REGISTRATION **Greater Milwaukee Plastic Surgeons, S.C.**

PATIENT INFORMATION *(please print & complete all areas)*

Name ______________________________ **SSN** ________ - ______ - ________
(Last First MI)

Address ______________________________ City ____________ State _____ Zip ________

Home # (______) ____________ **Work #** (______) ____________ **Cell#** (______) ____________

* List only numbers we have your consent to call

 Male Female **Date of Birth** ______/______/______ Single Married Divorced Separated Widowed

Ethnicity African-American Asian Caucasian Hispanic Other **Age** ________

Employer ______________________________ **Occupation** ____________________

Employer Address ____

Spouse's Name ______________________________ **Spouse's Soc.Sec.#** ________ - ______ - ________

Spouse's Employer ______________________________ **Date of Birth** ______/______/______

Referring Doctor's Name ____________________ **Primary Doctor's Name** ____________________

Emergency Contact ____________________ **Phone #** (______) ____________ **Relationship** __________

INSURANCE

Person Responsible for Account / Insured ______________________________
(Last First MI)

Primary Insurance ____________________ **Secondary Insurance** ____________________

Policy Holder Name ____________________ **Policy Holder Name** ____________________

Subscriber # ____________________ **Subscriber #** ____________________

Group # ____________________ **Group #** ____________________

***** If patient is the <u>CHILD OF THE INSURED</u>, the parent's information must be completed below:***

SSN ______ - ____ - _______ DOB _____/______/_____ Home # (_____) ____________ Relationship __________

Address ______________________________ City ____________ State _____ Zip ____________

Employer ______________________________ Work # ____________________

ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage with aforementioned insurance carrier(s) and assign directly to my doctor all insurance benefits, if any, otherwise payable to me for services rendered. ***I understand that I am financially responsible for all charges whether or not paid by my insurance and accept responsibility for any balance remaining after payment of such benefits.*** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I further authorize the physician to release any information required in the course of my treatment as authorized according to HIPAA Privacy Rules.

______________________________ ____________________ ____________________
Signature of Insured or Guardian Relationship Date

MEDICAL HISTORY FORM

Rev'd 1/2012

Greater Milwaukee Plastic Surgeons, S.C.

Patient's Name: ____
First MI Last

Height: ____________ Weight: ____________ Age: ________ y/o

List your primary physician (or pediatrician if child): ____________________

List reason for visit or current medical problem(s): ____________________

____

List medications you are currently taking: ____________________

____

Do you have any know **ALLERGIES and/or DRUG SENSITIVITIES**? ☐ No ☐ Yes, please list: __________

____

List any vitamins and/or herbal supplements that you currently take: ____________________

List previous operations with dates: ____________________

____

Circle "Y" for "Yes", "N" for "No" in response to the following:

Do you smoke? Y N How much per day? ____________________
Do you drink? Y N How often? ____________________
Do you bruise easily? Y N
Do you take aspirin, ibuprofen or similar over-the-counter medication? Y N

Family History:						
	Diabetes	Y	N	Cancer	Y	N
	Heart Disease	Y	N	Other: ____________		

Do you have now or have you ever had:

breathing problems	Y	N	kidney disease	Y	N
high blood pressure	Y	N	bladder infection	Y	N
heart disease	Y	N	arthritis	Y	N
epilepsy	Y	N	auto immune disease	Y	N
glaucoma or cataracts	Y	N	(AIDS/HIV, lupus, polyarthritis, etc.)		
stomach ulcers	Y	N	blood clots in leg	Y	N
hepatitis/jaundice	Y	N	pulmonary embolus (blood	Y	N
estrogen therapy	Y	N	clot in lung)		
psychiatric counseling	Y	N	diabetes	Y	N
gout	Y	N	cancer	Y	N

Have you ever had a blood transfusion? Y N If Yes, enter date or year __________
Would you accept a blood transfusion if needed in an emergency situation while under the physician's care? Y N

Are there any medical problems not listed above that you would like the physician to be informed about?

____

I certify that the above information is correct to the best of my knowledge:

Patient Signature: ______________________________ Date: ____________

PATIENT FINANCIAL POLICY
Greater Milwaukee Plastic Surgeons, S.C.

Thank you for choosing Greater Milwaukee Plastic Surgeons, S.C. for your care. We will provide medical services to you provided that you understand and comply with the following financial policies of our practice. If you have any questions about the following, please ask to speak with one of our billing staff or office manager.

SUBMISSION OF INSURANCE CLAIMS

YOUR HEALTH INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR HEALTH INSURANCE PLAN. You are responsible for understanding and following your health plan's required procedures and policies. It is your responsibility to provide us with accurate and up-to-date insurance information, so that we can file an insurance claim on your behalf for services rendered. If we do not receive payment within 60 days from the date the claim is filed with your health plan, you are responsible for the unpaid balance and we may request immediate payment from you. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Is is your responsibility to contact your health plan regarding benefits or coverage issues.

REFERRALS AND PRIOR AUTHORIZATIONS

If your health plan requires you to have a referral authorization from your primary care physician in order to be seen by our practice, it is your responsibility to verify that a referral has been received by our office prior to your visit. FAILURE TO HAVE A VALID REFERRAL AUTHORIZATION MAY RESULT IN YOUR APPOINTMENT BEING RESCHEDULED UNTIL A VALID REFERRAL IS OBTAINED. If you request to be seen without a valid referral, you will be responsible for payment of services rendered and will need to complete additional paperwork that will allow us to bill you for services rendered. If your health plan requires surgery pre-authorization, please notify your provider of this provision. Our billing office will assist you in pre-authorization of your surgery. During the pre-authorization process, your health plan and your employer may be contacted to verify plan enrollment. Pre-authorization does not guarantee payment of your surgery costs. Failure to have your surgery pre-authorized if required by your health plan may result in denial of medical payment for services rendered. If payment is denied, you may be responsible for payment of the balance in full. If you have any questions about your benefits or what services are covered under your health plan, it is your responsibility to contact your health plan prior to your surgery.

