder DOB: _____ Relation to Policy Holder: _____

Policy #: _____ Group #: _____

I understand that office visit charges are payable on the day service is rendered. I authorize William A. Wallace, MD to bill my insurance company. Regardless of insurance coverage, I am responsible for bills being paid in a timely manner. I understand that my contract is between William A. Wallace, MD and myself.

Signature: (Patient, Parent or Guardian) _____ Date: _____

HIPAA Authorization to Discuss Your Medical Information

Indicated below are names of any Person(s) to whom I would like Fleming Island Plastic Surgery to allow disclosure of Protected Health Information (PHI). (Please specify the type of information that may be disclosed, such as lab test, appointment information, prescription information, bill information, etc. You may indicate "All" if appropriate). I understand that I am not required to list anyone and I may change this list at any time in writing.

Authorization

I authorize the Practice to disclose my PHI to those individuals listed below (*specify name, relationship and contact information if applicable*):

Name: _____ Relationship: _____ Contact Number: _____

Name: _____ Relationship: _____ Contact Number: _____

Please acknowledge that you have been offered a "Notice of Privacy Practices" by signing below:

"I have been offered a Notice of Privacy Practices by the office of Fleming Island Plastic Surgery and I fully understand and accept the terms of this consent."

Signature: (Patient, Parent or Guardian) _____ Date: _____

Procedure Information

What is the reason for your visit today? _____

Please describe why you are interested in the procedures listed above: _____

Have you consulted with other surgeons about the procedure(s) indicated above? ☐ Yes ☐ No

Is this procedure a revision from a previous surgery? ☐ Yes ☐ No

If yes, how many previous surgeries? _____

Pharmacy Information

Pharmacy Name: _____

Address: _____ City: _____ Zip: _____

Health Information & Medical History

Date of Your Last Physical Examination _____ Weight _____ Height _____

Primary Care Physician _____

Address _____

Phone Number _____ Fax Number _____

Surgery (Operations and Cosmetic Surgery)

	Type	Date	Complications/Difficulties
1.			
2.			
3.			
4.			
5.			

Medical Problems or Conditions Now Under Treatment by a Physician

Explain _____

_____

Admissions to Hospital

	Reason	Date	Complications/Difficulties
1.			
2.			
3.			
4.			

Medications, Vitamins, or Herbal Supplements You Take Now

	Type	Dosage/Amount If Known	Take How Often
1.			
2.			
3.			
4.			
5.			

Social History

☐ Caffeine use ☐ Tobacco/Nicotine ☐ Alcohol ☐ Other(s) _____

Exercise Habits _____

Allergies (Please list)_____

_____

Bleeding Problems

Do you bruise or bleed easily? ☐ Yes ☐ No (With cuts/tooth extractions/pregnancy/surgery)

Explain_____

Do you have a family history of bleeding problems? Explain_____

Difficulties with Local or General Anesthesia

Explain_____

Have You Ever Had a Blood Transfusion? ☐ Yes ☐ No

Have You Ever Had, Have, or Been Exposed To?

☐ Yes ☐ No Intravenous Drugs

☐ Yes ☐ No Infectious Diseases

☐ Yes ☐ No Tuberculosis

☐ Yes ☐ No Hepatitis

☐ Yes ☐ No HIV/AIDS

☐ Yes ☐ No Liver Transplant

If Yes to Any Explain_____

_____

Family History

Any family history of medical problems or illness?

Mother_____

Father_____

Sister_____

Brother_____

Other_____

Fleming Island
Plastic Surgery

REVIEW OF SYSTEMS

Please check the box below if you currently have or have ever had a problem with:

ABDOMEN & LIVER

- ☐ Ulcers
- ☐ Colon Disease
- ☐ Gallbladder Disease
- ☐ Inflammatory Bowel Disease (IBS)
- ☐ Reflux
- ☐ Hiatal Hernia
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Liver problems
- ☐ Cirrhosis
- ☐ Heartburn

KIDNEY & ENDOCRINE

- ☐ Diabetes
  - ☐ Insulin Dependent
  - ☐ Oral Hypoglycemic Agent
  - ☐ Diet Controlled
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Low Blood Sugar
- ☐ Kidney Stones
- ☐ Kidney Disease or Failure
- ☐ Kidney Infection
- ☐ Difficulty Passing Urine

NEUROLOGICAL & PSYCHOLOGICAL

- ☐ Stroke
- ☐ Seizures
- ☐ Fainting
- ☐ Headaches
- ☐ Emotional Problems
- ☐ Psychiatric Problems or Treatment
- ☐ Depression
- ☐ Anxiety
- ☐ Sciatica
- ☐ Herniated Disc

SKIN

- ☐ Scar Badly
- ☐ Keloids or Thick Scars
- ☐ Wound Healing Problems or Open Sores
- ☐ Atypical Skin Lesions
- ☐ Previous Skin Tumors or Cancers

MUSCULOSKELETAL

- ☐ Back Pain
- ☐ Neck Pain
- ☐ Arthritis - Osteo
- ☐ Arthritis - Rheumatoid
- ☐ Muscular Dystrophy
- ☐ Muscular Sclerosis
- ☐ Fibromyalgia

EYES

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Dry Eyes
- ☐ Do you wear contact lenses?

