THE CENTRE, P.C.
COMPREHENSIVE PLASTIC SURGERY
Because You Deserve The Best

Patient Information Form

Patient

Last Name: _____ First Name: _____ Mid ____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Preferred Email: _____

Gender ☐ F ☐ M Social Security Number _____ Ethnicity: Hispanic or Latino ☐ No ☐ Yes

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Unknown

Race: ☐ Black ☐ American Indian/Native ☐ Hispanic/ Latino ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Other

Employer

Employer Name: _____ Address: _____ Phone: _____

List your Occupation (including basic duties): _____

Is this a work-related injury? ☐ Yes ☐ No Supervisor's Name: _____

How did the injury occur? _____

Spouse/Guardian/Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Do you give consent to the above contact to discuss your medical information in your absence or should you be unable to speak? ☐ Yes ☐ No

Insurance

	Primary	Secondary
Ins. Co Name		
Ins. Co Address		
Ins. Co, City/State/Zip		
Policy Holders' Name		
Group Number		
Policy Number		
Employer		

Visit Reason

Reason for today's visit? _____

How did you hear about us? (ex. TV, radio, social media, etc. – list) _____

Who may we thank for referring you to us? _____

Have you had prior surgery on this area? ☐ Yes ☐ No If so when and where? _____

Were you referred by another physician? ☐ Yes ☐ No Physicians Name _____

Primary Care Physician _____ Phone # _____

FAMILY HEALTH BACKGROUND

Do any of your blood relatives have the following?

	Yes	No	Relationship to Patient	Age if Living	Age of Death & Cause of Death
Allergies	□	□			
Birth Defects	□	□			
Blood Disorder	□	□			
Breast Disease	□	□			
Cancer-List _____	□	□			
Diabetes	□	□			
Genetic Defects	□	□			
Heart Disease	□	□			
High Blood Pressure	□	□			
Lung Disease	□	□			
Other	□	□			

Women Only: Are you Pregnant? □ Yes □ No □ Unsure Week# _____

Consumption of the following:		**Amount/#**	**Circle one:**
Alcohol	□ Yes □ No	_____	Daily or Weekly
Aspirin	□ Yes □ No	_____	Daily or Weekly
Ibuprofen (Advil, Motrin, Nuprin)	□ Yes □ No	_____	Daily or Weekly
Tylenol	□ Yes □ No	_____	Daily or Weekly
Caffeine (pop, coffee)	□ Yes □ No	_____	Daily or Weekly

Tobacco Products:		Former Smoker		Never Smoked		Current Smoker		Social Smoker		
Check what applies:		Cigars		E-Cigarettes		Nicotine Gum		Chewing Tobacco		Patches
		Vaping								

Do you presently have or have you ever experienced the following?

Yes	No		Yes	No		Yes	No		Yes	No	
□	□	Acne	□	□	Chicken Pox	□	□	Herpes	□	□	Scarlet Fever
□	□	AIDS/HIV	□	□	Cold Sores	□	□	High Blood Pressure	□	□	Seizure/Epilepsy
□	□	Alcohol Abuse	□	□	Colitis	□	□	Hospitalized	□	□	Shingles
□	□	Anemia	□	□	Congenital Heart Defect	□	□	Kidney Problems	□	□	Sickle Cell Disease
□	□	Anxiety	□	□	Coronary Artery Disease	□	□	Liver Problems	□	□	Sinus Problems
□	□	Arthritis	□	□	Diabetes	□	□	Low Blood Pressure	□	□	Stroke
□	□	Artificial Bones/Joints	□	□	Difficulty Breathing	□	□	Mental Illness/Depression	□	□	Sun Exposure
□	□	Artificial Valves	□	□	Drug Abuse	□	□	Mitral Valve Prolapse	□	□	Tanning Products
□	□	Asthma	□	□	Eczema/Rosacea/Psoriasis	□	□	MRSA	□	□	Thyroid Problems
□	□	Auto Immune Disease	□	□	Emphysema	□	□	Neuromuscular Disorder	□	□	Tonsillitis
□	□	Bell's Palsy	□	□	Fainting Spells	□	□	Pacemaker	□	□	Tuberculosis
□	□	Beta Thalassemia's	□	□	Frequent Headaches	□	□	Persistent Cough	□	□	Undiagnosed Cough
□	□	Cancer – List	□	□	Glaucoma	□	□	Radiation Treatment	□	□	Ulcers
□	□	Cardiac Stents	□	□	Hay Fever	□	□	Reproductive Disorder	□	□	Venereal Disease (VD)
□	□	Chemotherapy	□	□	Hepatitis	□	□	Rheumatic Fever			

Blood Disorder: □ None ***Other not listed:*** _____

Circle if any applies: Abnormal bleeding Clots Cryoglobulinemia Hemophilia

Previous Surgeries: (type, when, where) □ None

Are you allergic to any of the following?

