The Plastic Surgery Clinic, PA **Dr. Kenneth A. Fischer**
1419 Westport Landing Place, Suite 101 Manhattan, KS 66502 Phone: (785) 776-7500 Fax: (785) 770-8558

Financial Policies

The purpose of this form is to explain The Plastic Surgery Clinic's financial policies. This is to help avoid any misunderstandings that might arise.

Cosmetic Patients

1. **Consultation fees** are to be paid at the time of your visit. Our fees for cosmetic consultations are $100.
2. **Surgical fees** are to be paid in full no less than two weeks prior to surgery to avoid possible cancellations of surgery.
3. The surgical fee includes all post-op visits related to that particular surgery. It does not include office visits for unrelated procedures.
4. **Surgery Postponement**: We understand that a situation may arise that could force you to postpone your surgery. We request your courtesy in notifying us as soon as possible as changes affect not only the surgeon, and other patients, but the hospital and anesthetists also. **If you need to re-schedule your surgery, all fees paid will be applied to the new surgery date. If, however, you cancel surgery less than 7 business days before and do not reschedule within 3 months, we will refund your payment minus a 10% administrative fee.*

Insurance Patients

Please note, your insurance is a contract between you, your employer, and the insurance company. Our relationship is with you, not your insurance company.
You are responsible for your bill and filing claims with your insurance company. This office may assist you with this process as a courtesy to you.

*** NOTE: THE PLASTIC SURGERY CLINIC IS NOT A PROVIDER OF ANY INSURANCE COMPANY.

1. Patients covered under managed care plans **(HMO/PPO/EPO's)** are responsible for complying with their insurance rules regarding referrals from primary care physicians to see specialists.
2. **Failure to comply** with your insurance requirements will make it necessary for us to bill you directly for charges incurred during a non-referred, non-covered visit.
3. **Co-payments** are required to be paid at the time of service.
4. **You are responsible** for your deductibles, co-insurance, and services or procedures not covered by your insurance company.
5. **You are responsible** for the portion of the bill that is not covered by insurance.

It is in your best interest to read your plan's rules, regulations and benefit information. If you have any questions regarding this information, please contact your customer service representative at the Insurance Company.

Self Insured Patients

1. **Unplanned Services:** Payment will be expected within 15 days of date of service or a payment plan will need to be in place. You may set up a payment plan by contact our office and speaking to the Office Manager.
2. **Planned Services:** Fees are to be paid in full at time of service for in office procedures. Surgical fees are to be paid in full no less than two weeks prior to surgery to avoid possible cancellations of surgery.

Payment is due at the time of service unless other arrangements have been approved in advance. You are responsible for timely payment of your account. If for any reason you experience financial difficulties, which may affect timely payment of your account, we encourage you to contact our office. If you have questions about our policies, please do not hesitate to ask.

Interest will be charged on all accounts and balances over 60 days old except MEDICARE, MEDICAID and HMO accounts. We charge 1.25% per month on the unpaid balance or 15% per year. Interest that is charged will not be paid by your insurance company. The best way to avoid interest charges is to make sure your bill is paid prior to 60 days.

I understand that if my account is sent to a Collection Attorney, all fees associated with collection will become my responsibility if the Account is not satisfied within a timely manner.

Signature Date:

The Plastic Surgery Clinic, PA **Dr. Kenneth A. Fischer**
1419 Westport Landing Place, Suite 101 Manhattan, KS 66502 785-776-7500 phone 785-770-8558 fax

⌘ Patient Information ⌘

Name: Social Security Number:
Last First MI
Address:
City: State: Zip: E-mail Address:
Home Phone: Daytime (Work) Phone: Cell Phone:
I give The Plastic Surgery Clinic, PA (or any business that represents them) permission to call my cell phone (please initial)_____
Date of Birth: Age: Male / Female Marital Status: Single, Married, Divorced, Widowed, Separated

Emergency Contact Information:
Name:
Address:
Phone: Cell Phone:
Relationship to Patient: Parent, Spouse, Child, Other:_____

Alternate Contact (not living in your household):
Name:
Address:
Phone: Cell Phone:
Relationship to Patient: Parent, Spouse, Child, Other:_____

Employment Status: Full Time, Part Time, Self Employed, Retired, Unemployed, Military, Student
Employer: Phone: Employer's Address

Injury Information: Is the reason for your visit injury related? Yes No Date of Injury:_____
Where were you injured? Home, School, During Recreation, Work Injury, Motorcycle Injury, Auto Accident

How will you be paying for your medical expenses? Insurance Self Pay Worker's Comp

Insurance Information:

Primary Insurance Company: Policy#: Group#:
Policy Holders Name (Subscriber): Relationship to Policy Holder: Self Spouse Child
Phone Number of Policy Holder: Policy Holder's SSN & DOB:

Secondary Insurance Company: Policy#: Group#:
Policy Holders Name (Subscriber): Relationship to Policy Holder: Self Spouse Child
Phone Number of Policy Holder: Policy Holder's SSN & DOB:

If there are any other Insurance Companies please list on back.

