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PLASTIC SURGERY

Patient Contact Information as of ____/____/____

Full Name_____ ◯ M ◯ F **DOB**_____ **Age**_____

Address _____ City: _____ State: _____ Zip: _____

Home Phone_____ Cell Phone _____ Other Phone_____

SS# _____ - _____ - _____ Martial Status: ◯ SINGLE ◯ MARRIED ◯ DIVORCED ◯ WIDOWED ◯ OTHER

E-mail _____

May we e-mail you specials, promotions and updates? ◯ Yes ◯ No

How did you hear about us?

◯ Website ◯ Social Media ◯ Google ◯ Referring Physician _____ ◯ Friend/Family _____
◯ Other_____

Emergency Contact Name_____ **Relationship**_____

Address _____

Home Phone_____ Cell Phone _____ Other Phone_____

Employer_____ **Occupation**_____

Address _____

Home Phone_____ Cell Phone _____ Other Phone_____

Pharmacy_____ **Phone Number**_____

Primary Health Insurance Company (Insurance Procedures Only) _____

Policy Number_____ Group Number_____ Phone Number_____

Policyholder's First Name (if different)_____ Their DOB_____

Relationship to Policyholder (ex: Spouse, dependent)_____ Policyholder Employer_____

Secondary Health Insurance Company (Insurance Procedures Only) _____

Policy Number_____ Group Number_____ Phone Number_____

Policyholder's First Name (if different)_____ Their DOB_____

Relationship to Policyholder (ex: Spouse, dependent)_____ Policyholder Employer_____

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Patient Medical History as of ____/____/____

Full Name_____ ☐ **M** ☐ **F** **DOB**_____ **Age**_____

Reason for Consultation _____

Height _____ Weight _____ Normal Weight _____

Allergies or Intolerance to Medications:_____

_____

Current Prescription Medications (Name, Dosage, Frequency):_____

_____

_____

Current Over-the-counter Medications (Name, Dosage, Frequency):_____

_____

Medical History:_____

_____

Surgical History (Including hospitalizations, childbirth, etc.):_____

_____

_____

Anesthesia Problems:_____

Alcohol use: ☐ Yes ☐ No How often? ☐ 1-3/week ☐ 4-6/week ☐ 6+/wk ☐ Other_____

Tobacco use: ☐ Yes ☐ No How often? ☐ 1-3/day ☐ 4-6/day ☐ 6+/day ☐ Other_____

☐ Prior Tobacco Use: Duration of use:_____ Quit date:_____

Other recreational drug use: ☐ Yes ☐ No Type_____

Please date the following:

Physical Exam _____ Chest X-ray _____

12-Lead EKG _____ Pneumonia Vaccination _____

Mammogram _____ Findings:_____

Have you ever been tested for the following:

Tuberculosis ☐ Yes ☐ No Date of test:_____ Results: ☐ Positive ☐ Negative

HIV ☐ Yes ☐ No Date of test:_____ Results: ☐ Positive ☐ Negative

Hepatitis ☐ Yes ☐ No Date of test:_____ Results: ☐ Positive ☐ Negative

Family history of (Please list relation to relative):

☐ Cancer _____ ☐ Heart Disease _____

☐ Diabetes_____ ☐ Other_____

Primary Care Physician _____ **Phone Number**_____

Cardiologist _____ **Phone Number**_____

Pulmonologist _____ **Phone Number**_____

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Patient Medical History as of ____/____/____

Name_____ DOB_____ Age _____

Please answer the following:

Seizures or Epilepsy Last episode:_____ Frequency:_____	☐ Yes ☐ No	Deep Vein Thrombosis Date:_____	☐ Yes ☐ No
Any Other Neurological Disorder Type:_____	☐ Yes ☐ No	Asthma Last episode:_____ Frequency:_____	☐ Yes ☐ No
Cancer Type:_____	☐ Yes ☐ No	Any Pulmonary Disorder Type:_____	☐ Yes ☐ No
Immune Disorder Type:_____	☐ Yes ☐ No	Stroke Date:_____	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Peripheral Vascular Disease	☐ Yes ☐ No
Any Other Blood Disorder Type:_____	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Diabetes Diagnosis Date:_____ Last HgA1c:_____	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Hepatitis/Jaundice	☐ Yes ☐ No
Heart Attack Date:_____	☐ Yes ☐ No	Kidney Failure/Dialysis	☐ Yes ☐ No
Heart Failure	☐ Yes ☐ No	Depression/Other Mood Disorder	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No	Alcohol/Drug Dependency	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No

