ST. PETERSBURG CENTER FOR
PLASTIC SURGERY

Date:_____

How did you hear about our office? _____

Patient Information

Age: _____ **Date of Birth: _____** **Sex: ☐ Female ☐ Male**

Patient's Name _____
Last First Middle

Mailing Address _____
Street Apt/Unit #

City State Zip Code

Home _____ Mobile _____ Work _____

Email: _____

Social Security #: _____ Driver License #: _____

Marital Status: ☐ Single | ☐ Married | ☐ Divorced | ☐ Widowed | ☐ Domestic Partnership | ☐ Other _____

Employer's Name _____ Occupation _____

_____
Street City State Zip

Spouse Information

Spouse's Name _____
Last First Middle

Spouse's Employer _____

Spouse's Cell # _____ Spouse's Work # _____

Please mark the ways that you consent to us communicating with you.

Method	Okay to Leave Voicemail	Okay to Leave Message with Another Person	Preferred Contact Method(s)
Cell Phone	☐	☐	☐
Home Phone	☐	☐	☐
Work Phone	☐	☐	☐

	Okay to Send Text Messages?	Okay to Send Emails?
Appointment Reminders	☐	☐
Medical/Schedule Info	☐	☐
Office Specials/News	☐	☐

ST. PETERSBURG CENTER FOR
PLASTIC SURGERY

Emergency Contact

Name _____ Phone Number _____ Relationship _____

Please allow the front desk to make a copy of your insurance card to keep on file.

Insurance Information

Primary Insurance Company Name _____
Name of Insured _____
Policy # _____ Group # _____
Secondary Insurance Company Name _____
Name of Insured _____
Policy # _____ Group # _____

I understand that office visit charges are payable on the day service is rendered. I authorize John J. O'Brien, Jr., MD to bill my insurance company. Regardless of insurance company, I am responsible for bills being paid in a timely manner. I understand that my contract is between John J. O'Brien, Jr., MD, and myself.

Signature (Patient, Parent, or Guardian) _____ Date _____

HIPAA Authorization to Discuss Your Medical Information

Indicated below are names of any person(s) to whom I would like St. Petersburg Center for Plastic Surgery to allow disclosure of Protected Health Information (PHI). I understand that I am not required to list anyone, and I may change this list at any time in writing.

Authorization

I authorize the Practice to disclose my PHI to those individuals listed below (specify name, relationship, and contact information if possible.)

Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

Please acknowledge that you have been offered a "Notice of Privacy Practices" by signing below.

"I have been offered a Notice of Privacy Practices by the office of St. Petersburg Center for Plastic Surgery, and I fully understand and accept the terms of this consent."

Signature (Patient, Parent, or Guardian) _____ Date _____

Procedure Information

What is the reason for your visit today? _____
Please describe why you are interested in the procedures listed above _____

Have you consulted with other surgeons about the procedure(s) indicated above? ☐ Yes ☐ No
If yes, who? _____

ST. PETERSBURG CENTER FOR
PLASTIC SURGERY

Is this a revision from a previous surgery? ☐ Yes ☐ No
If yes, how many previous surgeries? _____

Pharmacy Information

Pharmacy Name _____
Address _____ City _____ Zip _____

Health Information & Medical History

Date of Your Last Physical Examination _____ Height _____ Weight _____
Primary Care Physician _____
Address _____
Phone Number _____ Fax Number _____

Surgery (Operations and Cosmetic Surgery)

	Type	Date	Complications/Difficulties
1.			
2.			
3.			
4.			
5.			

Medical Problems Now Under Treatment by a Physician

Explain_____
_____

Admissions to Hospital (including childbirth)

	Reason	Date	Complications/Difficulties
1.			
2.			
3.			
4.			

