COTTER
PLASTIC SURGERY



**WELCOME!** Thank you for selecting COTTER PLASTIC SURGERY! We strive to provide you with the best possible health care. To help us meet all of your healthcare needs, please complete this form in **ink**. If you have any questions or need assistance please ask, we will be happy to help!

**PLEASE SIGN AND DATE AT THE END OF THIS SECTION**

**Personal Information**

Date: ______________ Patient's Name: ________________________________ Prefer to be called: ____________________

Birthdate: __________________________ Current Age: ___________ Soc. Sec. #: ________________________________

Address: __________________________________________ City, State, Zip: _____________________________________

Home Phone: _____________________ Cell Phone: ______________________ Work Phone: ______________________

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell Cell Carrier ______________________________

When is the best time to call? ☐ AM ☐ PM Email Address: ______________________________________________

Employer: _____________________________________________ Occupation: ____________________________________

Referred by: ___________________________________________ Family Physician: _________________________________

Specialists: ______________________________________________________________________________________________

In the event of an emergency, whom should we contact? _______________________________________________________

**Responsible Party -** Who is responsible for the account?

Name: ___________________________ Relationship to Patient: _______________________ Birthdate: ________________

Home Phone: _______________________________________ Cell Phone: ________________________________________

Address: _______________________________________ City, State, Zip: ________________________________________

Employer: ___________________________ Occupation: ______________________ Work Phone: ___________________

**Insurance**

**PRIMARY -** Insurance Company and Policy # __________________________________________________________

**SECONDARY** – Insurance Company and Policy # ______________________________________________________

**Antibiotics Before Surgery:** Have you been instructed to take antibiotics prior to surgery? ☐ Yes ☐ No

**Surgical History:** Please list ALL surgeries you have had with approximate date:

| Procedure | Date | Procedure | Date |
|---|---|---|---|
| 1) | | 4) | |
| 2) | | 5) | |
| 3) | | 6) | |

**Anesthesia:** Have you ever had problems with: ☐ Local Anesthesia ☐ IV Sedation ☐ General Anesthesia

**Medications:** Please list all medications you take on a regular basis (include Aspirin, Ibuprofen, Coumadin, Herbal Meds, etc.)

| | | |
|---|---|---|
| 1) | 5) | 9) |
| 2) | 6) | 10) |
| 3) | 7) | 11) |
| 4) | 8) | 12) |

**Pharmacy You Prefer:** Name/Location of Pharmacy: ____________________________Telephone: ___________________

**Allergies:** Please list any allergies to drugs/anesthetic agents or other materials (e.g., tape, iodine, food).

______________________________________________________________________________________________

**Personal History:** Height:______________ Current Weight:_______________ Maximum Weight:______________

Do you live: ☐ Alone ☐ with Family ☐ Roommate ☐ Retirement Community ☐ Nursing Home

Do you smoke? ☐ Yes ☐ No If yes, how much? ______________________________________________________

Do you drink alcoholic beverages on a regular basis? ☐ Yes ☐ No ☐ Socially

**Family History:**

| | Yes | No | Relationship | | Yes | No | Relationship |
|---|---|---|---|---|---|---|---|
| Diabetes | ☐ | ☐ | | Breast Cancer | ☐ | ☐ | |
| Hypertension | ☐ | ☐ | | Other Cancer | ☐ | ☐ | |
| Heart Disease | ☐ | ☐ | | Stroke | ☐ | ☐ | |
| Melanoma | ☐ | ☐ | | Bleeding Problem | ☐ | ☐ | |
| Skin Cancer | ☐ | ☐ | | Other | ☐ | ☐ | |

**Females Only:**

Are you pregnant? ☐ No ☐ Yes Have you had Breast/Other Implants surgery? ☐ No ☐ Yes/Type______________

**Patient Signature** ____________________________________________ **Date** _______________________________

# MEDICAL & SURGICAL HISTORY

PATIENT NAME: ______________________________________________ DATE: ____________

Under each heading, please check any items you may have, had or pertain to you. If NONE apply, please check the box marked **NONE**. Please sign and date at the end of this section. Thank you for your help and cooperation!