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HIPAA PATIENT CONSENT FORM

Our *Notice of Privacy Practices* provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment of health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment of health care operations
- The Practice has a *Notice of Privacy Practices* and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the *Notice of Privacy Practices*
- The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

Communicating Health Information to the Patient:

I may be contacted by (Check ALL that apply): ◯ HOME PHONE ◯ CELL PHONE ◯ EMAIL ◯ OTHER

Persons Authorized to be informed of my medical conditions, if any:

_____ Relation_____

_____ Relation_____

_____ _____

Print name (Patient or Representative) Relationship to Patient

_____ _____

Signature Date

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PLASTIC SURGERY

FINANCIAL POLICY

Your health and wellbeing are our primary concerns. We feel we provide the highest quality in plastic surgery available to our patients. It is important for our patients to understand the fees involved so they can consider their payment options. To avoid any misunderstanding, we wish to explain our office policy regarding payment or fees relating to your insurance supplemented or self-pay case.

Surgery Supplemented by Health Insurance

The most common misunderstanding about insurance is the belief that your policy will cover the total cost of surgical charges. Insurance is designed to reduce your costs; it is not pre-paid medical care. We remind our patients that insurance is considered a method of reimbursement not a substitute for payment. You will generally see three to four bills depending on the procedure you are having. All of these entities bill separately and you could have a bill from each. Facility, anesthesia and pathology is billed separately by the individual entities and not by Godat Plastic Surgery.

The amount that is due on your pre-op date is your unsatisfied deductible for the year and the estimate percentage of what your insurance will not pay. Any unpaid amount, within the reasonable and customary fees are regulated by the insurance company must be paid by the patient within 45 days from the billing date.

Cosmetic Surgery

To reserve a cosmetic surgery date, a non-refundable deposit of $1,000 is required, which will be applied towards Dr. Godat's surgery fee. The balance of the surgery fee is due on the pre-operative visit, which must be 7-30 days before surgery. Rescheduling less than 7 days prior to surgery may be subject to a $250 rescheduling fee. Any cancellations less than 7 days prior to surgery are subject to a $500 cancellation fee. There are no refunds on cosmetic procedures.

Outstanding Balance Policy

Payments for services rendered are due at the time of service. For insurance cases, our office will collect at the time of service estimated financial patient responsibilities and bill or refund any differences upon receiving an explanation of benefits from your insurance carrier, if applicable. Any account that becomes delinquent may be subject to additional charges. Our office will take necessary steps to collect this debt, which may include turning the account over to a collection agency.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE OR PRIOR TO THE SERVICE. WE ACCEPT CASH, PERSONAL CHECKS, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, AND CARE CREDIT.
I HAVE READ AND COMPLETELY UNDERSTAND THIS FINANCIAL POLICY.

Print name (Patient or Representative)	Relationship to Patient
Signature	Date

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PLASTIC SURGERY

PHOTO RELEASE FORM

Patient Name _____

I consent to the taking of photographs by David M. Godat, M.D., P.A. or his designee, of myself or parts of my body in connection with the plastic surgery procedure(s) to be performed by David M. Godat, M.D., P.A. I further authorize David M. Godat, M.D., P.A. or one of his/her associates to release to the American Society of Plastic Surgeons® ("ASPS®") such photographs.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of David M. Godat, M.D., P.A. and may be retained by David M. Godat, M.D., P.A. or released by David M. Godat, M.D., P.A. for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals, textbooks, or Web sites for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from David M. Godat, M.D., P.A.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below.

I understand that the information disclosed, or some portion thereof, may be protected by state law, and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because David M. Godat, M.D., P.A. is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA.

I release and discharge David M. Godat, M.D., P.A., ASPS, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____

Signature Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

_____ _____

Print name (Patient or Representative) Relationship to Patient

_____ _____

Signature Date