ETPS
East Tennessee Plastic Surgery

Date _____

GENERAL INFORMATION

Name (first, middle, last) _____ Gender _____ DOB ___- ___- ___ Age ___

Mailing Address _____ City _____ State _____ Zip_____

Street Address (if different than above) _____ Email _____

Home Phone (_____) _____ Cell Phone (_____) _____

Social Security # _____ Marital Status Married ____ Single ____ Divorced ____

EMERGENCY CONTACT

Emergency Contact (other than spouse) _____ Relationship to Patient _____

Phone number (_____) _____

GENERAL AUTHORIZATION – ALL PATIENTS PLEASE READ AND SIGN

ASSUMPTION OF RESPONSIBILITY: the undersigned, whether he/she signs as an agent or as a patient, agrees to pay East Tennessee Plastic Surgery all fees for services rendered. This includes services rendered at our office and practice/surgeon fees for services rendered at an outside facility. Should the account be referred for collection, the undersigned shall pay all reasonable fees and collection expenses. All delinquent accounts to bear interest at the legal rate. It is understood that bills are payable within 30 days of receipt. I have read and understand the above information. It is understood that all injectable service payments are due the day of procedure.

Signature _____ Date _____

ALL INSURANCE AND COSMETIC PATIENTS – PLEASE READ AND SIGN

A **NONREFUNDABLE** deposit of $500 is required to schedule surgery. The remaining surgery balance is due four weeks before your surgery. If you cancel surgery after the balance is paid in full, $500 or 25% of the price of the practice fee (whichever is greater) will be forfeited. If you need to reschedule surgery before the balance is due, a second deposit of $500 is required. We accept cash, checks, and all major credit cards. We also accept Care Credit. Any refunds on credit cards will be assessed a 3.5% refund fee. **East Tennessee Plastic Surgery** will **NOT** file health insurance or provide information for the patient to file health insurance on any procedure or surgery that is paid for as cosmetic by the patient. **You will receive more detailed policies with your quote**. I have read and understand the above information regarding payments to East Tennessee Plastic Surgery.

Signature _____ Date _____

ALL INSURANCE PATIENTS – PLEASE READ AND SIGN

ASSIGNMENT OF INSURANCE BENEFITS: I/We hereby guarantee payment of all charges incurred for the account of the above said patient from the date of first treatment until discharge or termination of treatment. I/We hereby assign all insurance benefits to be paid to East Tennessee Plastic Surgery, P.C. I understand that I am responsible for any deductible and co-insurance. I authorize the release of my medical records to the insurance company for the determination of benefits. All non-covered expenses will be considered cosmetic and applicable policies will apply. I have read and understand the above information.

Signature _____ Date _____

MEDICARE and MEDICARE HMO PATIENTS – PLEASE READ AND SIGN

I request that payment of authorized Medicare benefits be made to East Tennessee Plastic Surgery for any covered services furnished to me by a provider at ETPS. I authorize the release of my medical records to Medicare for benefits to be determined. I understand that I am responsible for my deductible and 20% of the allowable Medicare charges (if not covered by my secondary insurance carrier or if I do not have secondary insurance). All non-covered procedures will be considered cosmetic and applicable policies will apply. I also request that payment of authorized Medigap benefits be made on my behalf to above listed provider and authorize release of medical information required to determine.

Signature _____ Date _____

PRIVACY POLICY

I have had the opportunity to review the privacy policy and have been offered a written copy of this policy.

Signature _____ Date _____

MEDICAL HISTORY

Primary Care Physician: _____ Office Phone Number (____) _____

Last date of visit to Primary Care Physician: _____ Other Physicians you have seen in the last year:

_____

History- Past and Current Problems:

Any changes in the last year to your medical history: □ No Medical Problems □ No □ Yes (please list below)

_____

_____

Current medications – prescription and non-prescription with doses: _____

_____

_____

Do you take Aspirin? Yes ____ No_____ Reason_____ Prescribing Physician: _____

Do you take a GLP-1? Yes _____ No _____ **If "yes", please list name_____**

Do you take: (circle all that apply) Ibuprofen Turmeric Flax Seed Fish Oil Vitamin E or **NONE**

Other supplements/vitamins: _____

Allergic to medications: □No □Yes (list with reaction)

_____

Allergic to Latex: □No □Yes and list reaction_____ **Allergic to Adhesives:** □No □Yes

Past Surgical History: Any changes in the last year to your surgical history: □ No □ Yes (Please list below with dates)

_____

_____

Social History:

Current Nicotine Use: □No □Yes/ Packs per day_____History of use: □No □Yes and cessation date: _____ **Vape**: □No □Yes

Drug Use History: □No □Yes/ Type_____ **Alcohol Use:** □No □Yes and Amount: _____

CONTACTING YOU

There may be occasions in which our office needs to contact you concerning your appointment, diagnostic testing results, billing problems, or any information pertaining to special services or promotions currently being offered at the office, or any other situation relating to your visit at our office. Please read and answer the following:

East Tennessee Plastic Surgery has permission to contact me by the options checked below:

Home _____ Cell _____ Text _____ Work _____ Email _____

ADVANCED DIRECTIVES

Do you have a current Advanced Directives: Yes _____ No _____

If you answered "Yes" to the question above, do you have a Do Not Resuscitate Order? Yes _____ No_____

If you would like more information on Advanced Directives, please visit: https://www.tn.gov/health/healthyaging/healthcare-decisions.html