Associated Plastic Surgeons, S.C.
Otto J. Placik, M.D., F.A.C.S.

Date _____

Name _____ **Home Phone** _____
(first) (middle) (last)

Address _____ **Work Phone**_____**ext**_____

City,State,Zip _____ **Cell Phone**_____

Occupation_____ **Date of Birth**_____**Age** _____

Employer/School_____ **Social Sec. #**_____

Email Address _____

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Referred By: [ ] Yelp _____**[ ]Google**_____ **[ ] Internet (Site)** _____

[ ] Previous Patient (name)_____

Name of Spouse _____**Spouse Occupation**_____

Spouse's Employer _____ **Business Phone** _____ **Ext** _____

Address _____

Has this office ever seen or treated any member of your family? Yes___ No

If yes, whom? _____ ***(name & relationship)***_____

Emergency Contact_____ ***Home Phone #***_____
(not living with patient)

Relationship _____ **Alternate Phone #**_____

**** * PLEASE PROVIDE YOUR INSURANCE CARD(S) FOR PHOTOCOPYING PURPOSES * * ****
(NON- COSMETIC PATIENTS ONLY)

Insurance Company_____ **Insurance Company** _____

Insured Party_____ **Insured Party** _____

Date of Birth_____ **Date of Birth** _____

Employer Insurance Plan Yes__ No__ **Employer Insurance Plan Yes___ No**

PERSON Financially Responsible *(other than patient)*: [ ] Spouse [ ] Parent [ ] Other

Name _____

Address _____

Occupation _____ **Employer** _____

Business Address _____ **Business Phone** _____

FIRST VISIT: Complete all sections EXCEPT shaded boxes. **PRE OP: Update form, complete shaded boxes & sign at bottom.**

Patient's full name: _____ Date: _____
first middle initial last

Age:_____ Sex: ☐ Male ☐ Female

Stated Height: _____ Weight: _____ Stable: ☐ No ☐ Yes

Exercise: ☐ No ☐ Yes Describe: _____

Home Phone: ( )
Work Phone: ( )
Cell Phone: ( )

FOR YOUR 20 MIN. CONSULTATION, PLEASE LIST BY PRIORITY WHICH CONCERN BRINGS YOU HERE?

_____

Have you consulted with other physicians? ☐ No ☐ Yes: Personal Physician's Name: _____

If yes, their names: _____ Phone: ( ) _____-_____

FOR OFFICE USE: Interview via: ☐Intake History ☐ Phone ☐ Prior to surgery *** Fax #: ( ) _____ - _____

PAST / PRESENT SERIOUS ILLNESSES (✓ "F" for FAMILY HISTORY) *** Joint Commission Required ☐ REFUSED

	Y	N	F		Y	N	F		Y	N	F		Y	N	F
Heart disease (past/present)				GI Disease? Irritable Bowel?				Motion Sickness/ Faint/Dizziness				Cancer? Type? _____			
Blood pressure disorder				Ulcers/Reflux/Hiatal Hernia?				Seizure Disorder (past/present)?				Bleeding or Bruising Problems?			
Mitral Valve Prolapse				Liver Disease/Jaundice?				Stroke (Past/Present)?				Blood Clots?			
Rheumatic Fever				Hepatitis? Type? _____				Severe Headaches / Migraine				Blood Transfusions?			
Irregular Heartbeat				HIV+ / AIDS?				Corneal Abrasions?				Anemia?			
Pacemaker? Date:_____				Total Joint Surgery? Where? _____				Glaucoma?				Malignant Hyperthermia			
Chest pain/pressure				Arthritis?				Dry Eyes Syndrome?				MRSA			
Asthma/Wheezing (Hospital)				Jaw/Neck/Back Pain or stiffness? Chronic Pain?				Psychologic Disease / Depression?				Special Needs / Communication			
Lung Disease?				Parkinson's Disease?				Thyroid Disease?				Neglect / Abuse?			
Emphysema/Bronchitis				Multiple Sclerosis?				Kidney Disease?				Sleep Apnea			
Tuberculosis (Exposure)				Poor Wound Healing /Keloid?				Diabetes (DDM/NIDDM)?				Cold in last 2 weeks? Date: _____			

Comments or Other Illness/Injury: _____

PREVIOUS SURGERY & ANESTHESIA: ☐ No ☐ Yes **(include ALL COSMETIC/PLASTIC SURGERY PROCEDURES…)**

SURGERY TYPE	DATE OF SURGERY	TYPE OF ANESTHESIA	ANESTHESIA PROBLEMS
1.			
2.			
3.			
4.			

