New Patient Form

Name: ____ **Date of Birth**: ____/____/____

Address: ____ **Zip Code**: _______________

Home Phone: (_______)________________________ **Cell Phone**: (_______)________________________

Email Address: ____

Pharmacy Name & Phone #: ____

Emergency Contact: ____ **Phone #:** (_____)________________

Primary Doctor (& city of practice): ____

Referral Doctor (& city of practice): ____

Current gender identity (check all that apply): ☐Male ☐Female ☐Other (specify): _____________

☐Transgender Male ☐Transgender Female ☐Non-binary ☐Decline to answer

Sex assigned at birth (check one): ☐Male ☐Female ☐Other ☐Decline to answer

Pronoun (check all that apply): ☐He/him/his ☐She/her/hers ☐He/him/his

☐They/them/theirs ☐Other:_________________

Reason for visit today: ____

Current Medications (list all, including vitamins): ____

____

Medical Problems (please check all that apply):

☐Diabetes
☐High Blood Pressure
☐Heart Disease
☐Asthma or COPD
☐Family history of blood clots

☐Bleeding disorder or blood clots (DVT)
☐History of recurrent miscarriages
☐Varicose veins or leg swelling
☐Sleep Apnea

☐Pacemaker/Defibrillator
☐History of radiation & when/where on body:
____
☐History of chemotherapy & when completed:
____

Drug Allergies AND reaction: ____

***Are you allergic to the following** (circle Y or N): Latex – Y / N Iodine – Y /N CT contrast dye – Y / N

Surgical History:

☐Mastectomy: L R Both
☐Lumpectomy: L R Both
☐Tummy Tuck

☐C-Section
☐Hysterectomy
☐Gall Bladder

☐Appendix
☐Other Breast Surgery:
____

☐Other Surgeries: ____

Do you smoke, vape, or use any form of tobacco/nicotine? YES NO

Height: ________________ **Weight:** ________________

Consent to Medical Care and Treatment

I consent to all medical and surgical care, examinations, and tests, which are determined to be necessary to me, while I am a patient of Midwest Breast & Aesthetic Surgery. I understand that the practice of medicine and surgery is not an exact science and that medical treatment may involve risks, injury, or even death. I acknowledge that no guarantees have been made to me as to the result(s) of any treatment, procedure, or examination to be performed on me while I am a patient of this practice.

____

Signature Date

Privacy Notice:

I hereby acknowledge that a copy of the Notice of Privacy Policy was made available to me by Midwest Breast & Aesthetic Surgery on the date indicated below.

____

Signature Date

Release of Information:

In order to ensure patient confidentiality, it is the policy of this office to release information only to the patient. If you wish for any others to receive ANY information regarding your care, you must sign the authorization form on the following page. By signing this release, you are giving Midwest Breast & Aesthetic Surgery permission to release medical information to your referring physician, your insurance company, and any other treating physicians, therapists, or hospitals.

I give permission for Midwest Breast & Aesthetic Surgery to release my medical information to the following people (in addition to those listed above):

NAME RELATIONSHIP TO PATIENT

____

____

If we are unable to reach you personally, do we have your permission to leave a message on your voicemail or answering machine? (circle one) YES NO

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the named health care provider to release the information or records specified to Midwest Breast & Aesthetic Surgery upon request in person or by mail to the address specified at the time of the request. **PLEASE FAX RECORDS TO (855)687-6227**

Provider (name & address):

____

____

____

Patient: __________________________

SSN: ____________________________

DOB: ____________________________

RECORDS AUTHORIZED TO BE RELEASED:

- Surgery & operative notes
- Lab reports
- Radiological images
- Other (specify): ____

Dates: ____

Extent or nature of records to be released (example, specific hospitalization or visit):
____

This information will be used for the purpose of:

- Investigating an allegation of abuse
- Providing advocacy services
- Verifying my eligibility for services offered by Midwest Breast & Aesthetic Surgery
- Legal representation
- Other activities at the request of the individual

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the health care provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization and that my health care or payment will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that Midwest Breast & Aesthetic Surgery may re-disclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original

Patient/Representative: ____Date:___/___/___

Printed name: ____ Relationship to Patient: __________

Photography Consent

Name: ____ Date of Birth: _____________

I consent to the taking of medical photographs by Midwest Breast & Aesthetic Surgery in connection with the plastic surgery procedure(s) intended or performed. I understand that photographs may be taken before, during, and after my procedure(s) for insurance purposes and as a routine part of my medical care.

Signature:____ Date:_________

Release of Photographs Consent

Additionally, I authorize the use of my photographs in the formats listed below. I waive any right to inspect or approve the finished product, advertising, or other copy that may be used in connection with the options below. I understand that Midwest Breast & Aesthetic Surgery will make every effort to exclude or reduce all identifying features and that these photographs will *never* be used with any identifying information, such as my name- as it may be I also acknowledge that it is still possible that someone may recognize me.

(Please initial YES or NO for each of the items below)

___YES ___NO for our **office photo gallery** to help future patients understand and see outcomes from surgical procedures with Midwest Breast & Aesthetic Surgery.

___YES ___NO on our **website, affiliated websites or in marketing materials** for prospective patients to see and understand outcomes from surgical procedures with Midwest Breast & Aesthetic Surgery.

___YES ___NO for **educational, lecture and training** use by Midwest Breast & Aesthetic Surgery and medical health professionals.

I release and discharge Midwest Breast & Aesthetic Surgery 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 photographs.

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

Printed name: ____ Date: ____________

Signature: ____

Witness: ____

Insurance Information

Insurance Carrier: ____

Name of Policy Holder: _________________________________ Employer: _______________

Relationship to Policy Holder:____

Policy Holder's Date of Birth: ________________ Policy Holder's SSN: ___________________

Member ID: _________________________________ Group #: _________________________

ADVANCED NOTICE OF NON-PARTICIPATING PROVIDERS

In an effort to optimize patient care and to give each patient the best experience possible, our practice enlists the services of physician assistants (Maggie Deardurff, PA-C, Michaelle Palmer, PA-C and Kaitlyn Schimmoeller, PA-C) on revisionary surgeries. These services are provided by **PTEK Solutions, LLC** which does not have network contracts with commercial insurance payers. However, we are very sensitive toward healthcare costs, and we work diligently to provide the best healthcare services at a fair and affordable cost. PTEK Solutions, LLC *does not employ a collection agency*, and they will work with you and your insurance company **to ensure that your financial liability does not extend beyond your current cost share from in-network deductible, copay, and coinsurance.** You may receive PTEK Solutions payments from your insurance provider. As such, you may be contacted to arrange for payments to be forwarded to PTEK Solutions. We appreciate your understanding, and should you have additional questions, please direct them to Bre in our office or PTEK Healthcare Solutions Office: (614)405-7293, Fax: (614)405-7293

Please initial/date that you have read and understand the above notice: ________________

initial & date

If desired, a copy of this notice is available upon request.