DR. CRAIG OSER
PLASTIC SURGERY AND MED SPA
DROSER.COM

PATIENT INTAKE FORM - PLASTIC SURGERY

In order for our office to best prepare for your visit, please complete the information below and bring this form with you on the day of your consultation.

PATIENT INFORMATION

Full Legal Name: _____ /_____ /_____
Last Name First Name Middle Int.

Age: _____ Date of Birth: _____ /_____ /_____ S.S. #: _____-_____-_____

Address: _____

City: _____ State: _____ Zip: _____

Home: (____) _____-_____ Mobile: (____ _____-_____ Work: (____) _____-_____

Do we have consent to call you and leave a message? ☐ Yes ☐ No

If yes, on what number: *(Check all that apply.)* ☐ Home ☐ Work ☐ Cell Phone

What is the best time to reach you? Morning / Afternoon / Evening

Email address: _____

May we email you promotions and/or specials: ☐ Yes ☐ No
(Please be aware that email is not a secure form of communication and that the discussion of your medical care will become part of your medical record.)

What way do you approve and prefer we communicate with you between office visits?
(Check all that apply.)(By checking the box, you are giving consent for the office to communicate by that method.)

☐ E-mail ☐ Home ☐ Work ☐ Cell Phone ☐ Text

Is there any place you do NOT want me to leave a message? _____

REFERRAL SOURCE

How were you referred to us? _____

How did you hear about us? *(Please check all that apply and list specific station, website or event.)*

TV: _____ Billboard: _____ Radio: _____ Internet: _____ Social Media: _____ Other: _____

GENDER

Female _____ Male _____

MEASUREMENTS

Height _____ Weight _____ BMI _____

MARITAL STATUS

Single _____ Married _____ Widow _____ Separated_____ Divorced_____ Other_____

OCCUPATION

Title: _____ *(Full time/Part time/Student/Retired)*

Employer/School: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Craig Oser, DO, FACOS, FACS
2201 PARK MANOR BLVD• Suite 400• Pittsburgh, PA
15205 Office: 1.844.4DROSER • Fax: 724.909.1711

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home: (____) _____-_____ Mobile: (____) _____-_____ Work: (____) _____-_____

MEDICAL CONTACT INFORMATION

Family Physician: _____ Phone # (____) _____-_____

Referring Physician: _____ Phone # (____) _____-_____

Dermatologist: _____ Phone # (____) _____-_____

Pharmacy: _____ Phone # (____) _____-_____

HEALTH INSURANCE

Do you have medical insurance? Yes ___ No ___

Do you have Medicare? Yes ___ No ___

Insurance Company Name: _____

Please provide your insurance card to be copied for our records.

Is your accident related to the following:

Auto: ☐ Yes ☐ No

Work: ☐ Yes ☐ No

TODAY'S VISIT

What brings you to our office? Please be as specific as possible.

_____

How long has this concerned you? _____

Have you had any previous treatment for this? _____

If yes, how and when was this treated?_____

ADDITIONAL PROBLEM AREAS:

Is there anything else you would like to discuss with the doctor? If yes, please describe?

_____

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PATIENT MEDICAL HISTORY

CHECK LIST SELF REVIEW

	YES	NO		YES	NO
AIDS or HIV			Hepatitis		
Anemia			High Blood Pressure		
Arthritis			Irregular Heart Beat		
Asthma			Kidney Problems		
Back Problems			Migraine Headaches		
Blood Clots in Legs			Nervous Breakdowns		
Blood Disorders			Nose/Throat Problems		
Bleeding Problems			Pneumonia		
Breathing Problems			Psychiatric Condition		
Cancer			Rheumatic Fever		
Chest Pains			Seizures		
Colitis			Shortness of Breath		
Diabetes			Skin Cancer		
Ear/Eye Problems			Stomach Problems		
Epilepsy			Stroke		
Heart Problems			Thyroid Problems		
Heart Murmur			Tuberculosis		
Heart Palpitations			Transfusion		

