Central Coast Institute for Plastic Surgery

A MEDICAL CORPORATION

Gary R Donath, M.D.

DIPLOMATE, AMERICAN BOARD OF PLASTIC SURGERY, INC.

921 OAK PARK BLVD. SUITE 201 A
PISMO BEACH, CA 93449
805-544-6000
FAX 805-544-5460

AESTHETIC AND RECONSTRUCTIVE PLASTIC SURGERY

WWW.CENTRALCOASTPLASTICSURGERY.ORG

Last Name: _____ First Name: _____ Date of Birth: _____ Age: _____

Sex: **female** **male** Marital Status: **M** **S** **D** **W** Social Security: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cellular Phone: _____

Employer: _____ Occupation: _____

Work Phone: _____ May we contact you at work? **Yes** **No**

Email Address: _____

Reason for visit today _____

Method of Payment for Today's Visit: _____ Check _____ Visa / Mastercard / Discover

all returned checks are subject to a $25.00 fee

How were you referred to us?

○ Former Patient: _____ ○ Yellow Book - San Luis Obispo ○ Website (**be specific**) _____

○ Physician _____ ○ Publication: _____ ○ Other: _____

Who should we contact in case of an emergency?

Name: _____ Phone Number: _____ Relationship _____

Name: _____ Phone Number: _____ Relationship _____

RESPONSIBLE PARTY / INSURANCE SUBSCRIBER

NOTE: Please complete this section if different from patient information above.

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cellular Phone: _____

Employer: _____ Work Phone: _____

Please be sure to give our staff your Insurance card to copy

● CONSENT TO RELEASE OF INFORMATION ●
● ACCEPTANCE OF FINANCIAL RESPONSIBILITY ●
● HIPAA ACKNOWLEDGEMENT ●

Central Coast Institute for Plastic Surgery, A Medical Corp and Gary R. Donath, M.D. are providers for certain health plans. Please refer to the Financial Policy provided to determine whether we contract with your health plan.

♦ I authorize Central Coast Institute for Plastic Surgery to release all medical records pertaining to medical history, services rendered or treatment for me or my dependents for *insurance claims*.

♦ I agree as guarantor for the above patient or as the patient, to pay for medical services at the time of service, unless prior arrangements have been made.

♦ I understand that I am ultimately responsible for payment of medical services provided to me or my dependent, regardless of my insurance status, including co-payments, deductibles, co-insurance, and any amounts above my insurance's allowable and non-covered, cosmetic, or denied services.

♦ I have reviewed Central Coast Institute for Plastic Surgery's *Notice of Privacy Practices* pursuant to the *Health Insurance Portability & Accountability Act* of 1996 (HIPAA). I understand Central Coast Institute for Plastic Surgery has the right to change its notice from time to time and I have to right to contact this organization at any time to obtain a current copy.

Do you wish correspondence to be confidential? Yes No

Do you wish phone calls to be confidential? Yes No

I hereby authorize Central Coast Institute for Plastic Surgery to discuss my medical and payment information with:

1. _____ Relationship _____

2. _____ Relationship _____

3. _____ Relationship _____

_____ _____ _____

Patient/Guardian Signature Date Relationship

MEDICAL INFORMATION

Name: _____ Date: _____ Height: _____ Weight: _____lbs.

Allergies to medication_____

List known food allergies: _____

Are you allergic to latex? Yes No

Are you allergic to adhesives? Yes No

Do you wear contacts? Yes No

Do you wear dentures? Yes No

Do you have bleeding problems? Yes No

Any difficulties with anesthesia? Yes No

Current Medications / Vitamins / Other Dietary Supplements:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Date of last physical exam: _____, By Whom_____

Primary Care Physician: _____

Do you use the following?			***How often?***				***How often?***
Alcohol	Yes	No	_____	Aspirin	Yes	No	_____
Tobacco	Yes	No	_____	Illicit Street drugs	Yes	No	_____

Any medical problems with the following;

Epilepsy/Seizure	Yes	No	_____	Lungs	Yes	No	_____
Headaches	Yes	No	_____	Heart	Yes	No	_____
Eyes	Yes	No	_____	Blood Pressure	Yes	No	_____
Nose	Yes	No	_____	Liver/Hepatitis	Yes	No	_____
Ulcers	Yes	No	_____	Kidneys/Bladder	Yes	No	_____
Thyroid	Yes	No	_____	Unsightly Scars	Yes	No	_____
Other:	Yes	No	_____				

Please list any previous surgeries or hospital admissions, including childbirth?

Type	Date	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____

→ → → → → → → → → → → → → → → **OVER** → → → → → → → → → → → → → → → → →

Do you have any current medical conditions for which you are under treatment by a physician?

No Yes, Explain:

_____

_____

_____

_____

Please list below any family history of medical problems:

Mother: _____

_____

_____

_____

Sister: _____

_____

_____

_____

Father: _____

_____

_____

_____

Brother: _____

_____

_____

_____

Other: _____

_____

_____

_____

Other: _____

_____

_____

_____

Are there any other medical disclosures you would like the physician to know or that might be helpful in your medical care? No Yes, explain:

_____

_____

I declare that I have disclosed all requested medical information honestly and completely to Central Coast Institute for Plastic Surgery to the best of my knowledge.

_____ _____ _____

Print Name (Patient) Patient Signature Date

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Policy for Post-Operative Visits and Appointments

For patients who undergo surgery, there are a certain number of routine postoperative appointments that are scheduled at given intervals based on the procedure that was performed. In keeping with Medicare guidelines, there is no charge for ***routine visits within 90 days of surgery***. These appointments are a courtesy to you and it is important that you keep them. Our time is valuable and we appreciate that your time is valuable, too.

Our office staff contacts all patients by telephone in advance to confirm upcoming appointments. If we are unable to reach you, we will leave a message and ask that you call to confirm the scheduled appointment. If we do not hear back from you, we will assume you are not coming and give that time to another patient.

If your appointment is confirmed, and you fail to make it, you will be charged a fee of $25.00.

We realize that unexpected events do occur and ask that you let us know in advance if you cannot make an appointment. If the doctor is called to the emergency room, we extend the same courtesy to you by contacting you to reschedule your visit. Should you have an unexpected situation arise, such as a sick child, please contact the office immediately. You may leave a voice message after hours for the front office staff, who will obtain it at 8:30 a.m. the next business day.

Any follow-up appointments that are not <u>rescheduled or cancelled in advance</u> will result in a fee of $25.00 being billed to the patient.

I have read and understand the “Financial Policy for Missed Appointments” and have received a copy.

Patient's Signature: _____ Date: _____

Witness: _____