



PATIENT INFORMATION

Last name: _____ First name: _____ Middle initial: _____

Date of Birth: _____ Age: _____ Gender: Male Female Marital Status: M S W D

Phone (H): _____ Phone (W): _____ ext. _____ Phone (C): _____

Preferred method contact: _____ Social Security Number _____

Address: _____ City/State: _____ Zip: _____

Occupation: _____ Employer: _____

Spouse or Contact person: _____ Phone number: _____

Did another physician **refer** you to Dr. Choe? YES NO Referring Physician: _____

Email: _____ May we email you monthly skin care special offers: Y N

Referred by: (please specify in the space provided)

Self _____
Newspaper _____
Magazine _____
Yellow Pages _____
Friend _____

Relative _____
Patient _____
Spa _____
Employee _____
Other _____

Reason for today's visit: _____

AUTHORIZATIONS

I authorize medical treatment of the person named above and agree to pay all fees and charges for such treatment. I authorize Dr. Choe s to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Dr. Choe's determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and if applicable to process the insurance claim for services rendered at The Choe Center for Facial Plastic Surgery.

I understand that I am responsible for any balance due for professional services in excess of the benefits provided by my policy. I agree to pay for services not covered by my insurance policy. I understand I am responsible for obtaining any prior authorizations required by my insurance policy. I understand that in the event of collection action, I am responsible for any legal fees incurred.

Signature: _____ Date: _____

PREVIOUS SURGERIES OR SERIOUS ILLNESSES

SURGERY	YEAR	SURGERY	YEAR
_____	_____	_____	_____
_____	_____	_____	_____

CURRENT MEDICATIONS

(Include all over the counter and prescription drugs; including aspirin)

DRUG / DOSE	PRESCRIBED BY:	DRUG / DOSE	PRESCRIBED BY:
_____	_____	_____	_____
_____	_____	_____	_____

List any medication(s) & material(s) that you are allergic or sensitive to:

PERSONAL INFORMATION

Height: _____ Current Weight: _____ Recent Weight Loss?: _____ If yes, how much? _____ lbs.

Do you smoke? YES NO How many? Drink Alcohol? YES NO How much?

HISTORY

Have you had (Restylane, Collagen, etc.) injections? _____ Last injection? _____
Have you had Botox injections? _____ Last injection? _____
Have you ever been pregnant? YES NO How many times? _____ Live births? _____
Are you currently pregnant? YES NO Are you planning more children? YES NO
Have you used Acutane? _____ For how long? _____
Have you recently had facial surgery? _____ Type and date: _____
Have you ever had laser resurfacing? _____ Type and date: _____
Have you had a bad reaction to local or general anesthesia? YES NO If yes, explain _____
Have you had significant emotional problems? YES NO If yes, explain _____
Have you had psychiatric care? YES NO If yes, explain _____
Have you seen other plastic surgeons about this same problem? YES NO If yes, explain _____
Do you have high blood pressure? YES NO If yes, explain _____
Do you bleed easily from cuts or surgery? YES NO If yes, explain _____
Do you form large scars or keloids? YES NO If yes, explain _____
Do you have frequent infections or boils? YES NO If yes, explain _____

HAVE YOU or DO YOU HAVE ANY ILLNESSES OF THE FOLLOWING? (Please circle)

Brain	Nose	Heart	Blood	Extremities	Eyes	Cancer
Ears	Lungs	Abdomen	Urinary	Nervous	Diabetes	Reproduction
Other						

Please explain, if you circled any of the above: _____

I hereby consent to be examined and treated by Kyle Choe, MD and that the above information is correct.

SIGNATURE OF PATIENT OR SPOUSE OR RESPONSIBLE PARTY

DATE



Financial Policy

Thank you for choosing The Choe Center for Facial Plastic Surgery for your cosmetic needs. Our goal is to make your surgical experience a pleasant one. For your convenience, and to avoid any future confusion, we would like to outline our financial policies and procedures for you.

