

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 Reactions

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: _____

Financial Policy

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines.

Payment Options:

We accept Visa, MasterCard, American Express, Discover, personal checks and cash for insurance co-pays. Please be aware that we will add a \$30.00 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.

Insurance

We offer assistance with benefit verification as a courtesy, however, it is your responsibility to obtain insurance coverage and benefits prior to your visit with us. As a patient, you will be responsible for any co-pays, additional testing, and services not covered by your insurance. If you do not have your insurance card, or we do not participate with your insurance plan, you can either reschedule your appointment or pay for your visit in full at the time services are rendered. We will supply you with the necessary information to submit the claim to your insurance company. Any balance left after your insurance has paid must be remitted within 30 days.

Uninsured Patients

If you plan to pay privately for your services, please be advised that it is the policy of Weniger Plastic Surgery to collect payment in full at the time of service. If you are unable to make payment in full at the time of service, your appointment will be rescheduled to a more convenient time.

Motor Vehicle Accidents (MVA)/Third Party Liability

We will require all claim detail (claim#, contact info, billing address) at the time of your appointment; otherwise we will require payment in full for services rendered for each patient being treated for a MVA/other accident-related injury. We will file claim(s) with the motor vehicle or third party insurance company that you designate, provided we receive all necessary information with which to bill. If the claims are denied, or a protracted lawsuit is involved, the patient is responsible to pay the account balance in full. We will bill your private health for balance left after your personal injury protection (PIP) is exhausted.

Form Fees

Forms and letters requested by our patients will be assessed a fee as listed below. This list is not meant to be all inclusive but is merely representative of the items that may incur a charge. This fee covers our administrative expenses related to physician/staff time, photocopying, mailing, etc.

Work Excuses	\$15 each
Disability forms	\$15 each
Letters of Medical Necessity	\$15 each
Family Medical Leave Act Forms	\$15 each

I acknowledge that I have received a copy of this financial policy. I agree to read this document and comply with the terms set forth for services rendered by _____

Patient Signature (Guarantor)

Date

