



**PRESENT HISTORY**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Name of Personal Physician \_\_\_\_\_

Address of Personal Physician \_\_\_\_\_ Phone# \_\_\_\_\_

Please list any serious illnesses: \_\_\_\_\_

**Medications:** List current medications including blood thinner, aspirin, Bufferin, Advil, birth control pills, diuretics, blood pressure or heart medications, steroids, tranquilizers, hormones, etc. \_\_\_\_\_

**ALLERGIES TO MEDICATIONS?** \_\_\_\_\_

**ARE YOU ALLERGIC TO LATEX?** \_\_\_\_\_

**USE OF HERBAL DRUGS OR THERAPIES?** \_\_\_\_\_

**USE OF DIET MEDICATIONS?** \_\_\_\_\_

Have you taken steroids, i.e. prednisone, cortisone, medrol, etc. in the past 12 months? \_\_\_\_\_

Have you ever had cold sores or fever blisters? \_\_\_\_\_

Have you ever had...? (Please check those that apply): mental or nervous disease \_\_\_\_\_ high blood pressure \_\_\_\_\_ lung disease \_\_\_\_\_ Keloids \_\_\_\_\_ glaucoma \_\_\_\_\_ heart disease \_\_\_\_\_ kidney disease \_\_\_\_\_ bruise/bleed easily \_\_\_\_\_ cataracts \_\_\_\_\_ Diabetes \_\_\_\_\_ asthma \_\_\_\_\_ allergies to adhesive tape \_\_\_\_\_

**RELEASE OF INFORMATION:**

I certify that the information I have reported with regard to my insurance coverage is correct. I authorize the necessary release of any information, including medical information to my insurance carrier.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PRESENT PROBLEM:**

**IS THIS TO BE SUBMITTED TO INSURANCE COMPANY** \_\_\_\_\_ **Yes** \_\_\_\_\_ **No**

Problem for which you are seeking plastic surgery: \_\_\_\_\_

Area(s) of the body \_\_\_\_\_

Is this related to an injury/accident? \_\_\_\_\_ if Yes, date injury occurred \_\_\_\_\_

Have you consulted other doctors about this? \_\_\_\_\_ If Yes, who \_\_\_\_\_

**Questions to discuss:** \_\_\_\_\_

**THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY BELIEF.** \_\_\_\_\_

\*\*\***(PATIENT'S SIGNATURE)**\*\*\*

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**INSURANCE INFORMATION:**

Primary Insurance Company \_\_\_\_\_ Policy Holder \_\_\_\_\_

Policy Holder's S.S.# \_\_\_\_\_ Policy Holder's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Identification # \_\_\_\_\_ Group # \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Patient \_\_\_\_\_ Spouse \_\_\_\_\_ Parent **PLEASE PROVIDE INSURANCE CARD & DRIVERS LICENSE.**

I authorize release of my medical records to the insurance company or responsible party for billing purposes. I authorize the insurance company or responsible party to pay directly to the Advanced Center for Plastic Surgery. For and in consideration of services rendered, the undersigned jointly and severally obligates themselves for the payment of all services rendered by Dr. Fischer and her staff. The undersigned hereby acknowledge that I/we are financially responsible for any health insurance deductible, coinsurance, or failure for any reason of any insurance carrier to pay Dr. Fischer's charges, which I/we are due and rendered. In the event the patient's account is referred for collection, the undersigned agrees to pay and be responsible for all such medical charges together with all court costs, private process fees, collection costs and attorney's fees in the amount of 1/3 of the balance, which sum the undersigned expressly agrees is reasonable. This assignment will remain in effect unless revoked by me in writing. A photocopy of this is to be considered valid as the original.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**FINANCIAL POLICY**

1. The fee for the initial cosmetic consultation is \$100.00, payable at the time of service. This fee includes a second consultation within 60 days, if needed. The fee for the initial insurance consultation ranges between \$100.00 - \$250.00 depending on length and focus of visit.
2. An estimate of the surgical fee will be provided at the time of consultation. This estimate does not include expenses which the patient may incur for a "History and Physical" examination, blood tests, and prescriptions. A 10% deposit is required when the surgery date is scheduled.
3. Final payment for all cosmetic surgeries must be made at least three (3) weeks prior to the scheduled surgery date. Fees are fully refundable for cancellations made no later than three (3) weeks prior to the date of surgery. A 50% refund will be made for surgeries which are cancelled 14-20 days prior to surgery. There will be no refunds for cancellations within 13 days of the scheduled surgery. A surgery which has been rescheduled and subsequently cancelled again is subject to no greater than a 50% refund.
4. The patient is solely responsible for the entire fee, regardless of the source of payment. In the case of insurance-covered procedures, the patient is responsible for any co-payments and/or deductibles. On rare occasions a surgery may include a procedure, which is covered by insurance and one, which is not. In these cases, there may be two consultation and two anesthesia charges. If the insurance company pays these, the patient will be responsible for any co-payments.
5. All post-operative visits relating to the original procedure are included in the surgical fee for up to one (1) year. Consultations for unrelated procedures will be billed separately.
6. There will be a reduced surgeon's fee assessed for cosmetic re-operations involving minor revisions, which are performed within twelve (12) months of the original date of surgery. The patient, however, is fully responsible for the operating room facility fee, anesthesia fee, and all supplies...minimum fee = \$1650.00.  
\*\*\*Initials \_\_\_\_\_\*\*\*
7. There will be a \$30.00 fee for any check returned to the practice unpaid.
8. Exceptions to this policy will be considered on a case by case basis and will be at the sole discretion of the Practice Administrator.
9. There will be a \$50.00 fee billed to new patients for missed consultation appointments without prior 48 hours notice.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**CONSENT FOR PHOTOGRAPHS**

I hereby authorize Dr. Fischer or any staff to take before and after photos for surgical purposes only.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_