SEASONS
PLASTIC & RECONSTRUCTIVE SURGERY
MICHELLE A. SPRING, M.D.

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www.seasonsplasticsurgery.com

We would like to welcome you as a new patient to Seasons Plastic & Reconstructive Surgery. We look forward to participating in your health care needs.

Here is a list of important information for your visit:

- Due to the high volume of patients, if you are not on time for your appointment, it may need to be rescheduled.
- We have a Medical Appointment Cancellation Policy (enclosed in New Patient Packet).
- If your insurance requires a referral or authorization, please make sure your Primary Care Physician (PCP) has certified your appointment with a written referral.
- Some insurance companies require a prior authorization to see a specialist PRIOR to your first appointment. If this applies to you, and you do not have a referral at the time of service, your appointment will need to be rescheduled.
- Bring with you to your appointment:
  - Current insurance information (claim #'s, insurance card(s), updated info, etc.)
  - Your (or your guardian's) Photo ID
  - New Patient Packet filled out in its entirety PRIOR to your appointment.
- If you do not have insurance, and are not a cosmetic patient, you will be required to pay a $150 deposit upon arrival. Any follow up visits will require a $75 deposit at the time of service. The balance of your visit will either be refunded or invoiced to you.
- If you are coming in as a result of a motor vehicle accident or a victim of violence or crime, we will require a $150 deposit upon arrival.
- Our business hours are Monday – Friday, 8:00am – 5:00pm.
- Please allow 48-72 hours for medication refills.

If you have any questions, please feel free to call our friendly staff, and we will be happy to assist you!

Truly Yours,

The Staff at Seasons Plastic & Reconstructive Surgery

CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY

CONFIDENTIAL HEALTH QUESTIONNAIRE

Patient Name ____

Birth Date ______________ Age __________ Height ____________ Weight ______________

Reason for this visit ____

SOCIAL HISTORY

Current Occupation: ______________________ Do you exercise regularly? ◻ Yes ◻ No

Who will care for you after surgery? ______________ What type of activity? ______________

Alcohol Use	◻ Yes	◻ No
Tobacco Use	◻ Yes	◻ No
Drug Use	◻ Yes	◻ No

If yes, amount of alcohol per week? ______________

Number of packs per day __________ Number of years __________

If yes, please describe ______________________

PERSONAL MEDICAL INFORMATION

Allergies: ____

Current Medications and Supplements *(including dietary supplements, nonprescription and herbal products)*

______________________________ Dose ______________

______________________________ Dose ______________

______________________________ Dose ______________

______________________________ Dose ______________

Past Medical History *(list any past or current medical problems or injuries)*

______________________________ Date ______________

______________________________ Date ______________

______________________________ Date ______________

______________________________ Date ______________

Operations, Procedures and Complications *(list any past or planned operations, including complications)*

