Raleigh Plastic Surgery Center

Raleigh Plastic Surgery Center, Inc.
PATIENT INFORMATION

Chart #_____

Are you a new patient? _____ How did you learn about our office? _____

Patient's Name: _____ (Last / First / Middle) Birthdate: __/__/__ (M D YR) Age: _____ Sex: _____

Patient's Address: _____ (Street / Apt# / City / State / Zip Code)

Patient's SS# _____ Phone (H): _____ (WK): _____ ext.____ Cell _____

At which number may we reach you? ☐Home ☐Work ☐Cell

Preferred Pharmacy: _____ Location: _____

Race: ☐ (1) Asian or Pacific Islander
☐ (3) Caucasian
☐ (5) American Indian or Alaskan Native
☐ (6) Black or African American
☐ (9) Other

Ethnicity: ☐ (1) Non-Hispanic
☐ (2) Hispanic
☐ (9) Declined/Unavailable

Preferred Language: _____

Employer and Address: _____

Emergency Contact: _____ Phone: _____ Cell: _____

Relation: _____

Receive information regarding special offers? ☐ Yes ☐ No ☐ Home ☐ Email _____

Is this a work related injury? ☐ Yes ☐ No Is this an attorney referred appointment? ☐ Yes ☐ No

Are you the Primary Insurance Holder?: ☐ Yes ☐ No

If you checked NO, information below MUST be completed.

Primary Policy Holders Name: _____ **SS#** _____ **DOB:** _____

Employer: _____

PRIVACY POLICIES NOTICE ACKNOWLEDGEMENT, IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

I _____ acknowledge that a copy of RPSC, Inc.'s Privacy Policies Notice has been made available to me in accordance with the Health Insurance Portability And Accountability Act of 1996 (HIPAA).

Signed _____ Date _____
(Patient Signature or Responsible Party)

Authorization and Assignment

I hereby authorize Raleigh Plastic Surgery Center, Inc. to furnish all necessary information to appropriate parties such as insurance carriers, physicians, and attorneys concerning treatments rendered. I understand that I am responsible for ALL medical expenses whether or not there is insurance coverage (and/or ANY expenses incurred as a result of collecting a past due account). I understand that payment for office visits is due the day of service and if insurance submitted for surgical services is not paid by 60 days, I must pay in full unless arrangements are made. I consent to be photographed and understand that the photographs are necessary for my treatment and/or determination for insurance benefits. The photographs will not be used for advertising purposes.

Patient (or legal representative) Signature: _____ Date: _____

Relationship to Patient (if legal rep.) _____

Raleigh Plastic Surgery Center, Inc.

Health History Questionnaire

Chart # _____

Name _____ D.O.B. _____ Age _____

1. Weight _____ Height _____ Name of Medical Doctor _____
2. Date of most recent physical _____ EKG _____ Chest X-ray _____
3. Allergies & **type of reaction** (medications, latex, adhesives, shell fish, bananas, kiwi, or other foods, environmental)

_____

_____

4. Please list all present medications including vitamins, herbal supplements, over the counter tablets, weight control substances, steroids, prescription drugs, etc:

MEDICATION	DOSAGE	HOW MANY TIMES/DAY

5. Please list all operations that you have had:

SURGERY	YEAR	SURGEON

6. Have you or a family member ever had a problem with anesthesia? **Yes** **No**
   If yes, please explain: _____
7. Have you or a family member ever been diagnosed with, suspected of having, or treated for Malignant Hyperthermia? **Yes** **No**
8. Have you ever been told that you are difficult to intubate? **Yes** **No**
9. Do any diseases run in your family: **Yes** **No** **If "yes"** explain: _____

   _____
10. Have you been hospitalized for any reason other than surgery? **Yes** **No**
    If "yes", state reason: _____

    _____
11. Do you smoke cigarettes? **Yes** **No**
    If "yes", what is your average daily consumption? _____ Packs/day for the past ____ years.
    If "no", have you ever smoked? **Yes** **No** When did you quit? _____

12. Do you drink alcohol? **Yes** **No** If yes, what is your average daily consumption?
13. Do you engage in recreational drug use? (Marijuana, Cocaine, etc.) **Yes** **No**
14. **If you are female please complete the following:**
    - **a** Date of last menstrual cycle _____
    - **b** Date of last mammogram _____
    - **c** Do you know or suspect that you may be pregnant? _____
    - **d** Are you breast feeding? _____
    - **e** How many times have you been pregnant? _____
    - **f** How many children do you have? _____
    - **g** Bra size _____ (If having a consult for breast surgery)

