

PRIMA CENTER FOR PLASTIC SURGERY

PATIENT INFORMATION: (Please Print)

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ (Required by hospital for surgery scheduling purposes.)

Email Address: _____

Telephone Numbers: Home: _____ Cellular: _____ Work: _____

Age: _____ Date of Birth _____ Marital Status: Single Married Divorced Widowed

Employer: _____

Emergency Contact Name: _____ Phone Number: _____

HOW DID YOU HEAR ABOUT US?

How did you hear about us? (Please check all statements that apply.)

- My Friend, _____, told me about Prima Center for Plastic Surgery.
- My Doctor, _____, referred me to this office.
- I saw your office while I was driving by.
- I saw your ad in the Yellow Pages.
- Hospital _____ recommended me to Prima Center for Plastic Surgery.
- I attended one of Prima Center for Plastic Surgery's Seminars.
- I heard your advertisement on _____ Radio Station.
- I saw your advertisement in the _____ Newspaper.
- I located you through the internet _____ website.
- I am a client at Prima Worx Day Spa.
- Other: _____.

POLICIES (Please read and sign)

I understand that this is a cosmetic surgical procedure (not medically necessary) and not reimbursable by Insurance / Medicare. I understand that payment in full is due at the pre-op visit.

We are pleased to accept MasterCard, Visa, American Express and Discover for your services. Financing is available through CareCredit®. We also accept personal checks, certified checks, money orders and cash. Personal checks are processed electronically, if returned unpaid, the collection of your payment and a return fee of \$30 or 5% (whichever is greater) will be automatically drafted from your account.

Our Privacy notice is located in the reception area. Your signature below indicates you have had the opportunity to review the privacy notice, and understand the policies outlined above.

Signature

Date

Name _____ Age _____

Today's Date _____

Date of Birth _____ Sex _____

Height: _____ Weight: _____

ALLERGIES: _____
(Drugs, Latex, Dye, etc.)

Occupation: _____

PURPOSE OF VISIT

What is the reason for your visit today? _____

What additional procedures/services might you like to learn about today?

- | | | | | |
|---|---|--|---|--|
| <input type="checkbox"/> Arm Lift | <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Dermabrasion | <input type="checkbox"/> Injectable Fillers | <input type="checkbox"/> Skin Rejuvenation |
| <input type="checkbox"/> Body Lift | <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Ear Surgery | <input type="checkbox"/> Liposuction | <input type="checkbox"/> Spider Veins |
| <input type="checkbox"/> Botox | <input type="checkbox"/> Brow Lift | <input type="checkbox"/> Eyelid Surgery | <input type="checkbox"/> Rhinoplasty | <input type="checkbox"/> Thigh Lift |
| <input type="checkbox"/> Breast Lift | <input type="checkbox"/> Chemical Peel | <input type="checkbox"/> Facelift | <input type="checkbox"/> Sculptra | <input type="checkbox"/> Tummy Tuck |
| <input type="checkbox"/> Other: _____ | | | | |

HEALTH REVIEW

DO YOU HAVE, OR HAVE YOU HAD?

- | | | |
|---|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous Breakdown |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Blood Clots / DVT (Deep Vein Thrombosis) | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatic Heart Disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tonsillitis |
| | | <input type="checkbox"/> Tuberculosis |

IS THERE ANY OTHER INFORMATION THAT WE SHOULD BE AWARE OF?

HAVE YOU HAD ANY PREVIOUS OPERATIONS?

_____ Year _____
_____ Year _____

HAVE YOU HAD ANY SERIOUS ILLNESSES/INJURIES?

_____ Year _____
_____ Year _____

PLEASE CHECK THE MEDICATION YOU ARE CURRENTLY TAKING (IF ANY)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Coumadin | <input type="checkbox"/> Iron | <input type="checkbox"/> Water Pills |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Digitalis | <input type="checkbox"/> Laxatives | <input type="checkbox"/> Weight Reduction Pills |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Dilantin | <input type="checkbox"/> Metabolife Type Pills | <input type="checkbox"/> Other, please List: |
| <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Herbal Medicine | <input type="checkbox"/> Sleeping Pills | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Blood Pressure Meds | <input type="checkbox"/> Hormones | <input type="checkbox"/> Thyroid Medication | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Blood Thinning Pills | <input type="checkbox"/> Insulin | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> _____ |

PERSONAL HEALTH

YES NO

- Do you regularly smoke?
 If yes, how many packs per day? _____ How many years? _____
 Do you usually drink over 6 cups of coffee per day?
 Do you regularly drink alcoholic beverages or beer?

