Reason for Consultation _____

Patients Name _____
First Middle Last

Address _____
Street City State Zip Code

Home Phone _____ Cell _____ Work _____

Social Security # _____ Birth Date _____ Age _____

Email Address _____

Gender: M F Marital Status: S M D W Spouses Name _____

Employer _____ Occupation _____

Emergency Contact (not in your household) _____ Relationship _____

Home Phone _____ Cell _____ Work _____

If Minor: Name of responsible party _____ Relationship _____

Address _____

Phone Number _____ SS# _____

How did you find out about Iowa Plastic Surgery? Please Mark All That Apply:

Referring Doctor _____

Current Patient _____ May we thank this person for referring you? ❒ Yes ❒ No

Newspaper: ❒ Quad City Times ❒ Dispatch/Argus

Search Engine: ❒ Google ❒ Yahoo ❒ MSN ❒ Ask ❒ Bing

Yellow Pages: ❒ Qwest Dex ❒ SBC/RH Donnelley ❒ Yellow Book

Iowa Plastic Surgery: ❒ Employee ❒ Seminar ❒ Handout ❒ Television ❒ Website

Other _____

I authorize Iowa Plastic Surgery to contact me by email or land mail for promotions/seminars? ☐ **Yes** ☐ **No**

I authorize Iowa Plastic Surgery to notify me of by phone/text/e-mail, or land mail appointments, surgery and/or follow up care. ☐ **Yes** ☐ **No**

Many procedures require photographs; I consent to be photographed and agree that the Photographs will remain the property of Iowa Plastic Surgery. **Initial _____**

I understand that I have the right to refuse care, treatment and/or services. **Initial _____**

I am aware of and understand HIPAA privacy regulations. I understand I may request a copy of the Iowa Plastic Surgery Privacy Policy at any time during my treatment. **Initial _____**

Signature_____Date_____

Iowa Plastic Surgery

4334 East 53rd Street ~ Davenport, Iowa 52807 ~ 563.322.8877

PAYMENT POLICY – COSMETIC

Please Read Carefully

In consideration of goods and services rendered to the Patient by 'Iowa Plastic Surgery, P.C. ('Provider'), the person ('Undersigned') signing this Payment Policy agrees to the following:

1. Agreement to Pay Charges - The Undersigned agrees to pay to Provider the total charges, on demand, for goods and services rendered. The Undersigned agrees to pay the charges that are listed in the current Provider fee schedule, which is available for inspection upon request. Provider reserves the right to accept periodic payment without waiving the right to demand payment in full as outlined above.

2. Surgery Charges - Surgery charges are payable in full at the time surgery is scheduled. Once surgery has been scheduled, $1000.00 of the fee is non-refundable due to costs incurred by the Provider at that time. Personal checks are accepted two weeks or more in advance of the surgery date.

3. Itemized Patient Bill - Upon request, the Undersigned will receive an itemization of charges for all goods and services rendered.

4. Procedures are Cosmetic - Not billed to Insurance - The Undersigned acknowledges that the Provider will not bill any insurance or third party payer, nor will the Provider submit/fill out insurance forms or provide diagnostic codes (these are cosmetic procedures and do not have applicable diagnostic codes). If the paying party chooses to submit insurance claims, payments made by insurance companies and received by the Provider, will be credited to the patient's account. The assignment of insurance benefits to the Provider, does not alter the Undersigned's obligation to pay for services rendered at the time of service.

5. Overpayment - Overpayment by or for the Patient will be applied to balances due, and then will be refunded to the paying party or held on account if requested by the paying party.

6. Returned Check or Chargeback Fee - Checks or charges returned from the bank will be reassessed to the patient account and bank charges added (minimum $25.00 fee).

7. Interest Charged - The Undersigned agrees that, if he/she is more than 30 days delinquent in the payment of any charges, interest may accrue at the maximum rate allowable by law.

8. Collection Costs - Should an account be more that 30 days delinquent it will be sent to collections. The Undersigned agrees to pay all collection costs, as well as reasonable attorney's fees, court costs, and other fees/expenses that Provider may incur in collecting any unpaid charges which were incurred for goods and services rendered by the Provider.

9. Decline Services - Provider reserves the right to decline further services to the Patient without notice.

10. Undersigned Authority - If the Undersigned and Patient are not the same, the Undersigned warrants that he/she has full legal authority to sign this Agreement on behalf of the Patient. The Undersigned shall be liable for all amounts due for goods and services rendered. If the Undersigned fails to make payment, this Agreement in whole, shall be binding upon the Patient's heirs, executors and administrators.

11. Notice to Undersigned - Do not sign this Agreement without having read it. All terms and conditions of this Agreement shall be valid and binding upon the Undersigned for any present or future services provided to the Patient by the Provider.

_____

Date Patient Signature Printed Patient Name

_____

Date Guarantor Signature Printed Guarantor Name

MEDICAL HISTORY

Patient's Name _____ Height _____ Weight _____

Name of Family Physician_____ Phone Number _____

Address _____

Do you take aspirin, ibuprofen or similar medications? □ Yes □ No

List Drug Sensitivities and/or allergies with reactions: None (circle if none)

_____

_____

Medications taken with dosage, including herbal medications and supplements: _____

_____

_____

Females**:** Are you currently pregnant? □ Yes □ No Last menstrual date? _____

List date(s) of childbirth(s) _____

List all previous surgeries with dates:_____

_____

_____

List all other hospitalizations with illnesses and year: _____

_____

_____

Do you use nicotine? □ Yes □ No What type? _____ How Much? _____

Do you consume alcohol? □ Yes □ No How much? _____

If necessary, will you accept a blood transfusion? □ Yes □ No

Do you now or have you ever had:

Anemia	□ Yes	□ No	Chronic Pain Disorders	□ Yes	□ No	Heart Disease	□ Yes	□ No
Diabetes	□ Yes	□ No	Epilepsy or Seizures	□ Yes	□ No	Easy Bruising	□ Yes	□ No
Asthma	□ Yes	□ No	Immune disorder/ HIV	□ Yes	□ No	Kidney Disease	□ Yes	□ No
Addiction	□ Yes	□ No	High Blood Pressure	□ Yes	□ No	Stomach Ulcers	□ Yes	□ No
Hepatitis	□ Yes	□ No	Bladder infections	□ Yes	□ No	Thyroid Problems	□ Yes	□ No
Glaucoma	□ Yes	□ No	Blood Clots in Legs	□ Yes	□ No	Emphysema/COPD	□ Yes	□ No
Counseling	□ Yes	□ No (if yes, see below)						

Regarding Counseling: Counselor/Physician Name, Date, and Nature of Counseling

_____

_____

_____

I attest that these statements regarding my medical history are true to the best of my knowledge.

Signature _____ Date _____

Cancellation Policy

Scheduling time for appointments and procedures takes planning and coordination. We understand that situations occur so if you anticipate not being able to make your scheduled appointment please let us know at least 24 hours beforehand. Failure to cancel your appointment before the 24 hour cancellation window or "no shows" will result in a twenty five ($25) fee.

I have read and understand the cancellation policy:

Patient Signature Date