GENERAL MEDICAL QUESTIONS

Are you in general good health? ☐ Yes ☐ No If no, please explain: _____
Have you ever had a mammogram? ☐ Yes ☐ No If yes, when was your last one? _____
Have you, or any of your relatives have had breast cancer? ☐ Yes ☐ No If yes, who_____
Have you or a member of your family ever had a problem with anesthesia? ☐ Yes ☐ No
Have you ever had radiation? ☐ Yes ☐ No
Have you been exposed to excessive sun? ☐ Yes ☐ No
Do you or any family member have problems with prolonged bleeding when cut? ☐ Yes ☐ No
Do you or any family member have problems with bruising easily? ☐ Yes ☐ No
Do you or any family member have problems with excessive scarring or keloid formation after being cut? ☐ Yes ☐ No
Do you wear contacts? ☐ Yes ☐ No
Do you have any problems with dry eyes? ☐ Yes ☐ No
Do you use wetting drops? ☐ Yes ☐ No If yes, how often? _____ How long? _____
If Female: Is there a chance that you might be pregnant? ☐ Yes ☐ No
Date of last menstrual cycle: _____

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MEDICATIONS AND SUPPLEMENTS

What medications *(prescribed or over the counter)* are you currently taking? Please list all medications including prescription and over the counter drugs, vitamins, herbs, blood thinners, aspirin, and/or supplements.

_____

_____

What medications have you previously taken?

_____

_____

ALLERGIES

Do you have any known allergies? ☐ Yes ☐ No

If so, please list: _____

Do you have any known food, drug or latex allergies? ☐ Yes ☐ No

If yes, please list: _____

SURGICAL HISTORY

Have you had any hospitalizations or surgeries? If so, please list and be sure to include dates:

_____

_____

SOCIAL HISTORY

Do you consume or have you consumed any of the following?

1. Tobacco? ___ YES ___ NO If yes, type? _____ How much? _____ How often? _____ How long? _____
2. Alcohol? ___ YES ___ NO If yes, type? _____ How often? _____
3. Caffeinated Beverages ___ YES ___ NO If yes, How often? _____
4. Street Drugs ___ YES ___ NO If yes, drug of choice? _____ ** Please discuss with doctor

FAMILY HISTORY

Please indicate if there have been any of the following diseases in you, your parents, grandparents, siblings, or children. Please mark family members on appropriate line:

Cancer _____	Stroke _____	Asthma _____	HIV _____
Diabetes _____	Anemia _____	Mental Illness _____	Hepatitis _____
Epilepsy _____	Kidney Disease _____	Arthritis _____	Bypass _____
Heart Disease _____	Glaucoma _____	Tuberculosis _____	Heart Attack _____
High Blood Pressure _____	Allergies _____	Alzheimer's _____	Other _____

If yes or other, please specify _____

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CONSENT FOR MEDICAL TREATMENT

I, the undersigned, hereby authorize physicians, agents and employees of Dr. Craig Oser to furnish such emergency care, outpatients care and/or inpatient care including but not limited, to investigative or diagnostic procedures, examinations, anesthesia, medical and/or surgical treatment which, in the judgment of the patient's attending physician, is recommended or necessary for the treatment of the patient's illness or condition. I understand it is solely within the capability of the physician(s) and/or his assistant(s) to explain to me the nature of any diagnostic, medical and/or surgical procedures necessary to treat me, or the registered patient and to explain the risks of consequences with the procedures.

Signature of Patient: _____ Date: _____

Signature of Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

SCHEDULED APPOINTMENTS

We understand that delays can happen, however, we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time, please let us know by calling the office at 844.437.6737. There is a chance we must reschedule the appointment.

CANCELLATION/NO SHOW POLICY FOR DOCTOR APPOINTMENT

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not canceled at least 24 hours in advance, you will be charged a fifty-dollar ($75) fee; this will not be covered by your insurance company.

CANCELLATION/NO SHOW POLICY FOR SURGERY

Surgical Deposits are non refundable. Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office. If surgery is not canceled at least 30 days in advance, we reserve the right to keep your deposit. In office procedures not canceled 48 hours in advance are subject to a $75 cancellation fee. This will not be covered by your insurance company.

