John J. O'Brien, Jr., M.D.
Plastic & Reconstructive Surgery

Date: ___/___/___

How did you hear about our office? _____

Patient Information

Age: _____ DOB: _____/_____/_____ ☐ Male ☐ Female

Patient's Name _____
Last First Middle

Mailing Address _____
Street Apt/Unit Number

_____
City State Zip Code

Home: _____ Mobile: _____ Work: _____

E-Mail: _____

Social Security #: _____ - _____ - _____ Driver License #: _____

Marital Status: ☐ Single | ☐ Married | ☐ Divorced | ☐ Widowed | ☐ Domestic Partnership

Employer's Name _____ Occupation: _____

_____
Street City State Zip

Spouse Information

Spouse's Name _____
Last First Middle

Spouse's Employer _____

Spouse's Cell: _____ Spouse's Work: _____

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)
☐ Call Home Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐
☐ Call Cell Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐
☐ Call Work Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐
Ok to send e-mail?		Ok to send Text Messages?	
Email Appointment Reminders	☐ Yes ☐ No	Text Appointment Reminders	☐ Yes ☐ No
Email Medical/Schedule Info	☐ Yes ☐ No	Text Medical/Schedule Info Staff	☐ Yes ☐ No
Email Office Specials/News	☐ Yes ☐ No	Text Office Specials/News	☐ Yes ☐ No

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Emergency Contact	*Please identify the name of a person who does not live with the patient.*		
Name: _____	Phone: _____	Relationship to Patient: _____	

Please allow the front desk to make a copy of your insurance card.

Insurance Information

Primary Insurance Company Name: _____
Name of Insured: _____
Policy #: _____ Group #: _____
Secondary Insurance Company Name: _____
Name of Insured: _____
Policy #: _____ Group #: _____

I understand that office visit charges are payable on the day service is rendered. I authorize John J. O'Brien, Jr., MD to bill my insurance company. Regardless of insurance coverage, I am responsible for bills being paid in a timely manner. I understand that my contract is between John J. O'Brien, Jr., MD and myself.

Signature: (Patient, Parent or Guardian)_____ Date:____/____/_____

HIPAA Authorization to Discuss Your Medical Information

Indicated below are names of any Person(s) to whom I would like St. Petersburg Center for Plastic Surgery to allow disclosure of Protected Health Information (PHI). I understand that I am not required to list anyone and I may change this list at any time in writing.

Authorization

I authorize the Practice to disclose my PHI to those individuals listed below (*specify name, relationship and contact information if applicable*):

Name: _____ Relationship: _____ Contact Number: _____

Name: _____ Relationship: _____ Contact Number: _____

Please acknowledge that you have been offered a "Notice of Privacy Practices" by signing below:

"I have been offered a Notice of Privacy Practices by the office of St. Petersburg Center for Plastic Surgery and I fully understand and accept the terms of this consent."

Signature: (Patient, Parent or Guardian)_____ Date:____/____/_____

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Procedure Information

What is the reason for your visit today? _____

Please describe why you are interested in the procedures listed above: _____

Have you consulted with other surgeons about the procedure(s) indicated above? ☐ Yes ☐ No

Is this procedure a revision from a previous surgery? ☐ Yes ☐ No

If yes, how many previous surgeries? _____

Pharmacy Information

Pharmacy Name: _____

Address: _____ City: _____ Zip: _____

Health Information & Medical History

Date of Your Last Physical Examination _____ Weight _____ Height _____

Primary Care Physician _____

Address _____

Phone Number _____ Fax Number _____

Surgery (Operations and Cosmetic Surgery)

	Type	Date	Complications/Difficulties
1.			
2.			
3.			
4.			
5.			

Medical Problems or Conditions Now Under Treatment by a Physician

Explain _____

Admissions to Hospital (including childbirth)

	Reason	Date	Complications/Difficulties
1.			
2.			
3.			
4.			

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Medications, Vitamins, or Herbal Supplements You Take Now

	Type	Dosage/Amount If Known	Take How Often
1.			
2.			
3.			
4.			
5.			

Social History

☐ Caffeine use ☐ Tobacco/Nicotine ☐ Alcohol ☐ Other(s) _____

Exercise Habits _____

Allergies (Please list)_____

_____

Bleeding Problems

Do you bruise or bleed easily? ☐ Yes ☐ No (With cuts/tooth extractions/pregnancy/surgery)

Explain_____

Do you have a family history of bleeding problems? Explain_____

Difficulties with Local or General Anesthesia

Explain_____

Have You Ever Had a Blood Transfusion? ☐ Yes ☐ No

Have You Ever Had, Have, or Been Exposed To?

☐ Yes ☐ No Intravenous Drugs
☐ Yes ☐ No Infectious Diseases
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No HIV/AIDS
☐ Yes ☐ No Liver Transplant

If Yes to Any Explain_____

_____

Family History

Any family history of medical problems or illness?