## GENERAL & HORMONAL

- ☐ Eating Disorder
- ☐ Thyroid Disease
- ☐ Chronic Fatigue Syndrome
- ☐ Chronic Disease or Cancer
  TYPE____________________
- ☐ Non-insulin Dependent Diabetes
- ☐ Insulin Dependent Diabetes
- ☐ **OTHER:** ________________
- ☐ **NONE**

## INTEGUMENT (SKIN)

- ☐ Skin Cancer ☐ Melanoma
- ☐ Dysplastic Nevi ☐ Acne
- ☐ Rosacea ☐ Eczema
- ☐ Psoriasis
- ☐ **OTHER:** ________________
- ☐ **NONE**

## BREAST – Note as R / L / Bilateral

- ☐ Biopsy ________________
- ☐ Cyst Drained ________________
- ☐ Lumpectomy ________________
- ☐ Mastectomy ________________
- ☐ Reconstruction________________
- ☐ Implant(s) ________________
- ☐ **OTHER:** ________________
- ☐ **NONE**

## HEAD & NECK

- ☐ Trauma ☐ Neurosurgery
- ☐ Facial Surgery ☐ Brain Shunt
- ☐ Thyroid Surgery
- ☐ Cervical Disc Surgery
- ☐ Arthritis in Neck
- ☐ Lymph Node Removed
- ☐ Cervical Disc Disease
- ☐ Carotid Artery Surgery
- ☐ Thyroid Surgery
- ☐ **OTHER:** ________________
- ☐ **NONE**

## MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Pins and/or screws for fracture
- ☐ Knee Replacement ☐ Hip Replacement ☐ Back Surgery
- ☐ **OTHER:** ________________
- ☐ **NONE**

## EYES / EARS / NOSE

- ☐ Glaucoma
- ☐ Cataract Surgery
- ☐ Eye Muscle Surgery
- ☐ Eyelid Surgery
- ☐ Hearing Aid
- ☐ Cochlear Surgery
- ☐ Skin Cancer Surgery
- ☐ Ears "pinned back
- ☐ Sinus Surgery
- ☐ Nasal Surgery for Broken Nose
- ☐ Septal Surgery ☐ Rhinoplasty
- ☐ **OTHER:** ________________
- ☐ **NONE**

## CARDIOVASCULAR & RESPIRATORY

- ☐ High Blood Pressure
- ☐ Heart Attack ☐ Pacemaker
- ☐ Chest Pain
- ☐ Heart Rhythm Abnormality
- ☐ Heart By-pass Surgery
- ☐ Heart Valve Surgery
- ☐ Mitral Valve Prolapsed
- ☐ Implanted Defibrillator
- ☐ Aneurysm Repair
- ☐ **OTHER:** ________________
- ☐ **NONE**

## GASTROINTESTINAL

- ☐ Gastric By-pass Surgery
- ☐ Hernia Repair
- ☐ Gallbladder Surgery
- ☐ Hepatitis ☐ Liver Disease
- ☐ Colon Cancer
- ☐ **OTHER:** ________________
- ☐ **NONE**

## GENITOURINARY

**WOMEN ONLY:**

- ☐ Hysterectomy ☐ Endometriosis
- ☐ Ovarian Cysts ☐ Abnormal PAP
- ☐ Childbirth # ________
- ☐ C-Section # ________

**MEN ONLY:**

- ☐ Testicular Surgery
- ☐ Kidney Stones
- ☐ Penile Prosthesis

## GENITOURINARY CONTINUED

**BOTH:**

- ☐ Biopsy: ________________
- ☐ Lesion Removed
- ☐ Hernia Repaired
- ☐ Kidney Transplant
- ☐ Kidney Disease
- ☐ **OTHER:** ________________
- ☐ **NONE**