Patient's Signature: _____ Date: _____

Thank you for taking the time to complete this information.
Please remember to bring this form with you on the day of your visit.

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Dr. Craig Oser, Plastic Surgery and Med Spa, has my consent to use and disclose my Protected Health Information ("PHI") to carry out treatment, to obtain payment from third parties and to perform healthcare operations as outlined below. _____ *(Initial)*

I have been given a copy of the HIPAA Notice of Privacy Practices *("HIPAA Notice")* which contains a complete description of PHI. _____ *(Initial)*

I have the right to review, and to the extent I desire to do so, I have reviewed the HIPAA Notice prior to signing this consent form. _____ *(Initial)*

I authorize Dr. Craig Oser, Plastic Surgery and Med Spa, to use and disclose my PHI in the following manner:

1. Transmit my PHI through the following means in order to carry out treatment, obtain payment from third parties and perform healthcare operations:

   ☐ Home/Cell Phone Number ☐ Fax Number

   ☐ Email Address ☐ Mailing Address

2. Disclose my PHI to the following family members in order to carry out treatment, obtain payment from third parties and perform healthcare operations:

   a. Name: _____ Contact Information: _____

   b. Name: _____ Contact Information: _____

   c. Name: _____ Contact Information: _____

   OR I do not authorize disclosure of my PHI to anyone other than myself _____ (Initial)

3. Transmit my PHI to other healthcare providers, as well as my health insurance carrier, in order to carry out treatment, obtain payment and perform healthcare operations _____ *(Initial)*

   By signing this form, I consent to Dr. Craig Oser, Plastic Surgery and Med Spa, the use and disclosure of my PHI as outlined above:

   I, _____, acknowledge that I have read and understand the above.

Name: _____ Date Signed: _____

Relationship to patient: (If other than self) _____

**I may revoke my consent in writing except to the extent that Dr. Craig Oser, Plastic Surgery and Med Spa, has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. Craig Oser, Plastic Surgery and Med Spa, may decline to provide treatment.

If you have any questions about the HIPAA Notice, please contact our office at 1.844.437.6737 and ask to speak with the Office Manager.

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(To be filed in patient's medical record)

I have been presented with a copy of Dr. Craig Oser's Plastic Surgery and Med Spa Notice of Privacy Practices detailing how my health information may be used and disclosed as permitted under federal and state law, as well as outlining my rights regarding my health information.

PATIENT'S NAME (Print): _____

PATIENT OR LEGAL GUARDIAN SIGNATURE: _____

RELATIONSHIP TO PATIENT (if other than self): _____

DATE SIGNED: _____

I wish to place the following restrictions on disclosure of my health information:

_____

ACKNOWLEDGMENTS

HIPAA RELEASE OF INFORMATION

Dr. Craig Oser and assistant(s) may release your protected health information for the purpose of treatment, payment and healthcare operations. Other allowed releases include: legal requirements, public health activities, health oversight, organ donation, research, prevention of serious threat to health or safety, governmental functions, appointment reminders and fundraising activities.

PATIENT BILL OF RIGHTS

Dr. Craig Oser and assistant(s) may release your protected health information for the purpose of treatment, payment and healthcare operations. Other allowed releases include: legal requirements, public health activities, health oversight, organ donation, research, prevention of serious threat to health or safety, governmental functions, appointment reminders and fundraising activities.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign Dr. Craig Oser all insurance benefits, including Major Medical benefits, due to me in consideration of the medical services I received, and I hereby authorize my insurance company to pay Dr. Craig Oser. I understand that if all or any part of my insurance benefits are denied, including failure to receive proper physician authorization, I will be liable for all medical service charges.

I ACKNOWLEDGE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT

Patient's Signature: _____ Date: _____

Guardian/ Representative: _____ Date: _____

Witness: _____ Date: _____

INTERNAL USE ONLY

If patient/patient's representative refuses to sign acknowledgment, please document date and time notice was presented to patient and sign below.