Medications, Vitamins, or Herbal Supplements You Take Now

	Type	Dosage/Amount If Known	Take How Often
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

ST. PETERSBURG CENTER FOR
PLASTIC SURGERY

Social History

☐ Caffeine Use ☐ Tobacco/Nicotine ☐ Alcohol ☐ Other(s) _____
Exercise Habits _____

Allergies (Please list. If none, please write none)

_____

Difficulties with Local or General Anesthesia

If yes, please explain. _____

Family History

Any family history of medical problems or illness?
Mother _____
Father _____
Brother _____
Sister _____
Other _____

Review of Systems

Please check the box below if you currently have or have ever had a problem with:

Abdomen & Liver

- ☐ **Ulcers**
- ☐ **Colon Disease**
- ☐ **Gallbladder Disease**
- ☐ **Inflammatory Bowel Disease (IBS)**
- ☐ **Reflux**
- ☐ **Hiatal Hernia**
- ☐ **Jaundice**
- ☐ **Hepatitis**
- ☐ **Liver Problems**
- ☐ **Cirrhosis**
- ☐ **Liver Transplant**
- ☐ **Heartburn**
- ☐ **Other _____**

Kidney & Endocrine

- ☐ **Diabetes—Insulin Dependent**
- ☐ **Diabetes—Oral Hypoglycemic Agent**
- ☐ **Diabetes—Diet Controlled**
- ☐ **Hyperthyroidism**
- ☐ **Hypothyroidism**
- ☐ **Low Blood Sugar**
- ☐ **Kidney Stones**
- ☐ **Kidney Disease or Failure**
- ☐ **Kidney Infection**
- ☐ **Difficulty Passing Urine**
- ☐ **Other _____**

Neurological & Psychological

- ☐ **Stroke**
- ☐ **Seizures**
- ☐ **Fainting**
- ☐ **Headaches**
- ☐ **Emotional Problems**
- ☐ **Psychiatric Problems or Treatment**
- ☐ **Depression**
- ☐ **Anxiety**
- ☐ **Sciatica**
- ☐ **Herniated Disc**
- ☐ **Other _____**

ST. PETERSBURG CENTER FOR
PLASTIC SURGERY

Skin

- ☐ Scar Badly
- ☐ Keloids or Thick Scars
- ☐ Wound Healing Problems or Open Sores
- ☐ Atypical Skin Lesions
- ☐ Previous Skin Cancers or Tumors
- ☐ Acne
- ☐ Other _____

Musculoskeletal

- ☐ Back Pain
- ☐ Neck Pain
- ☐ Arthritis—Osteo
- ☐ Arthritis—Rheumatoid
- ☐ Muscular Dystrophy
- ☐ Muscular Sclerosis
- ☐ Fibromyalgia
- ☐ Other _____

Eyes

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Dry Eyes
- ☐ Wear Contact Lenses
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Other _____

Heart

- ☐ High Blood Pressure
- ☐ Born with Heart Problems
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Heart Murmur
- ☐ Heart Failure
- ☐ Chest Pains
- ☐ Heart Bypass Surgery
- ☐ Other _____

Lungs

- ☐ Abnormal Chest X-Ray
- ☐ Asthma
- ☐ Bronchitis
- ☐ Shortness of Breath
- ☐ Recent Chest Infection
- ☐ Emphysema/COPD
- ☐ Pulmonary Embolism
- ☐ Cough or Cold Present
- ☐ Sleep Apnea
- ☐ Use a C-PAP Machine
- ☐ Tuberculosis
- ☐ Other _____

Hematologic/Oncologic

- ☐ Excessive Bleeding
- ☐ Bruise Easily
- ☐ Anemia
- ☐ Sickle Cell Disease
- ☐ Blood Clots in Legs
- ☐ Blood Clots in Lungs
- ☐ Radiation Therapy
- ☐ Cancer
- ☐ Other _____

Please list any other medical conditions not listed above

_____

_____

Signature _____ Date _____

ST. PETERSBURG CENTER FOR
PLASTIC SURGERY

Payment Policy

For all cosmetic patients during your visit, you will be given a fee estimate for your proposed aesthetic procedure(s). This quote will include fees for the Operating Room and fees for the Anesthesiologist, as well as any special equipment fees or Assistant fees. Please note that Dr. John J. O'Brien's portion of the quote is good for 60 days only. If you choose to schedule the procedure more than 60 days in the future, it is possible that the fee will be different than the original quote. Payment for surgery may be made by cash, major credit card, or cashier's check. We also offer patient financing through CareCredit® and ALPHAEON®. Payment of non-surgical treatments such as BOTOX® Cosmetic and fillers are made at the time of service by cash or debit/credit card. At times, a revision or "touch up" procedure may be desired. Should that be the situation, you the patient will be responsible for additional fees including, but not limited to, Operating Room or Anesthesia. Payment is due in full upon reserving the date of your revision procedure.

