THE PLASTIC SURGERY & VEIN CLINIC

2600 Rib Mountain Drive
WAUSAU, WI 54401
715.870-2162

Welcome to The Plastic Surgery & *Vein* Clinic

Please take time to review some general information about our office.

OUR PATIENT..AN IMPORTANT PERSON

Our concern is to achieve quality results with our state-of-the-art facilities and medical approaches and practices. We believe it is important to stress one idea-your importance to us as an individual. When you trust us to treat you, you are committing to care which is designed for you. We value our association. We hope to see you when you need us. And should or when you need us, we'll be there for you, our patient - to us, the most important person. We look forward to your arrival and appreciate the trust you have placed in us as your health care provider.

BOARD CERTIFICATION

Dr. Butler, Dr. Fox and Dr. Asplund are Board Certified. This means they have graduated from an accredited medical school and completed five to seven years of post-graduate training, including a thorough grounding in general surgery and intensive study at a plastic surgery training facility or general and vascular surgery facility. Rigorous examinations are then conducted by the American Board of Plastic Surgery as well as the American Board of General Surgery. Only the most qualified physicians are awarded Board Certification.

Enclosed are forms, which will need to be completed and signed prior to your appointment. It is important that the forms are **completed in entirety** to provide us with detailed information for your medical record as well the insurance filing process. To protect your identity, we will also need to make a copy of a photo ID for personal verification. If you have any questions regarding the forms, please contact our office and we will be glad to assist you.

(OVER)

FINANCIAL COMMENTS

Health insurance and Workman's Compensation claims will be processed and submitted as a courtesy to our patients. We will also submit claims to secondary carriers. You will need to bring your insurance card to your appointment in order for us to send the claim to your insurance company. We will collect your co-pay prior to your appointment.

Patients with medical insurance are asked to remember that professional medical services are rendered to you, the patient, not to the insurance company. You remain responsible for any fees arising from services rendered. We recommend that you review your medical insurance policy to become familiar with its provisions. We would be happy to assist you if needed. Just let us know if you would like our help to understand your insurance coverage and how it impacts the services you may be considering.

We will also submit a pre-authorization to your insurance company whenever it is required. Keep in mind that even if your insurance company authorizes your surgery, this does not necessarily mean it will be paid in full.

Medicare does not offer preauthorization for services.

☞ **REMEMBER PLASTIC AND VASCULAR SURGEONS ARE CONSIDERED SPECIALISTS. DO YOU NEED A WRITTEN REFERRAL OR AUTHORIZATION? PLEASE CHECK WITH YOUR INSURANCE CARRIER PRIOR TO YOUR APPOINTMENT.**

☞ **YOU MUST BRING AND PRESENT YOUR INSURANCE CARDS AND PHOTO IDENTIFICATION. THIS INFORMATION ENABLES US TO FILE A CLAIM TO YOUR INSURANCE COMPANY. IF YOU DO NOT PROVIDE THIS INFORMATION, YOU WILL BE BILLED FOR ALL RENDERED SERVICES.**

IF YOU ARE BEING SEEN IN STEVENS POINT, PLEASE MAIL, OR FAX A COPY (ALL SIDES), OF YOUR CARD AND PHOTO IDENTIFICATION TO THE WAUSAU OFFICE. FAX: 715-870-2163

☞ **A 48 HOUR CANCELLATION NOTICE IS REQUIRED**

The Plastic Surgery Group, S.C.
2600 Rib Mountain Dr., Suite 200, Wausau, WI 54401

SECTION I PATIENT INFORMATION

Last Name _____ First Name _____ Initial ____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Leave Message? Y☐ N☐ Cell Phone _____ Leave Message? Y☐ N☐

Birthdate _____ Sex M☐ F☐ Social Security Number _____ Marital Status _____

Employer _____ Address _____

City _____ State _____ Zip _____ Phone _____ Ext. _____

Referral Source _____ Family Physician _____

Email Address _____ Would you like to receive our email newsletter? Y☐ N☐

ALTERNATIVE CONTACT

(relative, or other, who we may contact regarding your protected health information)

Last Name _____ First Name _____ Middle Inital _____

Address _____ City _____ State _____ Zip _____

Relationship to Patient ☐ Spouse ☐ Parent ☐ Child ☐ Friend ☐ Other _____

Home Phone _____ Leave Message? Y☐ N☐

Other Phone _____ Leave Message? Y☐ N☐

Cosmetic (non-insurance) Patients - Skip Section II and Go to Section III
Health Insurance Patients - Complete Sections II and III
Other Insurance Type Patients - Complete Section III and Complete Green Billing Form