HEART

- ☐ High Blood Pressure
- ☐ Born with Heart Problems
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Chest Pains
- ☐ Heart Bypass Surgery
- ☐ Pacemaker
- ☐ Irregular Heartbeat
- ☐ Heart Murmur

Comments_____

LUNGS

- ☐ Abnormal Chest X-Ray
- ☐ Asthma
- ☐ Bronchitis
- ☐ Shortness of Breath
- ☐ Recent Chest Infection
- ☐ Emphysema/COPD
- ☐ Pulmonary Embolism
- ☐ Cough or Cold at Present
- ☐ Sleep Apnea
- ☐ Use a C-PAP Machine

HEMATOLOGIC/ONCOLOGIC

- ☐ Excessive Bleeding
- ☐ Bruise Easily
- ☐ Anemia
- ☐ Sickle Cell Disease
- ☐ Blood Clots in Legs
- ☐ Blood Clots in Lungs
- ☐ Radiation Therapy
- ☐ Cancer
  - ☐ Where?_____

Please list any other medical conditions not listed above_____

_____

Signature:_____ Date:_____

Fleming Island
Plastic Surgery

PAYMENT POLICY

For all cosmetic patients during your visit, you will be given a fee estimate for your proposed aesthetic procedure(s). This quote will include fees for the Surgery Center and fees for the Anesthesiologist, as well as any special equipment fees or Assistant fees. Please note that Dr. William A. Wallace's portion of the quote is good for 30 days only. If you choose to schedule the procedure more than 30 days in the future, it is possible that the fee will be different than the original quote. The Surgery Centers control their own fee schedules, and may increase their fees at any time. Payment for surgery may be made by cash, major credit card, or cashier's check. We also offer patient financing through CareCredit® and ALPHAEON®. Payment of non-surgical treatments such as BOTOX® Cosmetic and fillers are made at the time of service by cash or debit/credit card.

In regards to procedures that may or may not be covered by medical insurance, there may be situations in which part of your surgery would be considered functional or medically necessary. In that case, your insurance may pay part of the surgery fee. As a courtesy to you, our office will pursue prior authorization for this procedure. You will be responsible for the Surgeon's fee, deductible and/or co-payments prior to the procedure. If the surgery center is a Preferred Provider, you will be responsible for your deductible and co-payments for the operating room & anesthesia, as well as payments for the cosmetic portion of your procedure. **Purely cosmetic services will not be billed to any third party insurer.**

Our office requires a non-refundable scheduling fee equivalent to 10% of the total surgery cost (or a minimum of $500) to guarantee your surgery date & time. Surgery fees are to be paid in full at your Pre-Operative appointment.

Fleming Island Plastic Surgery and Dr. William Wallace is not responsible for refunding any surgical fees or rescheduling fees that result from a patient's non-compliance. The failure to follow pre-surgical instructions includes: nicotine, alcohol, drug use, failure to avoid or to take specific medications as instructed, and failure to follow day of surgery instructions. With that said the following below applies due to a non-compliant patient and or patients decision to cancel:

Cancellation up to 14 days prior to your procedure date will result in a 25% loss of all fees. Cancellation within one week (7 days) of your procedure will result in a 50% loss of all fees. If you cancel 48 hours or less from your procedure date, you will forfeit 100% of all fees. These penalties do not apply to illness related cancellations where a Doctor's note is provided.

In the event, that Dr. Wallace feels that a revision or touch-up is necessary, you the patient will be responsible for additional fees. These fees may include: Surgeon Fee, Facility, Anesthesia, and any additional supplies. The same cancellation policy mentioned above will also apply.

We encourage you to contact our office staff for any questions that you may have, so that this policy may be clarified for you prior to scheduling any procedures.

Statement of Financial Responsibility

"I, the undersigned, have read the above & understand that I am responsible for all medical & surgical charges incurred by myself or my dependents. I authorize the release of any medical information necessary to process any claims that are processed on my behalf by the office of Dr. Wallace. I understand that my medical insurance contract is between my insurance company and myself and that the failure of the insurance company to pay my claim does not absolve my financial responsibility to Dr. Wallace. All court and attorney fees or other fees associated with the collection of my account are my financial responsibility."

Signature: (Patient, Parent or Guardian) _____ Date: ____/____/_____

Fleming Island
Plastic Surgery

PHOTO CONSENT

As part of your medical care, Fleming Island Plastic Surgery will take medical photography related to the surgical and/or non-surgical care you receive. When taken for clinical reasons, this does not require your permission. Your written permission is however required to use any such photography for non-clinical reasons.

By consenting to photography, you understand that you will not receive payment from any party. Whenever possible, your photos will be used without identifying information however, you understand that it may be possible for someone to recognize your photo if used outside of your medical record. By completing the section(s) below, you hereby authorize Fleming Island Plastic Surgery to create and retain photography of you prior to, during, and after receiving treatment or services.

