Hyde Park Cosmetic Surgery Center

Frank Wm. Rieger M.D., P.A.

Please Print Legibly & Fill In All Fields

Today's date:___________________________

Patient's Name: ____
Last First Middle

Address: ____
Street & Apt # City State Zip

Home Phone: ____________________ Cell Phone: ____________________ Other Phone: ____________________

Any restrictions for contacting you? ☐ No ☐ Yes

Contact Restrictions: ____________________

E-mail: ____________________

Add Me To The Mailing List: ☐

Drivers License # (include State): ____________________

Age: ________ Birthdate: ____/____/________ SSN: ______-______-________ Sex: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse/Partner: ____________________

Patient's Employer ____________________ Occupation ____________________

Work Phone ____________________ Ext: ________ Is it okay to call you at work? ☐ Yes ☐ No

Address ____
Street & Suite # City State Zip

Emergency Contact: ____________________ Relationship to Patient: ____________________

Home Phone: ____________________ Work Phone: ____________________ Other Phone: ____________________

Address: ____
Street & Apt # City State Zip

Health Insurance Company: ____

Policy #: ____________________ Group #: ____________________ Ins. Phone: ____________________

PHOTO RELEASE

AS PART OF THE MEDICAL SERVICES WHICH I AM RECEIVING FROM DR. RIEGER, I AGREE THAT PHOTOGRAPHS MAY BE TAKEN OF THE SURGICAL AREA(S) BEFORE, DURING AND AFTER TREATMENT. THESE PHOTOGRAPHS MAY BE TAKEN BY DR. RIEGER OR HIS DESIGNEE. THESE PHOTOGRAPHS SHALL ONLY BE USED FOR MY MEDICAL RECORDS. ANY OTHER USE WOULD REQUIRE FURTHER WRITTEN CONSENT EXCEPT FOR INFORMATION REQUESTED BY MY INSURANCE CARRIER TO AUTHORIZE SURGICAL PROCEDURES.

____________________	____________________	__________
Patient/Guardian Signature	Printed Name	Date
____________________	____________________	__________
Witness	Relationship to Patient	Date

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1. Which cosmetic procedures would you like to discuss with Dr. Rieger today? ______________________

2. How long have you been thinking about this procedure? ______________________

3. Have you had any previous consultations with other Plastic Surgeons regarding this procedure? ☐ Yes ☐ No

4. Have you thought about when you would like to have the procedure done? ______________________

5. Have any of your friends or family had this procedure done before? ______________________

6. Have you had any cosmetic surgery performed in the past? ______________________

7. Have you had any facial fillers or Botox in the past? ______________________

8. Have you in the past, or are you currently, involved in a medical malpractice lawsuit? (If yes, please explain): ☐ Yes ☐ No

9. Is there a specific concern that you have regarding your procedure of interest?

Recovery	Resuming Daily Activities	Time Off Work
Finances	Upcoming Travel	Other (Please Specify): ______

10. How were you referred to our office? ______________________

Primary Care Physician: ______________________ Phone: ______________________

Do you see any other Doctors on a regular basis? ☐ Yes ☐ No If yes, please list below:

Name:	Phone:	Specialty
Name:	Phone:	Specialty:
Name:	Phone:	Specialty:

______________________ ______________________ ______________________

Patient/Guardian Signature | Printed Name | Date

Medical History

Current Height: ____________ **Current Weight:** ____________

ENT
- ☐ Dry Eye
- ☐ Glaucoma
- ☐ Difficulty Breathing
- ☐ Nasal Fracture
- ☐ Sinus Condition
- ☐ Mouth/Throat Issue
- ☐ Thyroid Disease
- ☐ Recent Cold

Cardiac
- ☐ High/Low Blood Pressure
- ☐ Stroke
- ☐ Irregular Heart Beat
- ☐ Breathlessness
- ☐ Angina/Chest Pain
- ☐ Heart Murmur
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Mitral Valve Prolapse

Respiratory
- ☐ **Do you smoke? ☐ Yes ☐ No**
- ☐ Asthma/Hay Fever
- ☐ Emphysema/Shortness of Breath
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Blood Clot in Lung
- ☐ Cough: Longer than 2 weeks
- ☐ Bloody Sputum
- ☐ Exposure to TB

Genito-Urinary
- ☐ Prostate Disease
- ☐ Painful Urination
- ☐ Kidney Infection
- ☐ Bladder Infection
- ☐ Kidney Stones
- ☐ History of MRSA

Extremities
- ☐ Blood Clot in Leg
- ☐ Numbness or Tingling
- ☐ Arthritis
- ☐ Back Pain/Injury
- ☐ Convulsions/Epilepsy