NAMES AND DOSAGE OF DAILY HOME MEDICATIONS (include Birth Control Pills)			HERBAL MEDS / VITAMIN & DIETARY SUPPLEMENTS	
1.	4.	7.	1.	4.
2.	5.	8.	2.	5.
3.	6.	9	3.	6.

Aspirin / NSAIDS (Motrin/ Advil) / Coumadin: ☐ No ☐ Yes Last Taken:

Steroids in last 6 months? ☐ No ☐ Yes

HABITS:	NEVER	FREQUENCY daily use	# YEARS	DATE LAST USED	ABUSE/INTERVENTIONS?
Tobacco/Hookah/Patch/E-Cig		packs/day			
Alcohol		ounces/day			
Caffeine		glasses/day			
Drugs Used:					

FEMALES: # Pregnancies: _____ # Children: _____ Average weight gain: _____ or Anticipated pregnancy? ☐ No ☐ Yes

Could you be pregnant? ☐ No ☐ Yes Date of last menstrual period: _____

ALLERGIES: ☐ No ☐ Yes (include food & latex & tape, list; if yes, describe reaction):_____

_____

*** **Distinguish ALLERGY (shock, hives & throat swelling) from ADVERSE REACTION (nausea & stomach upset) *****

I confirm that I have stated ALL my current and past medical history, current medications (including over-the-counter medications) and any allergic reactions I may have:

Patient/Guardian Signature: _____ **Date:** _____

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THIS MUST BE SIGNED TO RECEIVE A WRITTEN QUOTE

ELECTIVE SURGICAL/NON- SURGICAL PROCEDURE FINANCIAL AGREEMENT

Many factors combine to determine the ultimate outcome with elective cosmetic surgical/ non-surgical procedures. The exact same technical procedure performed on ten different patients will yield ten slightly different outcomes. This is because each person is genetically different, heals differently, has different skin tone, bruises differently, and procedures are tailored to you as an individual. I have tried to be as honest as possible in order to paint the average postoperative/ post procedure case scenario and outcome with your procedure. **The need to perform minor revisions or touch-ups is infrequent but possible. In the event that this is necessary in the postoperative/ post procedure period the following will apply:**

1). Any revisions performed in an office based setting will be done at a minimal charge to cover for supplies and room use. The surgeon has to agree that the revision will improve the patient's concern.

2). Any revisions or secondary procedures performed that require nursing support and a certified nurse anesthetist, anesthesiologist or certified surgical technician will be charged no surgeon's fee but will incur the minimum cost **(anesthesia/facility/supplies)** related to their revision procedure. In general, as these more major revisions will not be performed until six to nine months post-operatively/ post procedure, the surgeon has to agree that the revision will improve the patient's concern. After fourteen months a minimal surgeon's fee will apply.

3). If the patient and surgeon are satisfied that the original operation/procedure met the planned goals, but the patient wants further improvement then this constitutes a new procedure.

Examples are:

A). Wanting to further increase breast size nine months after the initial breast augmentation.

B). With liposuction and abdominoplasty procedures, any revision due to weight gain over the baseline pre-operative weight constitutes a new procedure in the same anatomic location.

C). Getting significant shape and contour improvements with liposuction and eight months after working out with weight loss wanting more muscle definition or shape to be evident.

D). The surgeon has to agree that further surgery will again help the patient with minimal risks.

A minimal surgeon's fee may apply, however the standard rates for anesthesia and facility will apply

4) BREAST/ IMPLANT SURGERY: In order to ensure that all arrangements are set in advance of your surgical procedure, we require that breast and other implants be ordered two (2) weeks prior to your surgery date. Any changes within the two (2) week deadline necessitate RUSH shipping charges as well as staff time, and therefore will incur a **$50.00 restocking fee.**

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ELECTIVE SURGICAL/ NON-SURGICAL PROCEDURE FINANCIAL AGREEMENT

On occasion the best made plans have to be changed. I understand this and will always work with you if you need to cancel surgery/procedure unexpectedly. However, if you cancel your surgery/procedure not because of illness, a penalty will apply. **When you make a commitment to a surgery/procedure date, other patients lose the opportunity of scheduling that date, the doctor makes a commitment to you for his time, special garments and implants have been ordered, and arrangements are made with nursing and anesthesia personnel to work on that date.**
In order to reserve a date for your procedure, we ask that you pay a $500.00 non-refundable "reservation fee". "Full payment" is due four weeks prior ("closing date") to the procedure in order to confirm the reserved time slot. If full payment is not received four weeks pre-operatively/ pre-procedure, the reserved date may be forfeited to another individual. The following rules apply to the full payment excluding the non-refundable $500.00 reservation fee.