SECTION II INSURANCE INFORMATION

*** PLEASE PRESENT ALL APPLICABLE INSURANCE CARDS TO THE FRONT DESK ***

****Primary Insurance**** _____ Address _____

City _____ State _____ Zip _____

Phone _____ Subscriber Name _____

Subscriber Birthdate _____ Subscriber SS# _____

Subscriber I.D.# _____ Group Number _____

Employer _____ Address _____

City _____ State _____ Zip _____ Phone _____ Ext. _____

****Secondary Insurance**** _____ Address _____

City _____ State _____ Zip _____

Phone _____ Subscriber Name _____

Subscriber Birthdate _____ Subscriber SS# _____

Subscriber I.D.# _____ Group Number _____

Employer _____ Address _____

City _____ State _____ Zip _____ Phone _____ Ext. _____

(Continued on side 2)

SECTION III AUTHORIZATION AND POLICY INFORMATION

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize this office to release any information necessary to expedite all types of insurance (including Medicare) claims. I authorize payment (including Medicare benefits) to be made directly to the physician for any services or supplies furnished by that physician. I understand I am responsible for all charges regardless of insurance coverage (excluding Medicare and Medicaid).

COLLECTION FEE POLICY

I understand the following policy: In the event any unpaid balance is placed for collections, with any 3rd party collection agency, and/or placed with an attorney to obtain judgment or otherwise satisfy payment of this account, a fee of 33.3% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly by The Plastic Surgery Group to collect amounts owed under this agreement. Such costs include, but are not limited to court costs, service fees, filing fees, and other incidentals associated with our collection efforts.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

In accordance with HIPAA (Health Insurance Portability & Accountability Act), I have been provided and/or offered a copy of The Plastic Surgery Group Privacy Notice. I understand the notice may also be found on their website at: www.wausauplasticsurgery.com

_____ _____

SIGNATURE DATE

SECTION V AUTHORIZATION FOR PHOTOGRAPHS

Photographs represent an important part of your medical record. They allow us to objectively evaluate your pre-operative status and your post-operative progress. In some cases the photographs can assist us in detecting important changes in your healing process. Other reasons for use of patient photography are also indicated below. Your photographs are treated with the same confidentiality restrictions as the rest of your medical record in accordance with the HIPAA Privacy Rule of 2001. The photographs will become a permanent part of your medical record. You may obtain copies of your photographs at any time for a nominal fee.

I authorize photographs to be taken and used as follows:

- ☐ For patient education purposes
- ☐ To use in consultation with other physicians if necessary
- ☐ To evaluate your pre-operative status and at intervals during your recovery
- ☐ For medical education purposes such as training other medical professionals
- ☐ To correspond with your insurance company if applicable.
  (In some cases, insurance companies have pre-authorization requirements which necessitate that photographs be obtained and submitted to them prior to surgery.)
- ☐ Website education

Your signature authorizes us to take, utilize, and store these photographs as indicated above.

_____ _____

SIGNATURE DATE

PATIENT MEDICAL HISTORY

PATIENT NAME _____ Date _____
(Last) (First) (Middle)

	PERSONAL HX	FAMILY HX
ANEMIA		
BLEEDING PROBLEMS		
BLOOD CLOTS/THROMBOSIS		
VASCULAR/VEIN DISEASE		
CANCER		
TYPE OF CANCER:_____		
CHRONIC INFECTION/STAPH/MRSA		
DIABETES		
TYPE OF DIABETES:_____		
PHYSICAL DISABILITY		
EMPHYSEMA/ASTHMA/COPD		
EYE DISEASE		
HEART DISEASE		
Heart Attack		
Pacemaker		
Atrial Fibrillation		
LIVER DISEASE/HEPATITIS		
HIGH BLOOD PRESSURE		
HIGH CHOLESTEROL		
HIV/AIDS		
INCONTINENCE		
KIDNEY DISEASE/RENAL DISEASE		
MALIGNANT HYPERTHERMIA		
NASAL/AIRWAY DISEASE		
EXCESSIVE SNORING/SLEEP APNEA		
PREGNANCIES (HOW MANY)		
PSYCHIATRIC HISTORY		
Type: _____		
SKIN PROBLEMS		
Type: _____		
STOMACH DISEASE/ULCER		
HEART BURN/ACID REFLUX		
STROKE		
TUBERCULOSIS		
WEIGHT CHANGE		
STENT PLACEMENT/DATE		
THYROID DISEASE		
JOINT REPLACEMENT		
ORGAN TRANSPLANT		

PHARMACY:

CITY:

PHARMACY PHONE NUMBER

ALLERGIES

ALLERGIES TO MEDICATIONS REACTION

ALLERGIES TO LATEX/OTHER

MEDICATIONS PRESCRIPTION/NON PRESCRIPTION

Name **Dose**

ARE YOU ON BLOOD THINNER?

