K PLASTIC SURGERY, PLLC DATE: _____

PATIENT NAME: _____ DOB:_____

PRIMARY PHYSICIAN:_____ REFERRING PHYSICIAN:_____

OTHER PHYSICIANS /SPECIALISTS:

CARDIOLOGY_____ PULMONARY_____ NEPHROLOGY_____

HEMATOLOGY / ONCOLOGY_____ OTHER_____

HEIGHT:_____ FT _____IN WEIGHT_____

RACE_____ PRIMARY LANGUAGE _____

ADDRESS:_____ CITY_____ STATE_____ ZIP_____

HOME PHONE_____ CELL PHONE_____WORK PHONE_____

MARITAL STATUS: **S M D W** SPOUSE NAME_____

SSN# _____

EMPLOYER _____ OCCUPATION _____

EMAIL ADDRESS _____

WOULD YOU LIKE TO RECEIVE OUR EMAIL NEWSLETTER: **Y / N**

PHARMACY _____ LOCATION _____

IF PATIENT IS A **MINOR**, MOTHER'S NAME _____FATHER'S NAME_____

PRIMARY INSURANCE HOLDERS **DOB** IF DIFFERENT THAN YOU OWN:_____

REASON FOR TODAY'S VISIT:_____

HOW LONG HAS THIS BEEN A PROBLEM:_____

WHERE IS THE LOCATION(S):_____

ASSOCIATED SYMPTOMS:_____

_____

_____

PAST MEDICAL HISTORY

DO YOU HAVE ANY ALLERGIES(MEDICATIONS,FOOD,INSECTS,TAPE,ADHESIVES):**Y/N**
IF YES, PLEASE STATE TO WHAT AND DESCRIBE THE REACTION:

_____

HAVE YOU EVER HAD A HYPERTROPHIC SCAR, KELOID OR POOR SCARRING: **Y / N**

ARE YOU PREGNANT OR NURSING: **Y / N**

DO YOU CURRENTLY TAKE OR HAVE RECENTLY DISCONTINUED ACCUTANE: **Y / N**

HAVE YOU EVER HAD A BLOOD CLOT / PULMONARY EMBOLISM: **Y / N**

HAVE YOU EVER HAD A PROBLEM WITH BLEEDING AFTER A PROCEDURE: **Y / N**

DO YOU TAKE BLOOD THINNERS(COUMADIN, ASPIRIN, ADVII, FISH OIL, HEPARIN): **Y/N**

DO YOU HAVE ANY IMPLANTABLE DEVICES (PACEMAKER, ARTIFICIAL VALVES, ARTIFICIAL JOINTS): **Y / N**

DO YOU HAVE TO TAKE ANTIBIOTICS BEFORE DENTAL SURGERY: **Y / N**

DO YOU OR ANY FAMILY MEMBERS HAVE DIFFICULTY WITH ANESTHESIA: **Y / N**

DO YOU HAVE DIFFICULTY GETTING NUMB FOR DENTAL WORK: **Y/ N**

DO YOU HAVE DIFFICULTIES WITH ANESTHESIA: **Y / N**
IF YES, PLEASE DESCRIBE:_____

FOR WEIGHT LOSS PATIENTS ONLY

WEIGHT AT YOUR HEAVIEST____ WHEN WAS THAT_____CURRENT WEIGHT____

IS YOUR CURRENT WEIGHT STABLE: **Y / N** FOR HOW LONG_____

ARE YOU STILL LOSING WEIGHT: **Y / N** HOW MUCH MORE DO YOU PLAN TO LOSE_____

CHECK ALL THAT APPLY

SKIN CANCER___ BREAST CANCER___ OVARIAN CANCER___ HEART DISEASE____
HIGH BLOOD PRESSURE___ NEUROLOGICAL DISEASE___RESPIRATORY DISEASE___
GASTROINTESTINAL DISEASE___ DIABETES___ LIVER DISEASE / HEPATITIS ____
KIDNEY DISEASE_____ HIV/INFECTIOUS DISEASE_____ BLEEDING PROBLEMS_____

DO YOU SEE A MENTAL HEALTH PROFESSIONAL: **Y/ N** THEIR NAME_____FOR WHAT?_____

PLEASE LIST ALL PRESENT MEDICATIONS INCLUDING BIRTH CONTROL, VITAMINS, OVER THE COUNTER MEDICATIONS AND SUPPLEMENTS

_____

_____

DO YOU TAKE ANY OF THE FOLLOWING REGULARLY:

