Winslow

Facial Plastic Surgery

Patient Information Questionnaire

Mr./Mrs./Ms./Dr.

Name _____Date of Birth_____ Age_____

Address_____ City_____

State _____Zip_____ Sex: M F Marital Status: M S D W Sep

Home Phone _____ Cell _____ Work Phone _____

School/Employer_____ Occupation _____

Height_____ Weight_____ Has your weight changed more than 5 pounds in the past 6 months? Y N

E-mail_____

Emergency Contact

Name:_____ Phone:_____

Address:_____

Relationship to Patient: _____

Contact and Communications

What is your preferred method of contact? **HOME PHONE** **CELL PHONE** **EMAIL**

May we contact you/confirm appointments via text? Y N

May we contact you/confirm appointments via email? Y N

May we leave a voicemail or message with a family member for appointment reminders? Y N

This office routinely receives phone calls and other communications from a patient's family member or friend to get information about an appointment or to make a payment for a procedure.

Do you consent to communication between this office and a designated individual or individuals for scheduling and payment activities?
Y N

If yes, please provide the name(s) and relationship(s) of the individual(s):

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Patient Healthcare Providers

Please provide a list of all current treating physicians, including your Primary Care Physician:

Physician Name and Address: _____

Phone: _____ Specialty or Type of Practice: _____

Physician Name and Address: _____

Phone: _____ Specialty or Type of Practice: _____

Physician Name and Address: _____

Phone: _____ Specialty or Type of Practice: _____

What is your preferred pharmacy? NOT WALMART OR SAMS CLUB_____

Address: _____ Phone: _____

Briefly describe the reason for your consultation:

_____

_____

How did you hear about our office?

_____Television _____Magazine

_____Phone Book _____Newspaper

_____Internet _____Spa/Salon (specify)_____

Friend (name) _____

Doctor (name) _____

Medical History

It is vitally important to answer each question honestly. Failure to do so can lead to adverse events and therefore surgery may need to be rescheduled to safely proceed. If it is determined that you did not fully disclose information, an administrative fee may be assessed. This may be in addition to a rescheduling fee if it is necessary to reschedule.

List **ANY** allergies or previous adverse reactions to medications:

List **ALL** medications you are taking (including over-the-counter, herbal supplements or vitamins & hormones):

Previous Surgeries & Dates (including any cosmetic surgery):

Current Active Illness:

Are you currently being treated by a psychiatrist? Yes No Name/#

Have you been diagnosed with:

____Borderline Personality Disorder ____Major Depressive Disorder _____Schizophrenia

____Body Dysmorphic Disorder ____General Anxiety Disorder

Nicotine/Smoker/Vape/Gum/Patches/Pouches/Chew: Yes No Type/Packs per day_____

Alcoholic drinks per week: _____

Do you wear glasses or contacts?

Do you wear hearing aids?

Are you a difficult IV Stick?

Do you have a personal history of?

_____Heart Disease ____Alcoholism _____Heart Attack (date) _____Diabetes

_____Tuberculosis ____Stroke ____Asthma _____Heart Murmur

_____Breathing Problems ____Chest Pain _____Hepatitis/HIV _____Nose Bleeds

_____Glaucoma/Eye Disorder ____Dry Eyes _____Skin Cancer _____Arthritis

_____ Reflux ____Other Cancer _____Headaches _____Latex Allergy

_____Pulmonary Edema ____Thyroid Prob. _____Blood Disorders _____Seizures/Epilepsy

_____MRSA ____Cold Sores ____High Blood Pressure _____Varicose Veins

_____Bad Scarring/Keloid ____Facial Paralysis _____Bronchitis/Emphysema / Abnormal Lung Function

_____Mitral Valve Prolapse _____Irritable Bowel Disease _____Previous post operative complications

_____Immunosuppression _____Blood Clots _____Pulmonary Edema

_____Easy Bruising or Prolonged Bleeding

_____Autoimmune Disease (name)_____

_____Accutane Use (Past or Present) Date Discontinued: _____

_____Other _____

Please specify if you checked any medical history:

Family history of?

_____Heart Disease _____Diabetes ____Tuberculosis

_____Stroke _____Asthma

_____Hepatitis/HIV _____Glaucoma/Eye Disorder _____Skin Cancer

_____Arthritis _____Other Cancer _____MRSA

_____Bad Scarring/Keloid _____Depression _____Mental Illness

_____High Blood Pressure _____Seizures _____Blood Disorder

_____Easy Bruising or Prolonged Bleeding _____Bronchitis/Emphysema _____Blood Clots

_____Previous Post Operative Complications

_____Autoimmune Disease_____

_____Other _____

Please specify if you checked any medical history:

1. PATIENT CONSENT TO MEDICAL CONSULTATION AND TREATMENT

I, _____, hereby authorize Winslow Facial Plastic Surgery, its employees, agents and contractors (collectively "WFPS") to perform any and all routine tests and procedures and/or emergency interventions during and immediately after my treatment and/or procedure for the purpose of ensuring my health, safety and well-being. I understand that such tests, procedures and/or interventions shall be provided in accordance with all medical and aesthetic standards, pursuant to applicable statutes, rules, and regulations. I understand WFPS does not complete, submit, or otherwise enter FMLA, disability, insurance or other paperwork/forms on behalf of the patient. _____

I further acknowledge that no representations, warranties, or guarantees as to results or cures have been made to me by WFPS, nor have I relied upon any such representations, warranties, or guarantees.

