CENTRAL OHIO PLASTIC SURGERY, INC. (740) 653-5064

Patient Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____

Last First Middle Nickname

Address _____

Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

May we leave a phone message or voicemail? ☐ No ☐ Yes **Where** do you prefer we contact you?_____ E-mail _____

If patient is under 18: Parents' names: _____

If patient is under 18: Who may authorize treatment: _____

Race: ☐American Indian or Alaska Native ☐Black or African American ☐White ☐Asian ☐Prefer not to answer

Are you Hispanic/ Latino? ☐ No ☐ Yes ☐Prefer not to answer **Preferred Language**: ☐English ☐_____

Age _____ Birthdate _____ SS# _____ ☐ Female ☐ Male

Marital Status ☐ Single Married to: _____ Other: _____

Patient's Employer_____ Occupation _____

Work Phone _____ Ext:_____ Is it okay to call you at work? ☐ Yes ☐ No

Address_____

Emergency Contact Name: _____ Relationship to Patient: _____

HomePhone: _____ Work Phone: _____ Other Phone: _____

Address _____

How did you hear about Dr. Lichten?

☐ Yellow Book ☐ Yellow Pages ☐ Friend ☐ Relative ☐ Doctor ☐ Web ☐ Other

If you were referred by a specific person, may we thank them? ☐ Yes ☐ No Who?_____

Primary Health Insurance Company_____ Policy#_____ Group#_____

Insurance Referral Required? ☐Yes ☐ No Copay? $ _____

Insured:Name:_____ DOB:_____ SSN:_____

Employer: _____

Secondary Health Insurance Company _____ Policy # Group #

Insured: _____DOB:_____ SSN:_____

I understand that office visit charges are payable on the day service is rendered. I authorize Central Ohio Plastic Surgery, Inc. and Dr. Lichten to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Central Ohio Plastic Surgery, Inc. and myself.

Signature _____ Date _____

CENTRAL OHIO PLASTIC SURGERY, INC.

Name: **Date of Birth:**

Height: _____ Weight: _____

Why are you seeing Dr. Lichten today?_____

Medical History: (**Circle** yes or no for **each** individual **answer**)

Coronary Artery Disease	Yes	No	Thyroid Problems (hypo/hyperthyroidism)	Yes	No
Heart Attack (**explain below**)	Yes	No	Diabetes	Yes	No
Heart Surgery (**explain below**)	Yes	No	Hepatitis	Yes	No
Congestive Heart Failure (CHF)	Yes	No	Cirrhosis of the Liver	Yes	No
Mitral Valve Prolapse	Yes	No	Ulcers	Yes	No
Do you take antibiotics prior to procedures?	Yes	No			
Hypertension	Yes	No	Kidney or Renal Disease	Yes	No
Asthma	Yes	No	Dialysis	Yes	No
Chronic Obstructive Pulmonary Disease	Yes	No	Coumadin/Heparin/Plavix Therapy	Yes	No
Sleep Apnea **USE OF BREATHING APPARATUS?**	Yes Yes	No No	Bleeding Tendency or Disorder	Yes	No
Stroke	Yes	No	Blood Clots or Pulmonary Embolism	Yes	No
Seizures/convulsions/fainting spells	Yes	No	Skin Cancers (Melanoma/Basal/Squamous cell)	Yes	No
Transient ischemic attacks	Yes	No	Arthritis	Yes	No
Anxiety	Yes	No	Palsy or Paralysis	Yes	No
Depression	Yes	No	Cancer (**unrelated** to skin.) **explain below**	Yes	No

Infectious Diseases Including MRSA: (include diagnosis and/or treatment for MRSA)

_____

Other illnesses NOT listed above:

_____

Family Illnesses: (include **relation** (**paternal/maternal** and **illness**)

_____

Surgeries: (include surgeries **as** a **child** and an **adult**)

_____

_____

Medications: (include prescription, over the counter ,vitamin and herbal remedies)

_____

_____

_____

REACTIONS and **Allergies** to Medication and Latex**:** (please **indicate if none**)

_____

CENTRAL OHIO PLASTIC SURGERY, INC.

