ROBERT ★★★★★ KRATSCHMER MD
SiliconeMD.com

Last Name:________________________________ First:______________________________ M.I._________

Mailing Address____
Street City State Zip Code

Physical Address (if different)____

DOB______/______/_______ Age: _____ Gender: M F SS#_______-______-_________

Marital Status: D S W M (Spouses name if applicable) _________________ Anniversary Date: ________

Home Phone (______)_____________ Work (_____)_______________ Cell (______)_____________

Please indicate if it is NOT okay to contact: Home ____ Work ____ Cell ____ E-Mail ____

OK to leave a message: Home: Yes / No Work: Yes / No Cell: Yes / No (circle preference)

Indicate any additional privacy instructions: ____

E-Mail ___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
Your e-mail address will be stored in a protected database and will remain confidential.

Please indicate if it is NOT okay to send monthly specials, notices, rewards, or appointment confirmations by email, mail, or text message (appointment reminders only): Do not email Do not mail Do not text message (Circle)

Occupation ______________________________________ Employer _________________________________

Responsible Party ____

Emergency Contact_______________________Relationship_________________Phone (_____)_____________

Reason for Today's Visit:____

Are you interested in applying for financing with CareCredit? ____

How were you referred to us? (Please be specific)

Website:____________________________ Physician:_________________________

Patient: _____________________________ Other: ___________________________

PHARMACY: ___________________________ PHONE: ______________________

AUTHORIZATION

I understand that a fee may be charged for all visits, examinations, cosmetic evaluations, and medical reports.

AUTHORIZATION OF ASSIGNMENT OF BENEFITS: I hereby authorize direct payment of insurance benefits to the physicians of the surgical, medical and/or facility at Robert Kratschmer MD. I understand that although Robert Kratschmer MD will bill my insurance company as a courtesy, I am ultimately responsible for any charges, bills, and balances relating to the services rendered to me by Robert Kratschmer MD. I agree to pay for all costs of collection, including reasonable attorney fees.

AUTHORIZATION FOR CONSULTATION AND TREATMENT: I hereby authorize consultation and any necessary medical treatment performed by the physicians of the surgical, medical and/or facility of Robert Kratschmer MD.

AUTHORIZATION TO RELEASE MEDICAL RECORDS: I hereby authorize the release of medical information to my insurance company(s), including but not limited to, records regarding HIV, alcohol and drug information that is necessary to secure payment of medical bills incurred as a result of services received at Robert Kratschmer MD.

AUTHORIZATION TO OBTAIN AND USE PHOTOGRAPHS: I hereby authorize the physician to obtain photographs before, during and after my treatment. I understand and agree that these photographs shall be the property of Robert Kratschmer MD as a part of my permanent record. As well I understand and agree that these photographs may be used for internal patient education and/ or teaching purposes.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, PATIENT'S BILL OF RIGHTS AND COMPLAINT PROCEDURES: I have been presented with a copy of the Patient's Bill of Rights and Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. I have also received Complaint procedures.

HIPAA WAIVER FOR DISPUTED TRANSACTIONS Patient understands they waive their HIPAA rights in the event that a credit card or financial transaction is disputed and the financial company, legal professionals or law enforcement requires proof of transaction details.

This facility monitors and evaluates the quality of patient care. In doing so, peer physicians may need to have authority to review your chart to obtain information about the medical care you received. In signing this authorization you have authorized a peer review.

_____

Patient Printed Name (or responsible party, if patient is a minor)

_____

Signature of Patient (or responsible party, if patient is a minor) Date

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I hereby authorize the release of information of my complete medical file to my treating doctor for review, consultation, treatment, teaching, publication in medical journals and/or insurance claims purposes. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected.
This authorization will expire (3) years from the date that I sign this document. A photocopy or "FAX" of this authorization is as valid as the original.

I HEREBY ACKNOWLEDGE THAT:

I HAVE READ AND UNDERSTAND THIS DOCUMENT
I HAVE SIGNED THIS CONSENT FOR TREATMENT
I HAVE SIGNED THIS CONSENT FOR RELEASE OF MEDICAL INFORMATION
I AGREE TO THE ASSIGNMENT OF BENEFITS AND AGREEMENT TO PAY FOR SERVICES
I HAVE DONE THE ABOVE ON MY OWN FREE WILL
ALL MY QUESTIONS HAVE BEEN ANSWERED IN LANGUAGE I UNDERSTAND

_____
Patient Printed Name (or responsible party, if patient is a minor)

_____
Signature of Patient (or responsible party, if patient is a minor) Date

PATIENT HISTORY AND REVIEW OF SYSTEMS

Physician: Robert Kratschmer MD **Date**:_____

Patient Name:_____

Medical History

· **Patient medical history:**

Previous Hospitalization/Surgeries/Serious Injuries When?

