Associated Plastic Surgeons, S.C.
Otto J. Placik, M.D., F.A.C.S.

Date ____________________

Name ____ Home Phone ______________________
(first) (middle) (last)

Address ____ Work Phone_________________ext_____

City,State,Zip ____ Cell Phone______________________

Occupation____ Date of Birth_________Age ________

Employer/School____ Social Sec. #____________________

Email Address ____

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Referred By: [ ] Doctor ____________________ [ ] Hospital _____________________
[ ] Previous Patient (name)__________________________ [ ] Telephone Book _____
[ ] Internet (site) ____

Name of Spouse __________________________________Spouse Occupation______________________

Spouse's Employer ____________________ Business Phone ______________ Ext ______

Address ____

Has this office ever seen or treated any member of your family? Yes__ No

If yes, whom? ___________________________________ *(name & relationship)*_____________________

*Emergency Contact*________________________________ *Home Phone #*______________________
(not living with patient)

Relationship ______________________________________ Alternate Phone #_____________________

** * PLEASE PROVIDE YOUR INSURANCE CARD(S) FOR PHOTOCOPYING PURPOSES * * **
(NON- COSMETIC PATIENTS ONLY)

Insurance Company______________________________ Insurance Company _______________________

Insured Party___________________________________ Insured Party ____________________________

Date of Birth____________________________________ Date of Birth _______________________________

Employer Insurance Plan Yes__ No__ Employer Insurance Plan Yes ___ No

PERSON Financially Responsible *(other than patient)*: [ ] Spouse [ ] Parent [ ] Other

Name ____

Address ____

Occupation _____________________________ Employer ____

Business Address __________________________ Business Phone __________________________________

FIRST VISIT: Complete all sections EXCEPT shaded boxes.

PRE OP: Update form, complete shaded boxes & sign at bottom.

Patient's full name: ____ Date: ______________
first middle initial last

Age: ______ Sex: ☐ Male ☐ Female

Stated Height: ______ Weight: ______ Stable: ☐ No ☐ Yes

Exercise: ☐ No ☐ Yes Describe: __________________________

Home Phone: ( )
Work Phone: ( )
Cell Phone: ( )

PRESENT PROBLEM/CONCERN, WHICH BRINGS YOU HERE?

____

Have you consulted with other physicians?: ☐ No ☐ Yes: Personal physician's name: ______________________

If yes, their names: ______________________ Phone: ( ) _______-______________

Interview via: ☐Intake History ☐ Phone ☐ Prior to surgery Source: ______________________

PAST/PRESENT SERIOUS ILLNESSES

	Yes	No		Yes	No		Yes	No
Heart disease (past/present)?			Hepatitis? Type? ________			Glaucoma?		
Blood pressure disorder?			HIV+/AIDS?			Corneal Abrasions?		
Mitral Valve Prolapse?			Total joint surgery? Where? ____			Dry Eyes Syndrome?		
Rheumatic fever?			Arthritis?			Thyroid disease?		
Irregular heart beat?			Jaw/Neck/Back pain or stiffness?			Kidney disease?		
Pacemaker? Date: ________			Poor wound healing/Keloid?			Diabetes (IDDM/NIDDM)?		
Chest pain/pressure?			Parkinson's disease?			Cancer? Type? ________		
Lung disease?			Multiple Sclerosis?			Blood clots?		
Asthma/Wheezing (Hospital)?			Motion sickness/Faint/Dizziness?			Bleeding or bruising problems?		
Emphysema/Bronchitis?			Stroke (past/present)?			Blood transfusions?		
Tuberculosis (exposure)?			Seizure disorder (past/present)?			Anemia?		
GI disease? Irritable bowel?			Severe headaches/Migraine?			Sleep apnea?		
Ulcers/Reflux/Hiatal hernia?			Psychologic disease/Depression?			Other Illness/Injury? ________		
Liver disease/Jaundice?			Special needs/communication			**Cold in last 2 weeks? DATE: __**		

Comments:____

PREVIOUS SURGERY & ANESTHESIA: ☐ No ☐ Yes **(include ALL COSMETIC / PLASTIC SURGERY PROCEDURES):**

SURGERY TYPE	DATE OF SURGERY	TYPE OF ANESTHESIA	ANESTHESIA PROBLEMS
1.			
2.			
3.			
4.			

NAMES OF DAILY HOME MEDICATIONS (include Birth Control Pills)		HERBAL MEDS / VITAMIN & DIETARY SUPPLEMENTS	
1.	5.	1.	5.
2.	6.	2.	6.
3.	7.	3.	7.
4.	8.	4.	8.

