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

Patient Information as of ______________ (enter today's date)
(Please Print Legibly & Correct or Fill In All Fields)

PATIENT INFO
____
First Name Middle Name Last Name Nickname

Address ____
Street & Apt # City State Zip

Home Phone ______________ Cell Phone ______________ Work Phone ______________

May we send a **text message** and/or leave a **voicemail?** ☐ No ☐ Yes E-mail: ______________

First Attempt to contact you should be (**circle one**):
Home Phone **Cell Phone** **Email**

If patient is under 18: Parents' names: ______________

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

Age **Birthdate** ______________ **SS#** ______________ ☐ Female ☐ Male

Marital Status ☐ Single ☐ Married to: ______________ Other: ______________

EMERGENCY CONTACT Name: ______________ Relationship to Patient: ______________

HomePhone: ______________ Work Phone: ______________ Mobile Phone: ______________

Address ______________

PATIENT'S EMPLOYER______________ **If retired, effective date:** ______________

Occupation: ______________

Address______________

DEMOGRAPHIC INFORMATION
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 ☐Other________

INSURANCE INFORMATION
Either as primary or secondary, do you have:
☐ Neither Medicare nor Medicaid ☐ Medicare ☐ Medicare Advantage or Replacement ☐ **Any** Medicaid plan
If you have Medicare/ Medicare Advantage **AND** Medicaid, are you a Qualified Medicare Beneficiary (QMB) ☐ Yes ☐ No

Primary Health Insurance Co______________ Policy#______________ Group#______________
Relationship to Insured: Self Child Spouse Partner Other

Insured Name:______________DOB (required):______________SSN:______________

Insured's Employer: ______________

Secondary Health Insurance Co. ______________ Policy # ______________ Group # ______________

Insured Name: ______________ DOB (required)::______________ 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:**

HEALTH HISTORY - NEW PATIENT

Height: ______ **Weight:** ______

Why are you seeing Dr. Lichten today?____

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

Coronary Artery Disease	Yes	No
Heart Attack (**explain below**)	Yes	No
Heart Surgery (**explain below**)	Yes	No
Congestive Heart Failure (CHF)	Yes	No
Mitral Valve Prolapse	Yes	No
Do you take antibiotics prior to procedures?	Yes	No
Heart Arrythmia		
Hypertension (High blood pressure)	Yes	No
Asthma	Yes	No
Chronic Obstructive Pulmonary Disease	Yes	No
Sleep Apnea **USE OF BREATHING APPARATUS?**	Yes Yes	No No
Stroke	Yes	No
Seizures/convulsions/fainting spells	Yes	No
Transient ischemic attacks	Yes	No
Anxiety	Yes	No
Depression	Yes	No

Thyroid Problems (hypo/hyperthyroidism)	Yes	No
Diabetes	Yes	No
Hepatitis – A B C (please circle)	Yes	No
Cirrhosis of the Liver	Yes	No
Ulcers	Yes	No
Kidney or Renal Disease	Yes	No
Dialysis	Yes	No
Coumadin/Heparin/Plavix Therapy	Yes	No
Bleeding Tendency or Disorder	Yes	No
Blood Clots or Pulmonary Embolism	Yes	No
Skin Cancers (Melanoma/Basal/Squamous cell)	Yes	No
Arthritis	Yes	No
Palsy or Paralysis	Yes	No
Cancer (**unrelated** to skin) **explain below**	Yes	No
Family History of Breast Cancer **(who)**	Yes	No

Explanation of Yes Answers Above: ____

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, **use nicotine products**? ☐ Yes ☐ No If so, **what kind? Cigarettes Chewing Tobacco Other**______

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: ☐ **No changes**

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?** __________________________________

Pharmacy Information

What is your **preferred pharmacy name and location?** _________________________________

What is their **phone number?** __________________________________

WOMEN ONLY:

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

Total number of **pregnancies**:_____

Total number of **live births**:_____

Did you **breastfeed**? ☐ Yes ☐ No

Have you had a **mammogram** within the last 2 years? ☐ Yes ☐ No (Please list reason) __________________________

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

Effective 8/1/2021

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 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 or telephone number you must inform us.

There will be a $25.00 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.

All patients who have a check returned for insufficient funds will be charged a service fee of $45.00, in addition to the original amount of the check.

Insurance Patients are responsible for supplying us with correct and updated insurance information at all times. Failure to do so may result in you being liable for the entire balance of your bill. As a courtesy, we will submit claims on your behalf to your medical insurance carrier. 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.

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 you cancel or reschedule surgery less than four 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.*

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)