YES NO

- Do you frequently have bleeding gums?
 Do you frequently have nosebleeds?
 Do you bleed excessively from a cut?
 Do you take aspirin regularly?

WOMAN ONLY

YES NO

- Do you have regular monthly menstrual periods?
 Do you have bleeding between your periods?
 Do you have heavy bleeding with your periods?
 Do you regularly have a pap smear?
 Have you had a discharge from the nipple of your breast?
 Do you have any children? If yes, how many? _____
 Have you ever had a miscarriage or still birth?
 Have you ever had a cesarean operation?

MEN ONLY

YES NO

- Have you ever been treated for genital problems?
 Have you ever had an abnormal discharge from your penis?
 Have you ever had a hernia?
 Have you ever had prostate trouble?

PRIMA CENTER FOR PLASTIC SURGERY

POLICY REGARDING SECONDARY SURGERY (TOUCH-UPS)

All surgery deals with living tissue. Your ability to heal is as individual to you as your personality and your fingerprint. Each of us must accept that the healing process and the body's response to surgery is not always predictable. Therefore, the results of any surgery can never be completely guaranteed.

1. Each patient must understand that their own particular healing characteristics will affect the results.
2. Each patient must understand and accept that Dr. Zwiren/Dr. Nakano/Dr. Song has absolutely no control over how your body heals and cannot predict healing (by tests or examinations prior to surgery) or control your own particular individual healing characteristics.
3. Each patient must understand and accept that if cosmetic deformities or areas of asymmetry should occur, even though the deformity may be visible, that Dr. Zwiren/Dr. Nakano/Dr. Song is in the best position to determine whether or not additional surgery is needed. Dr. Zwiren/Dr. Nakano/Dr. Song will base this decision on whether or not he feels the potential benefits outweigh the potential risks of additional surgery. This will be based upon whether or not he feels that you will get predictable improvement from additional surgery.
4. Each patient must understand and accept that Dr. Zwiren/Dr. Nakano/Dr. Song must work on what you bring him to work with, and that he cannot change the qualities of your tissues, skin or muscle. At the time of your consultation Dr. Zwiren/Dr. Nakano/Dr. Song will, to the best of his ability, discuss any particular anatomic factors that may affect your result. Together, as a team, we will plan an approach that would be thought to yield an optimal and satisfactory result. I would stress again that this is a team approach.

Cosmetic Surgery – Surgical Touch up

If, after your cosmetic surgery, there are areas which both you and Dr. Zwiren/Dr. Nakano/Dr. Song feel warrant a touch up to achieve an optimal result, this surgery will be done without a surgeon's fee. You will, however, be responsible for the facility fee, equipment, supplies, and anesthesia fees. Some Surgical Touch up procedures can be performed under local anesthesia and others will require conscious sedation or general anesthesia. Dr. Zwiren/Dr. Nakano/Dr. Song is in the best position to determine what type of anesthesia is indicated for your touch up procedure if needed. If desired, we will make available average charges for surgical touch ups. Examples include revising a suboptimal face-lift scar, treatment of significant asymmetry following cosmetic breast surgery or correction of implant malposition, revision of breast lift scars, refining a rhinoplasty, excision of skin at the margins of an abdominoplasty scar (dog ears) or refining an area of liposuction. All surgical touch ups must be performed within one year following the original procedure. The cost of a touch up under local anesthesia scheduled for less than one hour is a minimum of \$175, if one hour or more, the minimum cost is \$250.

Cosmetic Surgery – Patient request for revision or repeat surgery

If after your cosmetic procedure there are areas for which you personally desire a revision, touch-up or repeated surgery and Dr. Zwiren/Dr. Nakano/Dr. Song feels that you have had a satisfactory outcome from your surgery, then this will be considered a new surgical procedure and you will be responsible for expenses. Expenses include the surgeon's fee, the facility fee, equipment, and anesthesia costs. Examples may include a secondary facelift for recurrent skin laxity, changing the size or shape of breast implants, recurrent breast sagging following a breast lift, redoing an area of liposuction after weight gain or pregnancy.

Insurance Covered Procedures – Secondary Surgery

If your insurance covered all or part of your expenses for your original surgery then you are responsible for that part of the expenses your insurance company does not cover. Your insurance company, depending on your particular policy, may cover secondary surgery. We will assist you in obtaining surgical pre-authorization -in this situation. If your insurance company determines that the secondary surgery is cosmetic in nature and not covered then you will be responsible for expenses. Expenses include the surgeon's fee, the facility fee, equipment, and anesthesia costs. Examples include revision of a scar following breast reconstruction, revision of a breast reduction or revision of a scar following skin cancer excision.

