Fox Valley Plastic Surgery, S.C. www.fvpsurgery.com

2400 Witzel Avenue, Suite A
Oshkosh, WI 54904
920-233-1540
920-651-6951 Fax

2500 E Capitol Drive, Suite 1500
Appleton, WI 54911
920-358-1810
920-358-1819 Fax

Name: _____

DOB:_____

BHRT HEALTH HISTORY - Male

History

1. What is your height? _____ Current weight? _____
2. Have you used or are you currently using male hormone replacement supplements or therapy? ☐ No ☐ Yes

   If yes, please describe (when, what you used and did it help?)_____

   _____
3. Have you tried any other supplements or medications to help with your symptoms? ☐ No ☐ Yes. If yes, please describe (when, what you used and did it help?)_____

   _____
4. Do you have a history of mumps? ☐ No ☐ Yes
5. Do you have currently or have you been treated for benign prostate hypertrophy (BPH)? ☐ No ☐ Yes
6. Do you have a **personal** history of testicular, colon or prostate cancer? ☐ No ☐ Yes. If yes, please describe (age, type, treatments):_____

   _____
7. Do you have a **family** history of testicular, colon, or prostate cancer? ☐ No ☐ Yes. If yes, please describe (relation, age, type):_____

   _____
8. When was your last testicular exam? _____
9. When was your last prostate exam? _____
10. When was your last Dexa scan (bone density test)? _____
11. When was your last colonoscopy? _____ Do you have regular colonoscopies? ☐ No ☐ Yes ☐ N/A
12. Do you have a primary care doctor you see regularly? ☐ No ☐ Yes

Are there any other comments or concerns of which we should be aware?

_____

_____

_____

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Name: _____

DOB:_____

Symptoms

1. Do you have difficulty sleeping or disruptive sleep? ☐ No ☐ Yes. If yes, please describe: _____

   _____
2. Do you have memory loss? ☐ No ☐ Yes
3. Do you have a loss of energy? ☐ No ☐ Yes
4. Do you feel irritable? ☐ No ☐ Yes
5. Are you currently depressed or are you being treated for depression? ☐ No ☐ Yes. If yes, please describe treatments:

   _____
6. Have you struggled to keep weight off? ☐ No ☐ Yes
7. Have you noticed a change in fat distribution? ☐ No ☐ Yes
8. Do you find it more challenging to maintain muscle tone? ☐ No ☐ Yes
9. Do you have a decreased libido (interest in sex)? ☐ No ☐ Yes. If yes, please describe: _____

   _____
10. Are you currently sexually active? ☐ No ☐ Yes
11. Are you satisfied with your sex life? ☐ No ☐ Yes
12. Do you have trouble climaxing/orgasm? ☐ No ☐ Yes
13. Do you have difficulty maintaining an erection? ☐ No ☐ Yes
14. Other:_____

Patient Signature: _____ Date: _____

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DOB: _____

OPTIONAL: VIDEO AND PHOTOGRAPH RELEASE AND AUTHORIZATION

I hereby consent to and authorize the use and reproduction by Fox Valley Plastic Surgery, or anyone authorized by them, of any and all photographs, electronic images or video footage of me taken by FVPS, or that FVPS has in its possession, provided either by me or by a third party (collectively, Images) for the purpose of informing the medical profession and the general public about plastic surgery and plastic surgery procedures and techniques without compensation to me. Such use shall include, but not be limited to, distributing the Images via print, visual and electronic media, specifically including the FVPS website and social media sites such as YouTube, Facebook and Twitter. The Images (including any photographic negatives) shall be the sole property of FVPS.

I understand that the Images will not be identified by my name, but that such Images may reveal my identity. I understand and accept these terms.

I hereby waive any right to inspect or approve the finished product, photograph, video, DVD, CD-ROM or matter that may be used in conjunction therewith or to the eventual use that it might be applied.

I hereby release, discharge and agree to hold harmless FVPS and its affiliates and their respective representatives, assigns, and employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and the reproduction thereof as stated above, including any claim for payment in connection with distribution or publication of the video and/or photographs.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Fox Valley Plastic Surgery.

I understand that once content is posted on the web, it may remain on the web even after the content is deleted from the source.

I hereby warrant that I am at least eighteen years old, and competent to contract in my own name insofar as the above is concerned.

The purpose of this form is to obtain my prior written consent so that Fox Valley Plastic Surgery may photograph or film me for one or more of the following purposes listed below for which I do hereby consent.

Initial all that apply:

	Medical Use: Use or disclosure of image for medical specialty board in formulating its examination of applicant physicians, or in a professional presentation or journal publication
	Office Use: Use or disclosure of image for marketing or advertising purposes and patient education within the office
	Website Use: Use or disclosure of image for marketing or advertising purposes and patient education via print, visual and electronic media
List any photo limitations (For example: No face, no tattoo, etc.)	

I have read and understand the foregoing release and authorization.