## NERVE CONDITIONS / NEUROLOGIC PSYCHIATRIC

- ☐ Neuropathy
- ☐ Shingles
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Migraine
- ☐ Headaches
- ☐ Carpal Tunnel Syndrome
- ☐ Depression
- ☐ Drug Dependency
- ☐ Alcoholism
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Anxiety Disorder
- ☐ ADHD/ADD
- ☐ **OTHER:** ________________
- ☐ **NONE**

## BLOOD DISEASE / IMMUNE SYSTEM

- ☐ Anemia
- ☐ Leukemia
- ☐ Sickle Cell Syndrome
- ☐ Fibromyalgia
- ☐ High Platelet Count
- ☐ Low Platelet Count
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma ☐ Lupus
- ☐ Organ Transplant
- ☐ Lymphoma ☐ Hodgkin's Disease
- ☐ HIV/AIDS
- ☐ **OTHER:** ________________
- ☐ **NONE**

# REVIEW OF SYSTEMS

## GENERAL/CONSTITUTIONAL
☐ Fever ☐ Fatigue or Malaise
☐ Flu-like Symptoms
☐ Unexplained Weight Loss/ Gain
☐ **OTHER** ____________________
☐ **NONE**

## HEAD/SKULL
☐ Lumps ☐ Irregularities
☐ Pain ☐ Congenital or Surgical Defects ☐ Lesions
☐ **OTHER** ____________________
☐ **NONE**

## EYES
☐ Blurred/ Double Vision
☐ Loss of Vision
☐ Difficulty Seeing at Night
☐ Irritated, Itchy, Watery
☐ Eye Pain ☐ Discharge
☐ **OTHER** ____________________
☐ **NONE**

## EARS
☐ Pain/Earache ☐ Drainage
☐ Difficulty Hearing ☐ Dizziness
☐ Ringing in the Ears
☐ **OTHER** ____________________
☐ **NONE**

## NOSE
☐ Pain ☐ Irritation ☐ Drainage
☐ Discharge ☐ Problems Breathing
☐ Loud Snoring
☐ **OTHER** ____________________
☐ **NONE**

## THROAT
☐ Pain ☐ Soreness
☐ Irritation or Redness
☐ Trouble Swallowing/Speaking
☐ Hoarseness
☐ **OTHER** ____________________
☐ **NONE**

## NECK
☐ Pain or Stiffness ☐ Growths
☐ Lumps/ Bumps ☐ Lymph Nodes
☐ **OTHER** ____________________
☐ **NONE**

## RESPIRATORY
☐ Cough ☐ Short of Breath
☐ Sputum Production ☐ Cough Blood ☐ Wheezing
☐ Pain w/ Deep Breath
☐ Stop Breathing when Sleeping
☐ **OTHER** ____________________
☐ **NONE**

## PSYCHIATRIC
☐ Frequently Depressed
☐ Constant Anxiety ☐ Memory Loss ☐ Suicidal Thoughts
☐ Hallucinations ☐ Paranoia
☐ **OTHER** ____________________
☐ **NONE**

## MUSCULOSKELETAL
☐ Joint Pain, Swelling
☐ Muscle Pain, Stiffness
☐ Upper Back Pain ☐ Lower Back Pain ☐ Shoulder Pain
☐ **OTHER** ____________________
☐ **NONE**

## GASTROINTESTINAL
☐ Nausea, Vomiting
☐ Chronic Diarrhea, Chronic Constipation
☐ Change in Bowel Habits
☐ Abdominal Pain
☐ Frequent Dark Black Stools
☐ Blood in Stools
☐ Jaundice (yellow skin)
☐ Pain/Discomfort after Eating
☐ **OTHER** ____________________
☐ **NONE**