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

ABDOMEN & LIVER
- ❑ Ulcers
- ❑ Colon disease
- ❑ Gallbladder disease
- ❑ Reflux or regurgitation
- ❑ Hiatal hernia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Liver problems
- ❑ Cirrhosis
- ❑ Heartburn
- ❑ Inflammatory Bowel Disease
- ❑ Irritable Bowel Syndrome (IBS)

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, fleeting blindness or weakness
- ❑ Seizures, convulsions, epilepsy
- ❑ Fainting
- ❑ Headaches
- ❑ Concussion or severe head injury
- ❑ Emotional problems
- ❑ Psychiatric problems or treatment
- ❑ Depression
- ❑ Anxiety

GENERAL
- ❑ Glaucoma
- ❑ Visual problems
- ❑ Tested positive for HIV or AIDS virus
- ❑ Been exposed to someone who is HIV positive
- ❑ Cancer of any kind
- ❑ Chemotherapy
- ❑ Radiation therapy

SKIN
- ❑ Scar badly
- ❑ Keloids or thick scars
- ❑ Wound healing problems or open sores
- ❑ Recent changes in any moles: color size, or appearance
- ❑ Recent changes in any skin lumps or colored areas
- ❑ Previous skin tumors or cancers

MUSCULOSKELETAL
- ❑ Leg pain
- ❑ Back pain
- ❑ Neck pain
- ❑ Arthritis
- ❑ Bone disease or tumors
- ❑ Physical limitations, appliances or prostheses
- ❑ Muscular dystrophy
- ❑ Multiple sclerosis
- ❑ Fibromyalgia

HEART
- ❑ Born with heart problems
- ❑ Heart murmur
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chest pains
- ❑ Heart attack
- ❑ Heart failure
- ❑ Hardening of arteries
- ❑ Congestive heart failure
- ❑ Scarlet or Rheumatic Fever
- ❑ Any heart valve disease
- ❑ Leg swelling or edema
- ❑ Leg cramping with walking
- ❑ High cholesterol
- ❑ Wolfe Parkinson White Syndrome (WPW)
- ❑ Had a stress test, if "yes" when? & results? _____
- ❑ Seen by a cardiologist, if "yes" what for? & name of the cardiologist? _____

LUNGS
- ❑ Cough or cold at present
- ❑ Bronchitis
- ❑ Shortness of breath
- ❑ Asthma
- ❑ Emphysema/COPD
- ❑ Tuberculosis
- ❑ Pulmonary embolism
- ❑ Sleep apnea
- ❑ Use of CPAP machine

BLOOD
- ❑ Low blood count or anemia
- ❑ Abnormal blood clotting
- ❑ Bruise easily or excessive bleeding
- ❑ Sickle cell trait or disease
- ❑ Varicose veins
- ❑ Deep vein thrombosis
- ❑ Blood transfusion

If you have any medical problems not on this list, please describe:

Signature: _____ Date: _____

Raleigh Plastic Surgery Center
Medical Privacy Authorization for Release of Information

Raleigh Plastic Surgery Center takes our patient's privacy very seriously. In accordance with the **Health Insurance Portability and Accountability Act** of 1996 **(HIPAA),** we can only discuss your health treatment and overall account information with you personally, or your legal guardian if a minor.

If you would like us to be able to discuss your health information with anyone else (i.e., spouse, children, significant other, or person responsible for providing care to you or financially responsible for your account, etc.) please list this person(s) below.

We will not be able to discuss your case with anyone other than those you have indicated below:

NAME **RELATIONSHIP**

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature_____ Date _____

RALEIGH PLASTIC SURGERY CENTER, INC.
FINANCIAL POLICY

Chart # _____

Please review the following Financial Policy, sign, date, and give to the receptionist for placement in your chart. We hope the following will answer any questions you may have about our insurance and billing procedures and policies in relation to your appointment.

1. We accept VISA, Master Card, Discover, American Express, cash, money orders, and checks.

2. We MUST have a copy of your current insurance card in order to file for you or your family member. If you do not have your insurance card, we will ask for payment in full at the time of visit.

3. If your insurance requires a referral or pre-authorization, we must have this in our office **prior** to your appointment. If we do not have this, we will ask you to reschedule your appointment to such time when the authorization or referral is in our office.

4. We will file any insurance with which we participate; however, we will ask you to pay for any non-covered, co-pay, co-insurance, or deductible amounts at the time of your visit/procedure.

5. Your Insurance Policy is a contract between you and your insurance company. We cannot guarantee to you that your insurance will pay all or any part, of your claim.