Patient's or Responsible Party's Signature Date

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Name: _____

DOB: _____

Demographics

First Name: _____ MI: _____ Last Name: _____ Former Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Cell Carrier: _____ Work Phone: _____

DOB & Age: _____ Race: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Sex: _____ SSN: _____ Email: _____

Who is your primary care physician? _____
First Name Last Name

Preferred Pharmacy (name & location): _____

How did you hear about our practice?

☐ Patient: _____ ☐ Dr. Referral: _____
First Name Last Name

☐ Friend: _____

☐ Other: _____

Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

HIPAA Notice of Privacy Practices

I have been given the opportunity to read, review, obtain a hard copy and ask questions about Fox Valley Plastic Surgery's **HIPAA Notice of Privacy Practices**, and how Fox Valley Plastic Surgery uses and discloses my information and my rights concerning my information. I consent and acknowledge my agreement to the terms set forth in the HIPAA information form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient Signature: _____ Date: _____

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Consent to Communicate including Transmission of Protected Health Information by Non Secure Means (Email & Text Message)

In order to secure your Protected Health Information (PHI), it is always best to personally go to the office and talk to a representative of Fox Valley Plastic Surgery (FVPS). If this is not possible, the next best methods are to communicate by phone, fax, or U.S. mail. All these methods are secure means of transmitting PHI.

In spite of these secure options, it sometimes may become useful for during the course of treatment for the patient to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with FVPS, there is a reasonable chance that a third party may be able to intercept those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

FVPS has found that some patients prefer to message or email the office with photos or questions. These are not secure avenues of communication. If you wish the office to respond in kind to your inquiries, you must expressly give FVPS permission to communicate with you with these insecure methods instead of phoning, faxing, or writing you. Please mark the ways that you consent to us communicating with you.

Communication Method	OK to Leave Voicemail?	OK to Leave Message with Another Person?	Preferred Method(s)	Best Time to Call
☐ Call Work Phone	☐ Yes	☐ Yes	☐	
☐ Call Cell Phone	☐ Yes	☐ Yes	☐	
☐ Call Home Phone	☐ Yes	☐ Yes	☐	
☐ Send Email	☐ Okay for appointment reminder? ☐ Okay for medical/schedule information? ☐ Okay for special offers including patient surveys and newsletter? No spam. We do not sell our lists.			
☐ Send US Mail to	Mail to ☐ present address, ☐ permanent address, ☐ employer address, ☐ emergency contact, ☐ responsible party			
☐ Send Text Message **Cell Phone Carrier:** _____	☐ Okay for appointment reminder? ☐ Okay for medical/schedule information? ☐ Okay for special offers? No spam.			

PERSONS TO WHOM WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION:

Name	Date of Birth	Relationship	Release Results	Expiration, if any, or Comments
John Doe	*MM/DD/YY*	*Spouse*	*Yes/No*	*No exp.*

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my PHI by unsecured means. I understand that message and data rates may apply. I understand that I am not required to opt into emails or texting, or sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Patient Signature: _____ Date: _____

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Health History

Section I: Surgery and Anesthesia History

1. List and describe your surgical history.

_____

_____

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

_____

Section II: Specific Medical History

HEIGHT & WEIGHT: _____

Do you have a history of the following?	No	Yes	Description
1. Anemia	☐	☐	
2. Anxiety	☐	☐	
3. Asthma	☐	☐	
4. Emphysema	☐	☐	
5. Bleeding tendency	☐	☐	
6. Blood clots	☐	☐	
7. Cancer	☐	☐	
8. CHF	☐	☐	
9. COPD	☐	☐	
10. COVID-19	☐	☐	
11. Depression	☐	☐	
12. Diabetes	☐	☐	
13. High Blood Pressure	☐	☐	
14. Heart disease	☐	☐	
15. Hepatitis	☐	☐	
16. Herpes/Cold Sores	☐	☐	
17. Kidney disease	☐	☐	
18. Melanoma	☐	☐	
19. Migraine headaches	☐	☐	
20. Periodontal disease – currently being treated	☐	☐	
21. Stroke	☐	☐	
22. Thyroid disease	☐	☐	
23. Problem Scarring	☐	☐	
24. Have you been advised to or had psychiatric care?	☐	☐	
25. Vein problems, such as venous reflux disease	☐	☐	
26. Others Not Listed			

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Section III: Social History

1. Do you smoke? ☐ No ☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Former Smoker---Quit date_____ ☐ Tobacco user
2. How often do you drink alcohol? ☐ Never ☐ Monthly ☐ Weekly ☐ Daily ☐ Socially
3. Number of children given birth to? ☐ No ☐ Yes, how many? _____
4. Do you drink caffeine? ☐ Never ☐ Occasionally ☐ Daily
5. Illicit drug use? ☐ No ☐ Yes
6. Do you exercise? ☐ Never ☐ Weekly ☐ Daily

Section IV: Family History

Do your blood relatives have any of the following?		Brother	Daughter	Father	Maternal Aunt	Maternal Grandfather	Maternal Grandmother	Maternal Uncle	Mother	Nephew	Niece	Paternal Aunt	Paternal Grandfather	Paternal Grandmother	Paternal Uncle	Sister	Son
1.	Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2.	Bleeding Tendency	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.	Blood Clots	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4.	Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.	Chronic Lung Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.	Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7.	Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8.	Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9.	High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10.	Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11.	Melanoma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12.	Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13.	Migraine Headaches	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14.	Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15.	Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16.	Thyroid Trouble	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Section V: Medications

List any medications, and oral or topical vitamins or herbal supplements you are taking.

