MELANIE PRINCE, MD
PLASTIC SURGERY

Patient Information

Date_____

Last Name_____ First Name_____ MI_____

Age_____ DOB_____ SS#_____ - _____ - _____ Sex Male □ Female □

If patient is a minor: Parent/Legal Guardian_____ SS#_____ - _____ - _____

Address_____ City_____ State_____ Zip_____

Email Address_____

Home Ph(_____)_____ Cell Ph(_____)_____ Work Ph(_____)_____

Employer_____ Occupation_____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

Emergency Contact_____ Relationship_____ Ph(_____)_____

PCP_____ Address_____ Ph(_____)_____

Pharmacy_____ Address_____ Ph(_____)_____

How did you hear about Melanie Prince, MD?_____

□ Referral_____ □ Friend_____ □ Internet_____ □ Ad_____

Insurance Information

Insurance Company_____

ID#_____

Group#_____

Subscriber Name_____

Relationship_____

DOB_____ SSN_____

Subscriber Employer_____

Subscriber Address_____

_____

Insurance Company_____

ID#_____

Group#_____

Subscriber Name_____

Relationship_____

DOB_____ SSN_____

Subscriber Employer_____

Subscriber Address_____

_____

Signature

Authorization: I hereby state the above information is true and correct to the best of my knowledge. I authorize Melanie Prince, MD, to release any information acquired in the course of my treatment to my insurance company, employer, other physicians, institutions, and/or third-party payor, as required for certain claims. I authorize Melanie, Prince, MD, to obtain any information from other physicians or institutions as needed for continuation of care.

Assignment of Benefits: I authorize direct payment to be made to Melanie Prince, MD, for any and all medical or surgical services rendered. I understand if any service or charges are not covered by my insurance carrier or if my eligibility cannot be verified, I am responsible for all charges incurred.

Acknowledge of Receipt of Privacy Notice: I hereby acknowledge the receipt of the Notice of Privacy Practices (attached) given to me by Melanie Prince, MD, PA. The notice describes the types of uses and disclosures of my protected health information (PHI) that might occur in my treatment, payment of my bills, or in the performance of health care operations.

You have my permission to discuss my medical care with: _____

Signature: _____ **Printed Name**: _____ **Date**: _____

8201 Cantrell Road, Suite 150 · Little Rock, AR · 72227 · Ph 501.225.3333 · Fax 501.225.3338
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Medical Questionnaire

Reason for consult_____ Referring MD_____

Height_____ Weight_____ Race_____

Past Medical History: List any medical conditions for which you have been treated

_____

_____

Do you have a history of:

High Blood Pressure		Bleeding Disorders		Diabetes	
Blood Clots / DVT / PE		Cancer: Type_____		HIV / AIDS	
High Cholesterol		Breast Disease		Depression / Anxiety	
Heart Disease		Autoimmune Disease		Kidney Disease	
Heart Attack		Acid Reflux / Ulcers		Stroke	
Asthma		Hepatitis		Seizures	
Thyroid Disease		Sleep Apnea / CPAP		Poor Circulation	

Past Surgical History: List any surgeries you have had

Surgery_____ Year_____ Hospital_____

Surgery_____ Year_____ Hospital_____

Surgery_____ Year_____ Hospital_____

Surgery_____ Year_____ Hospital_____

Surgery_____ Year_____ Hospital_____

Current Medications: Please include name, dose, frequency (Include herbal supplements)

_____

_____

_____

_____

Allergies:

Medication_____ Reaction_____

Medication_____ Reaction_____

Medication_____ Reaction_____

Medication_____ Reaction_____

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Medical Questionnaire (cont.)

Anesthesia: Have you or your family ever had difficulty with anesthesia? □ No □ Yes

Please explain_____

Family History:

	Father	Mother	Children	Siblings	Grandparent	Other
Alive (Y / N)						
Ages						
Health						

Social History:

Tobacco use: □ Never □ Previously Quit, Date_____ □ Yes, Type_____ Amount_____

Exposure to Nicotine / Second-Hand Smoke: □ No □ Yes, How Often_____

Alcohol use: □ Never □ Rare □ Occasionally □ Frequently □ Daily, Amount_____

Drug use: □ Never □ Rare □ Occasionally □ Frequently □ Daily, Amount_____

Type of water system in your home: □ Well Water □ City Water

For Women Only:

Bra Size_____ Desired bra size_____ Are you currently breastfeeding □ Yes □ No

Number of pregnancies_____ Number of living children_____ Ages_____

Date of last menstrual period_____ Could you possibly be pregnant □ Yes □ No

Last mammogram_____ Results_____ Facility_____

Last PAP smear_____ Results_____

Review of Systems: Please check the following that currently pertain to you

General	___ Weight changes ___ Fatigue ___ Chills ___ Fevers
Head / Neck	___ Eye pain ___ Excessive tearing ___ Dry eyes ___ Double vision
	___ Difficulty chewing ___ Dentures ___ Hearing loss
Cardiovascular	___ Chest pain ___ Irregular heartbeat ___ Extremity swelling
Pulmonary	___ Shortness of breath ___ Recent cough ___ Congestion
Gastrointestinal	___ Ulcers ___ Heart burn ___ Constipation ___ Diarrhea
Genitourinary	___ Pain with urination ___ Kidney stones
Skin	___ New or changing lesion ___ Previous skin cancer ___ Rash
Hematologic	___ Abnormal bleeding ___ Easy brusing
Neurologic	___ Stroke ___ Seizures ___ Sensory loss
Psychiatric	___ Depression ___ Anxiety ___Alcoholism ___ Drug dependence

