AISHA WHITE, MD | QUINTESSENCE PLASTIC SURGERY

DEMOGRAPHICS

Today's Date: ______________________ SSN#: _____________________________ Driver's License #: _______________________

Name: ____ DOB: ______ / ______ / _______ AGE: _______
Last First

Home Address:

____
Street Apt. #

____
City State Zip Code

Home Phone:(________) ________________ Cell Phone: (_______) _________________Work Phone: (________) ________________

Male: ________ Female: ________ Marital Status: Married Single Divorced Widowed

Employer: ____ Occupation: ________________________

Best Time and Number to reach You? ____ **Email:** _____________________________

INSURANCE

Primary Insurance Carrier: _________________________________Member ID: ______________________ Group #: _____________

Policy Holder: Self Spouse Parent/Guardian

Secondary Insurance Carrier: _______________________________ Member ID: _____________________Group #: ____________

Policy Holder: Self Spouse Parent/ Guardian

EMERGENCY CONTACT

Name: ____ Relation: _________________________________

Home Phone:(________) ________________Pager/Cell: (________) _________________Work Phone: (________) _______________

GUARDIAN INFORMATION

Name: ____ Relation: _________________________________

DOB: ______ / ______ / __________ SSN#: ______________________________ Driver's License #: ___________________________

Home Phone:(________) ________________Pager/Cell: (________) _________________Work Phone: (________) _______________

VISIT INFORMATION

Reason for visit:

____

Is the problem related to personal Injury? YES NO Date of Injury: ______________________

How did you hear about our practice? ____

Primary Care Physician: ____________________________________ Referring Physician: __________________________________

AUTHORIZATOIN

Consent for treatment: I authorize Dr. Aisha White, MD, MBA at Quintessence Plastic Surgery to provide me with reasonable and proper medical care according to today's standards.

Financial Responsibility, Authorization to Release Information, Assignment of Benefits: I authorize Quintessence Plastic Surgery to release information in connection with my treatment to my insurance company or companies, my employer or any third-party payer at such time as information is requested. I authorization assignment of benefits to Quintessence Plastic Surgery**. I understand and agree that I am financially responsible for any and all charges incurred.**

Patient or Guardian Signature: ____ Date: ___________________

MEDICATIONS

Name:	Dosage:	Frequency:

Preferred Pharmacy: ___________________________________ Address: ____

ALLERGIES

___ Aspirin	___ Iodine	___Sedatives
___ Sulfa Drugs	___ Narcotics	___ Tetracycline
___ Codeine	___ Penicillin	**___ No Known Drug Allergies**
___ Erythromycin	___ Latex	**Other:** _____________________
___ Anesthesia	___ Tape	**Other:** _____________________

SOCIAL HISTORY

Do you smoke/use tobacco or nicotine products?	NO YES Daily amount: ______________ ****If yes, it is <u>MANDATORY</u> to <u>QUIT SMOKING 4 weeks before and 4-6 weeks after surgery.</u> If you cannot comply, please let us know.** ____ Yes, I can stop smoking _____ No, I cannot quit smoking **Signature**__________________________________
Do you drink alcoholic beverage?	NO YES Daily amount: ______________
Do you use recreational drugs?	NO YES Name of drug(s)_____________

PERSONAL HEALTH HISTORY

Do you presently have or have you experienced the following? If so, please circle all that apply:

Hypertension	Emphysema	ESRD	Sickle Cell	Hepatitis
Heart Disease	Lung Cancer	Breast Cancer	Bleeding Disorder	Cold Sores
Heart Attack	Stroke	Ovarian Cancer	Anemia	Shingles
Arrhythmia	TIA	Radiation	Clotting Disorder	Sinus Problems
Pacemaker	Seizures	Skin Cancer	DVT	Arthritis
Asthma	Thyroid Disease	Melanoma	PE (pulmonary embolus)	High Cholesterol
COPD	Diabetes	Liver Disease	Reflux (GERD)	
Bronchitis	Kidney Disease	Body Dysmorphia	Stomach Ulcers	
Depression	Bipolar	Anorexia/Bulimia	Schizophrenia	
Anxiety	Alcohol Abuse	Drug Abuse	HIV/AIDS	

FOR WOMEN:

Are you pregnant? Yes No Unsure If yes, # of weeks: _________ Are you breastfeeding? Yes No

**** Please note, you <u>CANNOT</u> have surgery if you are pregnant****

Age of Menstrual: _____ Age of first pregnancy: _____ Number of pregnancies: _____ Number of Children: ______

