BURGESS
PLASTIC SURGERY

COSMETIC & RECONSTRUCTIVE PLASTIC SURGERY
PATIENT INFORMATION

Date:_____
Patient Legal Name:_____ Phone: (hm)_____
Name we can call you:_____ (cell)_____
Permanent Address and/or PO Box:_____
City/State/Zip:_____ Email Address_____

Height:_____ft._____in Weight:_____lbs Sex: Male Female Transgender Nonbinary

Birthdate:_____/_____/_____ Age:_____ Pronouns:_____

Marital Status: Single Married Life Partner Other:_____

Employer:_____ Phone #:_____
Occupation:_____

Emergency contact person and phone #:_____Relationship:_____

REASON FOR INITIAL VISIT:_____
_____

HOW DID YOU HEAR ABOUT US?

Friend/Family:_____ Insurance Company Attended Event
Referring Provider:_____
If you found us on the internet, which website did you find us on?_____

Primary Care Physician (name):_____
Address:_____
City/State/Zip:_____ Phone #:_____

INSURANCE INFORMATION

SUBSCRIBER INFORMATION IS REQUIRED:
Relationship to patient: □ Self □ Spouse □ Parent □ Other:_____
Subscriber Name:_____Phone #:_____
Date of Birth:_____ SS #: _____-_____-_____
Address:_____City/State/Zip:_____

Primary Insurance:_____
Policy holders Name:_____
ID#:_____
Group #:_____
Address:_____
Phone #:_____

Secondary Insurance:_____
Policy holders name:_____
ID#:_____
Group #:_____
Address:_____
Phone #:_____

Signed:_____ Date:_____
Patient's signature/Guardian Signature

COSMETIC & RECONSTRUCTIVE PLASTIC SURGERY
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Please list all surgeries, serious injuries, illnesses or diseases:

Type	Year	Surgeon/Physician	City/State

Please list any allergies: (example: Penicillin, sulfa, iodine, seafood, codeine, anesthesia, tape, eggs)

Food/Drug	Reaction

NO ALLERGIES _____ LATEX ALLERGY? Y or N TAPE ALLERGY? Y or N

Current Medications: (please include herbal supplements or over-the-counter remedies)

Name of drug	Dose (mg)	How often taken

Do the following Medical Conditions run in your family? (please circle and state the relation & maternal or paternal).

High Blood Pressure _____
Stroke/Cardiovascular Disease _____
Blood Clots (DVT) or Bleeding Disorders _____
_____
Cancer (any type) _____
Asthma _____
Diabetes _____
Any other conditions_____

Do you smoke cigarettes and/or marijuana? ___Yes___No How much & how often?_____
Have you ever smoked? ___Yes___No When did you stop?_____
Do you use drugs? ___Yes___No
Do you use alcohol? ___Yes___No
If you use drugs or alcohol, what do you use and how often?_____

Do you have history of substance abuse or alcoholism? ___Yes ___No
If yes to either, please explain_____

For women: Are you pregnant? ___Yes___No ___Maybe
Are you breastfeeding? ___Yes___No

Have you had any diagnostic tests done? Where? When?

____ X-rays_____
____ Mammogram_____
____ MRI_____
____ EMG_____
____ CT scan_____
____ Ultrasound_____
____ EKG/Stress test_____
____ Other_____

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MEDICAL HISTORY:

Do you have any of the following medical problems? (please circle or add)

Constitutional: Recent unexpected weight loss, change in appetite, problems sleeping, fever, chills, fatigue, headache, other.
Details:_____

Allergic/Immunologic: rash, anaphylactic reactions, HIV/AIDs, TB(tuberculosis), prolonged or persistent infections, other.
Details:_____

Ophthalmologic: Dry eyes, red eyes, discharge, wears glasses, wears contacts, other.
Details:_____

Ears, Nose, Mouth, Throat: difficulty breathing, difficulty swallowing, previous injury, hearing aids, nosebleeds, sore throat, swollen glands, seasonal allergies, other.
Details:_____

Endocrine: thyroid problem, diabetes, hormonal problems, other
Details:_____

Respiratory: pneumonia, asthma, smoking, other.
Details:_____

Breast: bloody nipple discharge, breast lump, breast pain, breast cancer surgery or biopsy, breast radiation, lymphnode biopsy, breast surgery including augmentation, reduction, lift, other.
Details:_____

Cardiovascular: high blood pressure, heart murmur, heart attack, irregular heartbeat, mitral valve prolapse, chest pain at rest, chest pain with exertion, leg pain with walking, fluid accumulation in the legs, shortness of breath, other.
Details:_____

Gastrointestinal, Pancreas, Liver: abdominal pain, change in bowel habits, constipation, diarrhea, exposure to hepatitis, heartburn/reflux, nausea, vomiting, ulcer, bleeding, pancreatitis, liver disease, motion sickness, history of post-op nausea or vomiting, other.
Details:_____

