

WENIGER PLASTIC SURGERY

Frederick G. Weniger, M.D.
25 Clark Summit Drive - Suite 104
Bluffton, South Carolina 29910

Today's Date: _____

Patient Last name: _____ First name: _____ Middle initial: _____
Age: _____ Date of Birth: _____ Gender: M F Marital Status: M S W D SS# _____
Phone (H): _____ Phone (W): _____ ext. _____ Phone (C): _____
Address: _____ City/State: _____ Zip: _____
Occupation: _____ Employer: _____
Email: _____

EMERGENCY CONTACT INFORMATION

Emergency contact: _____ Relation to patient: _____
Primary Phone: _____
(if your emergency contact person lives with you please provide an alternate number other than home phone number)

GUARANTOR INFORMATION (if different than above)

Guarantor Name: _____ Relation to patient: _____
Age: _____ Date of Birth: _____ Gender: M F Marital Status: M S W D
SS# _____
Phone (H): _____ Phone (W): _____ ext. _____ Phone (C): _____
Address: _____ City/State: _____ Zip: _____
Occupation: _____ Employer: _____

PRIMARY INSURANCE

Primary insurance _____ ID# _____ Group# _____
Subscriber Last name: _____ First name: _____ Middle initial: _____
Date of Birth: _____ Gender: M F Marital Status: M S W D SS# _____
Relationship to patient: _____
Phone (H): _____ Phone (W): _____ ext. _____ Phone (C): _____
Address: _____ City/State: _____ Zip: _____
Employer Name/Address: _____

SECONDARY INSURANCE

Secondary insurance _____ ID# _____ Group# _____
Subscriber Last name: _____ First name: _____ Middle initial: _____
Date of Birth: _____ Gender: M F Marital Status: M S W D SS# _____
Relationship to patient: _____
Phone (H): _____ Phone (W): _____ ext. _____ Phone (C): _____
Address: _____ City/State: _____ Zip: _____
Employer Name/Address: _____

AUTHORIZATIONS

I authorize **Frederick G. Weniger, M.D.** to treat me. I represent to the physician and staff that I am at least 18 years of age or, if not, accompanied by a legal guardian. I hereby consent to and authorize examination and the treatment by my doctor and such assistant or staff as may be assigned by him.

Signature: _____

Date: _____

I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize the taking of photographs at the direction of Dr. Weniger and under such conditions as may be approved by him. These photographs will be used solely for documentation purposes and be kept confidential.

Signature: _____

Date: _____

I authorize **Weniger Plastic Surgery** to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in **Weniger Plastic Surgery** determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and to process the insurance claim for services rendered at **Weniger Plastic Surgery**.

I authorize payment of medical benefits for treatment and/or surgery to **Weniger Plastic Surgery**. I understand that any outstanding balance not covered or paid by insurance, in addition to all consultation fees, will be my responsibility to pay. If my account is turned over to an attorney or collections agent to obtain payment, then I shall be responsible for the attorney's fee, court costs, and any other costs incurred by the collection agency. A copy of my signature shall have the same force and effect as the original.

Signature: _____

Date: _____

Medicare Patients Only – Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: _____

Date: _____

WENIGER PLASTIC SURGERY
RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____ have been informed that a copy of Weniger Plastic Surgery's Notice of Privacy Practices is posted in the waiting room(s). A copy of this Notice will be furnished to me upon my request.

Signature of Patient

Date

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

It is our policy to not release confidential and/or unauthorized information except appointment confirmation by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. If you would like to have information released to someone other than yourself please complete the following:

Please list names of people we can discuss your medical or skin care with:

Spouse Name _____ yes _____ no _____

Parent Name _____ yes _____ no _____

Other Name _____ yes _____ no _____

Please give name and relationship such as boyfriend, sister, etc.

Signature of Patient/Guardian

Date

WENIGER PLASTIC SURGERY

Frederick G. Weniger, M.D.