Diabetes	No	Yes	_____
Hypertension	No	Yes	_____
Cancer	No	Yes	_____
Stroke	No	Yes	_____
Heart Trouble	No	Yes	_____
Arthritis/gout	No	Yes	Medications:
Convulsions	No	Yes	_____
Bleeding tendency	No	Yes	_____
Acute Infections	No	Yes	_____
Venereal disease	No	Yes	_____
Hereditary disease	No	Yes	_____

· **Patient social history**:

Marital status: Single____ Married____ Separated____ Divorced ____ Widowed____

Use of alcohol: Never____ Rarely____ Moderate_____ Daily_____

Use of tobacco Never____ Previously, but quit _____Current packs/ day_____

Use of drugs Never____ Type/Frequency:_____

Excessive exposure Air-borne at home or work to: Fumes:___ Dust:____ Solvents:____ Particles____ Noise____

· **Family medical history:**

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

We have many cosmetic treatment options available. To better serve you, please describe the **main reason for today's consultation**:_____

Please explain how the problem affects you, and why you've decided to seek treatment now.

_____

What is important to you when deciding on a treatment? _____

· **CONSTITUTIONAL SYMPTOMS**

Good general health lately…….....	No Yes
Recent weight change……..	No Yes
Fever……	No Yes
Fatigue…….	No Yes
Headaches……	No Yes

· **EYES**

Eye disease or injury…….	No Yes
Wear glasses/contact lenses……	No Yes
Blurred or double vision……	No Yes
Glaucoma……	No Yes

· **EAR/NOSE /MOUTH/THROAT**

Hearing loss or ringing…….	No Yes
Earaches or drainage…….	No Yes
Chronic sinus problem or rhinitis……	No Yes
Nose bleeds…….	No Yes
Mouth sores……	No Yes
Bleeding gums……..	No Yes
Bad breath or bad taste……..	No Yes
Sore throat or voice change……	No Yes
Swollen glands in neck…….	No Yes

· **CARDIOVASCULAR**

Heart trouble…….	No Yes
Chest pain or angina pectoris……	No Yes
Palpation……..	No Yes
Shortness of breath with walking or lying flat……	No Yes
Swelling of feet, ankles, or hands……	No Yes

· **RESPIRATORY**

Chronic or frequent coughs…….	No Yes
Spitting up blood……	No Yes
Shortness of breath……..	No Yes
Asthma or Wheezing……	No Yes

· **GASTROINTESTINAL**

Loss of appetite……	No Yes
Change in bowel movements…….	No Yes
Nausea or vomiting……..	No Yes
Frequent diarrhea……..	No Yes
Painful bowel movement or constipation..	No Yes
Rectal bleeding or bloods in stool……	No Yes
Abdominal pain……	No Yes
Peptic ulcer(stomach or duodenal)…….	No Yes

· **GENITOURINARY**

Frequent urination……	No Yes
Burning or painful urination……	No Yes
Blood in urine……..	No Yes
Change in force of strain when urinating..	No Yes
Incontinence or dribbling…….	No Yes
Kidney stones……..	No Yes
Sexual difficulty……	No Yes
Male- testicle pain……	No Yes
Female- pain with periods……..	No Yes
Female- irregular periods……	No Yes
Female-vaginal discharge……..	No Yes
Female- # of pregnancies……..	_____
Female- # of miscarriages…….	_____
Female- date of last pap smear…….	_____

· **MUSCULOSKELETAL**

Joint pain…….	No Yes
Joint stiffness or swelling…….	No Yes
Weakness of muscles or joints…	No Yes
Muscle Pain or cramps…….	No Yes
Back Pain.....	No Yes
Cold extremities.....	No Yes
Difficulty in walking……	No Yes

· **INTEGUMENTARY (skin, breast)**

Rash or itching…….. .	No Yes
Change in skin color…….. .	No Yes
Change in hair or nails……...	No Yes
Varicose Veins…….. ..	No Yes
Breast Pain…….. .	No Yes
Breast Lump…….. ..	No Yes
Breast Discharge…….. ..	No Yes

· **NEUROLOGICAL**

Frequent or recurring headaches…	No Yes
Light headed or dizzy……	No Yes
Convulsions or seizures……..	No Yes
Numbness or tingling sensations…	No Yes
Tremors……...	No Yes
Paralysis……	No Yes
Stroke……..	No Yes
Head injury…….	No Yes