_____

2. OTHER CONSENTS AND ACKNOWLEDGEMENTS

Privacy

I acknowledge that I have received a copy of the WFPS Patient Admission Packet, which includes but is not limited to the **HIPAA Notice of Privacy Practices ("Notice")**. I understand that I may obtain a written copy of this Notice at any time upon request or via the website at http://www.IndyFace.com. _____

Late or Cancelled Appointments/Refund Policy

I hereby acknowledge that if I am more than **ten (10) minutes** late for a scheduled appointment, I will be asked to reschedule my appointment. _____

I agree that if I miss or cancel any scheduled appointment with **less than 24 hours prior notice**, I will pay WFPS a $75.00 cancellation fee before a replacement appointment can be rescheduled. I understand that there are **NO REFUNDS** for aesthetic purchases or packages, prepurchase of injectables or aesthetic treatments. _____

I understand that no refunds are available for amounts paid toward a procedure or service, but that I may receive an in-office credit for the amount paid, subject to the Late or Cancelled Appointments Policy above.

_____

Further, I acknowledge that all in-office credits expire twelve (12) calendar months from the date of issue unless the credit is for a surgical procedure, in which case it will expire twenty-four (24) calendar months from the date of my most recent payment. _____

Insufficient Funds

I hereby agree that if I have a check returned for insufficient funds, there will be a $50.00 fee each time a check is returned, and I will pay WFPS the full amount of the returned check. Any check totaling more than $500 will be assessed an administrative fee of 2% of the total cost. I am responsible for any and all costs, including reasonable attorney fees generated in recovering these funds. _____

3. FINANCIAL AGREEMENT

I hereby agree to pay WFPS for all services rendered during my treatment and/or procedure. I understand that I must pay WFPS in full for any and all cosmetic procedures at least **three (3) weeks** in advance of the scheduled date of the procedure. I understand that WFPS does not accept or bill insurance for any treatments or procedures, and that if I elect to request insurance reimbursement on my own that WFPS accepts no responsibility. _____

I also acknowledge and understand that WFPS will not accept responsibility or involvement in negotiating a settlement on any claim. _____

_____ _____

Patient Signature Date

CONSENT FOR USE AND DISCLOSURE OF PROTECTED INFORMATION SECTION

Name: _____ DOB: _____ Telephone: _____

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to the use and disclosure of certain protected information to carry out treatment, payment activities, and healthcare operations. You will also be consenting to the use and disclosure of your image and contact information for other limited purposes listed below, unless you choose to restrict such use.

Your Consent will expire upon the end of the treating physician's practice of facial reconstructive surgery or your written revocation. There is no expiration of your Consent for the use or disclosure is for the purposes of medical or scientific research of use in Specialty Board examination absent your specific written revocation.

Notice of Privacy Practices: You have been provided a copy of our Notice of Privacy Practices and should review it carefully before you decide whether to sign this Consent. This Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

Right to Revoke: You have the right to revoke this Consent at any time by giving WFPS written notice of your revocation submitted to:

WFPS
2000 E. 116th Street, Suite 200
Carmel, Indiana 46032

The revocation must be signed by you or your legal representative. Please understand that revocation of this consent will not affect any action WFPS took in reliance on this consent before it received your revocation.

SECTION C: OTHER USES AND DISCLOSURES

In addition to the use and disclosure of protected health information for treatment, payment, and business operations, WFPS may wish to conduct surveys for purposes of patient satisfaction and quality assurance, seek testimonials from patients for use in public relations and advertising activities and use patient images for promotional purposes. Please initial your consent or refusal to the following:

Consent	Refuse	Use or Disclosure
		Photographic or video images for promotional and patient information/education in the office
		Photographic or video images for promotional and patient information/education outside of the office, to include social media
		Photographic or video images for medical Specialty Board in formulating its examination of applicant physicians.
		Photographic or video images in professional presentations or journal publications by Dr. Winslow
		Contact information for purposes of obtaining patient feedback, including testimonials for use in advertising and publication on various social media and other internet sites.*

***The organization that receives patient contact information has entered into a Business Associate Agreement with WFPS and is required to comply with all HIPAA privacy and security requirements under that Agreement.**

SECTION D. SIGNATURE AND ACKNOWLEDGEMENT

I have had a full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that by signing this Consent form, I am agreeing to the use and disclosure of my protected health information as set forth above.

Signature: _____ Date: _____

Authorization for Disclosure of Information

Because we offer an in-house surgical suite, it is required that we undergo peer review for accreditation purposes. A licensed medical professional will randomly pull charts for evaluation to ensure all standards are met and exceeded. We must obtain authorization for this practice; please be assured your information remains protected and is never released without additional consent.