Name of Medication	Strength (mg)	How many times a day?

Do you have a Pain Contract with another physician? ☐ **No** ☐ **Yes**

Section VI: Allergies and Sensitivities

List all allergies and sensitivities:

Allergy:	Severity:	Reaction: (list #'s from bottom)
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	

Reaction List: 1) Arthralgia, 2) Chills, 3) Cough, 4) Fever, 5) Headache, 6) Hives, 7) Malaise/Fatigue, 8) Myalgia, 9) Nasal Congestion, 10) Other, 11) Pain/Soreness at injection site, 12) Rash, 13) Rhinorrhea, 14) Shortness of breath/Difficulty breathing, 15) Sore Throat, 16) Swelling, 17) Unknown

Are you allergic to medical adhesives such as tape, steri-strips, band-aids? ☐ No ☐ Yes, please list:
Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

Section VII: Women Only

Date of last mammogram: ____________________ Number of pregnancies: ____________________

Do you do regular breast self-exams?	☐ Yes	☐ No
Do you breast feed?	☐ Yes	☐ No
Breast lump or discharge?	☐ Yes	☐ No
Are you pregnant or trying to get pregnant?	☐ Yes	☐ No
Are you on birth control pills or hormone replacement therapy?	☐ Yes	☐ No

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: ______________________________ Date: ____________________

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Financial Policy

ALLOWABLE FORMS OF PAYMENT

With the exception of insurance covered procedures, full payment is due at least one week before the scheduled surgery, or on the day of service for non-surgical procedures. Some procedures, such as Thermi and Coolsculpting, have $250 fee payable at the time of booking. The booking fee will be applied to the cost of the actual procedure, or used to cover the cost of consumables and room setup, if the patient cancels the appointment without the required 24 hour notice. You will be notified if your service requires a booking fee. Our office accepts payment by cash, check, money order and credit cards from Visa, Mastercard, Discover and American Express. We also offer patient financing through Care Credit and Alphaeon Credit. Not all patients will qualify for financing, and not all procedures are eligible to be financed.

INSURANCE, CO-PAYS, DEDUCTIBLES

The patient or his/her legal representative is ultimately responsible for all charges incurred. Our office accepts assignment of benefits for many insurance companies. However, we are not preferred providers with all of them. It is your responsibility to **contact your insurance as to whether we are in your plan**, obtain your individual benefits and to be prepared to pay for any out of pocket expenses such as co-pays, deductibles and co-insurance before any surgery or office procedure is done. **Co-pays and past due balances are due at time of check-in**.

Your health care policy is a contract between you and your insurance company. If your insurance company does not cover your surgery, you will be liable for the payment. For example, Medicare does not have a pre-authorization process. If it is determined that your surgery was not medically necessary, you will then be billed for the surgery. It is ultimately **your responsibility to pay for all services** provided by Fox Valley Plastic Surgery.

BILLING

Statements are mailed monthly and expected to be paid in full within 60 days after your insurance has settled your claim. If you have financial difficulties, please contact our Financial Supervisor as soon as you are aware of the situation. The worst thing that you can do is to ignore the bill. Doing so will make you ineligible for any further service. If payment is not received within 90 days, your account may be referred to a collection agency.

CANCELLATIONS AND NO-SHOWS

If you must cancel or change your appointment, please notify us at least 24 hours prior to your appointment time so that we can fill your slot with another patient. In many instances with notice, we can schedule a patient in your place. Without this advance notice, you will either forfeit your $250 booking fee, if applicable, or be charged a **$50 service fee**. This also applies to no-shows. It is your responsibility to call us if you wish to reschedule. Your appointments may have a sequential and cumulative sequence that must be followed. If one appointment is missed, the rest are timed incorrectly and must be rescheduled. If we cannot contact you, or you do not contact us, then all your remaining appointments will be cancelled. If you arrive late for your treatment, you may be asked to reschedule, so as not to delay the next scheduled client.

DISPUTES

Services that are performed that are paid with a credit card, debit card or with financing, are not eligible for post-care payment challenges. The practice encourages a complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy. I agree that this credit, debit card or financing challenge agreement is irrevocable.

I have read the above Financial Policy. I understand and agree to this.

Patient Signature: _____ Date: _____

INSURANCE CASES ONLY: I have insurance coverage and directly assign to FVPS all medical benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for any out of pocket expenses such as, but not limited to co-pays, deductibles and co-insurance.

Patient Signature: _____ Date: _____