ASPIRIN/EXCEDRIN	Y/ N	HERBAL REMEDIES	Y/ N
IBUPROFEN/ADVIL/MOTRIN	Y/ N	GREEN TEA	Y/ N
VITAMIN E / MULTIVITAMIN	Y/ N	FISH OIL/OMEGAS/FLAX SEED OIL	Y/ N
COUMADIN / WARFARIN	Y/ N	HEPARIN	Y/ N

PAST SURGICAL HISTORY

PLEASE LIST ALL SURGICAL PROCEDURES INCLUDING COSMETIC PROCEDURES, WHO IT WAS PERFORMED BY AND WHEN:

_____

_____

FAMILY HISTORY

PLEASE CHECK ALL CONDITIONS THAT HAVE AFFECTED YOUR PARENTS, GRANDPARENTS, SIBLINGS, AND CHILDREN

CONDITION	FAMILY MEMBER
___ BREAST CANCER	
___ OTHER CANCER (PLEASE INDICATE WHICH TYPE) _____	
___ HIGH BLOOD PRESSURE	_____
___ DIABETES	
___ HEART OR LUNG PROBLEMS	_____
___DIFFICULTY WITH ANESTHESIA	_____
___ OBESITY	_____
___ OTHER	_____

SOCIAL HISTORY

DO YOU DRINK ALCOHOL: **Y / N** HOW MUCH DAILY _____

DO YOU USE STREET DRUGS: **Y / N** HOW MUCH DAILY_____

DO YOU SMOKE / VAPE / CHEW OR USE ANY OTHER NICOTINE CONTAINING PRODUCTS: **Y / N** HOW MUCH DAILY_____ SINCE WHEN_____

IF YOU ARE NO LONGER A SMOKER, WHEN DID YOU QUIT _____

WOMEN ONLY

HOW MANY PREGNANCIES_____BIRTHS____ C-SECTION(S)_____ MISCARRIAGES___
DID YOU BREASTFEED: **Y / N** HOW MANY TIMES_____
DO YOU PLAN ON GETTING PREGNANT IN THE FUTURE: **Y / N**
WHEN WAS YOUR LAST MAMMOGRAM_____WHERE WAS IT DONE_____
RESULTS _____
ANY PERSONAL OR FAMILY HISTORY OF BREAST CANCER: **Y / N**
HAVE YOU EVER HAD A BREAST BIOPSY: **Y / N**

BREAST PROCEDURE CONSULTATION ONLY (REDUCTION, AUGMENTATION, BREAST LIFTING)

CURRENT BRA SIZE_____ DESIRED BREAST SIZE_____
DO YOU CURRENTLY HAVE IMPLANTS_____
IF YES, DO YOU KNOW THE SIZE OF IMPLANTS_____ WHEN WERE THEY PLACED / BY WHOM_____
FOR BREAST AUGMENTATIONS: WOULD YOU PREFER TO LOOK NATURAL OR AUGMENTED: _____

ANYTHING NOT PREVIOUSLY COVERED THAT THE DOCTOR SHOULD KNOW?

FOR OFFICE USE ONLY

EXAM (TO BE FILLED OUT BY DOCTOR)

BMI_____ BSA_____

PANNICULECTOMY CONSULTS:

Hygiene issues Y/N Odor Y/N Rashes/infections/ulcers/cellulitis Y/N

Chronic wound Y/N Medical Treatment Y/N: If yes, for how long (at least 3m-6m)_____

Treatment Details:

Topical antifungal/antibiotic, local/systemic antibiotic, topical/systemic corticosteroids

Documentation Y/N

Request notes from:_____

Interference with activities of daily living/ functional impairment:

Ambulating Exercising Clothes fitting intimate relations back pain Other

Physical exam:

Pannus hangs below pubis Y/N

Infrapannicular irritation/rashes/skin breakdown Y/N

Photos taken Y/N

	RIGHT	LEFT
SN-N		
BW		
N-IMF		
AE		
AD		
APSS		

Check All That Apply

Skin/Breast System Reviewed
( )Rash ( )Itching ( )Breast Lump ( )Dry Skin
( )Breast Tenderness ( )Breast Swelling ( )Nipple Discharge
( )Pigmentation

Ear/Eyes/Nose/Mouth/Throat System Reviewed
( )Headaches ( )Vertigo ( )Lightheadedness ( )Tearing
( )Head Injury ( )Vision Change ( )Double Vision ( )Eye Pain
( )Nose Bleeds ( )Hoarse Voice ( )Gum Bleeding ( )Sinusitis
( )Trouble Hearing ( )Thyroid Mass
( )Neck Stiffness, Pain or Tenderness