Presented on *(date and time)*: _____ By *(name and title)*: _____

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FINANCIAL POLICY & PATIENT RESPONSIBILITY

Dr. Craig Oser, Plastic Surgery and Med Spa, is dedicated to providing the highest level of care. This financial policy has been prepared to make your visit pleasant and informative, as well as to inform you of your financial responsibility to Dr. Craig Oser Plastic Surgery and Med Spa. Please read carefully and insert your initials at the end of each advisory, indicating that you have read this information and agree to it – then sign and date at the bottom of the page.

- ☐ Payment for your visit is due at the time service is rendered. If you have insurance, or we participate in your insurance plan, we will bill your insurance carrier as a courtesy to you, but we make no assurances about your carrier's decision to make payment. UNLESS DR. CRAIG OSER PLASTIC SURGERY AND MED SPA PARTICIPATES IN YOUR INSURANCE PLAN, YOU ARE FINANCIALLY RESPONSIBLE AND OBLIGATED TO PAY ALL SUMS CHARGED, INCLUDING ALL SERVICES RENDERED BY DR. CRAIG OSER PLASTIC SURGERY AND MED SPA PRIOR TO THE DATE OF THIS FINANCIAL POLICY. ***(Initial: _____)***
- ☐ If you have arrived at Dr. Craig Oser Plastic Surgery and Med Spa for a complimentary cosmetic consultation and during your visit there is a discussion and/or exam concerning a medically necessary condition, we will bill your insurance carrier for the visit and require that payment be assigned to us. If your insurance company makes payment directly to you for services rendered by Dr. Craig Oser Plastic Surgery and Med Spa, you agree to immediately forward it to us upon receipt. ***(Initial: _____)***
- ☐ You will receive a monthly statement if your account has any balance due, even if an insurance claim has been filed on your behalf. The date of the insurance submission and any credits to your account will be noted on this statement. ***(Initial: _____)***
- ☐ A deposit for cosmetic surgery is required at time of scheduling. All cosmetic procedures must be paid in full prior to surgery. Please be aware that the surgeon's fee does not include lab fees, and there could be an additional charge for anesthesiology fees, pathology charges, hospital charges or ambulatory surgery center charges (also known as facility fees.) There will be a non-refundable surgery fee if surgery is not canceled within five (5) days prior to your scheduled date. You agree to all applicable cancellation fees. ***(Initial: _____)***
- ☐ While the medical group's staff makes every effort to assist you with processing your insurance claim, any incorrect or incomplete insurance information will usually result in reduced benefits and add to your financial burden. It is your responsibility to understand and know the terms and conditions of your insurance plan, any necessary referrals, preauthorizations, pre-certifications and all insurance related requirements. **UNLESS DR. CRAIG OSER PLASTIC SURGERY AND MED SPA PARTICIPATES IN YOUR INSURANCE PLAN, YOU ARE FINANCIALLY RESPONSIBLE AND OBLIGATED TO PAY ALL SUMS CHARGED BY DR. CRAIG OSER PLASTIC SURGERY AND MED SPA, INCLUDING FOR ALL SERVICES RENDERED BY DR. CRAIG OSER PLASTIC SURGERY AND MED SPA PRIOR TO THE DATE OF THIS FINANCIAL POLICY.** ***(Initial: _____)***
- ☐ Insurance companies do not pay for cosmetic procedures. If you are having a cosmetic procedure at the same time as a non-cosmetic procedure, we will submit to your insurance company only for the non-cosmetic procedure. Every insurance company determines its own payment schedule in accordance with the plan selected. Please be aware that you may have a deductible, co-insurance, out-of-network penalty or an uncovered claim, resulting in payments due from you to Dr. Craig Oser Plastic Surgery and Med Spa. ***(Initial: _____)***
- ☐ Dr. Craig Oser is a Medicare Participating Provider which means that Medicare will tell us the amount to charge for our services. Of the amount Medicare allows us to charge, Medicare will pay eighty percent (80%) and you (unless you have supplemental insurance) are obligated to pay the remaining twenty percent (20%). In addition, Medicare has a yearly deductible that you will need to pay before Medicare payments begin/commence. Your co-pay (which is twenty percent (20%) of Medicare's allowed amount) is due at the time of your appointment unless you have a supplemental insurance policy. If you have a supplemental insurance policy, we will file with that secondary insurance carrier after we receive a check or payment from Medicare. We allow sixty (60) days from the date Medicare responds or makes payment for your supplement policy to pay the outstanding balance. After the sixty (60) days expires, the outstanding balance becomes your responsibility. ***(Initial: _____)***
- ☐ I have received a copy of this Financial Policy & Patient Responsibility, understand the terms stated herein and have voluntarily executed this agreement. ***(Initial: _____)***

