WENIGER 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 ___/___/___ SS# ___-___-___ 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 ? (Mark all that apply)

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

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

If you were referred by a specific person, may we thank them? ❒ Yes ❒ No

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** _____

Would you like a complimentary skin evaluation while you are here today? ❒ Yes ❒ No

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

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 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

Dr. Frederick G. Weniger
Weniger Plastic Surgery

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
() Heart Valve Issues
() 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-Strokes/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:_____

Financial 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:
Cosmetic consultations with Dr. Weniger are $50.00. This fee is to be collected upon scheduling your consultation appointment. This consultation is designed for you and our providers to meet and discuss your surgical needs, outline the procedure, and inform you of the fees. If you have had a surgical procedure with another doctor and are here for a second opinion (follow-up or post op appointment), there will be a $200.00 consultation fee paid at the time of booking the appointment.****There is a 24 hour (or day before) cancellation policy for all cosmetic consultations. The cancellation fee is $50.00, you must pay this fee in order to reschedule any cancelled (24 hours (day before) or less) or no showed appointment.**

Insurance Consultations with Dr. Weniger $150.00
We are currently In Network with Medicare only. We do not accept Medicare Replacements or Supplements.
We can 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. In order for us to verify, we will require your insurance information prior to your visit. 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 will be required to pay for your visit in full at the time services are rendered. We will only submit Medicare claims to your insurance company that are not considered to be cosmetic. Any balance left after your insurance has paid must be remitted within 30 days. All out of network insurance procedures must be paid in full prior to your procedure and you will be reimbursed by your insurance company based on your out of network benefits. If your appointment is booked as a cosmetic consultation and you are discussing an insurance procedure, your consultation fee will be $150.00

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 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.
****** Weniger Plastic Surgery does not offer refunds or credits for LUX, a medical spa. This is a separate business from Weniger Plastic Surgery.**

Scheduling and Pre-Payment (Surgery Deposits)
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. This fee is used to cover the booking and scheduling expenses involved with your surgery. This amount will be applied to the total cost of your surgery. These deposits may be used for surgery only.

Pre-Surgical Visit
Prior to surgery (four (4) weeks before your surgical date), you will meet with the practice manager/ patient coordinator and Dr. Weniger. We will explain pre-operative instructions, review 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 Fees and Anesthesia fees at Hilton Head Surgical Suites are fixed pricing and are included in your surgical quote unless otherwise noted. If you have surgery at another location this may affect the facility cost and anesthesia cost and is not under the control of this office. You will be responsible for any charges related to those facility fees.
*****If you are having sedation or general anesthesia, certain laboratory tests may be required. The costs of lab tests, prescriptions, and surgical clearance are not included in your cost estimate.**
Any additional biopsys or labs required during your surgery are the financial responsibility of the patient.
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 the case of surgical complications, you as a patient are responsible for any revisional fees. Your insurance may or may not assist you in covering the expenses related to complications following Cosmetic Surgery and/or other medically related problems. This determination is based on what your insurance plan is and is not the responsibility of Weniger Plastic Surgery.
*****There will be a $1,000 minimum fee for any revisional procedures performed in the office and/ or the operating room. Additional fees may apply if the patient would like to have additional procedures at that time. Again, you require a surgery at an outside outpatient center or hospital, additional fees will apply.**

Surgery Final Payment
No later than four (4) 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, Alphaeon Credit, and Cash.
Cancellation and Rescheduling Policy: If for any reason, medical or personal, you cancel or reschedule 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 or rescheduling of a 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: _____

Financial Policy Regarding Insurance

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 $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.

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. You are responsible for letting us know if your insurance company has changed.

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

Cancellation of Consultation Appointments
If for any reason, medical or personal, you cancel your consultation appointment; fees will be charged directly to you as follows:
1 day prior to your scheduled date: $150.00
2 days prior to your scheduled appointment: $75.00

Cancellation of Insurance Procedures/Surgeries
If for any reason, medical or personal, you cancel your procedure or surgery date prior to your scheduled date; fees will be charged directly to you as follows:
1 day prior to your scheduled date: $200.00
2 days prior to your scheduled date: $150.00

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 Weniger Plastic Surgery.

_____

Patient Signature (Guarantor)

_____

Witness Signature

WENIGER PLASTIC SURGERY INSURANCE CONSULT

Weniger Plastic Surgery no longer contracts directly with insurance companies other than Medicare. Therefore if your visit is for non-cosmetic purposes, it will be considered an out of network insurance consultation.

I understand that if I am discussing an insurance procedure at a cosmetic consultation, I will be charged a $150 consultation fee. Weniger Plastic Surgery will file my claim to my private insurance company as a complimentary service. I am responsible for understanding what my out of network benefits are and understand that I may or may not be reimbursed for this visit.

Patient Signature: _____ Date:_____

Witness: _____ Date: _____

Weniger Plastic Surgery
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 form 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: _____