______________________________ Date ______________

______________________________ Date ______________

______________________________ Date ______________

______________________________ Date ______________

REVIEW OF SYSTEMS

Unexpected Weight Loss	◻ Yes	◻ No	Recent fever	◻ Yes	◻ No	Stroke	◻ Yes	◻ No
Recent changes in appetite	◻ Yes	◻ No	Chronic dry eyes	◻ Yes	◻ No	Nervous breakdown	◻ Yes	◻ No
Ear, Nose, Throat problems	◻ Yes	◻ No	Seizures	◻ Yes	◻ No	Bulimia or anorexia	◻ Yes	◻ No
Heart attack	◻ Yes	◻ No	Heart failure	◻ Yes	◻ No	Unexplained infections	◻ Yes	◻ No
Irregular or rapid heart beat	◻ Yes	◻ No	Pulmonary edema	◻ Yes	◻ No	Cold sores around mouth	◻ Yes	◻ No
Angina or chest pain	◻ Yes	◻ No	High blood pressure	◻ Yes	◻ No	AIDS or HIV positive	◻ Yes	◻ No
Heart murmurs	◻ Yes	◻ No	Heart surgery	◻ Yes	◻ No	Immune disorders	◻ Yes	◻ No
History of rheumatic fever	◻ Yes	◻ No	Asthma	◻ Yes	◻ No	Menstrual abnormalities	◻ Yes	◻ No
Shortness of breath/wheezing	◻ Yes	◻ No	Chronic cough	◻ Yes	◻ No	Mood disorder	◻ Yes	◻ No
Frequent heartburn or reflux	◻ Yes	◻ No	Sleep apnea	◻ Yes	◻ No	Cancer or tumor	◻ Yes	◻ No
Jaundice or liver disease	◻ Yes	◻ No	CPAP machine	◻ Yes	◻ No	Blood transfusion	◻ Yes	◻ No
Stomach bleeding	◻ Yes	◻ No	Lung disease	◻ Yes	◻ No	Easy bruising	◻ Yes	◻ No
Stomach/duodenal ulcer	◻ Yes	◻ No	Abdominal pain	◻ Yes	◻ No	Frequent gum/nose bleeds	◻ Yes	◻ No
Diarrhea/constipation	◻ Yes	◻ No	Hepatitis	◻ Yes	◻ No	Autoimmune disease	◻ Yes	◻ No
Recent painful urination	◻ Yes	◻ No	Kidney disease	◻ Yes	◻ No	Anemia	◻ Yes	◻ No
Blood in urine	◻ Yes	◻ No	Arthritis	◻ Yes	◻ No	Thyroid disease	◻ Yes	◻ No
Unsightly/bothersome scars	◻ Yes	◻ No	Varicose veins	◻ Yes	◻ No	Diabetes mellitus	◻ Yes	◻ No

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Breast cancer	□ Yes	□ No	Muscle disease	□ Yes	□ No	Numbness/Tingling	□ Yes	□ No
Fibrocystic breast disease	□ Yes	□ No	Breast biopsies	□ Yes	□ No	Fainting/dizziness	□ Yes	□ No
Changes in skin color, temperature, rashes, lesions, scars, masses				□ Yes	□ No	Sensation Changes	□ Yes	□ No
Any history of problems with anesthesia? □ Yes □ No If yes, explain:								
Have you or any blood relative had problems with:								
Abnormal or excessive bleeding □				Abnormal or excessive blood clotting □				
Deep Venous Thrombosis (DVT) □				Pulmonary Embolism IPE) □			**None of these** □	

CHECK ANY FAMILY HISTORY OF THE FOLLOWING

Strokes	□ Yes	□ No	Who?
Heart Disease	□ Yes	□ No	Who?
Genetic Conditions	□ Yes	□ No	Who?
Diabetes	□ Yes	□ No	Who?
Breast Cancer	□ Yes	□ No	Who?
Breast Disease	□ Yes	□ No	Who?
Blood Clotting Problems	□ Yes	□ No	Who?
High Blood Pressure	□ Yes	□ No	Who?
Anesthesia Problems	□ Yes	□ No	Who?
Cancer: Type?	□ Yes	□ No	Who?

SKIN HEALTH HISTORY

Have you ever been under the treatment of a: Dermatologist □ Plastic Surgeon □ Aesthetician □

What skin care line are you currently using? ______________________________

Do you or have you used any oral or topical skin care products prescribed by a medical provider in the last year?

For example, Accutane, Obagi, Hydroquinone, Retin A or any medical grade skin care products

□ Yes □ No Which kinds? ______________________________

Have you ever been treated by a medical professional for acne? □ Yes □ No

Do you use a tanning bed? □ Yes □ No How often? ________________ Last use? ______________________

Females:

Is there a chance you are pregnant? □ Yes □ No

Do you take any type of hormone replacement? □ Yes □ No What type? _________________

Are you taking a birth control pill or hormone contraception? □ Yes □ No What type? _________________

Number of pregnancies ________ Number of live births _________ Age of children ____________ Future pregnancies?