□ Yes	□ No	Aspirin	□ Yes	□ No	Codeine	□ Yes	□ No Phenol
□ Yes	□ No	Barbiturates	□ Yes	□ No	Jewelry	□ Yes	□ No Sedatives
□ Yes	□ No	Eggs	□ Yes	□ No	Latex	□ Yes	□ No Sulfa Drugs
□ Yes	□ No	Erythromycin	□ Yes	□ No	Penicillin	□ Yes	□ No Tetracycline

□ Yes	Other_____
□ Yes	Other_____
□ Yes	Other_____
□ Yes	Other_____

Medications (include prescription and non-prescription medications that you are currently taking) – I take no medications ☐

Name	Dosage	How Often	Name	Dosage	How Often

REVIEW OF SYSTEMS (within the last month have you had…)

CONSTITUTIONAL		EYES, EARS, NOSE & THROAT		EXTREMITIES	
☐ Yes ☐ No	Weight loss; If so, how much? _____lbs.	☐ Yes ☐ No	Sinus infection/pain	☐ Yes ☐ No	Redness of a limb
☐ Yes ☐ No	Decrease in energy	☐ Yes ☐ No	Ear pain	☐ Yes ☐ No	Swelling of a limb
☐ Yes ☐ No	Decrease in appetite	☐ Yes ☐ No	Change in hearing	☐ Yes ☐ No	Discoloration of a limb
☐ Yes ☐ No	Night sweats	☐ Yes ☐ No	Eye pain		
☐ Yes ☐ No	Fever; If so, how high? _____	☐ Yes ☐ No	Change in vision	**SKIN/INTEGUMENTARY**	
HEMATOLOGIC		☐ Yes ☐ No	Nasal discharge	☐ Yes ☐ No	Abnormal growths
☐ Yes ☐ No	Cold intolerance	☐ Yes ☐ No	Throat pain	☐ Yes ☐ No	Lesions
☐ Yes ☐ No	Easy bruising	☐ Yes ☐ No	Sleep Apnea	☐ Yes ☐ No	Jaundice
☐ Yes ☐ No	Nosebleeds, rectal bleeding or bleeding at other sites	**NEUROLOGICAL**		☐ Yes ☐ No	Rashes
		☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Ulcers
GASTROINTESTINAL		☐ Yes ☐ No	Troublesome or frequent headaches	**MUSCULOSKELETAL**	
☐ Yes ☐ No	Difficulty swallowing food	☐ Yes ☐ No	Recent change in vision	☐ Yes ☐ No	Arthritis
☐ Yes ☐ No	Pain with swallowing food	☐ Yes ☐ No	Recent change in hearing	☐ Yes ☐ No	Back pain
☐ Yes ☐ No	Indigestion	☐ Yes ☐ No	Change in ability to feel things	☐ Yes ☐ No	New back pain
☐ Yes ☐ No	Nausea	☐ Yes ☐ No	Painful sensations	☐ Yes ☐ No	Bone pain
☐ Yes ☐ No	Vomiting	☐ Yes ☐ No	Decrease in muscle strength	☐ Yes ☐ No	Muscle soreness
☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No	Decrease in ability to ambulate	☐ Yes ☐ No	Recent trauma or fractures
☐ Yes ☐ No	Abdominal bloating	☐ Yes ☐ No	Experience memory loss		
☐ Yes ☐ No	Black stools	**RESPIRATORY**		**PSYCHIATRIC**	
☐ Yes ☐ No	Blood from the rectum	☐ Yes ☐ No	Blood in sputum	☐ Yes ☐ No	Change in mood
CARDIAC		☐ Yes ☐ No	Coughing or changes in cough	☐ Yes ☐ No	Experience anxiety
☐ Yes ☐ No	Chest pain	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No	Change in behavior with family
☐ Yes ☐ No	Palpitations	☐ Yes ☐ No	Mucous production with cough	☐ Yes ☐ No	Change in ability to think
☐ Yes ☐ No	Shortness of Breath	**GENITOURINARY**		☐ Yes ☐ No	Losing track of where one is, what time it is or who one is with
☐ Yes ☐ No	Fatigue	☐ Yes ☐ No	Burning with urination		
☐ Yes ☐ No	Decrease in ability to exert oneself	☐ Yes ☐ No	Blood in urine		
☐ Yes ☐ No	Episodes of shortness of breath at night	☐ Yes ☐ No	Increase in need to urinate	☐ Yes ☐ No	Increase in need to urinate at night

I affirm under the penalties of perjury that the above statements are true.