## GENITOURINARY
☐ Pain/ Discharge with Urination
☐ Frequent / Urgent Urination
☐ Recent Change in Urinary Habits
☐ Rashes, Sores, Growths

**WOMEN ONLY:**
☐ Vaginal Irritation or Discharge
☐ Menstrual Irregularities
☐ **OTHER** ____________________
☐ **NONE**

## NEUROLOGIC
☐ Seizures ☐ Tremors
☐ Weakness ☐ Numbness
☐ Tingling ☐ Poor Balance
☐ Difficulty Walking
☐ Temporary Paralysis or inability to talk ☐ Dizziness
☐ **OTHER** ____________________
☐ **NONE**

## CARDIOVASCULAR
☐ Chest Pain
☐ Palpitations or Skipped Beats
☐ Fainting Spells ☐ Leg Swelling
☐ Shortness of Breath on Exertion
☐ Shortness of Breath if Sleeps Flat
☐ **OTHER** ____________________
☐ **NONE**

## INTEGUMENTARY (SKIN)
☐ Painful Area
☐ Rash, Itching, Dryness
☐ Unusual Lesions/Crusted Patches ☐ Wounds/Lumps/Bumps
☐ Acne ☐ Redness ☐ Drainage
☐ **OTHER** ____________________
☐ **NONE**

## ENDOCRINE (HORMONAL)
☐ Increased Hunger ☐ Increased Thirst ☐ Frequent Urination
☐ Heat or Cold Intolerance
☐ Excessive Sleepiness After Meals
☐ Tingling/Numbness Fingers/Toes
☐ **OTHER** ____________________
☐ **NONE**

## BREAST
☐ Lumps, Bumps, Dimpling
☐ Drainage/ Discharge
☐ Pain ☐ Change in Size
☐ Shoulder Grooving
☐ Stretch Marks
☐ **OTHER** ____________________
☐ **NONE**

## HEMATOLOGIC
☐ Abnormal or Prolonged Bleeding
☐ Bruising ☐ Fatigue ☐ Pallor
☐ **OTHER** ____________________
☐ **NONE**

## ALLERGIES
☐ Frequent Sneezing
☐ Itchy / Watery ☐ Runny Nose
☐ Hay Fever / Hives
☐ **OTHER** ____________________
☐ **NONE**

## IMMUNOLOGIC
☐ Exposure to HIV/AIDS
☐ Exposure to Hepatitis
☐ Frequent or Persistent Infections
☐ Slow to Heal ☐ Enlarged Lymph Nodes or Glands in Axillary area, Groin, or Neck
☐ **OTHER** ____________________
☐ **NONE**

PROVIDER INITIALS ____________________

PATIENT/GUARDIAN SIGNATURE ________________________________________ DATE ____________________

# COTTER
PLASTIC SURGERY

## CONDITIONS AND CONSENT FOR TREATMENT

Welcome to our office! We are glad you have selected COTTER PLASTIC SURGERY. So that we may assist you better, the following is an outline of our office policies. We will do our best to make your visit as pleasant as possible. By clearly communicating our policies we hope to avoid any problems or misunderstandings. Please let us know if you have any questions about your care, our policies, or the need for additional information.

**INITIAL ALL AND SIGN AND DATE WHERE NOTED**

__________ **MEDICAL / SURGICAL CONSENT:** I give my consent for myself/family member(s) to undergo diagnosis and treatment at or by the providers and staff of COTTER PLASTIC SURGERY. I understand that during the course of medical, or surgical, diagnostic, laboratory, or treatment procedures, a variety of personnel working under the direction of the treating physician may be involved with or provide care to me or my family member(s).
Care may be rendered by, and may involve, personnel such as, but not limited to, nurse practitioners, physicians assistants, RN's, BSRN's, MSRN's, LPN's, medical assistants, medical technologists, operating room/scrub technicians, nurses in training, interns and physicians in training.

