



# PRIMA CENTER FOR PLASTIC SURGERY

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

DRUG ALLERGIES: \_\_\_\_\_ Occupation: \_\_\_\_\_  
(prescriptions, latex, dyes, etc.)

## PURPOSE OF VISIT

What is the reason for your visit today? \_\_\_\_\_

What additional procedures/services are you interested in? (Please check all that apply)

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Abdominoplasty (Tummy Tuck) | <input type="checkbox"/> Breast Reduction    | <input type="checkbox"/> Eyelid Surgery            | <input type="checkbox"/> Medical Grade Skincare     |
| <input type="checkbox"/> Arm Lift                    | <input type="checkbox"/> Brow Lift           | <input type="checkbox"/> Face Lift                 | <input type="checkbox"/> Non-invasive Fat Reduction |
| <input type="checkbox"/> Breast Augmentation         | <input type="checkbox"/> CO2 Laser           | <input type="checkbox"/> Fillers/Botox/Injectables | <input type="checkbox"/> Rhinoplasty                |
| <input type="checkbox"/> Breast Lift                 | <input type="checkbox"/> Double Chin/Kybella | <input type="checkbox"/> Laser Services            | <input type="checkbox"/> Thigh Lift                 |
| <input type="checkbox"/> Breast Reconstruction       | <input type="checkbox"/> Ear Surgery         | <input type="checkbox"/> Liposuction               | <input type="checkbox"/> Other: _____               |

## HEALTH REVIEW

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING (CHECK ALL THAT APPLY)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Arthritis                              | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Migraine                |
| <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> Epilepsy   | <input type="checkbox"/> Nervous Breakdown       |
| <input type="checkbox"/> Bleeding Tendency                      | <input type="checkbox"/> Hay Fever  | <input type="checkbox"/> Pneumonia               |
| <input type="checkbox"/> Blood Clots/DVT (Deep Vein Thrombosis) | <input type="checkbox"/> Heart Attack   | <input type="checkbox"/> Rheumatic Heart Disease |
| <input type="checkbox"/> Bronchitis                             | <input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> Sleep Apnea             |
| <input type="checkbox"/> Cancer                                 | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Stomach Ulcer           |
| <input type="checkbox"/> Colitis                                | <input type="checkbox"/> HIV  | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Congenital Heart Defect                | <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Tonsillitis             |
|   |   | <input type="checkbox"/> Tuberculosis            |

IS THERE ANY OTHER MEDICAL INFORMATION WE SHOULD BE AWARE OF? \_\_\_\_\_

HAVE YOU HAD ANY PREVIOUS OPERATIONS?

\_\_\_\_\_ Year \_\_\_\_\_  
\_\_\_\_\_ Year \_\_\_\_\_

HAVE YOU HAD ANY SERIOUS INJURIES OR ILLNESSES?

\_\_\_\_\_ Year \_\_\_\_\_  
\_\_\_\_\_ Year \_\_\_\_\_

PLEASE INDICATE MEDICATION(S) YOU ARE CURRENTLY TAKING (if any)

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Antibiotics         | <input type="checkbox"/> Coumadin        | <input type="checkbox"/> Iron                  | <input type="checkbox"/> Water Pills            |
| <input type="checkbox"/> Aspirin             | <input type="checkbox"/> Digitalis       | <input type="checkbox"/> Laxatives             | <input type="checkbox"/> Weight Reduction Pills |
| <input type="checkbox"/> Barbiturates        | <input type="checkbox"/> Dilantin        | <input type="checkbox"/> Metabolife Type Pills | <input type="checkbox"/> Other Please List      |
| <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Herbal Medicine | <input type="checkbox"/> Sleeping Pills        | _____   |
| <input type="checkbox"/> Blood Pressure Meds | <input type="checkbox"/> Hormones        | <input type="checkbox"/> Thyroid Medication    | _____   |
| <input type="checkbox"/> Blood Thinners      | <input type="checkbox"/> Insulin         | <input type="checkbox"/> Tranquilizers         | _____   |