· **PSYCHIATRIC**

Memory loss or confusion……	No Yes
Nervousness…….	No Yes
Depression…….	No Yes
Insomnia……..	No Yes

· **ENDOCRINE**

Glandular or hormone problem…….	No Yes
Thyroid disease……	No Yes
Diabetes (insulin or non insulin)…… -circle one	No Yes
Excessive thirst or urination……..	No Yes
Heat or cold tolerance……	No Yes
Skin becoming dryer……..	No Yes
Change in hat or glove size……..	No Yes

· **HEMATOLOGIC/LYMPHATIC**

Slow to heal after cuts……	No Yes
Bleeding or bruising tendency……..	No Yes
Anemia……	No Yes
Phlebitis……	No Yes
Past transfusion…….	No Yes
Enlarged glands……..	No Yes

· **ALLERGIC/IMMUNOLOGIC**

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics……	No Yes
Morphine or other antibiotics……..	No Yes
Novocain or other anesthetics…….	No Yes
Aspirin or other pain remedies…….	No Yes
Tetanus antitoxin or other serums…	No Yes
Iodine, methiolate or other antiseptic	No Yes

Other drugs/medications:_____

Known food allergies:_____

Environmental allergies:_____

Patient name: _____ Date: _____

COSMETIC SURGERY PAYMENT POLICIES

CONSULTATION FEE POLICY

We offer 30-Min Cosmetic Consultations. A One Hour Cosmetic Consultation requires a $75.00 Consultation Fee due at scheduling and must be scheduled and paid in advance. This payment is non-refundable. Should the appointment need to be rescheduled, you must do so at least 24 hours in advance. If rescheduling is done with less than 24 hours notice, a $49 Cancellation Fee is applied to your account, and the original payment is applied to the Cancellation Fee. To schedule another Cosmetic Consultation, you must pay a Consultation Fee again when you make the next appointment.

COSMETIC CONSULTATIONS

Cosmetic Consultation fees are deducted from your surgery balance if you schedule a surgery on the same day of your consultation. Cancellation Fees are non-refundable and will not be deducted from your surgery balance.

SURGERY DEPOSIT AND PAYMENT

Full payment for cosmetic procedures is due at least two weeks prior to your scheduled surgery date and a minimum of $250.00 per procedure is required the day you book your surgery. (This schedule may be adjusted in accordance with the payment terms of a specific finance plan).

SURGERY CANCELLATION & REFUND POLICY

If you cancel your surgery more than twenty-one (21) days before the scheduled surgery date, you will receive a refund of your payment minus a $1,500.00 Cancellation and Refund Processing Fee. We rely on your commitment to have your surgery when you pay, therefore if you cancel your scheduled surgery less than twenty-one (21) days before the surgery date you will receive a refund of your payment minus a $2,500.00 Cancellation and Refund Processing Fee and an additional $650.00 Anesthesia Booking Fee. No refunds are to be granted if the surgery is cancelled within 7 days except in the event of a documented medical emergency for the patient and as determined on a case-by-case basis.

Immediately after the deposit is paid, it is bound to the terms of this policy.

SURGERY RESCHEDULE POLICY

We understand you may need to reschedule your surgery unexpectantly and you are allowed up to two reschedule dates with no penalty as long as we have at least thirty-five days notice from the original surgery date. Any occurrence thereafter will have a Processing Fee of $150.00 each if at least thirty-five (34) days notice or a Processing Fee of $650 each if within thirty-five days. Rescheduled surgery is subject to scheduling availability.

POLICY FOR ENHANCEMENT PROCEDURES

All pre and post-operative visits are at NO ADDITIONAL CHARGE. We strive to achieve an improvement in your appearance; however, this may not be perfection. If enhancement procedures related to your surgery are necessary within the first 12 months, there may be surgeon's fees; however the cost of the operating room, supplies, and anesthesia would be your responsibility. To be eligible for discounted fees, YOU MUST attend your One Month, Three Month, Six Month, AND 9-12 Month post-operative visits. Failure to attend those designated post-operative visits excludes your eligibility for any discount on further enhancement or possible revisions.

ALL QUOTES ARE VALID FOR 30 DAYS FROM YOUR INITIAL CONSULTATION DATE.

By my signature below, I acknowledge receipt of a copy of this quote and confirm that I have read and understand the terms of the quote including the Refund Policy and I further acknowledge that my payment of the surgery will bind me to the terms of the quote including the refund policy.

I have read, understand, and agree to the above statements.

_____

Patient Printed Name (or responsible party, if patient is a minor)

_____

Signature of Patient (or responsible party, if patient is a minor) Date