Medical and Surgical History

Name: _____ Age: _____ Height: _____ Weight: _____

Occupation: _____

Primary Care Physician: _____ Referring Physician: _____

How did you hear about our practice? _____

What is your reason for coming to see us today? _____

Areas of Interest: (mark all that apply)

Facial Procedures

- Blepharoplasty (Eyelid Lift)
- Botox
- Brow or Forehead Lift
- Earlobe Repair
- Facial Liposuction (Neck, Jowls)
- Face or Neck Lift
- Lip Enhancement
- Otoplasty (Ear Pinning)
- Rhinoplasty (Nose Reshaping)
- Skin Resurfacing (Laser, Peel, Etc)
- Wrinkle Fillers (Injections)

Breast Procedures

- Breast Augmentation
 - Breast Reconstruction
 - Breast Reduction
 - Mastopexy (Breast Lift)
 - Nipple Reduction or Inversion
- ### Body Procedures
- Abdominoplasty (Tummy Tuck)
 - Brachioplasty (Arm Lift)
 - Full Body Lift
 - Liposuction (Thighs, Abdomen, Etc.)
 - Thigh or Buttock Lift

Other Procedures

- Skin Care
- Endermologie
- Telangectasia (spider veins)
- Laser Hair Removal
- Laser Tattoo Removal
- Leg Veins
- Lesions/Moles

Please list all current and past medical issues, including dates:

Please list all previous surgeries, including dates:

Allergies and Reactions: _____

Medications & Dosage. Please include Herbal Medicines, Aspirin & Pain Medications:

Social History:

Exercise: () None () Light () Moderate () Heavy How Often: _____

Alcohol: () Never _____ Drinks per _____

Tobacco: () Never () Current: Years _____ () Discontinued: When _____

In the last year, have you used any non-prescribed controlled drugs:

() None () Marijuana () Other: _____

What medical problems run in your family: _____

Constitutional

- No Complaints
- Pain
- Weakness/Fatigue
- Fever/Chills
- Weight Loss

Cardiovascular

- None
- MI/Heart Attack
- Coronary Artery Disease
- Peripheral Artery Disease
- High Blood Pressure
- Abnormal EKG
- Mitral Valve Prolapse
- Blood Clots in legs +/- or lung
- Aneurysm
- Rheumatoid fever
- Need for antibiotics before dental procedures

Hematological/Immunologic

- None
- Spontaneous or prolonged bleeding
- AIDS/HIV
- Hepatitis
- Anemia
- Immune deficiency
- History of Splenectomy
- Other blood or immune problems

Extremity

- None
- Hand Infection
- Hand Injury
- Muscle/joint Problems
- Leg swelling
- Swollen/Red Joint
- Extremity pain
- Extremity Numbness
- Extremity Weakness
- Arthritis

Neurological

- None
- Loss of Facial Expression
- Weak Grip
- Paralysis
- CVA/Stroke
- Epilepsy
- Head/Spinal Injury
- Myasthenia Gravis
- Tingling/Burning Numbness
- Depression
- Seizures
- Mini-Stroke/TIA's

EENT

- None
- Nasal Deformity/Trauma
- Facial Fractures
- Dry Eyes
- Nasal Obstructions
- Double Vision
- Recent Head Trauma
- Problem with proper fitting teeth

Abdomen

- None
- Nausea or vomiting
- Hernias
- Liver disease/jaundice
- Diarrhea
- Cirrhosis
- Hepatitis
- Kidney problems
- Heartburn or Reflux
- Currently Pregnant
- Adhesions
- Chron's/Ulcerative Colitis

Skin

- None
- Abscess
- Wound
- Burns
- Skin Cancer
- Animal Bite
- Varicose veins
- Suspicious lesions and/or moles
- Skin Color Changes
- Rash
- Recent international travel

Endocrine

- None
- Thyroid Disorders
- Diabetes
- Other Endocrine Problems

Surgical Complications

- None
- Wound Healing Complications
- Bleeding Complications
- Post Op Blood Clots
- Anesthesia Complications
- Post Op Shortness of Breath
- Difficulty Voiding
- History of post op nausea
- Family History of Anesthesia Reaction

Breast

- No abnormalities
- Breast Deformity
- Small Breast
- Breast Skin Changes
- Shoulder Pain from Large Breast
- Back Pain from Large breast
- Shoulder Grooved from bra strap
- Neck Pain from Large breast
- Personal or Family History of Breast Cancer

Patient or Guardian signature: _____ Date: _____

Physician Signature : _____ Date: _____

Cosmetic Payment Policy

Thank you for choosing **Weniger Plastic Surgery** for your cosmetic needs. Our goal is to make your surgical experience a pleasant one. For your convenience, and to avoid any future confusion, we would like to outline our financial policies and procedures for you.