Aspirin / NSAIDS (Motrin/ Advil) / Coumadin: ☐ No ☐ Yes Last Taken:

Steroids in last 6 months? ☐ No ☐ Yes

HABITS:	NEVER	FREQUENCY daily use	# YEARS	DATE LAST USED	ABUSE/INTERVENTIONS?
Tobacco		packs/day			
Alcohol		ounces/day			
Caffeine		glasses/day			
Drugs Used:					

FEMALES: # Pregnancies: ______ # Children: ______ Average weight gain: ______ or Anticipated pregnancy? ☐ No ☐ Yes

Could you be pregnant? ☐ No ☐ Yes Date of last menstrual period:_______________

ALLERGIES: ☐ No ☐ Yes (include food & latex & tape, list; if yes, describe reaction):______________________

____

*** **Distinguish ALLERGY (shock, hives & throat swelling) from ADVERSE REACTION (nausea & stomach upset)** ***

Patient/Guardian (initials):_______ Date: ________ **Patient/Guardian (initials):_______ Date: ________**

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THIS MUST BE SIGNED TO RECEIVE A WRITTEN QUOTE

ELECTIVE SURGERY FINANCIAL AGREEMENT

Many factors combine to determine the ultimate outcome with elective cosmetic surgical procedures. The exact same technical procedure performed on ten different patients will yield ten slightly different outcomes. This is because each person is genetically different, heals differently, has different skin tone, bruises differently, and procedures are tailored to you as an individual. I have tried to be as honest as possible in order to paint the average postoperative case scenario and outcome with your procedure. **The need to perform minor revisions or touch-ups is infrequent but possible. In the event that this is necessary in the postoperative period the following will apply:**

1). Any revisions performed under local anesthesia or minor sedation administered by the surgeon in an office-based setting will be done at a minimal charge to cover for supplies.The surgeon has to agree that the revision will improve the patient's concern.

2). Any revisions or secondary procedures performed that require nursing support and a certified nurse anesthetist, anesthesiologist or certified surgical technician will be charged no surgeon's fee but will incur the minimum cost **(anesthesia/facility)** related to their revision procedure. In general, as these more major revisions will not be performed until six to nine months post-operatively, the surgeon has to agree that the revision will improve the patient's concern. After fourteen months a minimal surgeon's fee may apply.

3). If the patient and surgeon are satisfied that the original operation met the planned goals, but the patient wants further improvement then this constitutes a new procedure.

Examples are:

A). Wanting to further increase breast size nine months after the initial breast augmentation.

B). With liposuction procedures, any revision due to weight gain over the baseline pre-operative weight constitutes a new procedure in the same anatomic location.

C). Getting significant shape and contour improvements with liposuction and eight months after working out with weight loss wanting more muscle definition or shape to be evident.

D). The surgeon has to agree that further surgery will again help the patient with minimal risks.

A minimal surgeon's fee may apply, however the standard rates for anesthesia and facility will apply

4) BREAST/ IMPLANT SURGERY: In order to ensure that all arrangements are set in advance of your surgical Procedure, we require that breast and other implants be ordered two (2) weeks prior to your surgery date. Any changes within the two (2) week deadline necessitate RUSH shipping charges as well as staff time, and therefore will incur a **$50.00 restocking fee.**

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ELECTIVE SURGERY FINANCIAL AGREEMENT

On occasion the best made plans have to be changed. I understand this and will always work with you if you need to cancel surgery unexpectedly. However, if you cancel without good cause, a penalty will apply. **When you make a commitment to a surgery date, other patients lose the opportunity of scheduling that date, the doctor makes a commitment to you for his time, special garments and implants have been ordered, and arrangements are made with nursing and anesthesia personnel to work on that date.**

In order to reserve a date for your procedure, we ask that you pay a $500.00 non-refundable "reservation fee". "Full payment" is due four weeks prior ("closing date") to the procedure in order to confirm the reserved time slot. If full payment is not received four weeks pre-operatively, the reserved date may be forfeited to another individual. The following rules apply to the full payment excluding the non-refundable $500.00 reservation fee.

