**Front Range Plastic and Reconstructive Surgery**
**Warren Schutte, MD**

Last Name_____ First Name _____MI_____

Date of Birth _____Male/Female SSN_____

Address _____Email:_____

City _____State_____ Zip_____Phone_____

Cell (____)_____ May we send you text message reminders: yes____ no ____

Emergency Contact_____Phone Number (____)_____

Patients Employer_____Phone_____

Spouse Name_____Spouse DOB_____

The following is information collected from all our patients and used it to track quality of care. This information goes into your medical record and it is confidential. It is a government requirement to monitor health care processes and outcomes for different population groups, target quality initiatives more efficiently and effectively, and provide patient-centered care.
*Please circle or fill in one of the following*:

**Race**: African-American Asian Caucasian Hispanic Other_____

**Ethnicity**: Non-Hispanic Hispanic Other_____

**Primary Language**: English Spanish Other:_____

**IF Patient is a Minor**
Guarantor Name_____DOB_____

Address_____

City_____State_____Zip_____SSN_____

**Referral Information**
Who referred you to our office_____

**Injury Information**
If your visit is due to an injury, please indicate how the injury happened and date

Date of Injury_____ Description_____

**Insurance Information *Please provide insurance card and ID***

Primary:Name of insured_____Birthdate of Insured_____

SecondaryName of insured_____Birthdate of Insured_____

**Assignment of Benefits/Communication Authorization**

I, the undersigned, authorize the release of any medical or other information necessary to process medical claims on my or my dependents behalf. I also authorize and request payment of benefits be made to Front Range Plastic and Reconstructive Surgery, PC. I understand and agree that (regardless of insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify the office of any changes in my status or the above information. I also acknowledge that I reviewed and received the practice privacy notice.

Signature:_____ Date:_____

**Front Range Plastic and Reconstructive Surgery**
**Policies**

Thank you for choosing Front Range Plastic and Reconstructive Surgery. We are dedicated to providing you the most efficient care and service possible. Your understanding of our policies is an essential element of your care and service. If you have any questions regarding any aspect of our policy, please feel free to present your question to any of our staff.

Front Range Plastic and Reconstructive Surgery and Dr. Schutte are affiliated with healthcare teaching institutions. We may participate in programs to teach resident doctors, medical students, nursing students, and other healthcare students. These healthcare workers in training may participate in your care and treatment including office evaluation and surgical procedure, under the guidance of Dr. Schutte.

**Payments are due when services are rendered**. If you are unable to make payment in full at the time of service, your appointment will be rescheduled to a more convenient time. We accept Visa, MasterCard, Discover, personal checks and cash. Please be aware that we will add a $30.00 charge to your account for returned checks. We reserve the right to send all accounts with balances over 60 days old to an outside collection agency. All accounts sent to collections will be charged a $50.00 processing fee and any additional fees associated. You may be responsible for all collections and attorney costs incurred.

**Insurance**:
It is your responsibility to obtain insurance coverage and benefits prior to your visit with us. As a patient, you will be responsible for any copays, deductibles and coinsurance. You are also responsible for any additional testing, and services not covered by your insurance. If you do not have your insurance card, or we do not participate with your insurance plan, you can either reschedule your appointment or pay for your visit in full at the time services are rendered. We will supply you with the necessary information to submit the claim to your insurance company. Any balance left after your insurance has processed your claim must be remitted within 30 days or each monthly billing charge will be applied to your account of $10 whichever is greater.

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible, coinsurance and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

It is your responsibility to know the details of your particular insurance policy. Not all services are covered by all carriers. Services which are not covered by your insurance are your responsibility. Diagnoses and services are carefully documented to comply with federal law. Under no circumstances will these be changed, altered or falsified in order to obtain coverage by insurance. You are responsible for any and all allowable charges which remain after your insurance has paid its portion.

If your insurance carrier has a “network” of providers, it is your responsibility to make sure that we are an “in network” provider prior to obtaining services. If we are not “in network,” we will still be happy to provide services; however, the percentage of charges for which you are responsible will be greater. It is also your responsibility to make us aware of any restrictions your policy has on ancillary services (such as requiring a specific lab). . If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

It is your responsibility to make sure we have accurate insurance carrier and billing information. If a claim is unsuccessful because of failure to provide complete insurance or billing information, you will be responsible for the balance. We will make every effort to assist you in understanding the above information. We will also assist with any problems arising with your insurance to the extent we can accommodate.

**Referrals and Preauthorizations**
If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility.

**Motor Vehicle Accidents (MVA)/Third Party Liability**
In order to file a claim for Motor vehicle or third party liability carriers we require all claim detail (claim#, contact info, billing address) at the time of your appointment. We require a partial payment at the time of service of $100 for consultation services and $1500 for surgical services. If benefits are exhausted, we will bill your health insurance. All previous policies listed under insurance above will apply.

**Cosmetic procedures Pre-Payment**
There is a deposit required before the date selected can be reserved exclusively for you. The deposit is $500.00 or 10% of surgery cost whichever is greater. This is a non-refundable deposit. This fee is used to cover the booking and scheduling expenses involved with your surgery. This amount will be deducted from your total cost.

