

Date: _____

Patient Name: (Last) _____ (First) _____ (M) _____

Local Address: _____ City _____ State _____ Zip _____

Permanent Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ Age: _____ Sex: **M** **F** Marital Status: _____

Social Security: _____ Drivers License: _____
(If Using Insurance) (If Using Insurance)

Employer: _____ Occupation: _____

In case of emergency, contact: _____ Relationship: _____ Phone: _____

How did you hear about us? _____ Email: _____

If we are billing your insurance company please complete the following:

Primary Insurance Co: _____ Insurance Phone: _____ Policy #: _____

Group #: _____ Employer: _____

Policy Holder's Name: _____ DOB: _____ SSN: _____

Secondary Insurance Co: _____ Insurance Phone: _____ Policy #: _____

Group #: _____ Employer: _____

Policy Holder's Name: _____ DOB: _____ SSN: _____

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that payment for services, whether cosmetic or not, is solely the responsibility of the patient or their guarantor and as a courtesy Dr. Olack will bill my insurance. I hereby authorize Dr. J. Brian Olack to bill my insurance company or other third parties responsible for my medical charges. I also authorize Dr. Olack to release any medical information that may be requested by my insurance company to help with the process of my claims. I authorize and request that payment be made directly to Summit Healthcare Plastic & Reconstructive Surgery for all medical and surgical services. I understand that I am responsible for any balance not covered by my insurance company.

Signature of patient/responsible party/legal guardian

Relationship to patient

Date

Patient Name: _____ Today's Date: _____

What procedures are you interested in? _____

Are you in good health? **YES NO** If **NO**, provide reason: _____

Age: _____ Height: _____ Weight: _____

List all medications which you are currently or have taken in the last 6 months (*prescription and non-prescription*):

Medication(s) (<i>ESPECIALLY ASPIRIN</i>):	Amount:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take herbal supplements (*especially Gingko, Ginger, Garlic, St. John's Wort*)?: _____

Do you take vitamins (*especially C, E, Fish oils*)?: _____

List all drug allergies: _____

Are you a smoker? **YES NO** If **YES**, how much: _____ How long? _____ Quit how long ago? _____

How much alcohol do you drink? _____ Caffeine? _____

Have you had the following?

- | | | |
|--|---|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO Chest Pain | <input type="checkbox"/> YES <input type="checkbox"/> NO Anemia | <input type="checkbox"/> YES <input type="checkbox"/> NO Seizures |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Heart Murmur | <input type="checkbox"/> YES <input type="checkbox"/> NO Diabetes | <input type="checkbox"/> YES <input type="checkbox"/> NO Problems with Scarring |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Mitral Valve Prolapse | <input type="checkbox"/> YES <input type="checkbox"/> NO Cancer | <input type="checkbox"/> YES <input type="checkbox"/> NO Emotional Problems |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Rheumatic Fever | <input type="checkbox"/> YES <input type="checkbox"/> NO Breast Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO Eye Disease |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Palpitations | <input type="checkbox"/> YES <input type="checkbox"/> NO Thyroid Disorder | <input type="checkbox"/> YES <input type="checkbox"/> NO Eye Itching |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Shortness of Breath | <input type="checkbox"/> YES <input type="checkbox"/> NO Hepatitis | <input type="checkbox"/> YES <input type="checkbox"/> NO Eye Burning |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Heart Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO Kidney Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO Dryness of Eyes |
| <input type="checkbox"/> YES <input type="checkbox"/> NO High Blood Pressure | <input type="checkbox"/> YES <input type="checkbox"/> NO Asthma | <input type="checkbox"/> YES <input type="checkbox"/> NO Bleeding Disorders |

Is there any possibility that you may be pregnant at this time? **YES NO**

List all surgeries that you have had (*Include Plastic Surgery*):

Date:	Surgery:
_____	_____
_____	_____
_____	_____

Have you or anyone in your family ever had unusual reactions to anesthesia? **YES NO**

(*Muscle weakness, jaundice, breathing problems or unexpected fevers*)

Do you have (*circle all that apply*): **LOOSE OR CHIPPED TEETH / CAPS / DENTURES / CONTACT LENSES**

NOTE: Please stop aspirin products and other blood thinners 2 weeks prior to surgery or discuss with the doctor.

Patient Signature _____ Date _____

FINANCIAL AGREEMENT



GENERAL AGREEMENT

I recognize that the practice of medicine and surgery is not an exact science. I understand and accept that fees are paid for performance of the procedure(s) only, and not a guaranteed result. I acknowledge that although a good outcome is expected, and a reasonable effort has been made to establish realistic expectations, there cannot be any warranty, expressed or implied, as to the results that may be obtained.

PROBLEMS AND COMPLICATIONS

I understand and accept that problems relating to or complications of my surgery may result in additional costs to me. These costs may include additional anesthesia and facility fees, hospital costs, physician's fees or other unspecified charges that may not be covered, or only partially covered, by my health insurance.

REVISIONS AND TOUCH-UPS

I understand and accept that on occasion "touch-ups" or revisions of surgery are necessary. I acknowledge that in such cases I am responsible for all operating room and anesthesia charges. I am also aware and accept that a surgeon's fee may also be charged, at my surgeon's discretion. I understand and accept that the need for, and timing of, revisions and touch-ups will be determined solely by my surgeon, as will the amount of the surgeon's fee.

AESTHETIC SURGERY PAYMENT AND CANCELLATION

A fee of \$500 will be collected at the time of booking in order to schedule and secure a date and time in the operating room. Full payment will be required 14 days prior to the scheduled surgery date.

If, for any reason, I cancel my surgery 14 days prior to the date surgery is scheduled all payments are refundable.

If, for any reason, I cancel my surgery less than 14 days before my scheduled surgery date, my payment will be refunded less my non-refundable surgery scheduling fee. This will be forfeited and retained as a processing fee and not returned to me.

If my surgery must be cancelled because I fail to provide requested pre-operative lab work, X-rays, medical evaluation, history and physical, letter of medical clearance, or other requested

Initials _____ Date _____

medical information, my payment will be refunded less my non-refundable surgery scheduling fee. This will be forfeited and retained as a processing fee and not returned to me.

If, for any reason, I fail to show for scheduled surgery without providing notice, my payment will be refunded less my non-refundable surgery scheduling fee, the aftercare fee (if any), 50% of my quoted anesthesia fee, 50% of the facility fee, and 50% of the surgeon's fee. These will be forfeited and retained as processing fees and not returned to me.

If surgery must be rescheduled, all fees will be applied to the new procedure date, and the cost will remain the same, provided it is within 6 months of the original date. After 6 months, fees can still be applied, but there may be additional costs for anesthesia, facility, or surgeon's fees.

If a refund is needed, it will be issued in the form of a check even if a credit card payment was made. Please allow one to two weeks for processing.

DECLARATION

I certify I have read and understand the financial agreement and I accept and agree to all of the above.

Patient signature

Date

Witness signature

Date

Patient Copy

FINANCIAL AGREEMENT



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Patient Copy
FINANCIAL AGREEMENT
Continued



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DECLARATION

I certify I have read and understand the financial agreement and I accept and agree to all of the above.

Patient signature

Date

Witness signature

Date



OLACK
PLASTIC SURGERY

PRIVACY PRACTICES ACKNOWLEDGEMENT

I hereby acknowledge that I have reviewed the Financial Agreement, the Outpatient Bill of Rights, and the Summit Healthcare Notice of Privacy Practices. I understand that copies are readily available upon my request.

Patient Signature

Printed Name

Date