1). There is no penalty if you cancel more than four weeks before surgery/procedure and have paid in full (excluding the reservation fee of $500.00). If your surgery/procedure is canceled between the closing date and two weeks before your surgery/procedure **due to illness and you do not reschedule the surgery/procedure within 10 days after the date of notification of cancellation, for a date within 45 days of the original surgery/procedure date**, or if canceled between the closing date and two weeks before surgery/procedure not because of illness, 10% of the total procedure cost will be withheld (surgeon's fee/anesthesia/facility) in addition to reservation fee of $500.00. **In addition,** the cost of any implants, garments or special devices already purchased at the time of cancellation will be withheld.

Initials_____

2). If your surgery/procedure is canceled within two weeks up to three days before the date of surgery/procedure **due to illness and you do not reschedule the surgery/procedure within 10 days after the date of notification of cancellation, for a date within 45 days of the original surgery/procedure date,** or if canceled within two weeks to 3 days before your surgery/procedure not because of illness**,** 25% of the total procedure cost will be withheld (surgeons fee/anesthesia/facility), in addition to the reservation fee of $500.00. **In addition,** the cost of any implants, garments, or special devices already purchased at the time of cancellation will be withheld.

Initials_____

3). If your surgery/procedure is canceled in any of the 3 days before the date of the surgery/procedure due to illness **and you do not reschedule the surgery/procedure within 10 days after the date of notification of cancellation, for a date within 45 days of the original surgery/procedure date,** or if canceled in any of the 3 days before surgery/procedure not because of illness, 50% of the total procedure cost will be withheld (surgeon's fee/anesthesia/facility), in addition to the reservation fee of $500.00**. In addition,** the cost of any implants, garments or special devices already purchased at the time of cancellation will be withheld.

Initials_____

4). If your surgery/procedure is canceled the same day of your surgery/procedure **due to illness and you do not reschedule the surgery/procedure within 10 days after the date of notification of cancellation, for a date within 45 days of the original surgery/procedure date**, or if canceled the same day of your surgery/procedure not because of illness, 50% of the total procedure cost will be withheld (surgeons fee/anesthesia/facility), in addition to the reservation fee of $500.00**. In addition,** a $300.00 charge will be added to cover the operating room personnel expenses, the cost of any implants, garments or special devices already purchased at the time of cancellation will be withheld as well.

Initials_____

5). The balance of monies owed will be refunded ten days after cancellation unless you have rescheduled.

6). In the event that external collection services become necessary to obtain payment, you will pay all collection agency fees, returned check fees and attorney fees, as well as court costs associated with such collections. You agree that all attorney's and collection agency fees that do not exceed one-third of the account balance are reasonable and you agree to pay the same.

You will find that this goes beyond what other plastic surgeons offer and is spelled out clearly. I do my best to ensure your satisfaction as my patient and want your procedure to be a positive experience that you will tell your friends and family about. Please ask any questions to clarify the above policy.

I have read the above policy on revisions & cancellations and understand and agree to abide by it.

Patient_____**Date**_____

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INSURANCE PAYMENT
MEDICAL INFORMATION
AUTHORIZATION

I authorize the release of medical or other information to my insurance company and authorize payment of medical insurance benefits to be issued to:

Associated Plastic Surgeons, S.C.
Tax ID# 36-282l079
Otto J. Placik, M.D., F.A.C.S.

880 West Central Road, Suite 3100
Arlington Heights, IL 60005

I permit a copy of this authorization to be used in place of the original. I agree to pay any remaining balance after insurance payment has been made.

PLEASE NOTE OUR OFFICE DOES NOT FILE CLAIMS TO YOUR INSURANCE CARRIER. WE ARE HAPPY TO PROVIDE YOU WITH A COPY OF YOUR BILL AND OPERATIVE REPORT FOR WHAT YOU HAVE INDICATED AND THE PROCEDURE YOU UNDERWENT.

Signature_____ Date _____

WE ARE NOT A PARTICIPATING PROVIDER IN YOUR INSURANCE PLAN. IT IS YOUR RESPONSIBILITY TO CONTACT YOUR INSURANCE CARRIER TO VERIFY THAT OUR SERVICES ARE COVERED UNDER YOUR SPECIFIC POLICY.

****

PATIENTS UNDERGOING ELECTIVE COSMETIC SURGERY ONLY

I have received the policies (PREVIOUS PAGE) regarding the elective surgery financial agreement.

Signature _____ Date _____

Associated Plastic Surgeons, S.C.
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AUTHORIZATION FOR RELEASE OF MEDICAL PHOTOGRAPHS/DIGITAL IMAGING

Photographs are an important part of the medical record. These photographs are used to track your progress and response to surgery.

