5605 WATERFORD LANE
APPLETON, WISCONSIN 54913
920-738-7200 • 800-801-3101
www.appletonplasticsurgery.com

Patient Name ______________________________
Last First Middle

Parent / Legal Guardian Name ______________________________
Last First Middle

Address ______________________________
Street & Apt # City State Zip

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Age ______ Birthdate ___/___/___ SS# ___–___–___ Sex ☐ Female ☐ Male

Marital Status ☐ Single ☐ Married to ____________ Email ____________

Spouse's Employer ____________ Primary Doctor ____________

Referred to office by ______________________________

Emergency Contact Name ____________ Relationship to Patient ____________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Address ______________________________
Street & Apt # City State Zip

Patient's Employer
(Or legal guardian's, if a minor) ____________ Occupation ____________

Address ______________________________
Street & Apt # City State Zip

Insured's Name ____________ Relationship to Patient ____________

Birthdate ___/___/___ SS# ___–___–___ Employer ____________

Are you a member of the armed forces? ☐ Yes ☐ No
If yes, are you currently on active duty? ☐ Yes ☐ No
Do you have a healthcare Power of Attorney? ☐ Yes ☐ No

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

Signature ______________________________ Date ____________

APPLETON PLASTIC SURGERY CENTER, SC

Cosmetic Surgery Interest Questionnaire

Having a cosmetic surgery at the same time as an insurance based surgery often offers a significant cost savings. Are you interested in having a cosmetic surgery at the same time as your insurance based surgery?

- ☐ Yes
- ☐ No

If you are interested in having a cosmetic surgery, please indicate your interest:

Check all that apply

- ☐ Abdominoplasty (tummy tuck)
- ☐ Breast Augmentation/Lift/Reduction
- ☐ Facial Surgery (facelift/necklift)
- ☐ Eyelid surgery
- ☐ Brachioplasty (arm lift)
- ☐ Liposuction
- ☐ Rhinoplasty (nose surgery)
- ☐ Other_________________________

If you are interested in non-surgical aging treatments please indicate your interest:

Check all that apply

- ☐ Botox
- ☐ Fillers (Juvederm, Restylane)
- ☐ Non-surgical neck tightening (Kybella)
- ☐ Microdermabrasion
- ☐ Glycolic skin care products for daily use
- ☐ Other________________________

Please list any other concerns that you may have today.

____

____

____

____

CURRENT MEDICAL HISTORY

Have you or any member of your family ever had a problem with anesthesia? ☐ YES ☐ NO

List any allergies to medication or substance (food, environment, or latex):

____

List current medications and dosages:

____

____

List previous surgeries or major illnesses and dates:

____

PERSONAL HISTORY

Do you:

Smoke ☐ YES ☐ NO

If former smoker, when did you quit?

Drink Caffeine ☐ YES ☐ NO

Drink Alcohol ☐ YES ☐ NO

Have any tattoos ☐ YES ☐ NO

Have any piercings ☐ YES ☐ NO

Height ________ Weight ________

Daily consumption:

________ Packages / Day

________ Cups / Day

________ Drinks / Day

When was your most recent tattoo? ________

When was your most recent piercing? ________

WOMEN ONLY

Age period began ________

Date of last mammogram ________

Do you do regular breast self-exams? ☐ YES ☐ NO

Number of pregnancies ________

Did you breastfeed? ☐ YES ☐ NO

Breast lump or discharge? ☐ YES ☐ NO

FAMILY HISTORY

Has any blood relative ever had the following? Please list their relation to you.