## PERSONAL HEALTH

PLEASE CHECK YES OR NO FOR THE FOLLOWING

- |   |                          |                                      |                          |
|---|--------------------------|--------------------------------------|--------------------------|
| YES   | NO                       | YES                                  | NO                       |
| <input type="checkbox"/>                                | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> |
| Do you smoke regularly?                                 |                          | Do your gums bleed frequently?       |                          |
| <input type="checkbox"/>                                | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> |
| If yes, how many packs per day? _____ # of years? _____ |                          | Do you have frequent nosebleeds?     |                          |
| <input type="checkbox"/>                                | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> |
| Do you drink over 6 cups of coffee a day                |                          | Do you bleed excessively from a cut? |                          |
| <input type="checkbox"/>                                | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> |
| Do you regularly drink alcoholic beverages?             |                          | Do you regularly take aspirin?       |                          |
| <input type="checkbox"/>                                | <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/> |

## WOMEN ONLY

- |   |                          |
|---|--------------------------|
| YES   | NO                       |
| <input type="checkbox"/>                          | <input type="checkbox"/> |
| Do you have regular monthly menstrual cycles?     |                          |
| <input type="checkbox"/>                          | <input type="checkbox"/> |
| Do you have bleeding between periods?             |                          |
| <input type="checkbox"/>                          | <input type="checkbox"/> |
| Do you have heavy bleeding with your periods?     |                          |
| <input type="checkbox"/>                          | <input type="checkbox"/> |
| Do you regularly have a pap smear?                |                          |
| <input type="checkbox"/>                          | <input type="checkbox"/> |
| Have you ever had discharge from your nipple(s)?  |                          |
| <input type="checkbox"/>                          | <input type="checkbox"/> |
| Do you have any children? If yes, how many? _____ |                          |
| <input type="checkbox"/>                          | <input type="checkbox"/> |
| Have you ever had a miscarriage or stillbirth?    |                          |
| <input type="checkbox"/>                          | <input type="checkbox"/> |
| Have you ever had a cesarean operation?           |                          |

## MEN ONLY

- |  |                          |
|--|--------------------------|
| YES  | NO                       |
| <input type="checkbox"/>                             | <input type="checkbox"/> |
| Have you ever been treated for genital problems?     |                          |
| <input type="checkbox"/>                             | <input type="checkbox"/> |
| Have you ever had abnormal discharge from your penis |                          |
| <input type="checkbox"/>                             | <input type="checkbox"/> |
| Have you ever had a hernia?                          |                          |
| <input type="checkbox"/>                             | <input type="checkbox"/> |
| Have you ever had prostate issues?                   |                          |
| If yes, please describe: _____                       |                          |
| _____  |                          |

## PRIMA CENTER FOR PLASTIC SURGERY

All surgery deals with living tissue. Your ability to heal is as individual to you as your personality and your fingerprint. Each of us must accept that the healing process and the body's response to surgery is not always predictable. Therefore, the results of any surgery can never be completely guaranteed.

1. Each patient must understand that their own particular healing characteristics will affect the results.
2. Each patient must understand and accept that Dr. Zwiren/Dr. Nakano/Dr. Song/Dr. Stephenson, Jr./Dr. Gupta has absolutely no control over how your body heals and cannot predict healing (by tests or examinations prior to surgery) or control your own particular individual healing characteristics.
3. Each patient must understand and accept that if cosmetic deformities or areas of asymmetry should occur, even though the deformity may be visible, that Dr. Zwiren/Dr. Nakano/Dr. Song/Dr. Stephenson, Jr./Dr. Gupta is in the best position to determine whether or not additional surgery is needed. Dr. Zwiren/Dr. Nakano/Dr. Song/Dr. Stephenson Jr./Dr. Gupta will base this decision on whether or not he feels the potential benefits outweigh the potential risks of additional surgery. This will be based upon whether or not he feels that you will get predictable improvement from additional surgery.
4. Each patient must understand and accept that Dr. Zwiren/Dr. Nakano/Dr. Song/Dr. Stephenson Jr./Dr. Gupta must work on what you bring him to work with, and that he cannot change the qualities of your tissues, skin or muscle. At the time of your consultation Dr. Zwiren/Dr. Nakano/Dr. Song/Dr. Stephenson Jr./Dr. Gupta will, to the best of his ability, discuss any particular anatomic factors that may affect your result. Together, as a team, we will plan an approach that would be thought to yield an optimal and satisfactory result. I would stress again that this is a team approach.