Worker's Compensation Information:
Name of Company: Contact Person: Phone:
Address:

⌘ Assignment and Release ⌘

- ⌘ I hereby authorize The Plastic Surgery Clinic to release information and photographs acquired in the course of my examination or treatment, including information necessary for medical insurance authorization, medical record requirements and educational purposes.
- ⌘ I hereby authorize any physician, hospital or medical care facility to provide information on my medical history and treatment to The Plastic Surgery Clinic.
- ⌘ I understand that I am financially responsible for all charges for my medical care. In the event of default, I agree to pay all costs of collection, and reasonable attorney fees.
- ⌘ I hereby give lifetime authorization for payment of insurance benefits to be made directly to The Plastic Surgery Clinic, and any assisting physicians for services rendered. I understand that I am finically responsible for all charges whether or not they are covered by insurance. ***(Pertains to patients filing with insurance only)***
- ⌘ I hereby authorize the above listed insurance companies to pay directly to The Plastic Surgery Clinic benefits due me, if any, as provided in the above un-expired policy. I will pay all charges in excess of whatever sums may be paid. I authorize The Plastic Surgery Clinic to release information to the insurance company for my claims to be paid. ***(Pertains to patients filing with insurance only)***

Responsible Party Signature: **Relationship to Patient:** **Date:**

MEDICAL HISTORY

Name: _____ Date: _____

Height: _____ Weight: _____ Age: _____

Reason for Visit: _____ Date Symptoms First Appeared: _____

Referred By: _____ Primary Care Physician: _____

PERSONAL HISTORY: (Circle Yes or No) Yes No Do you smoke? _____ packs per day

PREVIOUS SURGERIES: (Please list all) _____

_____

_____

SCARRING: Have you formed keloids, excessive or unsatisfactory scars in the past? Yes No

PERSONAL MEDICAL HISTORY: (Circle Yes or No)

Yes No High blood pressure
Yes No Heart disease or attack
Yes No Heart Murmur or disorder
Yes No Chest pain or shortness or breath
Yes No Stroke
Yes No Prolonged bleeding, excessive bruising
Yes No Fainting or blackout episodes
Yes No Ulcer disease or abdominal problem

Yes No Hepatitis
Yes No Diabetes
Yes No Other significant illness. If so, describe:

_____

_____

_____

_____

CURRENT MEDICATIONS: List all, including aspirin, birth control, over-the-counter

Medication	*Dose / Strength*	*Frequency Taken*

DIETARY SUPPLEMENTS: Vitamins, herbs, natural health supplements

Medication	*Dose / Strength*	*Frequency Taken*

ALLERGIES: Allergic medications, reactions to medications, drugs, or local anesthesia

Medication	*Reaction when taken last*

FAMILY HISTORY: Is there a history of the following in your immediate family? If so please list the family member beside the disease.

Yes No Any anesthetic problems_____
Yes No High blood pressure_____
Yes No Diabetes_____
Yes No Bleeding problems (hemophilia) _____
Yes No Hepatitis_____

Yes No Heart attack_____
Yes No Cancer (skin)_____
Yes No Stroke_____
Yes No Other Cancers (type)_____

1. To my knowledge the above information is complete and accurate:

_____
(sign & date)

2. We may take photographs. They could be used for teaching and advertising purposes, including our website. We would like your permission to do this:

_____
(sign & date)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I hereby acknowledge that I have received a copy of The Plastic Surgery Clinic's Notice of Privacy Practices, effective April 10, 2003.

_____
Patient's Printed Name

_____ _____
Signature of Patient Date

OR

_____
Signature of Patient Representative

_____ _____
Relation to Patient Date

Return this page and keep the attached Privacy Policy for your records.
Original copy will be placed in patient's permanent medical record

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PERMISSION TO SHARE YOUR MEDICAL INFORMATION

Other than myself, my medical information (including, but not limited to office exam notes, lab results, billing info, etc.) may be shared with those parties listed below. I understand that this permission will remain in effect unless and until I revoke permission in writing.

Name of person	Phone number	Relationship to patient
Name of person	Phone number	Relationship to patient
Name of person	Phone number	Relationship to patient
Name of person	Phone number	Relationship to patient

☐ I do not wish my medical information be shared with any person other than myself.

_____ _____ _____
Patient's Printed Name Patient's Signature Date

For patient medical records to be released from this facility, the patient must contact
The Plastic Surgery Clinic's office to obtain and sign a separate Authorization to Release Medical Information.