Fox Valley Plastic Surgery, S.C.
2400 Witzel Avenue, Suite A
Oshkosh, WI 54904
920-233-1540
920-651-6951 Fax

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

Name: <PersonalInfo.FullName>

DOB: <PersonalInfo.DOB>

LIFESTYLE QUESTIONNAIRE - FEMALE

Gynecological History

1. What is your height? ______________ Current weight? __________________ Date of your last period?_______________
2. Have you had a hysterectomy and oophrectomy? ☐ No ☐ Yes, if yes please describe (why and how old were you?)
   ____
3. Have you had an oophrectomy? ☐ No ☐ Yes, if yes please describe (why and how old were you?)
   ____
4. Have you tried any supplements or medications to help with your symptoms? ☐ No ☐ Yes If yes, please describe (when, what you used and did it help?)____
5. Do you have a **personal** history of breast, uterine, colon or ovarian cancer? ☐ No ☐ Yes If yes, please describe (age, type, treatments):____
   ____
6. Do you have a **family** history of breast, ovarian, uterine or colon cancer ? ☐ No ☐ Yes If yes, please describe (relation, age, type):____
7. When was your last mammogram? __________________
8. When was your last pap smear? ____________________
9. When was your last colonoscopy? _________________
10. Do you have mammograms annually? ☐ No ☐ Yes ☐ N/A
11. When was your last dexa scan? _____________________
12. Do you have a primary care doctor you see regularly? ☐ No ☐ Yes
13. Do you have hot flashes or night sweats? ☐ No ☐ Yes If yes, please describe: _________________________________
14. Are you currently depressed or being treated for depression? ☐ No ☐ Yes If yes, please describe treatments:_________
    ____
15. Have you noticed in change in your skin and hair? ☐ No ☐ Yes If yes, please describe: ____________________________
    ____
16. Have you struggled to keep weight off? ☐ No ☐ Yes
17. Have you noticed a change in fat distribution? ☐ No ☐ Yes
18. Do you find it more challenging to maintain muscle tone? ☐ No ☐ Yes
19. My birth control method is:

☐ Abstinence	☐ Birth Control Pill
☐ Hysterectomy	☐ IUD
☐ Menopause	☐ Tubal Ligation
☐ Vasectomy	☐ Other: ______________________________

Patient Signature: **Date:**

_______________________________ _______________________________

Fox Valley Plastic Surgery, S.C.
2400 Witzel Avenue, Suite A
Oshkosh, WI 54904
920-233-1540
920-651-6951 Fax

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

Name: <PersonalInfo.FullName>

DOB: <PersonalInfo.DOB>

Checklist Before FEMALE BHRT Treatment

Place an "X" for EACH symptom you are currently experiencing. Mark only ONE box. Mark NONE for symptoms that do not apply.

		None 1	Mild 2	Moderate 3	Severe 4	Very Severe 5
1.	**Hot flashes, sweating** (episodes of sweating)	☐	☐	☐	☐	☐
2.	**Heart discomfort** (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
3.	**Sleep problems** (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	☐	☐	☐	☐	☐
4.	**Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	☐	☐	☐	☐	☐
5.	**Irritability** (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
6	**Anxiety** (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
7.	**Physical and mental exhaustion** (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
8.	**Sexual problems** (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
9.	**Bladder problems** (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
10.	**Dryness of vagina** (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
11.	**Joint and muscular discomfort** (pain in the joints, rheumatoid complaints)	☐	☐	☐	☐	☐

Please share any additional comments about your symptoms you would like to address.________________________________

____

Do you have cold hands and feet? ☐ Yes ☐ No **Do you have daily bowel movements?** ☐ Yes ☐ No

Do you have gas, bloating or abdominal pain after eating? ☐ Yes ☐ No

Please select your WEEKLY Activity Level based on this criteria ➔ *Physical activity that accelerates heart rate / Breathlessness*

☐ 0-1 day per week (Low) ☐ 2-3 days per week (Average) ☐ More than 3 days per week (High)

Please list any prior hormone therapy?____

____

Fox Valley Plastic Surgery, S.C.
2400 Witzel Avenue, Suite A
Oshkosh, WI 54904
920-233-1540
920-651-6951 Fax

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

Name: ____________________________

DOB:___________________________

Demographics ~ <Appointment.Date>

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 Address: ________________________________

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: ____________________________

Fox Valley Plastic Surgery, S.C.
2400 Witzel Avenue, Suite A
Oshkosh, WI 54904
920-233-1540
920-651-6951 Fax

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

Name: ____________________________

DOB:___________________________

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 appt 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 appt reminder? ☐ Okay for medical/schedule information? ☐ Okay for special offers?			