### **Cosmetic Surgery – Surgical Touch up**

If, after your cosmetic surgery, there are areas, which both you and Dr. Zwiren/Dr. Nakano/Dr. Song/Dr. Stephenson, Jr./Dr. Gupta feel warrant a touch up to achieve an optimal result. You will, however, be responsible for the facility fee, equipment, supplies, and anesthesia fees. Some Surgical Touch up procedures can be performed under local anesthesia and others will require conscious sedation or general anesthesia. Dr. Zwiren/Dr. Nakano/Dr. Song/Dr. Stephenson, Jr./Dr. Gupta is in the best position to determine what type of anesthesia is indicated for your touch up procedure if needed. If desired, we will make available average charges for surgical touch ups. Examples include revising a suboptimal face-lift scar, treatment of significant asymmetry following cosmetic breast surgery or correction of implant malposition, revision of breast lift scars, refining a rhinoplasty, excision of skin at the margins of an abdominoplasty scar (dog ears) or refining an area of liposuction. All surgical touch ups must be performed within one year following the original procedure. The cost of a touch up under local anesthesia scheduled for less than one hour is a minimum of \$175.00, if one hour or more, the minimum cost is \$250.00.

### **Cosmetic Surgery – Patient request for revision or repeat surgery**

If after your cosmetic procedure there are areas for which you personally desire a revision, touch-up or repeated surgery and Dr. Zwiren/Dr. Nakano/Dr. Song/Dr. Stephenson, Jr./Dr. Gupta feels that you have had a satisfactory outcome from your surgery, then this will be considered a new surgical procedure and you will be responsible for expenses. Expenses include the surgeon's fee, the facility fee, equipment, and anesthesia costs. Examples may include a secondary facelift for recurrent skin laxity, changing the size or shape of breast implants, recurrent breast sagging following a breast lift, redoing an area of liposuction after weight gain or pregnancy.

### **Insurance Covered Procedures – Secondary Surgery**

If your insurance covered all or part of your expenses for your original surgery then you are responsible for that part of the expenses your insurance company does not cover. Your insurance company, depending on your particular policy, may cover secondary surgery. We will assist you in obtaining surgical pre-authorization in this situation. If your insurance company determines that the secondary surgery is cosmetic in nature and not covered then you will be responsible for expenses. Expenses include the surgeon's fee, the facility fee, equipment, and anesthesia costs. Examples include revision of a scar following breast reconstruction, revision of a breast reduction or revision of a scar following skin cancer excision.

These notes are provided for your information in an attempt to clarify our approach to billing secondary surgical procedures. If you have any questions or if this information is unclear to you, please contact our office manager for further explanation.

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Patient/Responsible Party Signature

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Date

# PRIMA CENTER FOR PLASTIC SURGERY

## Cigarette Smoking/Tobacco Use Informed Consent

When you smoke cigarettes or use any tobacco products, either before or after your plastic surgery procedure you are accepting additional risks greater than those discussed with patients who do not now or never smoked cigarettes. The longer you have smoked cigarettes and the more packs of cigarettes smoked per day also increases your risk of healing complications.

There is a definite yet undetermined increased risk of healing complications that can be directly linked to cigarette smoking. These include scarring, poor healing, skin loss and complications in general. **It is always best to stop smoking at least two (2) weeks prior to surgery and to continue to not smoke for two (2) weeks after surgery.** The exact length of time smoking should be discontinued to ensure good healing is unknown, but it would seem reasonable that more time is better. There is also no guarantee that even if all of the no smoking instructions are followed that healing will be satisfactory and without complications.

If you elect not to stop smoking or discontinue the use of all tobacco products and all medications containing nicotine, you will be unnecessarily accepting an increased risk of healing difficulties including the sloughing (dissolving away) of skin or fat. The result of these potential healing problems may require additional surgery, additional costs and additional time off of work. This is a choice, which you and you alone will be making. The physicians of Prima Center for Plastic Surgery are expressing our considerable concern on this issue in order to decrease, but not eliminate, healing difficulties after surgery. **By signing this form and continuing to smoke, use medications with nicotine or use any tobacco product** during the minimum two week before and two week after surgery restricted period you are accepting and acknowledging the increased chance of wound healing difficulties. You are also cautioned against **second hand smoke**, which has the same consequences as smoking.

