

MELANIE PRINCE, MD

PLASTIC SURGERY

Patient Information

Date _____
Last Name _____ First Name _____ MI _____ Age _____ DOB _____
SS# _____ - _____ - _____ Birth Sex Male Female Gender Identity _____
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 _____	Insurance Company _____
ID# _____	ID# _____
Group# _____	Group# _____
Subscriber Name _____	Subscriber Name _____
Relationship _____	Relationship _____
DOB _____ SSN _____	DOB _____ SSN _____
Subscriber Employer _____	Subscriber Employer _____
Subscriber Address _____	Subscriber Address _____
Office or Specialist Co-pay: \$ _____	Office of Specialist Co-pay: \$ _____

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:** _____

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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 _____

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

Please explain _____

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Medical Questionnaire (cont.)

Family History:

Father

Mother

Children

Siblings

Grandparent

Other

Alive (Y / N)

Ages

Health

Have any of your family ever had blood clots? No Yes

Please explain _____

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 bruising

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.

Consultation Appointments: If two business days prior notification is not given, the \$100 consultation fee will be forfeited. If greater than two business days notification is given, the \$100 consultation fee will be converted to an in-office credit that can be used on other products and services.

Non-Consultation Appointments: If two business days prior notification is not given, a \$75 fee 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, Care Credit, and PatientFi. Refunds needed for credit/debit card purchases will be issued to the card that was used at the time of payment. Care Credit and PatientFi are accepted for cosmetic services only.

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 \$1,000 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

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cash, check, or credit/debit card. Care Credit and PatientFi 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 surgery is cancelled 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:** _____