Consultation:

A cosmetic consultation is scheduled from your initial telephone call. This consultation is designed for you and Dr. Weniger to meet and discuss your surgical needs, outline the procedure, and inform you of the fees. The charge for your consult is \$75.00. The amount paid will be deducted from your surgical payment.

Payment Options:

We accept all major credit cards and personal checks and cash for insurance co pays. Please be aware that we will add a \$50.00 charge to your account for returned checks. We reserve the right to send all accounts with balances over 60 days old to an outside collection agency. All accounts sent to collections will be charged a \$20.00 processing fee and any additional fees associated. You may be responsible for all reasonable collections and attorney costs incurred.

Scheduling

After your consultation, if you decide to go ahead with surgery you will work with our patient care coordinator to select a date for your surgery.

Pre-Payment

There is a deposit required before the date selected for your surgery can be reserved exclusively for you. The deposit is \$500.00 or 10% of surgery cost whichever is greater. This is a non-refundable deposit. This fee is used to cover the booking and scheduling expenses involved with your surgery. This amount will be applied to your total cost. There will be no refunds for services already provided.

Pre-Surgical Visit

Prior to surgery (preferably two (2) weeks before), you will meet with the nurse and/or Dr. Weniger. We will explain pre-operative instructions, order lab tests required, review your surgical procedure and post-operative limitations with you, and give you your post-operative prescriptions with instructions for their use, we will also review consent forms at this time. Post-operative appointments are scheduled at this time. Any questions you may have will be answered at this consult.

Additional Surgical Fees

The facility fee is a fixed price and is included in the above cost estimates unless otherwise noted. If you have surgery at another location this may affect the facility cost and is not under the control of this office. You will be responsible for any charges related to those facility fees.

There is a fee for the services of an Anesthesiologist or Certified Registered Nurse Anesthetist. These fees are based on the anticipated duration of your surgical procedure and the location at which your surgery is done. Please note that our facility has no control over anesthesia cost.

If you are having sedation or general anesthesia, certain laboratory tests may be required. The costs of lab test, medication, and surgery clearance are not included in your cost estimate.

The practice of medicine and surgery is not an exact science. While the procedures are performed with a high probability of success, disappointments occur and results are not always acceptable to patients or the surgeon. Surgical revisions and/or other medical treatment or management of problems and/or complications may be required. In case of surgical revisions the physician's fee may be waived or discounted, and you as a patient are responsible for facility fees and anesthesia. These could result in additional charges for which you are responsible. Your insurance may or may not assist you in covering the expenses related to complications following Cosmetic Surgery and/or other medically related problems.

Surgery Final Payment

By at least two (2) weeks prior to surgery, you will be expected to pay the remaining balance due on your account. We accept: Visa, Mastercard, American Express, Discover, Money Orders, Cashiers Checks, Care Credit, Capital One financing & cash.

Cancellation Policy: If for any reason, medical or personal, you cancel your surgery prior to your scheduled surgery date, fees will be charged as follows:

- 1 week or more prior to surgery – 10% or \$500 whichever is greater of your surgery fee for expenses incurred.
- Less than one (1) week prior to surgery – 25% of surgical fee
- Less than one (1) day (24 hours) prior to surgery – entire surgical fee.
- Repeat cancellation of surgery or procedure may be subjected to a 25% cancellation fee regardless of the time of surgery.

If you have any questions, our staff will be happy to assist you. We look forward to caring for you.

I understand and agree to the above fee estimate and financial policy.

Financial Guarantor Signature: _____ Date: _____

Witness: _____ Date: _____