FAMILY MEMBERS				
Name	Date of Birth	Relationship	Release Results	Expiration or Comments

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: ______________________

Fox Valley Plastic Surgery, S.C.
2400 Witzel Avenue, Suite A
Oshkosh, WI 54904
920-233-1540
920-651-6951 Fax

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

Name: ______________________________

DOB:_____________________________

Health History

Section I: Surgery and Anesthesia History

1. List and date 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. Depression	☐	☐	
11. Diabetes	☐	☐	
12. High Blood Pressure	☐	☐	
13. Heart disease	☐	☐	
14. Hepatitis	☐	☐	
15. Herpes/Cold Sores	☐	☐	
16. Kidney disease	☐	☐	
17. Melanoma	☐	☐	
18. Migraine headaches	☐	☐	
19. Multiple Endocrine Neoplasia (MEN)	☐	☐	
20. Pancreatitis	☐	☐	
21. Periodontal disease – currently being treated	☐	☐	
22. Stroke	☐	☐	
23. Thyroid Cancer	☐	☐	
24. Thyroid disease	☐	☐	
25. Problem Scarring	☐	☐	
26. Have you been advised to or had psychiatric care?	☐	☐	
27. Vein problems, such as venous reflux disease	☐	☐	

28. Others Not Listed ____

Fox Valley Plastic Surgery, S.C.
2400 Witzel Avenue, Suite A
Oshkosh, WI 54904
920-233-1540
920-651-6951 Fax

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

Name: ______________________________

DOB:_____________________________

Section III: Social History

1.	Do you smoke?	☐ No ☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Former Smoker---Quit date_____________ ☐ Tobacco user
2.	Do you Vape?	☐ No ☐ Yes If yes does it contain nicotine ☐ No ☐ Yes
3.	How often do you drink alcohol?	☐ Never ☐ Monthly ☐ Weekly ☐ Daily ☐ Socially
4.	Number of children given birth to?	☐ No ☐ Yes, how many? ____________
5.	Do you drink caffeine?	☐ Never ☐ Occasionally ☐ Daily
6.	Illicit drug use?	☐ No ☐ Yes
7.	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	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.	Multiple Endocrine Neoplasia (MEN)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15.	Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16.	Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
17.	Thyroid Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Fox Valley Plastic Surgery, S.C.
2400 Witzel Avenue, Suite A
Oshkosh, WI 54904
920-233-1540
920-651-6951 Fax

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

Name: ______________________________

DOB:_____________________________

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, 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.

Patient Signature: ______________________________ Date: ____________________

Fox Valley Plastic Surgery, S.C.
2400 Witzel Avenue, Suite A
Oshkosh, WI 54904
920-233-1540
414-386-4625 Fax

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

Name: ____________________________

DOB: ____________________________

Financial Policy

Appointment scheduling requires careful planning and coordination between our office, surgery centers and contracted staff. Special medical instrumentation and supplies may be ordered and are sterilized for each individual procedure. Please consider the importance of this policy before scheduling a procedure.

SURGERY SCHEDULING

A $1,000 down payment is required to secure a scheduled surgery time. **Full payment is due 21 days prior to a scheduled surgery date.** This includes complete payment of deductibles, co-insurance and copays for insurance cases. Immediately upon scheduling, patients have a **24-hour grace period** to make changes including cancelling the surgery without incurring a rescheduling/cancellation charge.

SURGERY RESCHEDULING / CANCELLATION FEES

Patients who wish to change the surgery date or cancel surgeries, will incur a fee. Patients, who **fail a cotinine test**, are considered patient cancellations. Adequate notice of cotinine testing is always given, so there is no reason for a failed test. A rescheduling/cancellation fee will be assessed on failed cotinine tests. Fees are first withheld from any down payments already paid before invoicing the patient. The fee schedule is as follows:

Days Prior to Surgery	Rescheduling Fee	Cancellation Fee
Over 21 days	$200.00	$300.00
15-21 days	$400.00	$500.00
8-14 days	$600.00	$700.00
1-7 days	$800.00	$900.00
24 hours or less	$1000.00	$1000.00

NON-SURGERY RESCHEDULING / CANCELLATION FEES

Generally, full payment is due on the day of service for non-surgical procedures such as those in the Renaissance Medispa and the Laser Institute of Wisconsin™. Some procedures have a non-refundable $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 adequate notice. You will be notified if your service requires a booking fee.

If you must cancel or change your non-surgical appointment, please notify us at least **24 hours** prior to your appointment time so that we can try to fill your slot with another patient. 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, such as in veins, 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.

ALLOWABLE FORMS OF PAYMENT

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, CO-INSURANCE, DENIALS

Our office is happy to file claims with your insurance company as a courtesy. However, your insurance policy is a contract between you and your insurance company. Verification of benefits is not a guarantee of payment. You are responsible for understanding your coverage. You are financially responsible for 1) co-pays, deductibles, and co-insurance, 2) services not covered by your insurance, 3) services your insurance denies for any reason, and 4) charges not paid by your insurance plan. If your insurance does not pay for a service, you agree to be responsible for the remaining balance. Some services require prior authorizations or referrals. While we may assist in obtaining them, Name: ___________________________

DOB: ____________________________

payment is not guaranteed by authorization approval. If your insurance denies payment, you are responsible for the balance.

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, estimated patient balances, and past due balances are due at time of check-in**.

Medicare does not have a pre-authorization process for most procedures. 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. Payment plans may be available upon request. If payment is not received within 90 days, your account may be sent to a collection agency.

DISPUTES

Performed services that are paid with a credit card, debit card or with financing, are not eligible for post-care payment challenges. Fox Valley Plastic Surgery 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: ____________________