6. Raleigh Plastic Surgery Center is a State and Federally licensed Ambulatory Surgical Facility. Since we fall into this category, your ***out-patient*** surgical benefits will apply. Our procedures are **not** considered an ***in-office procedure***, rather an outpatient surgical procedure. This is due to the fact that all of our procedures ***must be performed in either our Surgery Center or local hospital facility,*** we are not allowed to perform these surgeries in our clinical office area. Please be aware that since we are a licensed Ambulatory Surgical Facility ***your deductible and coinsurance benefits apply.*** Given that we contract with your insurance company, we ***are required*** to collect all deductibles and coinsurance due associated with the procedure you are having performed. ***Your "Specialist" visit co-pay does not apply for your surgery, only for your initial doctor visit***. If you have any questions regarding your outstanding deductible and/or surgical co-pays, please consult your insurance company prior to scheduling surgery.

7. Please remember that any charges you were provided when you scheduled surgery were ESTIMATES only. Due to the complexity of some treatment, we have no way of stating exactly what the charges will be prior to a surgical procedure.

8. **We do not file with your insurance any charges relative to Pathology services**. All tissue studies and lab tests are sent to either Wake Medical or Greensboro Pathology for processing. If your insurance plan has an exclusive contract with another laboratory provider, you may be subject to out-of-network benefits, or non-coverage of the service. Please verify your coverage with your insurance benefits department.

9. Payment of services rendered to any dependent children rests with the parent who seeks treatment.

10. A $35.00 service charge will be applied to your account for all returned checks or any stopped payment on an issued check.

11. It is not our policy to issue refunds unless your account has a credit balance and all claims have been paid. Refunds will not be issued for amounts less than $10.00.

12. MISSED APPOINTMENTS / CANCELLATIONS – Our policy is to charge for missed appointments or appointments cancelled with less than 24 hours notice at a rate of $35.00. A $100 fee will be charged for any surgery missed or cancelled with less than 24 hours notice.

Authorization

I agree to be responsible for any medical expenses incurred with Raleigh Plastic Surgery Center, Inc., therefore, I authorize my insurance company, attorney, or other parties to pay directly to Raleigh Plastic Surgery Center, Inc. and/or provide any information regarding payment of my bill. I have read, understood, and agreed to the financial policy stated above and I accept responsibility for any balance not covered by my insurance company.

Signature _____ Date _____

Chart #_____

RALEIGH PLASTIC SURGERY CENTER, INC.
COSMETIC PATIENT AND SELF-PAY PATIENT FINANCIAL POLICY

Please review the following Financial Policy, sign, date and give to the receptionist for placement in your chart. We hope the following will answer any questions you may have about our financial policies.

1. We accept VISA, Master Card, Discover, American Express, cash, money orders, and checks.

2. A deposit of $500 is required to schedule a cosmetic surgery.

3. The $500 cosmetic surgery scheduling deposit is refundable only in the event that you cancel your surgery at three weeks (21 days) prior to your surgery date.

4. If you cancel your surgery with less than three weeks (21 days) notice in advance of the date of your surgery, your deposit becomes non-refundable, and you will forfeit such deposit to Raleigh Plastic Surgery Center.

5. If you need to reschedule the date of your surgery for unforeseen reasons without 21 days advance notice, your $500 deposit remains non-refundable and can only be applied to a new surgery date.

6. We will reschedule your cosmetic surgery once at no additional charge. If there is the need to reschedule your surgery again, there will be an additional $500 non-refundable fee.

7. If you cancel your surgery with less than three (3) business days of notice in advance of the date of your surgery, you will forfeit 50% of the total surgery cost to Raleigh Plastic Surgery Center.

8. Please be advised that payment for cosmetic surgery is due in full three weeks (21 days) prior to your surgery date.

9. If payment for your cosmetic surgery is paid with less than 21 days in advance of your surgery date, payment must be in the form of cash, credit card, money order or certified check. Personal checks will not be accepted less than 21 days in advance of your surgery date.

10. Refunds are issued by check bi-weekly. There are no cash refunds.

11. A $35.00 service charge will be applied to your account for all returned checks or any stopped payment on an issued check.

12. There is a $20 fee for completion of FMLA, disability, work release and related forms.

13. Payment of services rendered to any dependent children rests with the parent who seeks treatment.

14. Payment of self-pay surgeries is required to be paid in full prior to your surgery.

15. MISSED APPOINTMENTS/CANCELLATIONS - Our policy is to charge for missed appointments or appointments canceled with less than 24 hours notice at a rate of $35.00.

16. **MISSED SURGERIES/CANCELLATIONS** - Our policy is to charge $100.00 for any missed minor/local self-pay surgery which is canceled with less than 24 hours notice.

AUTHORIZATION

I have read, understood, and agree to the financial policy stated above and I accept responsibility for payment of all fees/charges incurred with Raleigh Plastic Surgery Center, Inc.

_____ _____

Signature Date