Mother_____

Father_____

Sister_____

Brother_____

Other_____

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REVIEW OF SYSTEMS

Please check the box below if you currently have or have ever had a problem with:

ABDOMEN & LIVER

- ☐ Ulcers
- ☐ Colon Disease
- ☐ Gallbladder Disease
- ☐ Inflammatory Bowel Disease (IBS)
- ☐ Reflux
- ☐ Hiatal Hernia
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Liver problems
- ☐ Cirrhosis
- ☐ Heartburn

KIDNEY & ENDOCRINE

- ☐ Diabetes
  - ☐ Insulin Dependent
  - ☐ Oral Hypoglycemic Agent
  - ☐ Diet Controlled
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Low Blood Sugar
- ☐ Kidney Stones
- ☐ Kidney Disease or Failure
- ☐ Kidney Infection
- ☐ Difficulty Passing Urine

NEUROLOGICAL & PSYCHOLOGICAL

- ☐ Stroke
- ☐ Seizures
- ☐ Fainting
- ☐ Headaches
- ☐ Emotional Problems
- ☐ Psychiatric Problems or Treatment
- ☐ Depression
- ☐ Anxiety
- ☐ Sciatica
- ☐ Herniated Disc

SKIN

- ☐ Scar Badly
- ☐ Keloids or Thick Scars
- ☐ Wound Healing Problems or Open Sores
- ☐ Atypical Skin Lesions
- ☐ Previous Skin Tumors or Cancers

MUSCULOSKELETAL

- ☐ Back Pain
- ☐ Neck Pain
- ☐ Arthritis - Osteo
- ☐ Arthritis - Rheumatoid
- ☐ Muscular Dystrophy
- ☐ Muscular Sclerosis
- ☐ Fibromyalgia

EYES

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Dry Eyes
- ☐ Do you wear contact lenses?

HEART

- ☐ High Blood Pressure
- ☐ Born with Heart Problems
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Chest Pains
- ☐ Heart Bypass Surgery
- ☐ Pacemaker
- ☐ Irregular Heartbeat
- ☐ Heart Murmur

Comments_____

LUNGS

- ☐ Abnormal Chest X-Ray
- ☐ Asthma
- ☐ Bronchitis
- ☐ Shortness of Breath
- ☐ Recent Chest Infection
- ☐ Emphysema/COPD
- ☐ Pulmonary Embolism
- ☐ Cough or Cold at Present
- ☐ Sleep Apnea
- ☐ Use a C-PAP Machine

HEMATOLOGIC/ONCOLOGIC

- ☐ Excessive Bleeding
- ☐ Bruise Easily
- ☐ Anemia
- ☐ Sickle Cell Disease
- ☐ Blood Clots in Legs
- ☐ Blood Clots in Lungs
- ☐ Radiation Therapy
- ☐ Cancer
  - ☐ Where?_____

Please list any other medical conditions not listed above_____

_____

Signature:_____ Date:_____

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PAYMENT POLICY

For all cosmetic patients during your visit, you will be given a fee estimate for your proposed aesthetic procedure(s). This quote will include fees for the Operating Room and fees for the Anesthesiologist, as well as any special equipment fees or Assistant fees. Please note that Dr. John J. O'Brien's portion of the quote is good for 60 days only. If you choose to schedule the procedure more than 60 days in the future, it is possible that the fee will be different than the original quote. Payment for surgery may be made by cash, major credit card, or cashier's check. We also offer patient financing through CareCredit® and ALPHAEON®. Payment of non-surgical treatments such as BOTOX® Cosmetic and fillers are made at the time of service by cash or debit/credit card. At times, a revision or "touch up" procedure may be desired. Should that be the situation, you the patient will be responsible for additional fees including, but not limited to, Operating Room or Anesthesia. Payment is due in FULL upon reserving the date of your revision procedure.

In regards to procedures that may or may not be covered by medical insurance, there may be situations in which part of your surgery would be considered functional or medically necessary. In that case, your insurance may pay part of the surgery fee. As a courtesy to you, our office will pursue prior authorization for this procedure. You will be responsible for the Surgeon's fee, deductible and/or co-payments prior to the procedure. If the surgery center is a Preferred Provider, you will be responsible for your deductible and co-payments for the operating room & anesthesia, as well as payments for the cosmetic portion of your procedure. **Purely cosmetic services will not be billed to any third party insurer.**

Dr. O'Brien is **not** responsible for refunding any surgical fees or rescheduling fees that result from a patient's non-compliance. The failure to follow pre-surgical instructions includes: nicotine, alcohol, or drug use, failure to avoid or to take specific medications as instructed, and failure to follow day of surgery instructions. Any surgical procedure rescheduled by the patient less than fourteen days prior to surgery **or** as the result of patient non-compliance, will forfeit their surgical deposit and incur a surgeon's rescheduling fee. All fees must be paid prior to confirming any new surgical date.

