Plastic Surgery Center, P.C.
The Best Training...The Most Experience

Dr. Stephen E. Zucker, FACS
621 Memorial Dr. Suite 511
South Bend, IN 46601
Ph: (574) 232-3919 Fax: (574) 233-1063

Welcome to the office of Dr. Stephen E. Zucker at the Plastic Surgery Center, P.C. We appreciate the confidence and trust that you have placed in us and look forward to meeting you personally and professionally. Our philosophy of care governs everything we do for you. It consists of the following key elements:

We are truly caring about our patients and want you to feel very comfortable with our entire staff.

We recognize that each patient is an individual and our goal is to provide you with exceptional personalized care.

We strive to stay on time and keep your waiting period as short as possible. We understand that your time is as important as ours. We will try to keep you notified of any delays.

We strive to be thorough in everything we do and provide our patients with compassionate patient focused care. At your first visit, we will take the time to get to know you (and you, us), review your medical history, discuss your individual goals, expectations, and concerns, and answer any questions you may have.

Enclosed you will find our new patient paperwork. Please fill this out and bring it with you to your first appointment. If you are unable to complete the paperwork prior to your arrival, we ask that you arrive 20 minutes early. We also ask that you bring the following items:

- Insurance Card (for all non-cosmetic or non-elective consultations)
- Photo ID (current driver's license, student ID or work ID)
- Referral from your primary care physician (if needed)
- Previous Medical Records (if applicable)

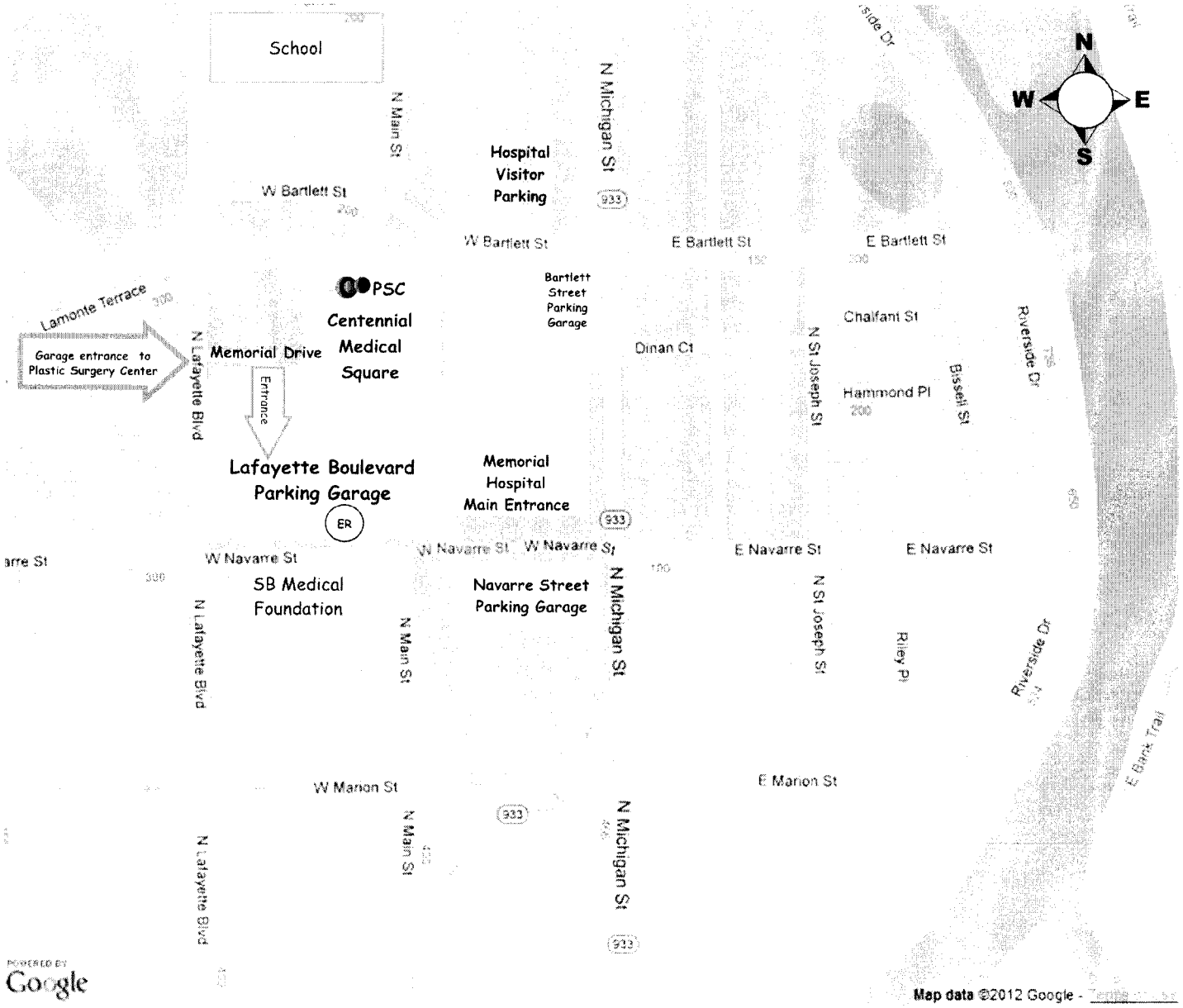
Initial cosmetic consultations are complimentary. Second opinion consultations for cosmetic procedures performed by a physician other than Dr. Zucker will require a $125 fee which can be applied toward future surgical procedures. For insurance to consider your procedure for coverage and payment, we will be required to bill your insurance for your first office visit and all co-pays and deductibles will be applied. Payment will be expected on the date of service. Scar revision consultations are $65.

