Osage Valley Plastic Surgery

985 Executive Drive Osage Beach, Mo 65065
Phone: 573-348-4863 Fax: 573-693-9052

Cosmetic Consultations are charged a $100 fee at the time of consult- if fee isn't collected you will receive a bill.

Date:_____ Main Phone:_____ Secondary Phone:_____

First Name: _____ Last Name: _____ M.I. _____

Address: _____City:_____

State: _____ Zip:_____ Email:_____

Social Security #_____ Date of Birth: _____ Sex: Male Female

Please Circle: Married Single Divorced Widowed Separated Domestic Partner

Primary Doctor's Name:_____ Referring Doctor:_____

Preferred Pharmacy: _____ Phone Number: _____

Whom may we thank for referring you? _____

In case of an emergency, who's notified? _____ Phone #_____ Relationship: _____

Patient Employer/School_____ Phone #_____

Employer/school address_____

Osage Valley Plastic Surgery has my permission to leave information on my answering machine, such as, test results, billing information, medical information, and appointment information.

☐YES ☐NO If we are unable to reach you, may we leave your information with someone specific?

Name: _____ Number: _____ Relationship: _____

Name of Primary Insurance_____ Name of policy holder_____

Date of birth of policy holder_____ Relationship to patient_____

Name of Secondary Insurance_____ Name of policy holder_____

Date of birth of policy holder_____ Relationship to patient_____

I certify that I, and /or my dependents(s), have insurance coverage with_____ and assign directly to Osage Valley Plastic Surgery 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 insurance. I authorize the use of my signature on all insurance submissions. The above named facility may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. Co-pays are required at the time of registration and self-pay payment the day services are rendered. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of patient, guardian or personal representative_____ Date_____

HEALTH QUESTIONAIRE

Name: _____ Age _____ Male or Female

Allergies

Please list all allergies: none

_____

Are you allergic to: latex | local | anesthetics | antibiotics | adhesive tape | None

Medications

Please list your current medications (or bring a copy to your appointment): none

_____

_____

Do you take: aspirin | ibuprofen (Aleve, Advil, etc.) | vitamin E | Fish Oil

Do you take: Coumadin | Plavix | Xarelto | Eliquis | Any other type of blood thinner?

_____

Family History

Please list any serious conditions that run in your family bloodline:

_____

_____

Medical History

Circle any diagnosed disorders

Pacemaker	Other prosthetic	HIV	Atrial Fibrillation	Anemia Asthma
Defibrillator	Organ transplant Diabetes	Hepatitis	Arthritis	Keloid scarring
High blood pressure	Thyroid disease	Liver disease	Mitral valve proplapse	Depression/Anxiety
Heart attack	Lymphoma	Gastric Reflux/Heartburn	Heart valve disease	High cholesterol
Stroke or mini-stroke	COPD	Kidney disease	Artificial joint	Back problems
Deep vein thrombosis	Cancer _____	Psychiatric disorder	Leukemia	
Pulmonary embolism	Gout	Keloid scarring	Heart Failure	

Do you have any other health conditions not listed on this form?

_____

_____

Social History

Do you drink alcohol? Yes | No

Do you smoke? Yes | No, if yes, for how long? ____ if no, have you ever? Yes | No How many years ago did you quit? _____

Surgical History

What surgeries have you had?

_____

_____

Height: _____ Weight: _____

Please sign your name and date, indicating that the above information is true and complete to the best of your knowledge.

Signature _____ Date _____

PATIENT POLICY

New Patients

New patient appointments are asked to arrive 10 minutes early for completion of necessary paperwork.

Please bring insurance cards, specialist co-pay according to your health insurance policy, and up to date medication list.

Cancellation Policy

If you are unable to keep a scheduled appointment, we require 24-hour prior notice of cancellation. If you do not give 24 hours' notice, you will be charged a $50 cancellation fee and may not be allowed to reschedule. Emergency situations will be handled on an individual basis.

Insurance

Our office will not bill insurance for any cosmetic procedure performed.

Not all procedures are covered by insurance. Our office will assist the patient with the pre-determination of benefits process to find out if your procedure will be covered by your insurance provider. We are in-network for the following insurance companies, Be advised, however, we are not in-network for all of the policies and groups for the listed companies and it is the patients responsibility to contact your insurance company to be sure we are in-network.

Blue Cross/Blue Shield (Blue Access Choice, Open Access), Healthlink, United Health Care, Tricare, Coventry, Healthlink, First Health, Cigna, Humana, Medicare and Railroad Medicare.

Be advised that we are out-of-network for most Healthcare Marketplace (Obamacare) plans and Missouri Healthnet (Medicaid). Please check with your insurance company before scheduling an appointment.

Financial Policies

We accept-Cash, Check, Cashier's Checks, American Express, Discover, MasterCard, Visa, Care Credit, and Prosper Healthcare Funding.

Payment for all services is due at the time of the service.

Any co-insurance/deductibles, per your insurance carrier, are your responsibility and are due within 30 days of notice. All

outstanding invoices of 90+ days will be automatically sent to collection without notice.

Cosmetic Surgery

10% deposit is due at the time of booking a cosmetic surgery. The surgeon and facility fees are due in full 10 days before the scheduled surgery. Cancellation within 10 days of surgery results in the loss of your 10% deposit. If notice of more than 10 days is given- patient will receive a full refund of their deposit minus the consultation fee.

Patient Signature: _____ Date: _____

Notice of Privacy Practices Acknowledgment- HIPAA POLICY

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature _____

Date _____

PHOTO CONSENT

As part of my consultation, I understand that photographs may be taken to record my pre-operative and/or post-operative status and will become part of my medical records.

Insurance covered procedures may require photographs to be sent to your insurance provider for pre-determination for payment of services.

_____ I give permission for photographs to be sent, if necessary, to my insurance provider for pre-determination for payment of services.

_____ I give my authorization for my before and after photographs to be shown to patients who are contemplating a similar procedure. Every attempt will be made to conceal my identity: however, I understand that photographs of facial procedures may not be able to conceal my identity.

_____ I DO NOT wish for my photographs to be shown to patients who are contemplating a similar procedure.

Signature _____ Date _____

PAIN MEDICATION AGREEMENT

Following a surgery performed by Dr. Huang, you will be given one prescription for pain medications that will last you approximately one week. There will not be any further refills of your pain medication after the first week following your surgery. No pain medications can be called in for you prior to having a surgical procedure with Dr. Huang unless you have been scheduled for an in office surgery.

Dr. Huang has the right to change directions and quantities of pain medications at his discretion. By signing below, you agree to these regulations and acknowledge that you have been informed of them.

Signature _____ Date _____