Date of last mammogram? ________________ □ Normal □ Abnormal

______________________________ __________ ______________________________ __________

Physician Signature Date Patient Signature Date

MD Notes:

PATIENT INFORMATION

Please complete this form in its entirety as well as having your insurance and ID cards ready

PATIENT INFORMATION

Referred By____________________________________ Primary Care Physician______________________________________

Name ____ Soc. Sec. # _______________________

Last Name First Name Initial

Address ____

City ____ State ____________________ Zip _____________________

Sex ☐ M ☐ F Age_______ Birth Date_____________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Email Address ____

Patient Employed By____ Occupation___________________________

Home Phone ______________________________________ Work/Mobile Phone _________________________________

In case of emergency, who should be notified? _____________________________________ Phone ___________________

PRIMARY INSURANCE

Person Responsible for Account ____

Last Name First Name Initial

Relationship to Patient ________________________ Birth Date ___________________ Soc. Sec. # _____________________

Address (if different from patient's) ____

City ____ State _____________________ Zip ___________________

Person Responsible Employed By ____ Occupation______________________

Business Address ____ Business Phone _________________

Insurance Company ____ Insurance ID # ___________________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Y ☐ N

Subscriber Name ______________________________ Relationship to Patient ________________ Birth Date _____________

Address (if different from patient's) ____

City ____ State ______________________ Zip ____________________

Subscriber Employed by ____ Business Phone ______________________

Insurance Company ____ Insurance ID # ______________________

Names of other dependents covered under this plan ____

WORKMANS COMPENSATION INSURANCE IF WORK RELATED INJURY

Employer ____ Employer Phone ________________________

Insurance Carrier Name ____ Insurance Carrier Phone __________________

Date of Injury _____________________ Claim # ______________________ Adjustor Name __________________________

AUTOMOBILE INSURANCE IF AUTOMOBILE ACCIDENT RELATED

Insurance Carrier Name ____ Insurance Carrier Phone __________________

Insurance Billing Address ____ Adjustor Name __________________________

Date of Accident _____________________ Claim # ______________________

PEOPLE AUTHORIZED TO RECEIVE INFORMATION

(Only people listed below will be able to receive your medical information)

Name and Relationship to Patient ____ Phone # ____________________

Name and Relationship to Patient ____ Phone # ____________________

Name and Relationship to Patient ____ Phone # ____________________

ASSIGNMENT AND RELEASE

- **PLEASE BRING INSURANCE CARDS AT THE TIME OF YOUR VISIT (if applicable)**
- **ALL CO PAYMENTS OR DEPOSITS ARE DUE AT TIME OF SERVICE (if applicable)**
- If you do not have health insurance to bill, you will be required to make a deposit of $150.00 on your first visit. A deposit of $75.00 is required for all follow-up visits.
- If you are a cosmetic patient, your insurance will not be billed and payment is due in full at the time of service.

Seasons Plastic & Reconstructive Surgery relies on the insurance and billing information provided to us by you or your referring provider. In the event that this information is not accurate, a case deposit may be required, or your appointment may need to be rescheduled. After services are provided, we will submit our claim to your insurance carrier if applicable. In the event that payment is denied, the patient is responsible for full payment. All patient balances are due within 30 days of the statement date. It is the patient's responsibility to contact the billing department if this obligation cannot be met. Seasons Plastic & Reconstructive Surgery is committed to assisting our patients in meeting their financial responsibility; however, if arrangements are not made, we will utilize the services of a credit bureau or a collection agency. I hereby assign Seasons Plastic & Reconstructive Surgery all money due for medical and/or surgical services rendered by Seasons Plastic & Reconstructive Surgery in the event of a settlement. I authorize Seasons Plastic & Reconstructive Surgery to send my medical information to my primary care provider and/or referring provider as necessary.

ASSIGNMENT: I HAVE READ, COMPLETED, AND FULLY UNDERSTAND THE ENTIRE PATIENT INFORMATION PACKET. I HEREBY AUTHORIZE PAYMENT OF MY INSURANCE BENEFITS DIRECTLY TO THE PHYSICIAN AND RELEASE OF ANY INFORMATION REQUIRED.