Cardiovascular System Review
( )Chest pain ( )Palpitations ( )Syncope ( )Difficulty Breathing ( )Heart Murmurs
( )Edema

Gastrointestinal System Reviewed
( )Loss of Appetite ( )Difficulty Swallowing ( )Abdominal pain after eating
( )Nausea and Vomiting ( )Vomiting Blood ( )Jaundice ( )Diarrhea
( )Abnormal Stools ( )Hemorrhoids ( )Heartburn ( )Constipation

Genitourinary System Reviewed
( )Urgency ( )Frequency ( )Painful/Difficult Urinating ( )Kidney Stones
( )Blood in urine ( )Urinary Retention ( )Recurring Infections
( )Vaginal Discharge ( )Vaginal Bleeding

Allergic/Immunologic/Lymphatic/Endrocrine System Reviewed
( )Bleeding Tendency ( )Transfusions ( )Heat or Cold Intolerance ( )Anemia

Vascular System Reviewed
( )Transient Ischemic Attacks ( )Expressive Asphasia ( )Transient Monocular Blindness ( )Claudication ( )Ischemic Ulcer ( )Unilateral Weakness or Numbness
( )Strokes ( )Rest Pain

Neurologic/Psychiatric System Reviewed
( )Seizures ( )Paralysis ( )Incoordination ( )Tremor ( )Odd Skin Sensations
( )Loss of Memory ( )Sensory of Motor Disturbances ( )Depression ( )Hallucinations
( )Suicidal Thoughts ( )Anxiety ( )Inability of Coordinate Muscle Movement

Musculoskeletal System Review
( )Pain ( )Swelling ( )Limited Range of Motion ( )Joint Pain ( )Weakness
( )Decrease in Muscle ( )Night Cramps

ADVANCED BENEFICIARY NOTICE

I understand that I am responsible for any amount not covered by my insurance. I understand that if I fail to furnish a required referral from my primary physician, I shall be responsible for payment in full for any charges related to this visit, for services provided to me or my dependent(s). All balances will be subject to interest after sixty (60) days. I hereby consent to give peer physician the authority to review my chart to obtain information about the delivery of medical care.

Signature: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge and agree that I have been given the opportunity to read and/or received a copy of Dr. Kayastha's Notice of Privacy Practices.

PATIENT RECORD OF DISCLOSURES

Per HIPPA regulations, we need to know how to contact you. Please check the box if it is OK to contact you in the following manner:

- ☐ OK to call your cell phone and leave a detailed message
- ☐ OK to call your work telephone and leave a detailed message
- ☐ OK to call home and leave a detailed message
- ☐ Ok to mail to your home address
- ☐ OK to email you if needed

Anyone else, besides yourself, that we may speak to regarding your care or appointments:

_____

_____ _____

Patient Signature Date

A NOTE TO PATIENTS CONCERNING POST-OPERATIVE VISITS:

Please be advised that not all procedures include post-operative visits, suture removals and/or scar evaluations at no charge to you. Each procedure performed has a specific number of follow-up days which are included at no additional charge. These global days are determined by your insurance company and CMS (The Centers for Medicine and Medicaid Services).

Please be advised that we do not schedule follow-up appointments based upon your included follow-up days. Appointments are scheduled based upon medical necessity and schedule availability.

I acknowledge that I have read and understand the global policy as indicated above and agree that I will be held responsible for balance due, including co-insurance, deductible and/or co-payments.

_____ _____

Patient Signature Date

Patient Initials:_____

Patient Financial Policy

Thank you for choosing K Plastic Surgery for your plastic surgery needs. We strive to exceed your expectations. We would like you to have a clear understanding of our financial policies. Please read this document carefully. Your signature on this document means that you have read, understood and accept the financial policies outlined in this document.

Insurable Procedures:

Health insurance is a contract between you and your insurance carrier.

You must provide us with current insurance information at your visit. If you do not, you will be responsible for all fees.

You are responsible for understanding your insurance policy.

If your plan requires a referral, you are responsible for obtaining one.

Copayments, coinsurance and deductibles are due at the time of your visit. These are a part of your contract with your insurance company. If you have a procedure done, a certain number of days for followup visits may be allowed without the need for additional copays. When your followup occurs is based on medical necessity. We are unable to waive these fees.

If your insurance company does not provide prior authorization for procedures that require it, a $1000 deposit along with copayments and deductibles will be collected. The deposit will be refunded once all fees have been paid.

Prior authorization from your insurance carrier is not a guarantee of payment. If your insurance denies coverage after a procedure, you will be responsible for all fees.