CO-PAYMENTS AND NON-COVERED SERVICES

If your health plan requires a co-payment, we are required to collect it at the time of your visit. We cannot waive co-payments, deductibles or co-insurance amounts, which are the patient's responsibility. Co-payments and non-covered services are collectable at the time of your visit. If you cannot make the required payment, your appointment may be rescheduled. If you do not have health insurance coverage or request a service that is not covered by your health plan (i.e., cosmetic in nature), we require that payment be made in full at the time that services are rendered. For your convenience, we accept cash, personal or cashier's checks, VISA, MasterCard or Discover Card payments.

COSMETIC SURGERY

If you are scheduled for surgery that is cosmetic in nature and not covered by your health plan at a facility other than Greater Milwaukee Plastic Surgeons, S.C., we require that payment be made in full 14 business days prior to surgery. For your convenience, we accept cash, personal or cashier's checks, VISA, MasterCard, Discover Card or cosmetic financing payments. Prepayment is also required by the facility and anesthesiologist, however, these are separate billing entities and you will be informed of their payment policies when you schedule your surgery. We are not responsible for any charges or billing practices of a facility, anesthesiologist or healthcare personnel that are not affiliated with Greater Milwaukee Plastic Surgeons, S.C.

PATIENT RESPONSIBILITY FOR BILLED AMOUNTS

We will send you a statement of any remaining balance on your account after health plan payments are applied. Payment is due in full within 30 days from the date that appears on your billing statement. If you cannot make payment in full, you will need to contact our billing department to arrange a payment plan. If we do not receive payment from you within 60 day from the date of the first billing notice, we will attempt to contact you for payment. If we receive no further response within the next 30 days, your account may be turned over to our collection agency. IF YOUR ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY, YOU WILL BE RESPONSIBLE FOR ALL COLLECTION COSTS AND LEGAL FEES INCURRED.

MINORS

A parent or legal guardian must accompany a minor and consent to treatment. Parents or legal guardians must comply with the terms of this financial policy. The parent or legal guardian that accompanies the minor will be held responsible for payment of services.

MISSING, INACCURATE OR INCOMPLETE BILLING INFORMATION

You are responsible for notifying our office of any health plan or billing information changes. Failure to notify us of changes may result in your being responsible for any remaining balance on your account. Our practice will not be responsible for any billing errors, lack of coverage or payment due as a result of missing, inaccurate of incomplete information that you have provided us, including inaccurate information on secondary or third party payment coverage.

I have read and understand the *Patient Financial Policy* for Greater Milwaukee Plastic Surgeons, S.C. and accept all the terms and conditions as stated above. I have received a copy of this policy.

____ ________________________
Signature of Patient Date

____ ________________________
Signature of Minor patient's parent of legal guardian Relationship to patient

PHOTOGRAPHIC RELEASE AND CONSENT
For Greater Milwaukee Plastic Surgeons, S.C.

This is a consent document that has been prepared to help inform you concerning permission to take photographs, slides and/or videotapes and to use these images for a purpose as defined within this consent document. It is important that you read this information carefully and completely before giving your signature consent. ***Any sections below that do not apply or that you do not consent to may be crossed out. All sections crossed out must be initialed by the patient.***

Medical photographs, slides and/or videotapes may be taken before, during or after a surgical procedure or treatment. Consent is required to take such images. Additionally, patients may consent to release these medical photographs, slides and/or videotapes for a stated purpose.

1. CONSENT TO TAKE PHOTOGRAPHS/SLIDES/VIDEOTAPES FOR TREATMENT PURPOSES
I authorize the following physician and/or his associate to take pre-operative, intra-operative and post-operative (before, during and after procedure) photographs, slides and/or videotapes. I additionally consent to photographs, slides and/or videotapes of my interview with the physician and/or his associates. These photographs, slides and/or videotapes will become a permanent part of my medical record for treatment purposes. Checkmark the physician you are authorizing:

☐ Paul W. Loewenstein, M.D. ☐ Philip L. Sonderman, M.D. ☐ Thomas E. Kinney, M.D.

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPE FOR EDUCATIONAL AND/OR SCIENTIFIC SETTINGS. ***I understand and accept that I may be recognized from my likeness or case history.***

a. I authorize the above physician and/or his associate to use my photographs, slides, videotapes and case information in **educational and scientific settings** including lectures and multimedia presentations for an audience of medical professionals, at which members of the press may be present, and medical, surgical and scientific journal articles.

b. I authorize the use of my photographs, slides, videotapes and case information in the following **commercial/educational settings**: my physician's office patient education materials; my physician's file of pre- and post-operative patient photographs available to prospective patients for viewing in the office; newspaper and magazine articles in which my physician participates; television programs in which my physician participates; my physician's personal web site or web page; and lectures and multi-media presentations given by my physician for the general public.

c. I authorize my physician's professional associations, the American Society of Plastic Surgeons and the American Society for Aesthetic Plastic Surgery, to use my photographs, slides, videotapes and case information **in fulfilling its mission of public education**, in any of the following settings: patient education brochures available for purchase; educational videotapes available for purchase; lectures and slide presentations available for purchase; information submitted by the Societies to consumer periodicals, magazines and web sites for press or Internet publication; television programs about plastic surgery; and case studies presented on the Societies websites.

Patient Signature: ______________________________ Date: ______________

Patient's Printed Name: ______________________________