______________________________	______________________	______________
Responsible Party Signature	Relationship	Date

MEDICAL APPOINTMENT CANCELLATION POLICY

Due to busy scheduling, we require 24 hour notice of cancellation. Failure to notify the office will result in a $50.00 fee. This charge cannot be billed to your insurance carrier, therefore you will be responsible for the payment.

If you are continually unable to notify the office of a cancellation in a timely fashion, we may be unable to continue to provide services.

I have read, and understand, the above information:

______________________________	______________________	______________
Responsible Party Signature	Relationship	Date

INSURANCE POLICY

To accommodate the needs and requests of our patients, we participate with certain insurance plans. We are pleased to be able to provide this service to you, yet it is very difficult for us to keep track of all the individual requirements of each plan as they change from time to time. It is ultimately your responsibility to check with your insurance to understand the contract and coverage.

Each plan has different restrictions regarding how often services may be rendered or more importantly, where you should obtain these services.

SP&RS contracts/participates with the following insurance payers:

Blue Cross* **Regence** **Medicare** **Medicaid****

You must have a referral to our facility with all managed care plans. Each authorization will specify the number of visits and expiration date. The patient is responsible for knowing when this authorization expires. Please contact your **primary care physician (PCP)** to find out the status of your referral before your scheduled appointment.

Providing the highest quality of care for our patients is our primary concern. We are more than willing to provide care within your insurance plan guidelines whenever possible. As a surgeon's office, we will contact your insurance for any pre-authorization for surgical procedures. To be sure there are no surprises, please check with your insurance regarding your benefits.

If you do not inform us of special requirements required by your plan and we perform a service that is not covered by your plan, we will bill you directly for those charges.

By working together, we can assist you in receiving the benefits you are entitled to. Any questions, please contact our office at (208) 265-4005.

I have read and understand the office policy stated above and agree to accept responsibility as described.

*Although we are contracted with *most* of these insurance plans, there are still some that we are either not contracted with and/or will need a written referral for prior to your first appointment. These include (but are not limited to) HMO, Managed Care, and Medicare Advantage plans. If you aren't sure about your plan, please don't hesitate to ask us!

**All Medicaid patients will need a Healthy Connections Referral from their PCP prior to their first appointment with us.

PATIENT CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Responsible Party Signature	Relationship	Date
______________________	______________________	______________

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AUTHORIZATION FOR AND RELEASE OF

MEDICAL PHOTOGRAPHS, SLIDES, DIGITAL IMAGES, AND VIDEOTAPES

INSTRUCTIONS:

This is a consent document that has been prepared to help inform you concerning permission to take photographs, slides, digital images, and videotapes and to use these images for a purpose as defined within this consent document. It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by Dr. Spring or her representative.

INTRODUCTION

Medical photographs, slides, videotapes or any other images of you, or components of your medical record, may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images. Additionally, patients may consent to release these medical photographs, slides, images, and videotapes for a stated purpose.

1. CONSENT TO TAKE PHOTOGRAPHS, SLIDES, DIGITAL IMAGES, AND VIDEOTAPES

I hereby authorize Michelle Spring, MD and or her associates or licensees to take pre-operative, intra-operative, and post-operative photographs, slides, digital images and videotapes. I additionally consent to photographs, slides, digital images and videotapes of my interview, if applicable.

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Michelle Spring, MD and or her associates or licensees to use pre-operative, intra-operative, and post-operative photographs, slides, digital images and videotapes for professional medical purposes deemed appropriate including but not limited to electronic digital networks including electronic medical records, print or visual or broadcast media, for purposes of examination, testing, credentialing and/or certifying purposes, for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups, for marketing and advertising, and for use in supporting documentation for insurance or third-party payer purposes, medical teaching, research or dissemination of medical information to medical and nonmedical audiences, including, but not limited to, journal or book publications, presentations, conferences or meetings.

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

I understand that I will **not** be identified by name in any release of these materials but in some cases the images may contain features that may make my identity recognizable. I release and discharge Dr. Spring and all parties acting on her authority from all rights that I may have in these images, and from any claims that I have related their use in the above mentioned manner.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and /or my interview.

Patient Name: ____________________________ Date: ____________________________

Patient Signature: ____

Witness: ____

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