Account balances must be paid in 60 days. If needed, payment arrangements can be made by calling the office. Failure to pay, will lead to referral to a collection agency unless payment arrangements have been made. You are responsible for all collection costs.

_____ Initials

K Plastic Surgery PLLC . Sanjiv Kayastha, MD
711 Troy-Schenectady Road Suite 206 Latham, NY 12110
518.346.0002 . Fax 518.220.9181
www.kplasticsurgery.com

We understand that sometimes financial responsibilities can represent a true hardship. If this is the case, please contact the office to arrange a plan of payment.

Cosmetic Procedures:

There is no fee for cosmetic consultations.

You will receive a quote for your desired procedures. This quote is good for 6 months. Your quote will include fees for the surgeon, anesthesia, hospital, recovery room and overnight stay. We do not control anesthesia and hospital fees. If they go up after you are given a quote, you will be informed of the increases at the first available opportunity. Additional fees may include those for preoperative testing, laboratory tests, garments and an assistant. The quote you receive is an estimate. If your surgery takes longer than expected, you will be responsible for additional fees from anesthesia and /or the hospital.

In order to reserve a surgery date there is a of $500 is non refundable administrative fee. This fee will be applied towards your total bill. If you need to cancel or reschedule surgery, this fee will be applied towards the fees for your new surgery date, if that surgery is done within three months. After three months a new administrative fee is required to schedule surgery.

The balance of your fees are to be paid at your preoperative appointment or two weeks before surgery, whichever comes first. If this is not done in a timely fashion, your surgery will be cancelled and you will forfeit your deposit.

If you cancel your surgery after full payment has been made, you will forfeit 50% of the fees.

Revisions are occasionally necessary. These will usually be performed within one year. You will incur additional surgeon's, hospital and anesthesia fees for a revision. If the surgeon feels that the revision is necessary to achieve the original intended outcome, there may be no additional surgeon's fees. In certain cases you have achieved what can be reasonably attained in one procedure. If that is the case and you want additional improvements you will be responsible for all additional fees.

_____ **Initials**

We offer financing through CareCredit. A link is provided on our website www.kplasticsurgery.com

Combination Insurance/Cosmetic procedures

You will be responsible for all copayments, coinsurances and deductibles. You will have to pay all the fees for the cosmetic portion of your procedure. This is outlined above under cosmetic procedures.

Office Policies

We accept payment via cash, checks, and most major credit cards. We offer financing through CareCredit. The CareCredit plans accepted are 6 month interest free, 24 and 36 months extended payment When using CareCredit separate payments must be made in person at both Schenectady Anesthesia and the hospital. Personal checks must be presented 14 days prior to your procedure so that they have time to clear. There is $50 fee for all returned checks.

I have read and understand the patient financial policy.

Signature **Date:**

Witness Date:

PLASTIC
SURGERY

Patient Consent for Use of Credit Cards, Debit Card, and Financing - Disclosure of Protected Health Information

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.

Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow K Plastic Surgery to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment.

I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.

____ ***Initial***

I agree that this non credit card challenge agreement is irrevocable.

____ ***Initial***

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

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PLASTIC
SURGERY

PHOTO CONSENT

For documentation purposes, Dr. Kayastha requires before and after photographs for confidential medical records. I will not be identified by name in any publications. I understand that in some circumstances the images may portray my identity.

Patient Name (print) _____

Patient Signature _____

Date _____

I also grant permission for Dr. Kayastha the use of my patient photographs for the following types of media including, but not limited to, print, visual, electronic and internet.

Patient Signature _____

Date _____

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PLASTIC
SURGERY

Patient Name_____ Date: _____

Other than the service you are here for today, what additional services would you like to receive more information about? Please check all that apply.

( ) Skin Care Advice
( ) Skin Care Products
( ) Facial Injectables/Fillers
( ) Facial Fine Lines/Wrinkles
( ) Length/Fullness of Eyelashes
( ) Chemical Peel
( ) Scar Revision
( ) Facial/Leg Spider Veins
( ) Varicose Veins
( ) Facial Redness
( ) Brown Spots/Age Spots/Freckles
( ) Drooping Eyelids
( ) Cellulite
( ) Facial Fullness/Drooping
( ) Neck Wrinkles
( ) Unwanted Hair/Laser Hair Removal
( ) Laser Resurfacing
Other: _____

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look:
( ) younger than my true age.
( ) the same as my true age.
( ) older than my true age.

When looking at my face in the mirror in regards to wrinkles, I am:
( ) not concerned.
( ) somewhat concerned.
( ) very concerned.

Any other procedures you would like information on:

_____