Last Mammogram Date: ______/______/______ Bra Size: _________ Do you have breast lumps? Yes No

REVIEW OF SYSTEMS

___ Weight Change	___ Rapid Heart Beat	___ Chest Pain
___ Chronic Cough	___ Shortness of Breath	___ Dry Eyes
___ Breast Mass	___ Nipple Discharge	___ Back Pain
___ Swollen Feet/Ankle	___ Easy Bleeding	___ Skin Rash
___ Joint/ Muscle Pain	___ Swollen Lymph Node	___ Numbness

Please list any Other Serious Medical Conditions that you have experienced: ____
____

List *ALL OPERATIONS* you have ever had in the past:

1.____ 6. ____
2.____ 7. ____
3.____ 8. ____
4.____ 9. ____
5.____ 10. ____

Anesthesia Problems? (include nausea/ vomiting, slow to wake up or high temperature): ____________________________________
____

FAMILY HISTORY

Condition:	Family Member:
Skin Cancer	
Melanoma	
Heart Disease	
Bleeding Disorder	
Clotting Disorder	
Anemia	
Bone/ Joint Disorder	
Rheumatoid Arthritis	
Breast Cancer	
Ovarian Cancer	
Other:	

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: ____ Date: _________________________

OFFICE POLICIES

Please initial the following:

- I understand that Quintessence Plastic Surgery and Dr. White will not bill insurance for cosmetic surgical procedures or aesthetic treatment services. ________
- Payment is due in full prior to cosmetic services rendered (Please see cosmetic procedure financial policy). ________
- I authorize the release of my medical records to insurance companies and authorize the release of any medical information necessary to process my insurance claim. ________
- If my medical insurance needs to be billed, I then authorize my insurance benefits to be paid directly to Dr. White. I also realize I am responsible to pay non-covered services and/or the balance not paid by insurance. I assume full responsibility for my balance regardless of the status of my insurance claim. If my insurance company is not billed or if my insurance company fails to pay for services or does not pay a claim in full, I understand that I am responsible for payment of charges for services rendered. ________
- If computer imaging is used in my evaluation, I understand that the alteration is purely for the purpose of illustration and discussion and in no way, constitutes an expressed or implied warranty as to my final results and appearance. ________

Missed Appointments / Late Cancellations Policy

We feel the practitioner/patient relationship is built on mutual trust and respect. As such, we strive to be on time for your scheduled appointments, and ask that you give us the same courtesy. We understand that unforeseen circumstances occasionally occur and you will be unable to keep your scheduled appointment. Please see our missed/ cancelled appointment guidelines below.

If you are unable to keep your scheduled appointment, we require a 24-hour notice (1 full business day) so that we may accommodate the needs of another patient. If an appointment is cancelled or rescheduled within 24 hours of the reserved appointment time, **Quintessence Plastic Surgery** may charge the patient $25 cancellation/no show fee.

Patient's Name: ___________________________________

Signature: ____ Date: _______________________

(To acknowledge receipt of Missed Appointments/Late Cancellations Policy, and Office Policies')

QUINTESSENCE PLASTIC SURGERY

NOTICE OF PRIVACY POLICY

Certain government regulations, known as Health Insurance Portability and Accountability Act of 1996 (HIPAA), require medical providers to explain their privacy and security policy so that information obtained by us about you is used appropriately.

***How we may use and disclose Protected Health Information (PHI) about you:**

- Treatment, management and coordination of your health care needs.
- Payment of any and all medical claims.
- Normal operation of our business, such as quality review and training of our staff.
- Communication from our office, such as to contact you to verify appointments, or to leave a message on voicemail with test results or to answer questions.
- As required by law, to include but not limited to Public Health activities, abuse issues and legal proceedings.

***Your rights regarding PHI about you:**

- You have the right to request restrictions.
- You have the right to receive confidential communications.
- You have the right to inspect and copy PHI about you (a charge may apply for copies received).
- You have the right to request that we amend your PHI.
- You have the right to receive an accounting of disclosures.
- You have the right to obtain a paper copy of our complete Notice of Privacy Practices.

Restrictions Requested:

____

____

____

Signature: ____ Date: ____________________

(To acknowledge receipt of Notice of Privacy Policy)

**This is not a complete listing of our Privacy Practices. Please ask to see our complete Notice of Privacy Practices.

***We reserve the right to make changes to this Notice and make such changes effective for all PHI we may already have about you. We will post any and all changes in a prominent location, and provide you a copy upon request.