These notes are provided for your information in an attempt to clarify our approach to billing secondary surgical procedures. If you have any questions or if this information is unclear to you, please contact our office manager for further explanation.

Signature

Date

Cigarette Smoking/Tobacco Use Informed Consent

When you smoke cigarettes or use any tobacco products, either before or after your plastic surgery procedure you are accepting additional risks greater than those discussed with patients who do not now or never smoked cigarettes. The longer you have smoked cigarettes and the more packs of cigarettes smoked per day also increases your risk of healing complications.

There is a definite yet undetermined increased risk of healing complications that can be directly linked to cigarette smoking. These include scarring, poor healing, skin loss and complications in general. **It is always best to stop smoking at least two (2) weeks prior to surgery and to continue to not smoke for two (2) weeks after surgery.** The exact length of time smoking should be discontinued to ensure good healing is unknown, but it would seem reasonable that more time is better. There is also no guarantee that even if all of the no smoking instructions are followed that healing will be satisfactory and without complications.

If you elect not to stop smoking or discontinue the use of all tobacco products and all medications containing nicotine, you will be unnecessarily accepting an increased risk of healing difficulties including the sloughing (dissolving away) of skin or fat. The result of these potential healing problems may require additional surgery, additional costs and additional time off of work. This is a choice, which you and you alone will be making. The physicians of Prima Center for Plastic Surgery are expressing our considerable concern on this issue in order to decrease, but not eliminate, healing difficulties after surgery. **By signing this form and continuing to smoke, use medications with nicotine or use any tobacco product** during the minimum two week before and two week after surgery restricted period you are accepting and acknowledging the increased chance of wound healing difficulties. You are also cautioned against **second hand smoke**, which has the same consequences as smoking.

When you smoke, there are both acute and long-term changes. The chronic changes associated with smoking are well known and include hardening of the arteries, the build up of plaque in the arteries, a condition known as atherosclerosis, acceleration of the aging process due to the absorption of multiple toxins including carbon monoxide which binds to hemoglobin in the blood and blocks oxygen saturation thus lowering the amount of oxygen available for the tissues. There is also a sensitization of the lining of the arteries causing them to be more likely to go into spasm thus narrowing their diameter and allowing less room for blood flow. The acute changes from smoking also create an increased risk of arterial spasm thus decreasing the diameter of the arteries and decreasing blood flow to healing areas.

I have read, understood and have received a copy of the Prima Center for Plastic Surgery Cigarette Smoking Informed Consent and I realize the serious negative implications of cigarette smoking/nicotine products/tobacco products on my surgical result. I was given the opportunity to stop smoking to help decrease these complications. I will notify my physician prior to surgery if I am unable to stop smoking at least two weeks prior to surgery and for the two weeks following surgery and if necessary my procedure will be cancelled. **I ALSO UNDERSTAND THAT IN ADDITION TO CIGARETTES, I WILL NOT EXPOSE MYSELF TO SECOND HAND SMOKE, BE IN THE PRESENCE OF SMOKERS, USE ANY TOBACCO PRODUCTS AND WILL NOT USE NICORETTE GUM OR NICOTINE PATCHES.**

Patient Signature

Date

DEPOSIT / CANCELLATION POLICY

In order to hold your requested date and time for surgery, we require receipt of a deposit at the time of scheduling your surgery.

The amount of the deposit is determined by the duration of your surgery .

2 hours and less - \$500

Over 2 hours - \$750

The deposit is applied to the cost of your surgery; however, if you need to cancel your surgery with less than 14 days notice, your deposit will be forfeited. The deposit will be refunded if more than 14 days notice of cancellation is given.

PAYMENT POLICY

The balance of your fees will be collected at your pre-op visit which is scheduled a few days prior to your surgery. Payment may be made by personal check, certified check, money order, Visa, MasterCard, American Express, Discover, or cash.

Procedures performed in our accredited operating room are paid with two transactions. Surgeon fees are payable to Prima Center for Plastic Surgery. Operating room/Anesthesia fees are payable to Prima Ambulatory Surgical Services.

Procedures performed in the hospital setting are paid with one transaction . all fees are payable to Prima Center for Plastic Surgery. The fees for an overnight stay at the hospital is approximately \$650, if more than \$650 is charged by the hospital, the additional amount is payable to Prima Center for Plastic Surgery and billed following surgery.

By signing below, I acknowledge receipt of the above payment polices.

Patient Signature

Date