If yes to any of the above, please explain:

_____

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Authorization for Use and Release of Medical Photos

Required:

I, _____, agree that Melanie Prince, MD, or designated representative, may take and use preoperative, intraoperative and postoperative photographs of my person for my confidential clinical record. The photographs will remain property of Melanie Prince, MD, PA.

Signature: _____ **Printed Name**: _____ **Date**: _____

Optional:

I grant my permission for the use of photographs, videotapes, or case information for the following additional purposes below. I understand that such consent is strictly on a voluntary basis. While every effort is taken to preserve the confidentiality of my identity, some photographs may make me identifiable to others. I will not be identified by name in any publication. I understand I will not be entitled to monetary payment as a result of use of the images. I consent for my photographs to be used by Melanie Prince, MD, PA, in the following education and scientific settings:

- At Dr. Prince's office to help educate other patients
- On Dr. Prince's website to help educate other patients
- Lectures given by Dr. Prince to the general public for education purposes
- Newspaper and/or magazine articles in which Dr. Prince participates
- On social medical platforms to help educate patients
- Television programs in which Dr. Prince participates.

Signature: _____ **Printed Name**: _____ **Date**: _____

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Financial Policies

Appointment Cancellation Policy: Prince Plastic Surgery is committed to providing each of our patients with exceptional care. When a patient cancels without giving enough advance notice, they prevent another patient from being seen. Please call our office two business days prior to your scheduled appointment to notify us of any changes or cancellations. If prior notification is not given, a $50 fee for the missed appointment will be charged to the credit card provided at the time of booking.

All payments are expected at the time of service: Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable co-insurance and co-payments for participating insurance companies. We accept cash, personal checks (in-state only), credit/debit card, and Care Credit. There is a service charge for returned checks.

Credit Card on File Authorization: For your convenience, our office can keep your credit card information on file for any future charges you may incur. Your card will automatically be charged for each account balance as it occurs. It is your responsibility to notify us of any changes to the credit card information provided. This service is optional and is not required and may be cancelled at any time by submitting a written request. Please initial one of the following:

_____ Please keep my credit card information on file. I authorize Prince Plastic Surgery to charge my card for all future services and fees.

_____ I prefer to receive paper statements for any future services.

Insurance: Your insurance card and photo ID must be presented at your initial visit; otherwise, full payment will be due. You are responsible for getting a referral, if needed, from your primary care physician. You are also responsible for determining if Dr. Melanie Prince is in-network or out-of-network with your insurance company. If you are being seen for a medically necessary condition or procedure, your insurance will be billed for all applicable visits, including initial consultation. As a service to our patients, our office will submit charges for medical / surgical treatments to the patient's insurance company. However, the patient is primarily responsible for paying any and all medical expenses incurred. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you are expected to pay the balance in full. You are responsible to be sure all charges are paid.

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1826(a)(1) of the Medicare law. If Medicare determines that a particular service, even though it may be otherwise covered, is "not reasonable and necessary" under Medicare program standards, Medicare or other insurance companies could deny payment for service. If you are a Medicare recipient, you must sign an Advance Beneficiary Form prior to your procedure.

We attempt to verify in advance that your insurance company will pay for specific medical procedures. On occasion, even though coverage was verified before the medical / surgical services were provided, the insurance company can deny the claim. If your claim is denied, you are personally and fully responsible for payment in full within 30 days.

Cosmetic: All cosmetic fees must be paid prior to service. To schedule surgery, a deposit of $500 is required to reserve operating room time, which will be applied to your balance. The deposit is refundable for up to one month to the calendar day of your procedure, and thereafter becomes non-refundable. The deposit must be paid with either cash, check, or credit/debit card. Care Credit will not be accepted for the deposit. The remaining balance must be paid one month prior to surgery and may be paid by any method you choose. If payment has not been received, surgery may be cancelled, and the deposit will not be returned. If you choose to cancel your surgery with less than a one-month notice, the entire surgery fee becomes nonrefundable.

Additional Information: *Disability forms:* There will be a $25.00 service charge for those requiring disability form completion. This will be due prior to the forms being sent. *Returned check:* There will be a $25.00 service charge on any returned checks. *Rescheduling:* If your surgery must be rescheduled with less than a one-month notice, a $1000 rescheduling fee will be charged.

Signature: _____ **Printed Name**: _____ **Date**: _____

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