__________ **NO GUARANTEE OR WARRANTY:** I acknowledge and understand that the practice of medicine and surgery is not an exact science and that no guarantees nor warranty, expressed or implied, are given by anyone in this office to me or my family member(s) as to the effect of examinations, or the results of any treatment, diagnosis, recurrence, scarring or surgery. I understand the term "treatment" does not imply cure nor does it necessarily imply complete resolution of any particular condition. Smoking, certain medical conditions and medications, as well as non-disclosure of medical conditions including mental illness, disease, or treatment may adversely affect your diagnosis, treatment, scarring, recurrence of the condition, and eventual outcome.

__________ **ANCILLARY SERVICES:** I understand there are other healthcare professionals and facilities, including, but not limited to, physicians, rehab facilities, hospitals, laboratories and diagnostic facilities that are not part of, or employed by, COTTER PLASTIC SURGERY and whose services may be requested, or who may become involved in the care of any particular patient, or whose consultative services are requested for the patient's benefit. These persons, facilities, or entities bill separately for their services rendered.

__________ **NON-COVERED CHARGES:** We want to provide you with the best healthcare that we can possibly deliver, however, we find that occasionally there are certain services that we consider **routine and necessary** for treatment that are **not covered** by some insurance carriers. Although we are happy to discuss changes in the manner that we deliver healthcare to any one individual, there may be charges that you or your family incur from our office that are **not covered** by your insurance plan. Unless you have specifically notified us **in writing** ahead of time or other financial arrangements have been made, you will be expected to pay for the charges incurred.

__________ **NON-COVERED PROCEDURES:** Certain insurance carriers such as Medicare, Blue Cross Blue Shield, and others limit procedures during your consultation to a small number of selected diagnostic and treatment procedures. In general, they do not provide for treatment or surgery which is considered elective and of a non-emergent nature **during your consultation**. These insurance carriers require that your procedure be scheduled separate form your consultation in order to provide coverage for you. Insurance carriers that allow procedures on the same day as consultation such as HMO's, PPO's, etc. will give permission for that treatment on their **written referral** and may require further determination before allowing further treatment.

__________ **RELEASE OF MEDICAL INFORMATION:** I authorize release of any and all medical records, related medical information, photographs, and billing information regarding my treatment for the purposes of substantiating insurance coverage and medical payment owed to this facility and its physicians or providers for all or part of the charges involving my care or the care of my family member(s), for treatment or for medico legal issues and/or testimony. This authorization includes, but is not limited to, hospital or medical service companies, insurance companies, worker's compensation carriers, or welfare funds.

I certify that the information given by me in applying for payment under Title XVII and XIX of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its intermediaries, or the Medicaid agency, or its intermediaries, any information needed for the processing of a Medicare or Medicaid claim.

I also authorize other healthcare providers and facilities that have provided examination, diagnosis and/or treatment to me, or my family member(s), to release any and all medical records, photographs, and related information regarding my diagnosis and treatment, to or by other healthcare providers for the purposes stated above.

I agree and consent to the release of any and all of said records and medical information by oral, written, or electronic means of communications, to or from this facility to the parties stated above.

COTTER PLASTIC SURGERY will not be responsible for the loss of, miscommunication or retrieval of, or confirmation of any electronically transmitted or non-certified correspondence to or from this facility.

__________ **PHOTOGRAPHS:** I consent to the taking of photographs for documentation of the area(s) involved in diagnosis and treatment and for these photographs to be made part of my medical record. I hereby consent to the use of said photographs for teaching purposes, publications including websites, scientific articles, medico legal testimony, and for insurance purposes. I release and indemnify COTTER PLASTIC SURGERY, its employees, and physicians from all damages connected with the release of and return of such photographs and waive all rights concerning publication including commissions and payments for the use of such photographs.

