Patient History
Non-Surgical Rejuvenation

Patient Name: ______________________ Today's Date: ______________________

Age: ______ Height: ______ Weight: ______ Date of Birth: ______________________

Natural Eye Color: ______________________ Natural Hair Color: ______________________

Reason for Visit: ______________________

Current Medical Problems: ______________________

Surgical History: ______________________

Allergies: ______________________

Medications (inc. vitamins): ______________________

Current skin care regimen/facial products: ______________________

Do you smoke? Y N Have you ever used Accutane? Y N When: ______________________

Have you ever received any of the following?

- ☐ chemical peel
- ☐ laser resurfacing
- ☐ alphahydroxyl acids
- ☐ facial fillers
- ☐ Retin-A
- ☐ Tazorac
- ☐ topical antibiotics
- ☐ micro-dermabrasion
- ☐ Differin
- ☐ Botox
- ☐ Hydroquinone

Have you ever had any of the following?

- ☐ Acne
- ☐ headaches
- ☐ lupus
- ☐ thyroid problems
- ☐ skin cancer
- ☐ cold sores
- ☐ pregnant
- ☐ heart condition
- ☐ rosacea
- ☐ varicose veins
- ☐ arthritis
- ☐ excessive bleeding
- ☐ diabetes
- ☐ hepatitis
- ☐ metal implants
- ☐ seborrhea
- ☐ depression
- ☐ excessive scarring
- ☐ eczema
- ☐ HIV/AIDS
- ☐ bruise easily
- ☐ poor healing
- ☐ keloid scars
- ☐ phlebitis
- ☐ change in moles

Any other medical problems: ______________________

The medical history above is true and accurate to the best of my knowledge. I fully understand all of the above questions and have answered them correctly and honestly. I am aware that individual results are dependent upon age, skin condition, genetics, and lifestyle.

I have had the opportunity to review the privacy statement.

Signature: ______________________ Date: ______________________

Patient Demographics

Patient Name: ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

Home phone: ______________________________

Work phone: ______________________________

Cell Phone: ______________________________

Social Security Number: ______________________________

E-Mail Address: ______________________________

Occupation: ______________________________

How did you hear about us? ______________________________

Primary Doctor: ______________________________

May we leave a message on your home phone? ______________________________

With the person answering your home phone? ______________________________

Is acceptable to contact you via e-mail? ______________________________

Emergency Contact: ______________ Relationship ______________

Home Phone: ______________ Cell Phone ______________

Address ______________ City/State/Zip ______________

Signature: ______________________________ Date: ______________

LAKE COUNTRY PLASTIC AND HAND SURGERY
P.O. Box 577, Pewaukee, WI 53072-0577

Financial Policy
Thank you for choosing us as your health provider. We are committed to your successful treatment. The following is a statement of our financial policy, which we require that you read and sign prior to treatment. Anytime you have questions regarding and treatment, fee, or service, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding.
Regarding Insurance
We will bill your insurance carrier for you. Any unpaid balances over 90 days will be assessed a service charge equaling 30% of the outstanding balance and will be submitted to small claims court if prior arrangements to pay have not been made or if you fail to make your agreed upon monthly payment. Please be aware some and perhaps all of the services provided may be "non-covered" services and are not considered reasonable and necessary under some medical insurance policies. If you are unable to pay in full, it is your responsibility to contact our billing office, and set up an agreeable payment plan. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Returned check fee is $25 or 30% of the amount of the check, whichever is greater. If you are notified by our office that you have a returned check you will have until the close of business the next day to present our office with cash or cashier's check in the amount outstanding plus service fee, or you will be referred to collections and/or be prosecuted criminally immediately. Persons who write bad checks will be prosecuted. Patients acknowledge that they are responsible for any and all collections costs and/or attorney fees and court costs associated with the collection of outstanding balances on their account.
Usual and Customary Rates
Our practice is committed to providing the best treatment possible for patients and we charge what is usual and customary for the area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of the usual and customary rates.
Injuries and Accidents Involving Legal Litigations
We will not accept third party billing if your injury or accident involves litigation. You are required to make payments on these charges even if a third party will cover them. You will promptly be reimbursed any fees that you have paid should we be reimbursed by a third party at some point in the future.
Completion of Medical Forms
A $3 fee per page plus actual postage will be charged for completion of all forms by our office. These forms include all disability, life, credit, loan claims, etc
Worker's Compensation
Our office will submit worker's compensation claims to your employer for payment. However, if the claim is denied, unsettled, or unpaid within 60 days from the initial visit we will request that you file a personal health insurance claim or pay the charges in full. If the situation becomes a legal matter, you are still ultimately responsible for the payment of the charges.
Co-pay/Deductibles
Payment is expected at the time of office visit for co-pays and/or deductibles that are required by your insurance policy.

Thank you for understanding our financial policy if you should have questions or problems, please let us know and we will be happy to assist you in every way possible.

I have read the financial policy (above). I understand and agree to this.

I thereby authorize my insurance benefits to be paid directly to Lake Country Plastic and Hand Surgery realizing I am responsible to pay any and all charges that exceed or that is not covered by insurance. I authorize the release of pertinent medical information to insurance and worker's compensation carriers.

Signature ______________________________ Date ____________________

For Medicare Patients Only
I also authorize Lake Country Plastic and Hand Surgery to bill my secondary or Medigap insurance carrier for any account balance remaining after Medicare part B payment has been received.

Signature ______________________________ Date ____________________