CONSENT TO USE PHOTOGRAPHY

I hereby consent to the release and use of photography and videos taken of me for the following purpose(s) below. BY SIGNING BELOW, I CONFIRM THAT THIS CONSENT HAS BEEN EXPLAINED TO ME IN TERMS THAT I AM ABLE TO UNDERSTAND AND THAT THIS CONSENT WAS GIVEN VOLUNTARILY BY ME.

The consent below applies to videos/images of me:

☐ I consent to images of me being used in **MEDICAL PUBLICATIONS,JOURNALS, TEXTBOOKS, CLINICAL STUDIES, ELECTRONIC PUBLICATIONS, OR OTHER PUBLIC MEDIUMS FOR TEACHING AND EDUCATIONAL PURPOSES.** I understand that the images may be seen by members of the general public, in addition to scientists and medical researchers that use these publications in their professional education.

☐ I consent to allowing photos and video recordings of me to be published on **INTERNET** sites including, but not limited to Fleming Island Plastic Surgery Website, social media sites (such as YouTube, Facebook, Instagram, RealSelf, and Periscope), and any other websites that might be viewed by the general public for any reason. I understand that once released onto the Internet, Fleming Island Plastic Surgery will no longer have control of the photos nor how they are used.

_____ _____ _____

Signature Witness Date

If you consent to only having your pictures used for the documentation of your medical record, please check the box below and sign.

☐ **I consent to having photos of me being used ONLY for the purposes of DOCUMENTING IN MY MEDICAL RECORD and that these will only be released by written request and authorization signed by me.**

_____ _____ _____

Signature Witness Date

Fleming Island
Plastic Surgery

PATIENT PARTNERSHIP PLAN

Dear Patient,

Welcome to Fleming Island Plastic Surgery. We hope to provide you with the care and service that you expect and deserve. Achieving your *best possible health* requires a "partnership" between you and your doctor. As our "partner in health", we ask you to participate in your care in the following ways:

I Will Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

I Will Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

I Will Inform My Doctor if I Decide Not to Follow His Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his recommendations so that he may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, seek an explanation, report symptoms, or discuss concerns. If you need more information about your health or condition, please ask.

_____ /____/ _____

Patient Signature Date Witness Signature

Fleming Island
Plastic Surgery

CANCELLATION POLICY

Medical Appointment Cancellation/No Show Policy

When you schedule an appointment with Fleming Island Plastic Surgery we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. ***Please see our appointment Cancellation/No Show Policy below:***

- *Effective June 1, 2018* a credit card number on file will be required to schedule all new patient consultation appointments/injection appointments.
- Any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show and charged a $50.00 fee.
- New Patients with two or more No Shows or cancellation/reschedules without a 24-hour notice will not be rescheduled again.
- Established patients with *3 or more* No Shows or cancellation/reschedules without a 24-hour notice may be dismissed from Fleming Island Plastic Surgery.

Office Procedure Cancellation Policy

Scheduling of in-office procedures requires careful planning and coordination. In addition, special medical instrumentation is prepared and sterilized for each individual procedure. Therefore, please understand the importance of respecting our Cancellation Policy which entails the following:

- Payment for certain procedures will be taken at the time of scheduling to secure your appointment.
- Cancellations three (3) days prior to your procedure(s) will result in a charge to your account of 50% of that procedure.
- Cancellations (or simply Not Showing) on the day of the procedure, will result in a charge to your account of 100% of that procedure.
- Cancellations of certain procedures will result in a minimum of a $500 inconvenience fee.
- All balances must be made prior to scheduling any future appointments.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact Fleming Island Plastic Surgery 24 hours a day, 7 days a week at 904-990-3477. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

I have read, understand, and accept the above policies.

Printed Name:_____

Signature:_____ Date:_____

Fleming Island
Plastic Surgery

Non-Smoking Agreement

At Fleming Island Plastic Surgery, we do everything we can to ensure that your surgical journey is as safe and effortless as possible. To achieve your best possible results, we require that every patient be completely nicotine free for at least ***one month*** prior to their procedure and ***one month after.*** This policy is set with our patients' best interest in mind and ***holds true regardless of whether this is a local procedure, or a procedure performed under general anesthesia.***

You will be ***required*** to provide a urine sample to test for nicotine at the day of your pre-operative appointment as well as the day of your procedure/surgery. If you test positive, your surgery will be canceled and you must test negative before we can reschedule your procedure. Each test taken thereafter will be patient responsibility at $25.00 a test. ***If a procedure must be canceled due to a positive test result, all cancellation fees still apply.***

Please be cautious as nicotine patches, gums, hookahs, and vapes that are not set to 0% nicotine, will all cause you to test positive.

I **(Print Name)**_____
have read, understand and agree to the FIPS non-smoking agreement.

Patient Signature: _____ **Date:**_____

Witness Signature:_____**Date:**_____