Should you have any questions or concerns regarding this policy, please feel free to discuss this with your patient coordinator. No changes to the terms set forth in this agreement are binding upon Dr. Craig Oser Plastic Surgery and Med Spa unless written below and signed separately by both you and an authorized representative of Dr. Craig Oser Plastic Surgery and Med Spa.

Signature: _____ Date: _____

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AUTHORIZATION FOR RELEASE AND CONSENT OF MEDICAL PHOTOGRAPHS, VIDEOS AND/OR TO PUBLISH

Please read this information carefully and completely concerning granting permission to take and use photographs, videos and/or testimonials. After reviewing, please sign the consent as proposed by Dr. Craig Oser Plastic Surgery and Med Spa.

I hereby authorize Dr. Craig Oser Plastic Surgery and Med Spa and his associates or licensees the right to use my photographs, videos and/or testimonials taken that showcase me and/or the procedure that I am having performed:

☐ **Snapchat**
☐ With eyes showing ☐ Without eyes showing

☐ **Instagram**
☐ With eyes showing ☐ Without eyes showing

☐ **Facebook**
☐ With eyes showing ☐ Without eyes showing

☐ **Twitter**
☐ With eyes showing ☐ Without eyes showing

☐ I hereby grant Dr. Craig Oser Plastic Surgery and Med Spa the right to use my photographs, videos and/or testimonials on their website and all digital media platform **(photo gallery, blogs, etc.)**

☐ I hereby grant Dr. Craig Oser Plastic Surgery and Med Spa the right to use my photographs, videos and/or testimonials for professional medical purposes, including but not limited to, showing these images on electronic digital networks for purposes of medical education, patient education, lay publication, advertising and marketing or during lectures to medical or lay groups.

PLEASE PRINT THE FOLLOWING

Patient Name:_____ Date of Birth: _____

Email Address: _____ Telephone: _____

Procedure(s): _____

Physician/Service Provider: _____ Date of Procedure: _____

I hereby certify that I am over 18 years old and that it is my intention to be legally bound by this agreement.

I understand that photographs and/or videos may be taken preoperative, intraoperative and postoperative and at any stage of my procedure and may contain recognizable images of my face and/or body. I understand that all information will be kept confidential and will be reported in an anonymous fashion. I will not be described by name in any publication.

The information, photographs, videos and/or testimonials disclosed under this consent, or some portion thereof, are protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any use or disclosure of such information, photographs, videos and/or testimonials carries with it the potential for an unauthorized redisclosure. I release Dr. Craig Oser Plastic Surgery and Med Spa, its agents and employees, from all liability in connection with any such redisclosure and/or disclosure and/or use of information, photographs, videos and/or testimonials by individuals and/or entities other than Dr. Craig Oser Plastic Surgery and Med Spa and its agents and employees.

I release Dr. Craig Oser Plastic Surgery and Med Spa, its agents and employees, from all liability in connection with information, photographs, videos and/or testimonials of me authorized pursuant to this release and consent. I waive any right to inspect or approve the information, photographs, videos and/or testimonials prior to use. I release Dr. Craig Oser Plastic Surgery and Med Spa, its agents and employees, from any claim I may have relating to use of the information, photographs, videos and/or testimonials, including any claim for payment in connection with the use of them.

I understand that I may revoke this consent at any time by providing a written request. If I do so revoke this consent, it will have no affect on any use or disclosure of photographs, videos or testimonials prior to the revocation date.

I may refuse to sign this Release and Consent without such refusal affecting the medical treatment I receive with Dr. Craig Oser Plastic Surgery and Med Spa.

Signature: _____ Date: _____

Witness: _____ Date: _____

Thank you for taking the time to complete this information.
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