Hematologic/Lymphatic: bruise easily, prolonged bleeding, recent transfusion, aspirin use, ibuprofen use, fish oil use, blood disorder, blood clot (DVT or PE), other.
Details:_____

Genitourinary: blood in urine, difficulty urinating, painful urination, bladder problems, kidney problems, other.
Details.:_____

Muskuloskeletal: carpal tunnel, joint replacement, muscle problems, gout, fibromyalgia, other.
Details:_____

Skin: rash, cold sores, acne, Accutane/Isotretinoin use, retin-a use, hydroquinone use, bronzing solution use, tanning bed use, keloid formation, skin cancer, severe sunburns, tattoos, permanent makeup, other.
Details:_____

Neurological: seizure, head injury, stroke, hand/foot numbness, nerve disease, headaches, migraines, fainting, other.
Details:_____

Psychiatric: depressed mood, anxiety, stressors, eating disorder, substance abuse, suicidal thoughts, seeing therapist, other.
Details:_____

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PHOTO CONSENT

I consent to have my photograph(s) taken to assist in my evaluation and medical treatment. Your photo is only of the area of concern and is for Dr. Burgess' evaluation only.

I consent to the use of photographs taken of me, for the discussion with other trained Plastic Surgeons, those practicing as Plastic Surgeons, or other medical professionals.

I consent for the use of any record, illustration, photograph, or other imaging record created in my case, for use in examination, credentialing, and certifying purposes by The American Board of Plastic Surgery and Dr. Elisa Burgess. (Dr. Burgess feels strongly that board certification is important. Her practice is periodically evaluated and she may share your file, which includes your photographs, with the American Board of Plastic Surgery to continue her high standards of care.)

We proudly offer TouchMD technology in our office. With this cloud based system, patients can easily access this from their home, including drawings and educational information gathered during the consultation.

None of the photos taken of you will be posted on any website or photobook of Dr. Elisa Burgess, unless a separate consent is given and signed by you, the patient.

* Photos are necessary at the time of consultation and before any treatment to establish a baseline for our patients. Refusal of photos may result in denial of treatment.

Patient/Guardian Signature **Date**

Elisa A. Burgess, M.D., F.A.C.S. - 503-699-6464 - 16865 Boones Ferry Road, Suite 101 - Lake Oswego, Oregon 97035
www.BurgessPlasticSurgery.com

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FINANCIAL POLICY

INSURANCE CONSULTATION:

If your consultation involves insurance, please be prepared to pay the co-pay if applicable.
If insurance is involved in your visit: We will bill primary and secondary insurance companies. Please provide us with complete and accurate insurance information, as well as any changes of address, telephone number or employer. If your plan requires referral from your primary care physician, we ask that you phone your primary care physician prior to your appointment for the necessary authorization. Lack of referral could result in patient responsibility for service requested that day. Your insurance contract is between you and your insurance company. You are ultimately responsible for payment of your account. Note: If we are using insurance for your consultation, your bill will be determined by your insurance company after being submitted by our office. *The $200 consultation fee does not apply to insurance visits. Charges to insurance will be billed at a different rate.*

COSMETIC CONSULTATION:

We require a $200 consultation fee for your first office visit with Dr. Burgess. **No insurance involved.** $100 of this fee will apply towards any cosmetic surgery or in-office procedure provided within one year of the consultation date. If Dr. Burgess agrees that you are an acceptable candidate for surgery, you will be presented with a cosmetic price quote at the end of your consultation. The **surgery fees for cosmetic procedures** include Dr. Burgess' fee, hospital operative room fees, anesthesiology fees, and any miscellaneous items such as implants/garments necessary for surgery. It will also include your pre-operative visit before surgery and office follow-up visits for one year following surgery. Signed price quotes are honored for 90 days from the day of quotation. There is a $500.00 non-refundable deposit due at the time of scheduling surgery that will be applied towards the surgeon's fee.
*Please see price quote given at your consultation for more information.
*Additional consultations after one year will require a $200 consultation fee.

If your consultation is scheduled with a registered nurse or advanced medical aesthetician, your consultation is complimentary. These providers will be able to provide recommendations for our non-surgical options. Should they feel you are a better candidate for surgery, we can schedule a consultation with Dr. Burgess with a $200 fee.

I have read, understand and agree to this financial policy.

_____ _____

Patient/Guardian Signature **Date**

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AGREEMENT TO PAY MEDICAL EXPENSES

1. Appointments involving insurance: Co-payments are collected at the time of your visits with the doctor. Your insurance company will be billed by a billing service. When you have a personal balance, you will receive a monthly statement. Prompt payment of personal balances are appreciated. If you require special payment arrangements, please call the billing service, Service Plus at 503-284-8841.