1). There is no penalty if you cancel more than four weeks before surgery and have paid in full (excluding the reservation fee). There is no penalty if you cancel after the closing date due to illness and reschedule your procedure within 45 days. If you cancel between the closing date and two weeks before your surgery, **and do not reschedule within 45 days**, 10% of the total procedure cost will be withheld (surgeon's fee/anesthesia/facility) in addition to reservation fee of $500.00. **In addition,** the cost of any implants, garments or special devices already purchased at the time of cancellation will be withheld. **Initials**_______________

2). If you cancel in any of the two weeks before surgery **and do not reschedule within 45 days,** 25% of the total procedure cost will be withheld (surgeons fee/anesthesia/facility), in addition to the reservation fee. **In addition,** the cost of any implants, garments, or special devices already purchased at the time of cancellation will be withheld. **Initials**_______________

3). If you cancel in any of the 3 days before surgery **and do not reschedule within 45 days,** 50% of the total procedure cost will be withheld (surgeon's fee/anesthesia/facility), in addition to the reservation fee of $500.00. **In addition,** the cost of any implants, garments or special devices already purchased at the time of cancellation will be withheld. If you do not reschedule in 45 days, an additional $300.00 charge will be added to cover the operating room personnel expenses by your initial cancellation the day of surgery. **Initials**_______________

4) The balance of monies owed will be refunded within ten days after the cancellation unless you have rescheduled your procedure.

5). In the event that external collection services become necessary to obtain payment, you will pay all collection agency fees, returned check fees and attorney fees, as well as court costs associated with such collections. You agree that all attorney's and collection agency fees that do not exceed one-third of the account balance are reasonable and you agree to pay the same.

You will find that this goes beyond what other plastic surgeons offer and is spelled out clearly. I do my best to ensure your satisfaction as my patient and want your procedure to be a positive experience that you will tell your friends and family about. Please ask any questions to clarify the above policy.

PLEASE NOTE THAT AN ADMINISTRATIVE FEE OF 5% WILL BE CHARGED FOR FILING CLAIMS TO YOUR INSURANCE CARRIER

I have read the above policy on revisions & cancellations and understand and agree to abide by it.

Patient____**Date**_________

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INSURANCE PAYMENT
MEDICAL INFORMATION
AUTHORIZATION

I authorize the release of medical or other information to my insurance company and authorize payment of medical insurance benefits to be issued to:

Associated Plastic Surgeons, S.C.
Tax ID# 36-2821079
Otto J. Placik, M.D., F.A.C.S.

880 West Central Road, Suite 3100
Arlington Heights, IL 60005

I permit a copy of this authorization to be used in place of the original. I agree to pay any remaining balance after insurance payment has been made.

PLEASE NOTE THAT AN ADMINISTRATIVE FEE OF 5% WILL BE CHARGED FOR FILING CLAIMS TO YOUR INSURANCE CARRIER.

Signature____ Date __________________

WE ARE NOT A PARTICIPATING PROVIDER IN YOUR INSURANCE PLAN. IT IS YOUR RESPONSIBILITY TO CONTACT YOUR INSURANCE CARRIER TO VERIFY THAT OUR SERVICES ARE COVERED UNDER YOUR SPECIFIC POLICY.

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PATIENTS UNDERGOING ELECTIVE COSMETIC SURGERY ONLY

I have received the policies (PREVIOUS PAGE) regarding the elective surgery financial agreement.

Signature ____ Date __________________

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AUTHORIZATION FOR RELEASE OF MEDICAL PHOTOGRAPHS/DIGITAL IMAGING

Photographs are an important part of the medical record. These photographs are used to track your progress and response to surgery.

BY SIGNING THE CONSENT BELOW, YOU WILL BE CONTRIBUTING TO OUR PHOTOGRAPHIC LIBRARY. YOUR SIGNATURE WILL ALLOW YOU THE PRIVILEGE OF VIEWING BEFORE AND AFTER PHOTOGRAPHS.

INSTRUCTIONS

This is a consent document that has been prepared to help inform you concerning permission to take photographs, and or digital imaging 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. After reviewing, please sign the consent as proposed by your plastic surgeon.

INTRODUCTION

Medical photographs and or digital imaging 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 photography and or digital imaging for a stated purpose.

CONSENT TO TAKE PHOTOGRAPHS/DIGITAL IMAGING

I hereby authorize Otto J. Placik, M.D. and his associates or licensees to take pre-operative, intraoperative, and postoperative photographs, and or digital imaging. I additionally consent to photographs, and/or digital imaging of my interview.

CONSENT FOR RELEASE OF PHOTOGRAPHS/DIGITAL IMAGING

I hereby authorize Otto J. Placik, M.D. and or his associates or licensees to use pre-operative, intra-operative, and postoperative photographs, slides and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on electronic digital networks, television, for the purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

Signature____Date ______________

Witness____