Our office requires a non-refundable scheduling fee equivalent to 10% of the total surgery cost to guarantee your surgery date & time. Surgery fees are to be paid in full at your Pre-Operative appointment. *Cancellation up to 14 days prior to your procedure date will result in a 25% loss of all fees. Cancellation within one week (7 days) of your procedure will result in a 50% loss of all fees. If you cancel 48 hours or less from your procedure date, you will forfeit 100% of all fees.* These penalties do not apply to illness related cancellations where a Doctor's note is provided. If a check is returned from the bank, the patient will be responsible for the amount of the check plus a $30.00 processing fee. We encourage you to contact our office staff for any questions that you may have, so that this policy may be clarified for you prior to scheduling any procedures. We have found that most patients are pleased to have all details known prior to scheduling.

Statement of Financial Responsibility

"I, the undersigned, have read the above & understand that I am responsible for all medical & surgical charges incurred by myself or my dependents. I authorize the release of any medical information necessary to process any claims that are processed on my behalf by the office of Dr. O'Brien. I understand that my medical insurance contract is between my insurance company and myself and that the failure of the insurance company to pay my claim does not absolve my financial responsibility to Dr. O'Brien. All court and attorney fees or other fees associated with the collection of my account are my financial responsibility."

Signature: (Patient, Parent or Guardian)_____Date:_____/_____/_____

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Plastic & Reconstructive Surgery

PHOTO CONSENT

As part of your medical care, Dr. O'Brien will take medical photography related to the surgical and/or non-surgical care you receive. When taken for clinical reasons, this does not require your permission. Your written permission is however required to use any such photography for non-clinical reasons.

By consenting to photography, you understand that you will not receive payment from any party. Whenever possible, your photos will be used without identifying information, however, you understand that it may be possible for someone to recognize your photo if used outside of your medical record. By completing the section(s) below, you hereby authorize Dr. O'Brien to create and retain photography of you prior to, during, and after receiving treatment or services.

CONSENT TO USE PHOTOGRAPHY

I hereby consent to the release and use of photography and videos taken of me for the following purpose(s) below. BY SIGNING BELOW, I CONFIRM THAT THIS CONSENT HAS BEEN EXPLAINED TO ME IN TERMS THAT I AM ABLE TO UNDERSTAND AND THAT THIS CONSENT WAS GIVEN VOLUNTARILY BY ME.

The consent below applies to videos/images of me:

☐ I consent to images of me being used in **MEDICAL PUBLICATIONS, JOURNALS, TEXTBOOKS, CLINICAL STUDIES, ELECTRONIC PUBLICATIONS, OR OTHER PUBLIC MEDIUMS FOR TEACHING AND EDUCATIONAL PURPOSES.** I understand that the images may be seen by members of the general public, in addition to scientists and medical researchers that use these publications in their professional education.

☐ I consent to having photos of me being used ONLY for the purposes of **DOCUMENTING IN MY MEDICAL RECORD** and that these will only be released by written request and authorization signed by me.

☐ I consent to allowing photos and video recordings of me to be published on **INTERNET** sites including, but not limited to Dr. John J. O'Brien, Jr. - St. Petersburg Center for Plastic Surgery Website, social media sites (such as YouTube, Facebook, Instagram, RealSelf), and any other websites that might be viewed by the general public for any reason. I understand that once released onto the Internet, Dr. John J. O'Brien, Jr. - St. Petersburg Center for Plastic Surgery will no longer have control of the photos nor how they are used.

_____ _____

Signature Witness

_____

Printed Name

John J. O'Brien, Jr., M.D.
Plastic & Reconstructive Surgery

PATIENT PARTNERSHIP PLAN

Dear Patient,

Welcome to St. Petersburg Center for Plastic Surgery. We hope to provide you with the care and service that you expect and deserve. Achieving your *best possible health* requires a "partnership" between you and your doctor. As our "partner in health", we ask you to participate in your care in the following ways:

I Will Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

I Will Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

I Will Inform My Doctor if I Decide Not to Follow His Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his recommendations so that he may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, seek an explanation, report symptoms, or discuss concerns. If you need more information about your health or condition, please ask.

_____ / ____ / _____

Patient Signature Date Witness Signature

John J. O'Brien, Jr., M.D.
Plastic & Reconstructive Surgery

CANCELLATION POLICY

Medical Appointment Cancellation/No Show Policy

When you schedule an appointment with St. Petersburg Center for Plastic Surgery we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our appointment Cancellation/No Show Policy below:

- A credit card number will be required to schedule all new patient consultation appointments. Payment is due at the time of scheduling.
- Any new patient with two or more No Shows or cancellation/reschedules with no 24-hour notice will not be rescheduled again.
- Established patients with multiple No Shows or cancellation/reschedules with no 24-hour notice may be dismissed from St. Petersburg Center for Plastic Surgery.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact St. Petersburg Center for Plastic Surgery 24 hours a day, 7 days a week at 727-341-2408. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

I have read, understand, and accept the above policies.

Printed Name: _____

Signature: _____ Date: _____