When you smoke, there are both acute and long-term changes. The chronic changes associated with smoking are well known and include hardening of the arteries, the buildup of plaque in the arteries, a condition known as atherosclerosis, acceleration of the aging process due to the absorption of multiple toxins including carbon monoxide which binds to hemoglobin in the blood and blocks oxygen saturation thus lowering the amount of oxygen available for the tissues. There is also a sensitization of the lining of the arteries causing them to be more likely to go into spasm thus narrowing their diameter and allowing less room for blood flow. The acute changes from smoking also create an increased risk of arterial spasm thus decreasing the diameter of the arteries and decreasing blood flow to healing areas.

**I have read, understood and have received a copy** of the Prima Center for Plastic Surgery Cigarette Smoking Informed Consent and I realize the serious negative implications of cigarette smoking/nicotine products/tobacco products on my surgical result. I was given the opportunity to stop smoking to help decrease these complications. I will notify my physician prior to surgery if I am unable to stop smoking at least two weeks prior to surgery and for the two weeks following surgery and if necessary my procedure will be cancelled. **I ALSO UNDERSTAND THAT IN ADDITION TO CIGARETTES, I WILL NOT EXPOSE MYSELF TO SECOND HAND SMOKE, BE IN THE PRESENCE OF SMOKERS, USE ANY TOBACCO PRODUCTS AND WILL NOT USE NICORETTE GUM OR NICOTINE PATCHES.**

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Date

**FINANCIAL/ DEPOSIT / CANCELLATION POLICY & AGREEMENT**

**Effective January 1<sup>st</sup>, 2018, the cosmetic consultation fee is \$75.00, due at the time of your scheduled consultation appointment. This fee is non-refundable; however, it will be applied to future surgeries.**

When scheduling surgical procedures, in order to hold your requested date and time for surgery, we require receipt of a non-refundable \$500.00 deposit at the time of scheduling your surgery.

The deposit is applied to the cost of your surgery. If rescheduling your surgery is necessary, we request that you reschedule no later than 14 days prior to your procedure. As a courtesy, we will reschedule your surgery. If you require us to reschedule your surgery more than one time, an additional non-refundable \$500.00 deposit may be requested.

We understand that a situation may arise that forces you to postpone your surgery. Please understand that such changes not only affect Dr. Zwiren/Dr. Nakano/Dr. Song/Dr. Stephenson, Jr./Dr. Gupta, but other patients as well. If you cancel your surgery prior to your surgery date and have paid in full, you will be refunded your fees minus the non-refundable deposit fee, and the consultation fee. Failure to pay the balance 14 calendar days prior to your scheduled surgery date will be treated as a cancellation and Prima Center Surgery will retain your non-refundable deposit.

**PAYMENT POLICY**

The balance of your fees must be made in full at your pre-op visit. We accept cashier's check, money order, Visa, MasterCard, American Express, Discover, CareCredit®, or cash.

Services that are performed that are paid with a credit card, debit card or with financing are not eligible for post-care payment challenges. The practice encourages a complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Secondary Surgery (Revisions) Policy. I agree that this credit card, debit card or financing challenge is irrevocable.

Procedures performed in our accredited operating room are paid with two transactions. Surgeon fees are payable to Prima Center for Plastic Surgery. Operating room/Anesthesia fees are payable to Prima Ambulatory Surgical Services as defined in your surgery quote.

Procedures performed in the hospital setting are paid with one transaction – all fees are payable to Prima Center for Plastic Surgery. The fees for an overnight stay at the hospital is approximately \$1,493.00, if more than \$1,493.00 is charged by the hospital, the additional amount is payable to Prima Center for Plastic Surgery and billed following surgery.

**I have read and understand the financial policy of this office.**

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Date

# PRIMA CENTER FOR PLASTIC SURGERY

## HIPPA EMAIL CONSENT

- HIPPA stands for the *Health Insurance Portability and Accountability Act*
- HIPPA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email
- **When we send you an email, the information that is sent to you is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPPA act, the federal government provided guidance on email and HIPPA.
- The information is available in a pdf (page 5643) on the U.S. Department of Health and Human Services website:
  - <http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf>
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

**Please Sign and Date ONE of the Options Below**

### ALLOW UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to Prima Center for Plastic Surgery to send me personal health information via unencrypted email.

\_\_\_\_\_  
Signature  
(parent or guardian if patient is a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Please Print Email Address

### DO NOT ALLOW UNENCRYPTED EMAIL

I do not wish to receive personal health information via email.

\_\_\_\_\_  
Signature  
(parent or guardian if patient is a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name