I authorize Dr. Winslow to disclose complete information concerning her medical findings and treatment of the undersigned, from initial office visit until the date of the conclusion of such treatment, to those individuals who, in Dr. Winslow's sole determination, are required to receive such information *for the purpose of medical treatment, medical quality assurance and peer review.*

Patient Signature_____ Date_____

SURGICAL SCHEDULING PAYMENT AND REFUNDS

Thank you for choosing Winslow Facial Plastic Surgery ("WFPS") for your cosmetic and reconstructive needs. We strive to build and sustain a relationship of trust, honesty and respect with every patient we serve.
We realize that there may be times when a change in circumstances impacts our patients' ability to go forward with a surgery as planned, and that in some situations a patient may have to postpone or even cancel the surgery. Please understand that such changes not only affect Dr. Winslow and our staff but other patients as well. Because of this, we want to be very clear about how refunds are calculated if this happens to you.
To that end, please read the Acknowledgement and Agreement carefully, because when you initial and sign this document, you are indicating that you understand and agree to its terms. If you have questions, please contact the office.

ACKNOWLEDGEMENT AND AGREEMENT

Quote: Dr. Winslow's professional fee to perform all cosmetic procedures will be quoted to you in full at the time of your consultation. This quote is good for 1 month (30 days) from the date of the consultation.
This professional fee only covers the actual items and services performed by
Dr. Winslow – the procedure, the pre and post operative visits, and any implants associated with the procedure. Facility fees and any other service fees or costs will be included in your quote and broken down separately. These fees do not include any fees related to insurance. WFPS will not bill insurance.

Scheduling Surgery: I agree to pay WFPS fifty percent (50%) of the total surgical fee to schedule my procedure whether in person or by phone. Of that, 20% is a non-refundable amount. If electing to finance, payment will be required in full in order to schedule surgery. If financing, the non-refundable 20% cannot be financed and must be paid through another means.
I understand and agree that if I reschedule my procedure within 3 weeks of surgery or after the pre-operative appointment, I will be charged a rescheduling fee.
I understand in the event of any cancellation, I will forfeit the 20% non-refundable portion. Additionally, if surgery is cancelled, there will also be a $2000 administrative fee and a $500 consultation fee assessed.

Balance Due: I agree to pay WFPS the remaining 50% or whatever balance is due towards my procedure no later than THREE WEEKS prior to the scheduled surgery date OR one week prior to my pre-operative visit, whichever comes first. I understand and agree that if the 50% or remaining balance is not paid when due, my surgical procedure will be rescheduled, and that I will forfeit my 20% scheduling fee and will be charged a $2,000 administrative fee as well as a $500 consultation fee.

Cancellation: I understand and agree that any cancellation of a scheduled surgery must be in writing, and that any refund(s) due will be issued within 30 days after WFPS receives the cancellation notice. Any refund I receive shall be as follows:
Any Cancellation - Forfeit 20% scheduling fee, $2000 administrative fee and $500 consultation fee.

Time of Cancellation Refund Amount: After the pre-operative visit and more than 14 days prior to scheduled surgery; 50% of the total surgical fees paid to WFPS will be refunded after 20% and cancellation fees applied 6 to 14 days prior to scheduled surgery; 25% of total surgical fees paid to WFPS will be refunded after 20% and cancellation fees applied
5 days or less, day of surgery or post-surgery; No refund of any surgical fees paid to WFPS.

Partial Cancellation: I understand and agree that if any portion of the scheduled surgery is cancelled that I will forfeit a portion of my payments that equals 20% of the scheduling fees for the cancelled procedure, $2000 administrative fee and $500 consultation fee.

Release for Treatment Form: I understand that a Release for Treatment form(s) will be provided to me during my consultation, and that the form(s) must be completed by my primary care physician, as well as any other treating physicians indicated by Dr. Winslow, and that the form(s) MUST be provided to WFPS no later than my preoperative visit. I further understand and agree that this is my responsibility as a patient to ensure this occurs, and my surgical procedure may be postponed or cancelled as a result with failure to obtain this. If this occurs, above noted rescheduling and/or cancellation fees will be applicable.

Morphing: Any photographic morphing is a representation for purposes of education and illustration only and does not construe a guarantee or promise of any specific results or surgical outcomes.

AFFIRMATION OF SURGICAL SCHEDULING PAYMENT AND REFUNDS

I hereby affirm that I have carefully read this policy and fully understand how it may apply to me. I understand that I can call or email the office with questions prior to completing this document.

Any questions or issues I raised have been addressed to my satisfaction.

I agree that in the event I take legal action (including legal correspondence) in order to obtain a larger refund than is set forth in this policy, I will be responsible for WFPS' costs of responding to such action should the matter be settled or WFPS prevails in litigation. Cost shall include reasonable attorney fees.

I understand that by signing my name below that I am agreeing to the terms in this agreement and affirming my understanding of the same.

_____ _____

Patient Signature Date