In regard to procedures that may or may not be covered by medical insurance, there may be situations in which part of your surgery would be considered functional or medically necessary. In that case, your insurance may pay part of the surgery fee. As a courtesy to you, our office will pursue prior authorization for this procedure. You will be responsible for the Surgeon's fee, deductible and/or co-payments prior to the procedure. If the surgery center is a Preferred Provider, you will be responsible for your deductible and co-payments for the operating room & anesthesia, as well as payments for the cosmetic portion of your procedure. Purely cosmetic services will not be billed to any third-party insurer.

Dr. O'Brien is not responsible for refunding any surgical fees or rescheduling fees that result from a patient's non-compliance. The failure to follow pre-surgical instructions includes nicotine, alcohol, or drug use, failure to avoid or to take specific medications as instructed, and failure to follow day of surgery instructions. Any surgical procedure rescheduled by the patient less than fourteen days prior to surgery or as the result of patient non-compliance, will forfeit their surgical deposit and incur a surgeon's rescheduling fee. All fees must be paid prior to confirming any new surgical date.

Our office requires a non-refundable scheduling deposit equivalent to 10% of the total surgery cost to guarantee your surgery date & time. The remaining balance for surgical fees is to be paid in full at your Pre-Operative appointment. Cancellation up to 14 days prior to your procedure date will result in a 25% loss of all fees. Cancellation within one week (7 days) of your procedure will result in a 50% loss of all fees. If you cancel 48-hours or less from your procedure date, you will forfeit 100% of all fees. These penalties do not apply to illness related cancellations where a Doctor's note is provided.

If a check is returned from the bank, the patient will be responsible for the amount of the check plus a $30.00 processing fee. Services that are paid with a credit card, debit card or financing are not eligible for credit card challenge. In signing this agreement, the responsible party and/or patient will not challenge credit card payments once the service is provided. We encourage you to contact our office staff for any questions that you may have, so that this policy may be clarified for you prior to scheduling any procedures. We have found that most patients are pleased to have all details known prior to scheduling.

<u>Statement of Financial Responsibility</u>
"I, the undersigned, have read the above & understand that I am responsible for all medical & surgical charges incurred by myself or my dependents. I authorize the release of any medical information necessary to process any claims that are processed on my behalf by the office of Dr. O'Brien. I understand that my medical insurance contract is between my insurance company and myself and that the failure of the insurance company to pay my claim does not absolve my financial responsibility to Dr. O'Brien. All court and attorney fees or other fees associated with the collection of my account are my financial responsibility."

Signature (Patient, Parent, or Guardian) _____ Date _____

ST. PETERSBURG CENTER FOR
PLASTIC SURGERY

Patient Partnership Plan

Dear Patient,

Welcome to St. Petersburg Center for Plastic Surgery. We hope to provide you with the care and service that you expect and deserve. Achieving your best possible health requires a "partnership" between you and your doctor. As our "partner in health", we ask you to participate in your care in the following ways:

I Will Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

I Will Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

I Will Inform My Doctor if I Decide Not to Follow His Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his recommendations so that he may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, seek an explanation, report symptoms, or discuss concerns. If you need more information about your health or condition, please ask.

Patient Signature _____ Date _____

Witness Signature _____

ST. PETERSBURG CENTER FOR
PLASTIC SURGERY

Medical Appointment Cancellation/No Show Policy

When you schedule an appointment with St. Petersburg Center for Plastic Surgery, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24-hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our appointment Cancellation/No Show Policy below:

• A credit card number will be required to schedule all new patient consultation appointments. Payment is due at the time of scheduling.
• Any new patient with two or more No Shows or cancellation/reschedules with no 24-hour notice will not be rescheduled again.
• Established patients with multiple No Shows or cancellation/reschedules with no 24-hour notice may be dismissed from St. Petersburg Center for Plastic Surgery.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Practice Manager, who may be able to waive the No Show fee. You may contact St. Petersburg Center for Plastic Surgery 24 hours a day, 7 days a week at 727-341-2408. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

I have read, understand, and accept the above policies.

Printed Name _____

Signature _____

Date _____