BY SIGNING THE CONSENT BELOW, YOU WILL BE CONTRIBUTING TO OUR PHOTOGRAPHIC LIBRARY. YOUR SIGNATURE WILL ALLOW YOU THE PRIVILEGE OF VIEWING BEFORE AND AFTER PHOTOGRAPHS.

INSTRUCTIONS

This is a consent document that has been prepared to help inform you concerning permission to take photographs, and or digital imaging and to use these images for a purpose as defined within this consent document.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

INTRODUCTION

Medical photographs and or digital imaging may be taken before, during or after a surgical procedure or treatment. Consent is required to take such images.

Additionally, patients may consent to release these medical photography and or digital imaging for a stated purpose.

CONSENT TO TAKE PHOTOGRAPHS/DIGITAL IMAGING

I hereby authorize Otto J. Placik, M.D. and his associates or licensees to take pre-operative, intraoperative, and postoperative photographs, and or digital imaging. I additionally consent to photographs, and/or digital imaging of my interview.

CONSENT FOR RELEASE OF PHOTOGRAPHS/DIGITAL IMAGING

I hereby authorize Otto J. Placik, M.D. and or his associates or licensees to use pre-operative, intra-operative, and postoperative photographs, slides and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on electronic digital networks, television, for the purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

Signature_____Date _____

Witness_____

PATIENT PRIVACY and CONSENT

FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby consent to the use or disclosure of my protected health information by the practice of Otto J. Placik, M.D., hereinafter referred to as ("Practice"), for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by the Practice may be conditioned upon my consent as evidenced by my signature on this document.

I understand that payment for procedures that are aesthetic or cosmetic in nature are my sole responsibility and will not be billed to any third party. I understand that payment for such procedures may be requested in advance of any treatment. I understand there are no warrantees, implied or otherwise, to the outcomes of any treatments or procedure.

I have been offered, read and/or understand the Practice's *Notice of Privacy Practices*, which has been offered to me by the practice, prior to signing this document. I understand that patient privacy rights and disclosure varies state by state.

In exchange and for the additional consideration of privacy protection while at the practice, the patient agrees to make no unauthorized public identification of any guests by name, photograph, or any other means; no publication that will invade or injure the practice. The patient also agrees not to publish any message, information, text, photo, or any other material capable of defamatory meaning or being obscene, pornographic, indecent, lewd, harassing, threatening, invasive of privacy, or publicity rights, abusive, inflammatory, fraudulent or otherwise objectionable relative to the practice or its patients; and grant the practice as the co-owner of copyright the exclusive right to demand the immediate removal of publications deemed offensive.

I also understand that the *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations. This *Notice of Privacy Practices* also describes my rights and the practice's duties with respect to my protected health information. The *Notice of Privacy Practices* for the Practice is available at the offices of Otto J. Placik, M.D.

Terms of the *Notice of Privacy Practices* may change. If changes are made, I may obtain a revised *Notice of Privacy Practices* by: calling the offices of the practice requesting a revised copy be sent in the mail, or by requesting one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative if the Patient is a Minor Date

_____

Printed Name of Patient or Personal Representative

_____

Relationship of Personal Representative to the Patient

_____

Signature of Practice Representative and Witness

Consent to Receive Text Messages from

ASSOCIATED PLASTIC SURGEONS, S.C.

(Required by the Health Insurance Portability and Accountability Act,

45 C.F.R. Parts 160 and 164)

By signing below or responding to any messages following this consent, I authorize ASSOCIATED PLASTIC SURGEONS, S.C. a/k/a Body Sculptor, to contact me by SMS text message. ASSOCIATED PLASTIC SURGEONS, S.C. may send me text messages in response to my questions to it and for any medical issue that may arise. ASSOCIATED PLASTIC SURGEONS, S.C. shall not text message any electronically protected health information to anyone but me.

I understand that messaging / SMS text message communication is not a substitute for medical care. In the event of a medical emergency I understand I should contact 911 or go to my nearest emergency room for assistance. I understand I should NOT wait for a response in a medical emergency.

I understand that message/data rates may apply to messages sent to and from ASSOCIATED PLASTIC SURGEONS, S.C.to my cell phone.

I acknowledge that I am not under any obligation to authorize ASSOCIATED PLASTIC SURGEONS, S.C. to send me text messages but voluntarily permit the same.

I may opt-out of receiving these communications from ASSOCIATED PLASTIC SURGEONS, S.C. at any time by calling ASSOCIATED PLASTIC SURGEONS, S.C. at 847-398-1660 or by texting 'STOP' in response to any message.

Name: _____

Signature: _____

My Authorized Cellphone Number: _____

Date: _____/_____/_____