__________ **PERSONAL VALUABLES:** This facility shall not be liable for the loss of or damage to any money, jewelry, glasses, dentures, documents, or other personal articles brought into this facility. Parking is provided for your convenience. We will not be responsible for damage, loss, theft, to or from vehicles parked on the office property.

__________ **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby assign my right to payment of all benefits otherwise payable to me under any policies of insurance providing coverage for such charges to SHLEBY PLASTIC SURGERY, its physicians and providers insofar as necessary to cover my expenses. This authorization is given for all insurance benefits to which I may be entitled whether designated as primary or secondary. I agree to permit a photocopy of this assignment to be used in place of the original. I agree to cooperate fully with this facility's efforts to obtain payment under any such policy (policies) and will execute any additional documents my insurance company may require in order to process this facility's claims. In the event of any over payment of insurance benefits, I authorize this facility to issue a refund to the company involved in making such overpayment and not to the owner or beneficiary of the policy directly.

__________ **DEDUCTIBLE AND CO-PAYS:** Payment of unpaid deductibles and copays will be expected at the front desk prior to your office visit when services are rendered, or when billed. It is not our policy to "write off" deductibles and copays. Non-payment will initiate the collection procedures.

__________ **FILING INSURANCE:** As a courtesy, we will file our charges for you with your health insurance carrier(s). We do not file separate cancer or other insurance policies that are not assigned to this facility or its providers. We will, however, provide you with information to file these policies yourself.

__________ **REFERRAL FORMS:** If your insurance requires a written referral from your primary physician, it is **your responsibility** to bring a **written referral** with you at the time of your consultation or treatment. By signing below, I am agreeing to pay charges for all services provided by this facility, its employees, and its physicians in good faith regardless of required referrals. I agree to waive any rights of exemption or protection provided to me by insurance carriers, state or federal laws, and cooperates fully with this facility's efforts to appeal any adverse decisions regarding referral forms or certifications. We will not be responsible for lost or forgotten referrals, unconfirmed faxes, or mailed referrals. You may incur additional administrative charges from this office for confirmation of referrals.

__________ **FINANCIAL RESPONSIBILITY:** By law, insurance carriers are required to pay their portion of the claim within 45 days after treatment has been rendered. Unless **specific prior arrangements** have been made, you will be expected to **pay the balance of your bill within 60 days after treatment has been rendered**. Unpaid balances after that date will initiate the collection process. Even small, unpaid balances such as copays and unpaid deductibles may be entered on your permanent credit record and may affect your ability to obtain future credit. We may be required to report to the IRS account balances that could be considered forgiven debts as taxable income. If you find that you are unable to make payment on you bill, please contact our office to make arrangements for payment. Failure to make payment is basis for legal action, and by signing below you are agreeing to pay all costs of collection including reasonable attorney fees and you are hereby waiving rights of exemption under the Constitution and Laws of the State of Alabama and any other state.

**The undersigned certifies that he/she has read the foregoing, including the front and back, has received a copy thereof, and is the patient, the patient's guardian, or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms.**

______________________________________ ______________________________________

Patient/Guardian Signature Date Witness Date

COTTER
PLASTIC SURGERY

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ________________________________________, have received a copy of this office's Notice of Privacy Practices.

______________________________________ ________________________
Signature Date

**To protect your privacy, please inform us of whom we may discuss your treatment with as well as how you would like to be contacted.**

I, ___________________________________, give permission for all medical and financial information to be discussed with the following individuals:

_______________________________________________________________________________
Name Phone # Relationship

_______________________________________________________________________________
Name Phone # Relationship

_______________________________________________________________________________
Name Phone # Relationship

_______________________________________________________________________________
Name Phone # Relationship

**Cotter Plastic Surgery staff members have permission to leave information as follows:**

___ Home Phone/answering machine ___ Work Phone/voicemail

___ Cell Phone/voicemail ___ Email/text

**The above information is valid for two (2) years from today unless noted otherwise by patient.**

_____________________________________ ________________________
Signature Date