_____ _____

Patient Signature **Date**

_____ _____

Parent/Guardian **Date**

*****If updating and verifying previous information, please initial that all information is correct.**

CONSENT FOR PHOTOS OR VIDEO RECORDINGS, COMMUNICATION BY EMAIL/TEXT MESSAGE, TRANSMISSION OF PROTECTED HEALTH INFORMATION (PHI), OR TELEHEALTH CONSULTATION

PHOTOGRAPHIC RELEASE AND CONSENT

I, AGREE that The Centre, P.C. ("The Practice") or designated representatives of The Practice may take and use preoperative and postoperative photographs of my person for confidential clinical record purposes and such other purposes ***AS I HAVE INITIALED BELOW*** and stated photographs shall remain the property of The Centre, P.C.

I fully and specifically grant my permission for the use of photographs, videotapes or case information for the following additional purposes as **indicated by my initials below**. As a result of this use, I understand that these photographs, videotapes, or case information may appear in other related, updated, or reprinted formats at any concurrent or future occasion. I understand that such consent is strictly on a voluntary basis. I understand a copy of this consent may be supplied with the images to any third party wherein they may be published or presented. I understand some photographs may, by their representation make me identifiable in appearance to others. I authorize The Centre, P.C. to use my photographs, videotapes, and case information in the following educational and scientific settings which I have initialed:

_____ The Practice's or my surgeon's file of pre- and postoperative patient photographs available to prospective patients for viewing in the office and on-line.

_____ Newspaper and magazine articles in which The Practice or my surgeon participates.

_____ Television programs in which my surgeon or The Practice participates.

_____ My surgeon's professional web site or web page.

_____ Lectures and multimedia presentations given by my surgeon or provider for the general public.

_____ Social media including Facebook, Instagram, Twitter, Pinterest, and any future social media streams.

****

NO USE OF MY PHOTOGRAPHS IS AUTHORIZED AS PER MY SIGNATURE BELOW.

Patient Signature _____ Date _____

RELEASE OF PHOTOGRAPHS AND/OR VIDEO RECORDINGS (FOR ADVERTISING PURPOSES)

Voluntary participation

I understand I am voluntarily agreeing to allow The Centre, P.C. to use my photographs and/or video recordings ("Content") in product/service-related advertising, online media, 3rd party vendor advertising and promotion. I waive any right of inspection or approval of the photographs/video recordings prior to use as stated above. I agree The Centre, P.C. is under no obligation to use the "Content," as defined below.

Grant of Rights to Content

I agree that The Centre, P.C. may take photographs and/or video recordings of me in connection with product/service-related advertising, online media, 3rd party vendor advertising and promotion. The Centre, PC shall be the exclusive owner of the photographs and/or video recordings (collectively "Content"), whether included in related advertising and promotion, or not, including all associated rights and intellectual property rights, throughout the universe in perpetuity. I further agree that The Centre, P.C. has the unlimited and unrestricted right and permission to copyright, use, re-use, publish, re-publish, distribute, publicly display, publicly perform, make derivative works and license others to use, in any manner, the photographic portraits, pictures and/or video recordings of me in which I may be included, in whole or in part, or reproduction thereof in color or otherwise, made through any and all media now or hereafter known, for illustration, promotion, advertising, commerce, or any other purpose whatsoever throughout the universe in perpetuity. I

further agree that The Centre, P.C. may transfer any and all of their rights hereunder as it sees fit.

I expressly waive any and all moral rights I may have in connection with Content. I represent that any statements made by me are true, to the best of my knowledge, and that neither they nor use of the Content will violate or infringe upon the rights of any third party. I acknowledge that The Centre, P.C. will rely on this permission, at substantial cost to them, and hereby agree not to assert any claim of any nature whatsoever against anyone relating to the exercise of the permission granted hereunder.