Our office will be calling to confirm your appointment the day before your scheduled arrival. If you are unable to keep your appointment, we ask that you call 24 hours in advance. Monday appointments must be cancelled or rescheduled by 5:00 PM Friday in order to avoid a late cancellation fee. If you are unable to keep your appointment and fail to show without calling, we will process a $125 no show fee on your account. Driving directions and practice information is also available on our website: plasticsurgerycenter.net along with our new patient paperwork.

We look forward to meeting you!

Plastic Surgery Center, P.C.

Appointment Date: _____ **Appointment Time:** _____**(EST)**



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Access to Plastic Surgery Center is through the Lafayette Blvd. Parking Garage. The entrance to the parking garage is from Lafayette Blvd. and is called Memorial Drive.

Parking is free.

We are on the 5th Floor in Suite 511.

If you use Google maps, MapQuest or GPS, please use Suite 511 in your address entry or it will take you to the Navarre Street parking garage.

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www.plasticsurgerycenter.net

PATIENT INFORMATION

Date _____ Patient Name _____ Patient # _____
(First / MI / Last)
SS # /SIN _____ ☐ Male ☐ Female Birthdate _____ Age _____ Home phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
E-Mail _____ Cell Phone _____
Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or parent/guardian's employer _____ Work phone _____
Business address _____ City _____ State/Prov. _____ Zip/P.C. _____
Spouse or parent/guardian's name _____ Employer _____
If patient is a student, name of school/college _____ City _____ State/Prov. _____
Whom may we thank for referring you? _____
How did you hear about us? ☐ TV ☐ Facebook ☐ Internet Search ☐ Radio ☐ Newspaper ☐ Direct Mail
Person to contact in case of emergency _____ Relationship to Pt. _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____
Address _____ Home phone _____
E-Mail _____ Cell phone _____
Birthdate _____ Social Security Number _____
Employer _____ Work phone _____

Insurance Information-Not Applicable for Elective & Cosmetic Surgery Patients

Name of insured _____ Relationship to patient _____
Birthdate _____ SS #/SIN _____ Date employed _____
Name of employer _____ Work phone _____
Address of employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance company _____ Group # _____ Union or local # _____
Ins. Co. address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Relationship to patient _____
Birthdate _____ SS #/SIN _____ Date employed _____
Name of employer _____ Work phone _____
Address of employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance company _____ Group # _____ Union or local # _____
Ins. Co. address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____ _____

Signature of patient or parent/guardian if minor — Date

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FINANCIAL POLICY

Please Read and Initial Each Item:

_____ I understand that all fees are due at the time of service. Alternate arrangements must be made prior to any service. I understand that, as a courtesy, my insurance will be filed for ***non-cosmetic services***, but the **Responsible Party** is financially responsible for all charges. Any amount failed to be paid by the insurance company is **between** the **Responsible Party** and the **Insurance Company**. Accounts are to be paid within 30 days from the date of service, and may be subject to a "late charge" of $5.00 per month in the event the account is not paid in full during this period. I understand that, in the event of collection activity, the **Responsible Party** will be held liable for interest charges, collection fees, reasonable attorney's fees, and court fees.

_____ The information I have provided today is complete and accurate to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my medical or residential status.

_____ The **Patient or Responsible Party**, by signature below, agrees that permission is granted for treatment by Plastic Surgery Center, PC.

_____ The **Patient or Responsible Party**, by signature below, authorizes payment directly to Plastic Surgery Center, PC of the group insurance benefits otherwise payable to the Patient. The signature also authorizes the release of any medical information necessary to process any claims and authorizes that this document serves as valid signature on file should it become necessary in the processing of additional claims.