Hematologic
- ☐ Blood Transfusion
- ☐ Anemia
- ☐ Bleeding Tendencies
- ☐ Blood Thinning Rx
- ☐ Sickle Cell Disease
- ☐ Vascular Disease

Gastrointestinal
- ☐ Recent/Unexplained Weight Loss
- ☐ Hiatal Hernia
- ☐ GERD/Ulcer
- ☐ Diabetes
- ☐ Jaundice/Hepatitis
- ☐ Liver Disease/Cirrhosis

Lifestyle
- ☐ Alcohol: ________ ____________
- ☐ Drug Use: ________
- ☐ Exercise: ________ ____________

Allergies
- ☐ **Do you have Medication Allergies?** ☐ **Yes** ☐ **No**

If **YES**, Please List: ____________________

- ☐ **Do you have Food Allergies?** ☐ **Yes** ☐ **No**

Please List ____________________

- ☐ **Are you Allergic to any of the following:** **Latex** **Pineapple** **Anesthesia**
- ☐ If **YES**, what is your reaction: ____________________

Women's Reproductive History

\# of Pregnancies: ____________

\# of Children: ____________

Ages: ____________

Last Mammogram: ____________

Last Menses: ____________

History Of: Menopause, Tubal Ligation Hysterectomy? (If Yes, Please Select)

Current Medications

Please list any medications that you are currently taking or have taken in the past year. Include prescription, non-prescription, and vitamins.

____

____

Surgical History/Hospitalizations

Procedure/Hospitalization	Date	Procedure/Hospitalization	Date

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HIPAA NOTICE OF PRIVACY

This document provides information about how we may use and disclose personal health information about you. You have the right to review our Notice before signing this consent. The terms of our Notice may change, and you are entitled to a revised copy if desired.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. Although not required to agree to this restriction, we may honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have a right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Number(s) to be used for all calls from this office:

(______)____________________ (______)____________________ E-mail:_________________________________

May we leave messages on an answering machine, voice mail or email? YES NO

List persons whom we may inform about your general medical condition, diagnosis, treatment, payment and health care options:

_____________________________________ ____

Name Phone Name Phone

List persons whom we may inform only in an emergency:

_____________________________________ ____

Name Phone Name Phone

Should correspondence from this office be marked CONFIDENTIAL? YES NO

Address where you would like correspondence sent if other than your home:

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment or health care operations.
2. The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
3. The practice reserves the right to change the Notice of Privacy policies.
4. The patient has the right to restrict the use of their information, however the practice reserves the right to contact the patient's financial institution, credit card company, Care Credit, or any third-party payee in matters of practice and/or surgical fees.

Patient/Guardian Signature	Printed Name	Date
Witness	Relationship to Patient	Date

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OFFICE POLICIES

PAYMENT SCHEDULE: 25% of the total fee is due to schedule a surgical date. The remaining balance is due no later than 2 weeks prior to surgery.

PAYMENT OPTIONS: Cash, credit card (Visa, Discover, MasterCard, American Express), or certified check (made payable to Hyde Park Cosmetic Surgery), Care Credit (for those who qualify).

MEDICAL INSURANCE: We do not accept any medical insurance for cosmetic surgery.

CANCELLATION/RESCHEDULE POLICY: We understand that a situation may arise that could force you to postpone your surgery. Please understand that such changes affect your surgeon, the operating room staff, and other patients as well.

IF YOU MUST CANCEL YOUR SURGERY:
o No penalty if surgery is rescheduled within 60 days of cancellation – or a mutually agreed upon date.

IF YOUR SURGERY IS NOT RESCHEDULED:
o If cancelled surgery was paid by credit card or third-party financing, you will be charged 10% to cover service fees.
o If you cancel your surgery less than 2 weeks to your scheduled date, you will forfeit your deposit amount.
o All surgeries are subject to a minimum $500 cancellation fee or the above financial policies.
o Cancellation requests must be received in writing and in the event of refund – please allow 45 to 60 days.

REVISIONAL SURGERY: Complication or the need for revision surgery is rare. In the event of revision surgery, you will be responsible for the cost of anesthesia and facility fee – Dr. Rieger's surgical revision fees may be at a reduced rate. In the event revision surgery is needed following the operation – it is necessary to wait for complete healing to occur.

ADDITIONAL MEDICAL TREATMENT: On very rare occasion complications may occur that require hospitalization or additional medical treatment. You are responsible for any cost not covered by your medical insurance.

LABORATORY TEST, PATHOLOGY TESTING AND PRESCRIPTIONS: Are not included in the price quote – you are responsible for any cost not covered by your insurance.

SURGICAL FACILITY AND ANESTHESIA: The quote received is an estimate only. You may be billed for extended time spent in the operating room.

SURGICAL GARMENTS: May not be included in the price quote – any garments that may be needed post-surgery are patient's responsibility.

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