Schaffer Plastic Surgery

PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt # :_____

City: _____ State: _____ Zip: _____

Best Phone: (_____) _____ E-mail Address: _____

Age: _____ Birth date: _____ Sex: Female / Male SS#: _____

Employer: _____ Occupation:_____

Employer Address: _____City: _____ State: ____Zip: _____

MARITAL STATUS: Single / Married / Divorced / Widowed

Spouse's Name _____Spouse Phone # (_____)_____

Spouse's Employer/Occupation: _____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship:_____

Phone: (_____)_____

INSURANCE INFORMATION:

Primary Insurance:_____ Policy #:_____

Policy Holder/Relationship :_____ Group#:_____

Policy Holders DOB:_____

HOW DID YOU HEAR ABOUT DR. SCHAFFER:

___Referral from Doctor: Name of Doctor:_____

___Referral from patient: Name of Patient:_____

___Family/ Friend:_____

___Internet/Web:Site:_____

___Other:_____

CONSULTATION INFORMATION

1. What specifically do you wish to talk about today? _____

2. Have you had ANY previous surgery (Cosmetic/General)? YES / NO If Yes, What procedure and year: _____

_____

_____

PLEASE CHECK (AND NUMBER IN PRIORITY) OF PROCEDURE(S) YOU ARE INTERESTED IN:

___ Abdominoplasty/Tummy Tuck	____ Brow Lift	____ Laser Resurfacing/Area(s):_____
___ Brachioplasty/ Arm Lift	____ Chin Augmentation	____ Injectables- Botox / Juvederm / Other
___ Breast Augmentation/ Implants	____ Blepharoplasty: Eyelids	____ Scar Revision-Area(s):_____
___ Breast Lift/ Mastopexy	____ Facelift	_____
___ Body Lift	____ Rhinoplasty/Nose Surgery	_____
___ Otoplasty/Protruding ears	____ Septoplasty	_____

___ Liposuction: Area(s)_____

___Other: _____

_____

_____

PERSONAL MEDICAL HISTORY

Medications(prescribed, blood thinners and OTC): _____

_____

_____

_____

Allergies (latex, betadine, tape, drug, etc): _____

_____

SOCIAL HABITS:
Smoke: Yes / No , If Yes, PPD: _____ Alcohol: Yes / No, If Yes, Amount: _____

R.O.S
Do you have any serious illnesses? Yes / No If Yes, explain: _____

_____

PLEASE CHECK IF YOU HAVE A PERSONAL CURRENT OR PAST HISTORY OF:

___Abnormal Bleeding ____Abnormal Clotting ____Acid Regurgitation ____Anemia ____Stroke ____Heart Attack

___Asthma ____Diabetes ____Hypertension ____Fainting Spell ____Hepatitis ____Sleep Apnea

____Major Weight gain/loss

Other:_____

FEMALE PATIENTS ONLY:

Number of Pregnancies:_____ Births:_____Last menstrual cycle:_____ Hysterectomy? _____
Date of last Mammogram:_____ Results:_____

FAMILY HISTORY:

Have any blood relatives ever had the following problems:

____Tape Allergy ____ Cancer ____Hypertension _____Kidney Disease ____ Abnormal Bleeding ____Stroke

____Coronary Surgery _____Abnormal Clotting ____Diabetes _____Anesthetic Problems ____Heart Attack

Other Serious Illness (Please describe):_____

_____

ANY OTHER COMMENTS/CONCERNS: _____

_____

_____

_____

_____

_____

Printed Patient Name

_____

Patient Signature

_____

Date

Schaffer Plastic Surgery

CHRISTOPHER J. SCHAFFER M.D

HIPAA

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

I acknowledge that I was provided with a copy of Christopher J. Schaffer M.D. and Schaffer Plastic Surgery Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. Provided that Christopher J. Schaffer, M.D. continues in its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my health information for the purpose and the activities permitted under the federal privacy law, which are described in the Notice of Privacy Practices.I understand that I should read the Notice of Privacy Practices carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by requesting one at the office of Christopher J. Schaffer, M.D.

_____

Printed Patient Name (or Personal Representative)

_____ Date:_____

Signature of Patient (or Personal Representative)

If you received this form electronically, please sign and date the form and return it to the office of Christopher J. Schaffer, M.D.

3595 GRANDVIEW PARKWAY SUITE 150
BIRMINGHAM, AL 35243
(205)278-7969

Schaffer Plastic Surgery

PHOTO/MEDIA RELEASE

Authorization for and Release of Medical Photographs/Media

I consent to the taking of photos, slides or video footage (portfolio, website, Facebook, Instagram, and/or Snapchat) by Dr. Christopher Schaffer or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Christopher Schaffer. I further authorize Dr. Christopher Schaffer or one of his/her associates to release to the American Society of Plastic Surgeons ("ASPS") such images.I hereby grant permission for the use 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. Neither I nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the images may portray features that will make my identity recognizable.I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, from Dr. Christopher Schaffer.I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire one year from the date written below.I understand that the information disclosed, or some portion thereof may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that because ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA the information described above may no longer be protected by HIPPA.I release and discharge Dr. Christopher Schaffer, ASPS, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I CERTIFY THAT I HAVE READ THE ABOVE AUTHORIZATION AND RELEASE AND FULLY UNDERSTAND ITS TERMS.

_____

Printed Patient Name

_____

Patient Signature

_____

Date

I have read the above Authorization and Release, I am the parent, guardian, or conservator of the above patient, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

_____

Parent/Guardian Printed Name

_____

Parent/Guardian Signature

_____

Date

Schaffer Plastic Surgery

FINANCIAL POLICY

Health Insurance is considered a method of partial reimbursement to patients for fees paid to the doctor and should not be considered a substitute for payment. Some insurance companies' pay fixed allowances for certain procedures and others pay a percentage of the charge after a deductible. it is the patients responsibility to pay any deductible amount, co-insurance, or any other balances not paid for by his or her insurance prior to procedure.

For Your Approval:

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of my medical record.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, in regard to the services and procedure(s) performed including private insurance and other plans to Schaffer Plastic Surgery, P.C.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary to secure payment.

ALL COPAYS, DEDUCTIBLES, AND/OR CO-INSURANCE FEES ARE DUE IN OUR OFFICE PRIOR TO DATE OF PROCEDURE.

I understand that i am financially responsible for all charges not covered in whole or in part by insurance. If these services are covered by insurance, I authorize you to release my medical records for insurance purposes and to file with my insurance carrier on my behalf. I assign any payments directly to Dr. Christopher J. Schaffer for the covered procedures. As consideration for the services provided, I agree to pay all charges for services not covered by my insurance carrier. If payment has not been received in completion of treatment, the physician may, at his discretion, place the unpaid account with an attorney for collection. If this action is necessary, I agree to pay an attorney's fee, court cost, and any other reasonable cost of collection.

I understand that a check returned by my bank for any reason is subject to a $50.00 service charge.

I consent to necessary treatment, including drugs and medications, tests, and procedures that may be administered or performed by attending physicians, nurses, and/or staff.

_____ _____

Printed Patient Name Date

_____ _____

Patient Signature Date