Release of Claims

Further, I do for myself, my heirs, legal representatives and assigns hereby release, waive and discharge The Centre, P.C. and its officers, directors, employees, agents, affiliates and other representatives ("Released Parties") of all liabilities, claims, actions, damages, costs, or expenses (including attorneys' fees) which I may have against them of any nature arising out of or resulting from my appearance in the content or related advertising promotions for claims for defamation, misappropriation of the right of publicity and/or invasion of privacy or other legal theories related to this Release.

Indemnification

I agree to indemnify and hold harmless The Centre, P.C. and its respective officers, directors, employees, agents, affiliates, assigns and other representatives from and against any and all claims, damages, liabilities, costs, and expenses (including attorneys' fees) arising from my statements being untrue, or the use of my photos or images infringing on any third party.

Please check by your initials your appropriate response below:

	I am over 18 years of age. I have read and fully understand and **DO voluntarily sign this irrevocable Release and Waiver** and further agree that no oral representation or other inducements apart from this written agreement have been made. I understand that this is the entire agreement between The Centre, P.C. and me.
	I am over 18 years of age. I have read and fully understand and **DO NOT agree to voluntarily sign this irrevocable Release and Waiver** and further agree that no oral representation or other inducements apart from this written agreement have been made.

COMMUNICATION BY EMAIL & TEXT MESSAGE

It may become useful during the course of treatment to communicate by email, text message (e.g., "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with The Centre, P.C./L.L.C. there is a reasonable chance that a third party may be able to intercept those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer if you use your work email to communicate
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I consent to allow The Centre, P.C./L.L.C. to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Appointment Reminders
- Health Related Information
- Marketing offers

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that message & data rates may apply. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Please check by your initials your appropriate response below:

	I am over 18 years of age. I have read and fully understand and **DO voluntarily consent** for Transmission of Protected Health Information by Non-Secure Means.
	I am over 18 years of age. I have read and fully understand and **DO NOT consent** for Transmission of Protected Health Information by Non-Secure Means.

INFORMED CONSENT FOR TELEHEALTH CONSULTATION

I understand Telehealth includes the evaluation of my medical history, assessment, consultation, and treatment plan. I understand I have the following rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand the information disclosed by me during the course of my sessions is confidential. I also understand the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
2. I understand I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the provider, the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. The Centre, PC utilizes secure, HIPPA compliant audio/video transmission software to deliver telehealth.
4. I understand if my provider believes I would be better served by another form of intervention (e.g., face-to-face consultation), I will be scheduled appropriately.
5. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology.
6. I understand I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

I have read and understand the information provided above regarding telemedicine and all of my questions have been answered to my satisfaction.

Please check by your initials your appropriate response below:

	I hereby voluntarily give my informed consent for the use of telemedicine in my medical care. I hereby authorize said provider to use telemedicine in the course of my diagnosis and treatment.
	I hereby DO NOT give my informed consent for the use of telemedicine in my medical care. I hereby **DO NOT** authorize said provider to use telemedicine in the course of my diagnosis and treatment.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I hereby acknowledge I have been shown The Centre, P.C. Notice of Privacy Practices for Protected Health Information. I acknowledge I have read and fully understand the Notice. I have been provided the opportunity to ask questions about the Notice and my questions have been answered to my satisfaction.

Please check by your initials your appropriate response below:

	I AM REQUESTING to receive a copy of The Centre, P.C. Notice of Privacy Practices for Protected Health Information.
	I choose NOT to receive a copy of The Centre, P.C. Notice of Privacy Practices for Protected Health Information.

AUTHORIZED TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment directly to the undersigned physician or licensed provider of any surgical and/or medical benefits, if any, otherwise payable to me for his/her services. Ultimately, I understand that I am financially responsible for the services rendered.

Patient Signature _____ Date _____

Witness Signature Date

THE CENTRE, P.C.
COMPREHENSIVE PLASTIC SURGERY
Because You Deserve The Best™

COSMETIC/SELF-PAY FINANCIAL POLICY

As you consider and /or approach your surgery, you most likely have questions regarding payment for services. It is important to get the information necessary to answer those questions **prior** to your surgery in order to avoid any misunderstanding and/or confusion.