Name: **Date of Birth:**

Social History:

Do you consume any **caffeine** products? ❒ Yes ❒ No If so, **how much per day?** _____

Do you consume any **alcoholic beverages**? ❒ Yes ❒ No If so**, how many per week?** _____

Do you, or did you ever, **smoke**? ❒ Yes ❒ No

If so, **how much per day?** _____ For **how many years?** _____ **When** did you **quit**? _____

Do you use any **recreational drugs**? ❒ Yes ❒ No If so, **what**? _____

Do you **exercise**? ❒ Yes ❒ No If so, **how often per week**?_____

Cardiology History:

Do you see a **cardiologist**? ❒ Yes ❒ No If so, **who**?_____

Have you ever had a **cardiac stress test**? ❒ Yes ❒ No If so, **where** and **when**?_____

Have you ever had a **cardiac cath**? ❒ Yes ❒ No If so, **where** and **when**?_____

Do you have a **pacemaker**? ❒ Yes ❒ No

Family Physician Information:

Who is your **primary care physician?** _____

What is their **phone number?** _____

Advanced Directives

Do you have any **advanced directives** (e.g. a **living will** or **power of attorney**)? ❒ Yes ❒ No

If so, **what**? _____

Would you like information concerning advanced directives? ❒ Yes ❒ No

WOMEN ONLY:

Are you **currently** or do you **plan** to become pregnant in the next 6 months? ❒ Yes ❒ No

Do you have a **family history of breast cancer**? ❒ Yes ❒ No If so, **who**?_____

Total number of **pregnancies**:_____

Total number of **live births**:_____

Did you **breastfeed**? ❒ Yes ❒ No

Have you had a **mammogram**? ❒ Yes ❒ No If so, **where, when** and **what** were the **results**?_____

_____

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____

Financial Policy

Central Ohio Plastic Surgery, Inc. recognizes the importance of communicating our financial policy to all patients. Our goal is to provide useful information about our billing process. **This policy applies to both self-pay and insurance patients.** Please contact us at (740) 653-5064 with any questions.

On your initial visit, you will be asked to provide demographic and insurance information. Following that visit, periodic updates will be requested. If, during the time you are a patient at our practice, you change any of your personal information, including address, telephone number, and insurance carrier, please inform us. As a courtesy, we will submit claims on your behalf to your medical insurance carrier. You are responsible for supplying us with correct insurance information at all times. Failure to do so may result in you being liable for the entire balance of your bill.

When you are treated at our facility, you are required to pay any co-pay at the time of service. If you do not have insurance that covers the cost of your visit, or if you are unable to provide sufficient insurance information, you will be expected to pay 100% of the charges at your visit. Checks returned for insufficient funds will be charged a service fee of $25.00, in addition to the original amount of the check.

Self-pay patients scheduling cosmetic surgeries will be charged a $500 deposit to secure their surgery date, which will be applied to the cost of the surgery. If you cancel surgery more than four weeks before the surgery date, the deposit will be fully refunded. If surgery is cancelled between four and two weeks of the surgery date, the $500 will become a non-refundable credit on your account that can be applied to a future surgery. After six months, the credit will be forfeited to the practice. If your surgery is cancelled less than two weeks before the surgery date, the deposit will be forfeited to the practice. *The non-refundability of the deposit is not meant to be a punishment. There is considerable time and effort that goes into the scheduling of and planning for a surgery. The deposit is meant to cover the expense of those efforts in the event of a late cancellation.*

There will be a $25 charge for all **FMLA and disability** paperwork completed by Dr. Lichten. Please allow seven business days for processing. There will be an additional fee to expedite the paperwork. In no event can completion of paperwork be guaranteed in less than three business days.

As part of your care, you may incur additional medical bills related to testing done through laboratory, radiology or pathology, as well as bills from consulting physicians. Medical bills may also be generated from hospital admissions or emergency room visits. It is our policy not to reimburse patients for any expenses arising from, or related to, services provided or recommended by Dr. Lichten. Patients should check with their medical insurance carrier about coverage and benefits for specific services required.

We welcome the opportunity to discuss any aspect of our financial policy.

My signature below indicates that I understand and agree to the above policy.

Signature _____ Date _____

A signed copy of this form is available to you upon request. Please see a member of our staff to receive a photocopy of this record.

CENTRAL OHIO PLASTIC SURGERY, INC.

ACKNOWLEDGMENT AND CONSENT
PRIVACY PRACTICES

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you.

Yes ( ) I would like to receive a copy of the Notice of Privacy Practices for Central Ohio Plastic Surgery, Inc. (Please ask receptionist for a copy)

No ( ) I do not wish to take a copy of the Notice of Privacy Practices at this time.

We take our patients' privacy very seriously in this office and we will not disclose any information without your consent.

Do you give permission for our office to discuss your health history or any medical concerns with anyone other than yourself?

( ) YES ( ) NO

If yes, please list the individual(s) and their relationship to you.

Name(s): _____ Relationship: _____

Name(s): _____ Relationship: _____

Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign
( ) Communications barriers prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining acknowledgement
( ) Other (Please specify)

Send