NAME

PRESCRIBING DOCTOR

PREVIOUS SURGERIES

EXPLANATION DATE

OTHER INFORMATION

HEIGHT WEIGHT

DO YOU SMOKE?

ARE YOU A FORMER SMOKER?

HOW LONG AGO?

DO YOU DRINK ALCOHOL?

HOW MUCH PER DAY?

HOW MUCH PER WEEK?

MARITAL STATUS: M S W D

DO YOU LIVE ALONE?

RELIGION

OCCUPATION

The Plastic Surgery & Vein Clinic, S.C.

Release of Information to Family Members, Relatives, or Other

I, _____authorize The Plastic Surgery Group to
(patient name printed)
share or disclose my protected health information to the parties designated below:

Information to be disclosed:

☐ Medical information
☐ Financial information
☐ None

Information to be disclosed to:

☐Spouse Name:_____

☐Relative(s) Name:_____
Name: _____
Name:_____

☐Friend(s) Name:_____
Name:_____
Name:_____

☐Other Name:_____
Name:_____
Name:_____

☐ None

_____ _____
Patient Signature **Date**

This authorization may be changed or revoked at anytime by notification of the patient.

THE PLASTIC SURGERY & VEIN CLINIC, S.C.
PAYMENT POLICY

Thank you for choosing our practice! First and foremost we are committed to the success of your treatment and plan of care. Please understand that payment of your bill is part of this treatment and care.

Deductibles and Co-pays

Prior to your appointment, contact your insurance company to determine if you have a deductible or co-pay responsibility. ***All co-pays and any un-paid deductibles will be collected at the time of your appointment****. Complete payment of your account is expected within 90 days. We accept payment by* ***Cash, Check, Money Order, Visa, Mastercard, Discover*** *or financing through* ***Care Credit. For more information on Care Credit call our office or visit their website at www.carecredit.com***

Insurance Identification Cards

In order for us to file a claim with your insurance company, you must present your insurance card(s) at the time of your appointment. A photocopy will be made and placed in your file. It will be your responsibility to notify us of any insurance coverage changes. We will not file a claim with your insurance company unless we have a copy of your insurance card. We will also need a copy of your photo identification such as a driver's license. This is to verify and protect the identity of the patient. We are not providers of any Medical Assistance plans. Therefore, we are unable to authorize any prescription use for Medicaid patients.

Workers Compensation

If the claim is to be filed with a Workers Compensation carrier, it will be your responsibility to contact your employer and obtain all of the requested information necessary to complete the enclosed Workers Comp form.

Cosmetic Consultations (For non-medically necessary procedures)

The cosmetic consultation fee of $75.00 is required three business days prior to your appointment. This applies only to patients who are seeking advice for cosmetic procedures or surgery. This does not apply to other types of consultations. This policy is to insure both you and our practice of your commitment to keep the scheduled appointment.

NOTICE: This is non-refundable without a 48-hour notice of cancellation.

Surgery

Our office will complete any pre-certification or pre-authorization if your insurance company requires it. If surgery is recommended, a pre-surgical deposit may be required. A cost estimate of your out of pocket expenses may be provided to you. We try our best to make the portion you are responsible to pay as exact as possible. However, please keep in mind the calculated amount is only an estimate. There is the possibility that after your insurance pays on your claim we may owe you a refund, or you may still have a balance due.

Disability Forms

A $15.00 fee will be charged for processing all disability forms (except workers compensation form WC-16). The $15.00 fee applies to ***each*** *form. Payment must be made when the form is submitted for processing. No forms will be sent to insurance carriers without the processing fee.*

If you have any questions regarding this policy, we invite you to call or office. Our office staff will be happy to help you.

Acknowledgement

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company as well as applicable co-payments and deductibles are my responsibility.

_____ _____ _____

Name of patient *Signature of Patient or Guardian* *Date*