1. Grandmother-Maternal 2. Grandmother-Paternal 3. Grandfather-Maternal 4. Grandfather-Paternal
5. Mother 6. Father 7. Sister 8. Brother 9. Son 10. Daughter 11. Niece 12. Nephew
13. Aunt-Maternal 14. Aunt-Paternal 15. Uncle-Maternal 16. Uncle-Paternal

Breast Cancer ☐ YES ☐ NO ________

Melanoma ☐ YES ☐ NO ________

Stroke ☐ YES ☐ NO ________

Kidney disease ☐ YES ☐ NO ________

High blood pressure ☐ YES ☐ NO ________

Heart Disease ☐ YES ☐ NO ________

Diabetes ☐ YES ☐ NO ________

Depression ☐ YES ☐ NO ________

PAST MEDICAL HISTORY

Have you ever had the following:

Heart Disease ☐ YES ☐ NO

Arthritis ☐ YES ☐ NO

Rhuematic Fever ☐ YES ☐ NO

Anemia ☐ YES ☐ NO

Tuberculosis ☐ YES ☐ NO

Hepatitis ☐ YES ☐ NO

Cancer ☐ YES ☐ NO

Glaucoma ☐ YES ☐ NO

Asthma ☐ YES ☐ NO

AIDS or HIV ☐ YES ☐ NO

Stroke ☐ YES ☐ NO

Stomach ulcer ☐ YES ☐ NO

Kidney Disease ☐ YES ☐ NO

Thyroid Disease ☐ YES ☐ NO

Bleeding Tendency ☐ YES ☐ NO

Diabetes ☐ YES ☐ NO

REVIEW OF SYSTEMS

Do you have now or have you had within the past year:

Weight Change ☐ YES ☐ NO

Dry Eyes ☐ YES ☐ NO

Chronic Cough ☐ YES ☐ NO

Swollen lymph nodes ☐ YES ☐ NO

Easy bleeding ☐ YES ☐ NO

Swollen feet/ankles ☐ YES ☐ NO

Skin Rash ☐ YES ☐ NO

Chronic Diarrhea ☐ YES ☐ NO

Chest pain ☐ YES ☐ NO

Rapid heart beat ☐ YES ☐ NO

Seizures ☐ YES ☐ NO

Joint/muscle pain ☐ YES ☐ NO

Depression ☐ YES ☐ NO

Jaundice ☐ YES ☐ NO

Easy bruising ☐ YES ☐ NO

I verify that the above information is true and accurate to the best of my knowledge.

Signature ______________________________ Date ________________

FINANCIAL POLICY

Thank you for choosing us as your health provider. We are committed to your successful treatment. The following is a statement of our financial policy, which we require that you read and sign prior to treatment. Anytime you have questions regarding any treatment, fee, or service, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding.

REGARDING INSURANCE
As a courtesy to you, we will bill your insurance carrier for you. If your insurance carrier fails to pay your claim within 45 days from the date of service, a second notice will be sent to your carrier, however, the balance will become patient responsibility, and it is your responsibility to contact your carrier regarding unpaid claims. Effective January 1, 2006, any unpaid balances 30 days and over will be assessed a service charge equaling 1% of the outstanding balance. If you are unable to pay your account in full, please contact us regarding payment arrangements. Often, we can work with you to keep your account current and avoid collection efforts. Please be aware some, and perhaps all, of the services provided may be "noncovered" services and are not considered reasonable and necessary under some medical insurance policies. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

Patients acknowledge that they are responsible for any and all collections costs and/or attorney fees, service fees, and court costs associated with the collection of outstanding balances on their account. I authorize Appleton Plastic Surgery Center, SC, to obtain employment information in accordance with Wisconsin Statute 103.13 from my employer.

Returned check fee is $40.

USUAL AND CUSTOMARY RATES
Our practice is committed to providing the best treatment possible for patients, and we charge what is usual and customary for the area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of the usual and customary rates.

INJURIES AND ACCIDENTS INVOLVING LEGAL LITIGATION
We will not accept third party billing if your injury or accident involves litigation. The services are provided to you, the patient, not your attorney. You are required to make payments on the charges even if they will be covered by a third party.

WORKER'S COMPENSATION
Our office will submit worker's compensation claims to your employer for payment. However, if the claim is denied, unsettled, or unpaid within sixty days from the initial visit, we will request that you file a personal health insurance claim or pay the charges in full. If the situation becomes a legal matter, you are still ultimately responsible for the payment of the charges.

