PRIMA CENTER FOR PLASTIC SURGERY

PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Name: _____ Date of Birth: _____ Age: _____

Legal First Middle Last

Address: _____ Cell Phone: _____

City: _____ State_____ Zip_____ Home Phone: _____

Email Address: _____ Work Phone: _____

Family Doctor: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Name of person(s) we have permission to discuss your care with: _____

Phone Number: _____ **Relationship to Patient:** _____

Phone Number: _____ **Relationship to Patient:** _____

HOW DID YOU HEAR ABOUT US?

(Please Check All Statements That Apply)

___ My friend, _____, told me about Prima Center for Plastic Surgery.

___ My doctor, _____, referred me to this office.

___ _____ Hospital recommended Prima Center for Plastic Surgery.

___ I located you through _____ website.

___ I located you through _____ social media (Facebook, Instagram).

___ Other: _____

PRIVACY POLICY

Our Privacy Notice is located in the reception area. Your signature below indicates you have had the opportunity to review the privacy notice.

_____ _____

Patient/Responsible Party Signature Date

POLICIES (Pease Read and Sign)

I understand that this is a cosmetic surgical procedure (not medically necessary), and not reimbursable by Insurance/Medicare. I understand that payment is due in full at the pre-op visit.

We are pleased to accept MasterCard, Visa, American Express, and Discover for your services. Financing is available through CareCredit®. We also accept cashier's checks and cash. We are sorry, but we do NOT accept personal checks.

_____ _____

Patient/Responsible Party Signature Date

PRIMA CENTER FOR PLASTIC SURGERY

Legal 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? _____
_____
_____

HEALTH REVIEW

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

___ Anemia
___ Arthritis
___ Asthma
___ Bleeding Tendency
___ Blood Clots/DVT (Deep Vein Thrombosis)
___ Bronchitis
___ Cancer
___ Colitis
___ Congenital Heart Defect
___ Diabetes
___ Epilepsy
___ Fainting
___ Heart Attack
___ Heart Disease
___ Hernia
___ Hepatitis __ A __ B __ C
___ High/Low Blood Pressure
___ HIV/AIDS
___ Kidney Disease
___ Migraine
___ Nerve Damage
___ Pneumonia
___ Sleep Apnea (CPAP/BiPAP)
___ Stomach Ulcer
___ Stroke
___ Tonsillitis
___ Tuberculosis

ANY OTHER SERIOUS ILLNESSES / INJURIES / MEDICAL INFORMATION:

_____
_____

HAVE YOU HAD ANY PREVIOUS OPERATIONS?

_____ Year_____
_____ Year _____
_____ Year_____
_____ Year_____
_____ Year_____
_____ Year _____
_____ Year_____
_____ Year _____
_____ Year _____
_____ Year _____

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

___ Antibiotics
___ Aspirin
___ Barbiturates
___ Birth Control Pills
___ Blood Pressure Meds
___ Blood Thinners
___ Coumadin
___ Digitalis
___ Dilantin
___ Herbal Medicine
___ Hormones
___ Insulin
___ Iron
___ Laxatives
___ Psychological Meds
___ Sleeping Pills
___ Thyroid Medication
___ Tranquilizers
___ Water Pills
___ Weight Reduction Pills
___ Other Please List
___ _____
___ _____
___ _____
___ _____

PERSONAL HEALTH

PLEASE CHECK YES OR NO FOR THE FOLLOWING

YES	NO		YES	NO	
___	___	Do you smoke/vape regularly?	___	___	Do you have frequent nosebleeds?
		If yes, how many packs per day? ___ # of years? ___	___	___	Do you bleed excessively from a cut?
___	___	Do you drink over 6 cups of coffee a day	___	___	Do you regularly take aspirin?
___	___	Do you regularly drink alcoholic beverages?			

WOMEN ONLY

YES	NO	
___	___	Do you have regular monthly menstrual cycles?
___	___	Do you have bleeding between periods?
___	___	Do you have heavy bleeding with your periods?
___	___	Have you ever had discharge from your nipples?
___	___	Do you have any children? If yes, how many? ___
___	___	Have you ever had a cesarean operation?

MEN ONLY

YES	NO	
___	___	Have you ever been treated for genital problems?
___	___	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 as an individual is unique. 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. Song/Dr. Sakharpe has absolutely no control over how your body heals and cannot predict healing (by tests or examinations prior to surgery) or control your own 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. Song/Dr. Sakharpe is in the best position to determine whether or not additional surgery is needed. Dr. Song/Dr. Sakharpe will base this decision on whether 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. Song/Dr. Sakharpe 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. Song/Dr. Sakharpe 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.

Cosmetic Surgery – Surgical Touch up

If, after your cosmetic surgery, there are areas, which both you and Dr. Song/Dr. Sakharpe 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. Song/Dr. Sakharpe 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 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 $250.00. If it exceeds one hour or more, the minimum cost is $375.00.**

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. Song/Dr. Sakharpe 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.

_____ _____

Patient/Responsible Party Signature Date

PRIMA CENTER FOR PLASTIC SURGERY

Cigarette Smoking/Tobacco/Vape Use Informed Consent

When you smoke cigarettes or use any tobacco/nicotine 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 <u>at least</u> 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. **<u>By signing this form and continuing to smoke, use medications with nicotine or use any tobacco product</u>** 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 **<u>second hand smoke</u>**, 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.

<u>I have read, understood and have received a copy</u> 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

PRIMA CENTER FOR PLASTIC SURGERY

FINANCIAL/ DEPOSIT / CANCELLATION POLICY & AGREEMENT

Effective January 1st, 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. In addition to rescheduling, you will be responsible to pay an additional non-refundable $500.00 deposit.

We understand that a situation may arise that forces you to postpone your surgery. Please understand that such changes not only affect Dr. Song/Dr. Sakharpe 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 $815.00, if more than $815.00 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

HIPPA EMAIL CONSENT

PRIMA CENTER FOR PLASTIC SURGERY

- 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 Date
(parent or guardian if patient is a minor)

_____ _____

Printed Name Please Print Email Address

DO NOT ALLOW UNENCRYPTED EMAIL

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

_____ _____

Signature Date
(parent or guardian if patient is a minor)

_____

Printed Name