_____ A $500 **non-refundable** deposit is required to schedule any elective cosmetic surgery at Plastic Surgery Center, PC. If a surgery is cancelled at least 30 days prior to surgery, the deposit may be applied to future surgeries. Any cancellation or re-scheduling of surgery within 30 days of the scheduled date will result in forfeiture of the deposit toward any future surgeries. I understand that all elective cosmetic surgeries performed at Plastic Surgery Center, PC must be paid in full at least three weeks prior to any scheduled surgery date and any cosmetic procedure cancelled within that timeframe will forfeit 25% of total charges. If surgery is re-scheduled for a future date, the forfeited 25% will not be applied to the re-scheduled surgery. Surgeries cancelled or postponed for medical reasons must be approved by Dr. Zucker and will be reviewed on a case by case basis.

_____ All co-pays, deductibles and co-insurance must be paid prior to any surgical procedure performed in the hospital or in our offices. Additionally, I understand that any past due outstanding balances must be paid in full prior to any additional surgeries being scheduled or performed.

_____ If applicable, by signing below, I give permission for Plastic Surgery Center, PC. to communicate with my credit card company regarding any issues or discrepancies on my bill.

_____ Pathology fees are billed separately from Dr. Zucker's fee and I acknowledge that I will be responsible for any pathology fees not covered by insurance.

_____ ***At least*** 24 hours notice is required for any cancellation of an appointment. Failure to do so will result in a **$125** no show fee processed to your account. Monday appointments must be rescheduled or cancelled by 5pm on Friday.

Patient Signature: _____ **Date:** _____

Responsible Party ***(if different from patient):*** _____ **Date:** _____

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Authorization for Use and Disclosure of Protected Health Information

I, _____, authorize Plastic Surgery Center, PC, the Administrative and clinical staff to:

- Use the following protected health information for treatment, payment, and other healthcare operations.
- Disclose the following health information to my primary care physician, other specialists and pertinent people and organizations related to my healthcare, (ie., lab, hospital, etc.)

Plastic Surgery Center, PC, may disclose my protected health information to the following family members:

1. _____ _____
   Name Relationship
2. _____ _____
   Name Relationship
3. _____ _____
   Name Relationship
4. _____ _____
   Name Relationship

Plastic Surgery Center, PC may leave a message on voicemail and answering machines regarding appointment reminders:

□ Yes
□ No

This authorization shall be enforced and in effect for the duration of my treatment at Plastic Surgery Center, PC. This authorization will otherwise remain valid for 15 years. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of my heath information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be disclosed by the recipient and may no longer be protected by State law. I understand that if I refuse to sign this authorization, I may not be eligible for or receive treatment that I have requested for the purpose of disclosure to others.

_____ _____
Signature of Patient, Parent of Minor Child or Patient Representative Date

Date:			☐ Right Handed ☐ Left Handed
Height	**Weight**	**Profession**	**Age**
Patient Name:		**Date of Birth:**	
Date of last mammogram:	Where performed:	Current bra size, if applicable to procedure, ie., aug, reduction, lift, etc.	

History of breast cancer in family ☐ **None** ☐ Maternal Grandmother ☐ Paternal Grandmother ☐ Mother ☐ Aunt ☐ Sister

Yes	No				
☐	☐	Pregnancies If yes, how many?		# Completed	# Miscarriages
☐	☐	Do you plan to have more children?		When?	
☐	☐	Did you breastfeed?		Current Ages of Children:	
Yes	**No**	**For All Patients**			
☐	☐	Alcohol Consumption		How much?	
☐	☐	Smoke		How much?	
☐	☐	Asthma		Do you use an inhaler? ☐ Yes ☐ No How often?	
☐	☐	Blood Clots		Where?	
☐	☐	Bleeding Tendencies			
☐	☐	COPD			
☐	☐	Diabetes			
☐	☐	High Blood Pressure			
☐	☐	Heart Disease			
☐	☐	Heart Murmur		If treated, how?	
☐	☐	Kidney Disease			
☐	☐	Latex Allergy		Reaction	Tested ☐ Yes ☐ No
☐	☐	Prostate Problems		Explain	
☐	☐	Psychological/Psychiatric			
☐	☐	Seizures/Epilepsy			
☐	☐	Sickle Cell Disease			
☐	☐	Sleep Disorders		Explain	
☐	☐	Strokes/TIA			
☐	☐	Thyroid Disease			
☐	☐	Have you or any member of your family ever been treated for MRSA or any staph infections?		Explain	

Please list any and all other conditions currently under treatment.

Allergies

Allergic To	Describe Reaction
☐ **No Known Allergies**	
Any reaction to general anesthesia? ☐ Yes ☐ No Personal ☐ or Family ☐	

Surgery	Date	Reason
Wisdom Teeth ☐ Yes ☐ No		
Please list all additional surgeries.		

Primary Care Physician:	**Phone:**
Referring Physician:	**Phone:**
Specialty Physician:	**Phone:**

Signature	Date

psc
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Medication Record

Date: _____

Name: _____ DOB: _____

☐ **No Medications**

Date	Medication	Dose Given	Frequency (i.e. 2x per day)	Time	am / pm