# WENIGER & ASSOCIATES PLASTIC SURGERY

(843) 757-0123

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

**Patient's Name** _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

Contact Restrictions: _____

Age _____ Birthdate ___/___/_____ Gender ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

**Patient's Employer** _____ Occupation _____

Work Phone _____ Ext. ____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

**Are you interested in financing options?**
❒ Yes ❒ No

**How did you hear about us?** (Mark all that apply)

❒ RealSelf ❒ LUX~A Medical Spa ❒ Magazine ❒ Newsletter ❒ Seminar ❒ Salon_____ ❒ Website

❒ Friend/Relative: _____ ❒ Doctor: _____ ❒ Other: _____

**Emergency Contact**
(preferably, not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

I understand that office visit charges are payable on the day service is rendered.

**Signature** _____ **Date** _____

**AUTHORIZATIONS**

I authorize **Weniger Plastic Surgery and/or its providers** 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 providers at **Weniger Plastic Surgery** and under such conditions that may be approved by them. 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**

Weniger Plastic Surgery no longer accepts Medicare

Beneficiary Signature: _____ Date: _____

# WENIGER PLASTIC SURGERY

**RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM**

I, _____ have been informed of Weniger Plastic Surgery's Notice of Privacy Practices is posted below.

_____ _____
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

Medical and Surgical History

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

Occupation: _____

Primary Care Physician: _____

How did you hear about our practice? _____

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

**Have you ever tested positive for COVID, and if so when**?_____

**Do you have Sleep Apnea?** _____

**Please list all current and past medical issues, including dates-Even if it is under control with medication:**

_____
_____
_____
_____

**Please list all previous surgeries, including dates:**

_____
_____
_____

**Allergies and Reactions:**

_____
_____

**Medications & Dosage. Please include Herbal Medicines, Aspirin, Over the counter medication & Pain Medications:**

_____
_____
_____
_____

**What medical problems run in your Family**:

_____
_____
_____

## Social History:

**Any major weightloss and if so how much:** _____

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

**Alcohol: ( ) Never ( ) Yes _____ Drinks per _____**

**Nicotine in any form: ( ) Never ( ) Current: Years _____ ( ) Discontinued: When _____**

**If yes, what do you use? _____**

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

**( ) None ( ) Marijuana ( ) Other:**_____

**PLEASE CHECK ALL THAT APPLY TO YOU:**

**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
() Heart Valve Issues
() Blood Clots in legs +/ or lung
() Aneurysm
() Rheumatoid fever
() Need for antibiotics before dental procedures
() **Heart Stents or Pacemaker**

**Hematological/Immunologic**
() None
() Spontaneous or prolonged bleeding
() AIDS/HIV
() Hepatitis
() Anemia
() Immune deficiency
() History of Splenectomy
() Other blood or immune problems
() Bleeding 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-Strokes/TIA's

**EENT**
() None
() Nasal Deformity/ Trauma
() Facial Fractures
() Dry Eyes
() Nasal Obstructions
() Double Vision
() Recent Head Trauma
() Problem with proper fitting teeth
() Glaucoma

**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
() History of difficulty airway

**Breast**
() No abnormalities
() Breast Deformity
() Small Breast
() Breast Skin Changes
() Shoulder Pain from large breasts
() Back pain from large breasts
() Shoulder grooved from bra strap
() Neck pain from large breasts
() Personal or family history of breast cancer

**Respiratory**
() No Resporatory problems
() COPD
() Asthmas
() **SLEEP APNEA**

Patient or Guardian signature: _____ Date:_____

Witness Signature :_____ Date:_____

# Financial Policy

Thank you for choosing **Weniger &Associates 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, because of our 48 hour cancellation policy, you were asked for a Debit/Credit card to hold your appointment, which is charged a $100 fee based on the type of consultation you are having. You will be refunded if the consultation is cancelled outside of the 48 hour cancellation. 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. If you have had a surgical procedure in the same area before with another doctor and are here for a second opinion from that procedure, this will result in a higher consultation fee.. There will also be charges for each visit thereafter. If your consultation is cancelled in the cancellation period, you will have to pay an additional $100 fee to reschedule.

**Insurance Information**
We do not accept any insurance at this time. If you have pathology with Weniger & Associates Plastic Surgery, we will send the lab your insurance information, as they take insurance. Weniger Plastic Surgery does not get involved with insurance billing between patients, insurance, and labs.

