

Fox Valley Plastic Surgery, S.C. www.fvpsurgery.com
 2400 Witzel Avenue, Suite A 2500 E Capitol Drive, Suite 1500
 Oshkosh, WI 54904 Appleton, WI 54911
 920-233-1540 920-358-1810
 414-386-4625 Fax 920-358-1819 Fax

Name: _____

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: _____

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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: _____

Friend: _____ First Name _____ Last Name _____

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: _____

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
<input type="checkbox"/> Call Work Phone	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/>	
<input type="checkbox"/> Call Cell Phone	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/>	
<input type="checkbox"/> Call Home Phone	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/>	
<input type="checkbox"/> Send Email	<input type="checkbox"/> Okay for appointment reminder? <input type="checkbox"/> Okay for medical/schedule information? <input type="checkbox"/> Okay for special offers including patient surveys and newsletter? No spam. We do not sell our lists.			
<input type="checkbox"/> Send US Mail to	Mail to <input type="checkbox"/> present address, <input type="checkbox"/> permanent address, <input type="checkbox"/> employer address, <input type="checkbox"/> emergency contact, <input type="checkbox"/> responsible party			
<input type="checkbox"/> Send Text Message	<input type="checkbox"/> Okay for appointment reminder? <input type="checkbox"/> Okay for medical/schedule information? <input type="checkbox"/> Okay for special offers? No spam.			
Cell Phone Carrier: _____				
PERSONS TO WHOM WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION:				
Name	Date of Birth	Relationship	Release Results	Expiration, if any, or Comments
<i>John Doe</i>	<i>MM/DD/YY</i>	<i>Spouse</i>	<i>Yes/No</i>	<i>No exp.</i>

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	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. CHF	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. COPD	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. COVID-19	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. Herpes/Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	_____
17. Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
18. Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
19. Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
20. Periodontal disease – currently being treated	<input type="checkbox"/>	<input type="checkbox"/>	_____
21. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
22. Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
23. Problem Scarring	<input type="checkbox"/>	<input type="checkbox"/>	_____
24. Have you been advised to or had psychiatric care?	<input type="checkbox"/>	<input type="checkbox"/>	_____
25. Vein problems, such as venous reflux disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
26. Others Not Listed			_____

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Section V: Medications

List any medications, and oral or topical vitamins or herbal supplements you are taking. <DataPoint.CurrentMedications>

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: <DataPoint.AllAllergies>

Allergy:	Severity:	Reaction: (list #'s from bottom)
	<input type="checkbox"/> Mild, <input type="checkbox"/> Moderate, <input type="checkbox"/> Severe, <input type="checkbox"/> Unknown	
	<input type="checkbox"/> Mild, <input type="checkbox"/> Moderate, <input type="checkbox"/> Severe, <input type="checkbox"/> Unknown	
	<input type="checkbox"/> Mild, <input type="checkbox"/> Moderate, <input type="checkbox"/> Severe, <input type="checkbox"/> Unknown	
	<input type="checkbox"/> Mild, <input type="checkbox"/> Moderate, <input type="checkbox"/> Severe, <input type="checkbox"/> Unknown	
	<input type="checkbox"/> Mild, <input type="checkbox"/> Moderate, <input type="checkbox"/> Severe, <input type="checkbox"/> Unknown	
	<input type="checkbox"/> Mild, <input type="checkbox"/> Moderate, <input type="checkbox"/> Severe, <input type="checkbox"/> Unknown	
	<input type="checkbox"/> Mild, <input type="checkbox"/> Moderate, <input type="checkbox"/> Severe, <input type="checkbox"/> Unknown	
	<input type="checkbox"/> Mild, <input type="checkbox"/> Moderate, <input type="checkbox"/> Severe, <input type="checkbox"/> 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, bandaids? 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.

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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: _____