2. Medicare: We are a participating clinic. We do accept assignment on Medicare claims.

3. No Insurance: Payment in full is required at the time of your appointment for all noninsured patients.

4. Deposit: We do require a non-refundable 50% deposit for **in-office cosmetic** procedures at the time the procedure is scheduled if insurance is not involved.

5. **No show/late cancellation policy:** Burgess Plastic Surgery requires at least 48 hours' notice to cancel or reschedule any in-office treatment. Appointments cancelled with less than 48 hours' notice, or in the event of a no show, your credit card will be held and subject to a charge of $200 for appointments with Dr. Burgess and her staff. Office visits including Botox®/Dysport®/Xeomin® require at least a 24 hours' notice to cancel or reschedule and will be subject to a $100 charge in the event of a late cancellation, reschedule, or no show.

6. Injectable procedures: Payment for in office injectable procedures (i.e. Botox®, Juvederm®, Restylane®, Belotero®, etc.) will be collected at the time of treatment. Deposit is required to schedule. Personal checks will not be accepted.

7. Product sales: For all purchased items in office i.e. skincare, sunscreens, etc., no returns or exchanges are allowed, for any reason.

I authorize the release of any medical or other information to my medical insurance company necessary to process my claim, authorize services, or coordinate treatment. I request payment of government or insurance benefits directly to Elisa Burgess, M.D. I understand I am personally responsible for all medical expenses provided by Elisa A. Burgess, M.D., for medical care and treatment. If for any reason there is dispute of payment after treatment has been received, I the patient, waive my rights to privacy under the Health Insurance Portability and Accountability Act of 1996 guidelines. However, I agree to pay all medical expenses within 30 days of the date I am billed for those expenses, unless other arrangements have been made with Dr. Burgess and/or her billing service. I also agree to pay all separate charges billed by a surgical assistant that Dr. Burgess requires to have during my surgery, whether the surgical assistant is in network or out of network with my insurance plan.

I have read, understand and agree to this expense policy.

Patient/Guardian Signature _____ **Date** _____

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PLASTIC SURGERY

TELEHEALTH INFORMED CONSENT

Telehealth (also called telemedicine) is a way to visit with your healthcare provider without going into a hospital or clinic. The visits are held by computer, tablet, or telephone.

This form gives permission for telehealth communication between Burgess Plastic Surgery and

_____ _____.
Patient name Patient DOB

• I understand that telehealth involves sharing my health information electronically. I will tell my healthcare provider if there is any information that I do not want to talk about in a telehealth visit.
• I understand that I may stop the telehealth visit at any time. If I decide to stop, I will still be able to receive care at this office.
• I understand that I may have to check with my insurance plan to see if telehealth visits are covered.
• I understand that telehealth visits carry some level of risk. These risks include but are not limited to:
    * My computer, tablet, or phone may not be private and secure, especially if other people use it. It is my responsibility to make sure my internet system is private and secure and to make sure I am in a private place during the visit.
    * Technical problems may interrupt or stop the visit before it is complete.
    * My healthcare provider cannot exam me as closely during a telehealth visit, and this may make it harder to correctly assess and/or diagnosis my issues.

• I agree that information shared during my telehealth visit will be kept by the healthcare providers and facilities involved in my care.
• I understand that the telehealth visit may be recorded.
• I understand that I will be asked to confirm my identity and current location to the healthcare provider seeing me.
• I also have the right to confirm the identity and credentials of the healthcare provider who will be seeing me.
• I agree to follow my healthcare provider's recommendations – including lab tests and x-rays, sending me to another specialist, or asking me to come into the office or go to an emergency department for an in-person visit.

By signing below, I agree that I've reviewed the information on this form, any questions I had are answered, and I agree to telehealth visits.

_____
Signature of patient or legal guardian/representative date/time

_____
Printed name of the above; relationship to patient if legal guardian

We understand you may not be scheduled for a virtual appointment at this time.
We do ask that you read through and sign this page for
possible future appointments that may be through telehealth.

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PLASTIC SURGERY

HIPAA Privacy Practices

I understand that Elisa A. Burgess, MD, PC (referred to below as "This Practice") will protect and not use my personal health information when the purpose does not directly relate to my care without my permission.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health and similar types of health-related information.

You have the right to restrict how your personal health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

I understand and agree that This Practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or other who may be responsible to pay for some or all of my healthcare; and
- Perform various office, administrative and business function that support my physician's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and that information practices followed by the employee, staff, and other personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices in effect will be posted in waiting/reception area.
I understand that I have the right to ask that some or all my health information not be used or disclosed in the manner described in The Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

Patient/Guardian Signature_____ Date_____

If you would like a copy of the entire Notice of Privacy Practices, please refer to our website:
www.BurgessPlasticSurgery.com/Patient-Resources/Patient-Forms/