SURGERY PAYMENTS

1. **Non-Refundable Deposit**: A 10% or $500.00 (whichever is greater) non-refundable deposit is due at the time of the booking of your surgery.
2. **Financing Fees**: An additional 20% deposit (off the original total surgery fee) is due for all BHG loans.
3. **Included in surgical fee for cosmetic procedures and/or self-pay procedures**: The surgical fees include all pre and post-operative visits for one year from the date of the surgery.
4. ***Not included*** **in surgical fee for cosmetic procedures and/or self-pay procedures**: laboratory fees, radiology fees, prescriptions or other testing procedures such as EKGs.
    a. Additionally, please note that should a hospital admission or additional surgery(ies) be necessary following your initial surgery due to a complication or unrelated event, the initial surgical fee will not cover those costs. Many insurance companies will not cover hospital or medical costs for complications associated with cosmetic surgery. It is advisable to check with your insurance carrier prior to your surgery regarding their policies related to cosmetic surgery.
5. **Insurance Coverage**: It has been our experience that the majority of cosmetic procedures are not covered by insurance plans. However, benefits paid by insurance companies do vary; therefore, you should check with your carrier regarding coverage for cosmetic surgery.

PLEASE NOTE: The Centre, P.C. will NOT submit any claims for a cosmetic and/or self-pay procedure on your behalf to any insurance carrier. You are completely responsible to The Centre, P.C. for the full amount of your bill.

Please refer to the Procedure Quote provided to you for additional information regarding your specific service.

1. **Balance Due**: The surgery balance is due in full two (2)weeks prior to the date of your procedure. All fees (Physician, Surgery Facility and Anesthesia) will be collected by the staff at The Centre, P.C.

PAYMENT OPTIONS

We accept the following forms of payment; use of a combination is acceptable:

- **Cash**
- **Personal Check:** For initial surgery deposit only. Personal checks will **NOT** be accepted for surgery balance. In the event that we receive a notice of Insufficient Funds, we will be required to charge an additional fee of $20 plus institutional charges per IN code section 26-1-3.1-502.5 to your account and require that the fee and the original amount be paid in cash.
- **Money Order or Cashier's Check**
- **Credit Cards:** Visa, Master Card, Discover or American Express
- **Financing Plans:** We accept payment from Care Credit (www.carecredit.com), BHG Lending, United Medical Credit (www.unitedmedicalcredit.com) and Prosper Healthcare Lending (www.prosperhealthcare.com)

CANCELLATION POLICY

We understand that a situation could arise which would require you to postpone your surgery. However, please understand that a cancellation/postponement affects many individuals including the healthcare professionals scheduled for your procedure as well as other patients. All surgeries at The Centre, P.C. may be cancelled or rescheduled without penalty until two (2) weeks prior to the surgery date. Any surgery that is cancelled within two weeks of the surgery date will result in a $300 non-refundable fee assigned to the patient. That fee must be paid, in full, prior to rescheduling. This rescheduling fee also includes patients who fail the drug/nicotine tests at the pre-surgical inform-and-consent appointment. If the surgery is rescheduled by The Centre, P.C. within two weeks of surgery date, no fee will be assigned. Therefore, we would ask that as soon as you become aware of the need to cancel/postpone your surgery, you notify our office at once.

Please keep in mind that your deposit is non-refundable; however, in the event that it is unavoidable for you to postpone your surgery, we will apply your deposit to your new surgery date if it is within six (6) months of the original procedure date. Unfortunately, if this is not possible we will be unable to return your deposit.

If at the time of the cancellation/postponement, you have paid the full amount, we will refund the amount remaining, after the deposit and any processing/cancellation fees are deducted. However, if you choose to reschedule your surgery within six (6) months of the original surgery date, the funds will be applied to the new surgery date. Please note that we will only be able to offer this courtesy for one cancellation.

INDEPENDENT PRACTITIONERS

The Centre, P.C. does not employ the anesthesia provider nor the providers of services rendered to you at hospitals and/or outpatient facilities. The Centre P.C., The Centre, L.L.C. (a licensed ambulatory surgery center owned and operated by The Centre, P.C.), the anesthesia provider and the hospital are independent entities, each exercising independent medical/nursing/health-related practices and judgment and each separately bill for their services. Complications arising from the surgery you will be undergoing may not be covered by your insurance carrier. It is your responsibility to contact your insurance carrier to determine as to what extent there may or may not be coverage for your surgery and/or complications that may arise from your surgery.

I HAVE READ THIS TWO (2) PAGE DOCUMENT, HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS, AND CLEARLY UNDERSTAND THE FINANCIAL POLICY OF THE CENTRE, P.C. REGARDING MY SCHEDULED COSMETIC SURGERY AND THE INDEPENDENT NATURE OF THE HEALTHCARE PROFESSIONALS INVOLVED.

Patient Signature	**Print Name**	**Date**
Parent/Guardian Signature	**Print Name**	**Date**
Witness Signature	**Print Name**	**Date**