MEDICARE
We do accept Medicare assignment and will bill Medicare and your secondary insurance for you.

CO-PAYS/DEDUCTIBLES
Payment is expected at the time of office visit for co-payments and/or deductibles that are required by your insurance policy. Payment is due at the time of service. A 1 percent per month late payment fee will be assessed on any an unpaid balance remaining after 30 days.

Thank you for understanding our financial policy. If you should have questions or concerns, please let us know and we will be happy to assist you in every way possible.

- I have read the financial policy (above). I understand and agree to this.
- I consent to the photographing of the operation(s) or procedure(s) to be performed, including appropriate portions of my body for medical, scientific, or educational purposes providing my identity is not revealed by the pictures.
- I hereby authorize my insurance benefits to be paid directly to Appleton Plastic Surgery Center, SC, recognizing that I am responsible to pay any and all charges that exceed or that are not covered by insurance. I authorize the release of pertinent medical information to insurance and worker's compensation carriers.

I also authorize Appleton Plastic Surgery Center to bill my secondary insurance carrier or Medigap insurance carrier for any account balance remaining after my primary insurance payment or Medicare Part B payment has been received.

ADDITIONAL DISCOLSURES FOR APPLETON PLASTIC SURGERY CENTER COSMETIC PROCEDURES
Full payment is due 10 business days prior to surgery. Failure to receive prepayment will result in the cancellation of the procedure. One year of follow-up appointments is included in this fee. The fees will be honored per the language on your quote.

PAYMENT OPTIONS
For full payment for the procedure either by cash, money order, or cashier's check, a courtesy discount will be offered. We also accept Discover, American Express, Mastercard, and Visa. For payment by credit card, a discount will not be offered.

Appleton Plastic Surgery Center will distribute payment of facility and anesthesia fees to the appropriate payees.

A $1,000 deposit will be required to schedule a cosmetic procedure. If you elect to cancel your surgery, we will refund 25% of the deposit. If you elect to cancel your surgery within two weeks of your scheduled date, there will be no refund issued. If you elect to reschedule your procedure, 50% of the deposit will be applied toward your outstanding balance. You may reschedule your procedure only once. Payment in full will be required in order to reschedule a cosmetic procedure a second time.

Items not included in the cosmetic fee quote:
- Lab work or x-rays (chest x rays and EKG) required for anesthesia purposes.
- Prescriptions.
- Pathology charges.
- Additional supplies (extra binder, girdle, skin care products, or other surgical supplies).
- Any emergency situation charges.
- Revisions.

COMPLICATIONS
Any complications from your cosmetic procedure requiring hospitalization and/or additional treatment or surgical management may not be covered by your health insurance.

The surgical fee is for the performance of an operation. It is not for a guaranteed result. I have read the above information, which has been fully explained to me, and understand its contents.

Signature ______________________________ Date ______________

I, ____ , acknowledge that I have received the written Notice of Privacy Practices from Appleton Plastic Surgery Center.

____ ____

Patient or Personal Representative Signature Date

____

If Personal Representative, describe relationship

****

☐ The patient's condition prohibits the individual from signing an acknowledgement at this time. It will be obtained as reasonably practicable after the patient's condition improves.

☐ Acknowledgment was unable to be obtained. Reason: ____

____

____ ____

Employee Signature Date

Disclosure of Private Patient Information

The following person(s) may receive private patient information without my written or verbal consent:

1. ______________________ ______________________ ______________________
   Name Relationship Date of Birth

2. ______________________ ______________________ ______________________
   Name Relationship Date of Birth

I hereby consent for Appleton Plastic Surgery Center, SC, to text, email or leave a message at my:

Please check all that apply:
- ☐ Home phone ______________________
- ☐ Cell phone ______________________
- ☐ Work phone ______________________
- ☐ Email ______________________

Please be advised that if any of the above information is not complete in nature, private patient information will be released ONLY to the patient. Your email address will never be shared with another entity.

Signature ____ Date ______________________