Consultation:

A **cosmetic consultation** is scheduled from your initial telephone call. This consultation is designed for you and Dr. Choe to meet and discuss your surgical needs, outline the procedure, and inform you of the fees. If insurance is involved, there will be an office visit charge. There is a fee for the consultation but if you decide to have surgery it will be deducted from your surgical fee.

Payment Options:

We accept Visa, MasterCard, American Express, personal checks and cash for insurance co-pays. Please be aware that we will add a \$30.00 charge to your account for returned checks. We reserve the right to send all accounts with balances over 60 days old to an outside collection agency. All accounts sent to collections will be charged a \$20.00 processing fee and any additional fees associated. You may be responsible for all reasonable collections and attorney costs incurred.

Scheduling

After your consultation, if you decide to go ahead with surgery you will work with our patient care coordinator to select a date for your surgery.

Pre-Payment

There may be a deposit required before the date selected can be reserved exclusively for you. The deposit is \$500.00 or 10% of surgery cost whichever is greater. This is a non-refundable deposit. This fee is used to cover the booking and scheduling expenses involved with your surgery. This amount will be deducted from your total cost.

Pre-Surgical Visit

Prior to surgery, preferably two (2) weeks, you will meet with the nurse and Dr. Choe. Our nurse will explain all pre-operative instructions, order lab tests required, review your surgical procedure and post-operative limitations with you, and give you your post-operative prescriptions with instructions for their use. Post-operative appointments are scheduled at this time. Any questions you may have will be answered at this consult.

Surgery Final Payment

Two (2) weeks prior to surgery, you will be expected to pay the remaining balance due on your account. We accept: Visa, MasterCard, American Express, Money Orders, Cashiers or personal Checks.

Cancel Policy: If for any reason, medical or personal, you cancel two weeks or less prior to your scheduled surgery date fees will be charged as follows:

- Two (2) weeks prior to surgery – 10% or \$500 whichever is greater of your surgery fee for expenses incurred.
- One (1) week prior to surgery – 25% of surgical fee
- One (1) day (24 hours) prior to surgery – entire surgical fee.

If you have any questions, the staff will be happy to assist you. We look forward to caring for you.

Please sign and date.

Financial Guarantor Signature: _____ Date: _____



Acknowledgment and Consent

I understand that *The Choe Center for Facial Plastic Surgery, PLC*, referred to in this document as "This Practice" will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have seen or received a copy (if requested) of the Notice of Privacy Practices.

By: _____ (Patient)	Date: _____	-OR-
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By: _____ (Patient representative)	Date: _____
Description of Representative's Authority _____	

Email Me

- Yes! I want to be included in future emails from Dr. Choe that include special offers, events and news.

Date: _____

Name: _____

Email Address: _____

Contact Number: _____

Dr. Choe will not sell or use your email address for any other purpose other than to send Marketing information from our office to your email address listed above.



INSURANCE WAIVER

Date of Service: _____

Patient Name: _____

Your signature below signifies that you clearly understand that:

Dr. Kyle S. Choe is **NOT** a member of your managed care plan. Because the doctor is **NOT** on your insurance plan, the expense for your visits to this office will be your responsibility. This means you will have to pay the doctor's charges in full at the end of each visit. After you have paid for your visit, if you ask, you will be provided with a properly coded insurance form. Take this form and forward it to your managed care plan, keeping a copy for your records. Depending on the type of plan you have, you may be reimbursed only a percentage of the money you paid.

Know your plan benefits. Certain types of plans will not reimburse any money if the patient requests and seeks services from a physician that is **NOT** part of the plan or network.

Do not sign this form unless you positively understand the financial responsibilities of your visit, the charges you will have to pay, and the fact that you may not receive any of the money back from your insurance carrier.

I understand all of the above and still want to receive services from the non-participating/out-of-network physician today.

Signature of patient: _____ Date: _____

Signature of Witness: _____ Date: _____