COSMETIC PROCEDURE FINANCIAL POLICY

Payment Information & Options:

A 20% *Non-Refundable* deposit is required at the time of scheduling, and the remaining balance is due at least 2 WEEKS PRIOR to the procedure date (typically collected upon arrival at the pre-op appointment). We provide a number of payment options which may be used individually or combined:

- Cash, Check, Visa, MasterCard, AMEX
- PAYMENT: If payment is made less than two weeks before surgery, your options for payment are limited to cash, credit card or cashier's check. Personal checks will *NOT* be accepted within two weeks of surgery.
- $50 service charge for each returned check.

Patient Cancellation and Rescheduling Policy:

We understand you may decide to postpone your surgery. We request your courtesy and understanding that changes in a surgical schedule affect not only Dr. White, the procedure/OR staff, but other patients and their families as well.

- If cancellation is more than two weeks prior to the date of surgery, surgical fees will be refunded, less the 20% deposit. We will apply the 20% deposit *ONE TIME ONLY* *within (30) days* toward the rescheduled procedure.
- If cancellation is less than two weeks prior to the date of surgery, 50% of the surgical fees will be refunded.
- There is a $350 rescheduling fee for *ALL* procedures re-scheduled within 7 days of surgery. It is incredibly difficult to fill a surgical spot within a week of surgery.

Revision Policy:

- Surgery fees are inclusive of all pre-and post-surgery related visits as well as revision surgery deemed necessary by the original surgeon *within 6 months* of the initial procedure.
- There is a $350 rescheduling fee for procedures re-scheduled within 7 days of surgery.
- Hospital fees for anesthesia, medication, and facilities associated with revision surgery are not included in this fee estimate.

Insurance & Other Expenses:

- Elective cosmetic surgery procedures are not covered by insurance. Therefore, Quintessence Plastic Surgery will not bill insurance.
- Some expenses (if necessary) may be covered by insurance: prescription medication, advance lab work, EKG, and additional fees related to post-surgical complications.
- Out of pocket expenses: Garments may be recommended for select procedures.
- *Hospital Procedures:* Dr. White is confident with the amount of time she has estimated for your procedure and length of stay. However, in the event this estimated time is exceeded, or unforeseen complications arise, you may be billed for additional facility and anesthesia care costs.

I have read and understand the above information:

Patient's Name: ___________________________________

Signature: ____ Date: _______________________

(To acknowledge receipt of Cosmetic Procedure Financial Policies)

QUINTESSENCE PLASTIC SURGERY

PATIENT CONSENT TO RECEIVE TELEPHONE MESSAGES AND/OR MAIL

Do we have your permission to:	**YES**	**NO**	**Comment**
Call you at home or another number that you provided?	( )	( )	____________________
Leave a message on your home answering machine?	( )	( )	____________________
Leave messages with persons answering your home telephone?	( )	( )	____________________
Call you at work and leave a message?	( )	( )	____________________
Leave messages on your cell phone?	( )	( )	____________________
Contact you by e-mail	( )	( )	____________________
Discuss your appointment information with another person?	( )	( )	____________________

Name: ____

Mail an appointment reminder, test result, or other report to your home?

Please specify any restrictions: ____

Patient's Name: ________________________________

Signature: ____ **Date:** ______________________

AUTHORIZATION TO RELEASE MEDICAL PHOTOGRAPHS

I, ____________________________[patient name], herby acknowledge that Quintessence Plastic Surgery will take pre-, intra-, and post- operative/treatment photographs.

I acknowledge that the Photographs may be stored in electronic and/or paper medical records and used in my clinical care related to surgeries by the Authorized Parties.

I hereby _______ Authorize _______ Do Not Authorize the Authorized Parties to use the Photographs for professional medical purposes including but not limited to testing and credentialing, educational purposes for other physicians and patients, and for medical presentations, teaching, and or medical journal articles.

I hereby _______ Authorize _______ Do Not Authorize the use of Photographs attached to this authorization by the Authorized Parties for marketing purposes, including publication in brochures, newsletters, and websites of any one or more Authorized Parties.

I understand that I will not be entitled to any payment or other form of compensation as a result of any use of Photographs, which shall be the property of the Authorized Partied, I understand that my clinical care will not be affected by my choice to authorize or not authorize use of the Photographs above. I hereby release and hold harmless the Authorized Parties of and from any and all claims, demands, damages or causes of action in connection with the use of Photographs, I hereby authorized.

Patient's Name: ____

Signature: ____ Date: _______________________