**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.
Medical Records- $35
Work Excuses- $15 each
Disability forms- $15 each
Letters of Medical Necessity- $15 each
Family Medical Leave Act Forms- $15 each

**Payment Options:**
We accept all major credit cards, certified checks and cash. Please be aware that we will add a $50.00 charge to your account for returned checks.

**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, this is a **non-refundable** deposit and is for **surgery only**. 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. The surgical deposit may not be transferred to LUX for services. Your surgery balance is due at your pre-op appointment, no later than 4 weeks prior to surgery.

**Pre-Surgical Visit**
Prior to surgery (a minimum of four (4) weeks before), you will meet with the surgical tach 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. 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 are medically required to have surgery at another location (Bluffton Okatie Outpatient Center or Coastal Carolina Medical Hospital) this may affect the facility cost and is not under the control of this office. You will be responsible for any additional charges related to those facility fees.

There is a fee for the services of an Anesthesiologist or Certified Registered Nurse Anesthetist. There 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.

- There will be a $1000.00 Minimum Fee for any surgical revisions in the office or in the operating room. The fee will be based on the time it will take for the revision. Additional fees will apply, if you wish to have additional procedures at the time of your surgical revision.

**Surgery Final Payment**
At your pre-op appointment you will be expected to pay the remaining balance due on your account. We accept: Visa, Mastercard, American Express, Discover, Cashier's Checks, Care Credit, PatientFi and 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:

- 29 days = 25% of total surgical fee.
- 7 – 28 days = 50% of total surgical fee.
- 2 – 6 days = 75% of total surgical fee.
- 1 day = 100% of total 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: _____

# Weniger and Associates Email Consent Form

Patient Name: _____ DOB: _____

**RISK OF USING EMAIL**

Transmitting patient information by email has a number of risks that patients should consider. These include, but are not limited to the following risks:

- Email can be circulated, forwarded and stored electronically and on paper
- Email can be immediately broadcast worldwide and be received by unintended recipients
- Email senders can easily misaddress an email
- Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
- Employers and online services have a right to archive and inspect emails transmitted through their systems
- Email can be intercepted, altered, forwarded, or used without authorization or detection
- Email can be used to introduce viruses into computer systems

**CONDITIONS FOR THE USE OF EMAIL**

Weniger Plastic Surgery cannot guarantee the security and confidentiality of email communication, and will not be liable for improper use and/or disclosure of confidential information that is not caused by Weniger Plastic Surgery's intentional misconduct. Patients must consent to the following conditions:

- ***Email is not appropriate for emergency situations***
- All emails containing protected health information (PHI) to or from a patient will be printed out and made part of the patient's record/chart
- Weniger Plastic Surgery staff may receive and read your email messages
- The patient is responsible for protecting his/her password or other means of access to email
- Weniger Plastic Surgery is not liable for breaches of confidentiality caused by the patient or any third party
- It is the patient's responsibility to follow up and/or schedule an appointment if warranted
- The patient shall avoid use of his/her employer's computer to send/receive emails to Weniger Plastic Surgery
- The patient shall inform Weniger Plastic Surgery in writing of changes in his/her email address
- The patient shall notify Weniger Plastic Surgery in writing when he/she no longer wants to receive emails from Weniger Plastic Surgery.

**PATIENT ACKNOWLEDGEMENT AND AGREEMENT**

I acknowledge that I have read and fully understand the information Weniger Plastic Surgery has provided me regarding the risks of using email. I consent to the conditions outlined above, and understand that Weniger Plastic Surgery may impose other conditions regarding email usage in the future.

Email Address: _____

Patient Signature: _____ Date: _____

Witness: _____Date: _____

## An Important Message Regarding Your Insurance

In order to focus our time and attention on customer service we have made the decision to eliminate the administrative overhead of a billing department and focus on ensuring that our customer service is of the same high quality as the clinical care that Dr. Weniger provides. We will no longer accept any insurance, including Medicare. This means we will not submit any procedure to Medicare and you will be unable to submit any procedure to Medicare. We will be happy to continue seeing you on an out-of-network basis. We realize that you have a choice in where you go to receive medical services and we value our relationship with you. We will be happy to speak with you regarding these changes and feel certain that you see how our practice differs from other practices.

Patient Signature _____

Date _____