**Surgery Final Payment**
You will be expected to pay the remaining balance due on your account two weeks prior to your surgery. We accept: Visa, MasterCard, Novus (Discover), Money Orders, Cashiers Checks and Cash. Personal checks are accepted only if paid two (2) weeks prior to surgery. No post-dated checks will be accepted. Please note if you plan to use a Bank DEBIT card for your final payment, they usually will not process over $500.00. We also accept Care Credit and United Medical Credit.

If for any reason, medical or personal, you cancel surgery two weeks or less than your scheduled surgery date you will be charged a cancellation fee: 14 days = 25% of total surgical fee, 7-13 days = 50% of total surgical fee; 2-6 days = 75% of total surgical fee, 1 day = 100% of total surgical fee

I acknowledge that I have received a copy of this financial policy. I agree to read this document and comply with the terms set forth for services rendered by Front Range Plastic and Reconstructive Surgery.

Patient Signature (Guarantor) Date

_____ _____

Print Name:_____

# Front Range Plastic and Reconstructive Surgery

**RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM**

I, Print Name:_____
have been informed that a copy of our offices Notice of Privacy Practices 2013 version is available in the waiting room(s) and online at www.frontrangeplasticsurgery.com. A copy of this Notice will be furnished to me upon my request.

_____ _____
Signature of Patient Date

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

It is our policy to not release confidential and/or unauthorized information except as defined in the Notice of Privacy Practices. If you would like to have information released to someone other than yourself please complete the following:

Please list names of people we can discuss your medical or skin care with:
Spouse Name _____ yes____ no____
Parent Name _____ yes____ no____
Other Name _____ yes____ no____
Please give name and relationship such as boyfriend, sister, etc.

I authorize the doctor's office to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them, in writing, whenever this information changes.

| | | | |
|---|---|---|---|
| Home telephone | yes____ no ____ | Voice mail | yes____ no____ |
| Answering machine | yes____ no____ | Cell phone/voice mail | yes____ no____ |
| Work phone | yes____ no____ | Text | yes____ no____ |

**Preferred Contact (circle one) Home / Work / Cell / Email**

May we fax medical records for referrals? yes____ no____

_____ _____
Signature of Patient/Guardian Date

Print Name:_____

# CONSENT TO PHOTOGRAPH

I understand that photographs will be taken periodically throughout my treatments. These photographs will be used to monitor progress and other factors. I understand that failure to consent to these photos will give Front Range Plastic and Reconstructive Surgery the right to decline my treatment.

I hereby grant permission for the use of any of my medical records including: illustrations, photographs or other imaging records created in my case for the use in examination, testing, credentialing and/or certification purposes by The American Board of Plastic Surgery, Inc., AAAASF, and Dr. Warren Schutte.

_____ _____

(Patient Full Name – Please Print) (Patient Signature)

_____

(Date)

# CONSENT TO USE PHOTOGRAPHS

I hereby give Dr. Warren Schutte and staff the absolute right and permission to copyright and/or publish, or use photographic portraits of me, or in which I may be included in whole or in part, or reproductions thereof in color or otherwise, for presentations, photo albums, display on the company's web site, art trade, news or any other lawful purpose whatsoever. I hereby waive any right that I may have to inspect and/or approve the finished product or the advertising copy that may be used in connection therewith, or the use to which it may be applied. Please check one below:

- ☐ Accept
- ☐ Decline

I understand that by signing below Front Range Plastic and Reconstructive Surgery need not approach me again for authorization on these photos.

_____ _____

(Patient Full Name – Please Print) (Patient Signature)

_____

(Date)

# ELECTRONIC COMMUNICATION

Email, text, or other electronic communication provides a fast and easy way to communicate with Front Range Plastic and Reconstructive Surgery (FRPS) for those issues that are non-emergent, non-urgent or non-critical. It is not a replacement for the interpersonal contact that is the very basis of the client practice relationship; rather it can support and strengthen an already established relationship.

The following summarizes the information you need to determine whether you wish to supplement your experience at our practice by electronically communicating with FRPS staff.

**General Considerations**

- Electronic communication will be considered and treated with the same degree of privacy and confidentiality as written medical records.
- Standard electronic communication services, such as text or gmail, AOL, and hotmail email services are not secure. This mean that the electronic messages are not encrypted and can be potentially intercepted and read by unauthorized individuals.
- Your electronic addresses will not be used for external marketing purposes without your permission. You may receive a group emailing from the practice; however, the recipients email addresses will be hidden.

**Provider Responsibilities**

- Staff will attempt to electronically confirm your email address by requesting a return response to all email messages.
- Your provider may route your electronic messages to other members of the staff for information purposes or for expediting a response.
- Designated staff may receive and read your electronic messages
- Every attempt will be made to respond to your electronic message within 2 business days (Monday – Friday, non-holidays). If you do not receive a response from the practice within 2 business days, please contact the practice by phone.
- Copies of electronic messages sent and received from and to you could be incorporated into your medical record. You are advised to retain all electronic correspondence for your own files.

**Client Responsibilities**

- Electronic messages should not be used for emergencies or time-sensitive situations. In the event of an emergency, you should call 911. For emergent or time-sensitive situations, you should contact the practice by phone.
- Electronic messages should be concise. Please arrange for an office appointment if the issue is too complex of sensitive to discuss via electronic messaging.
- Please include your full name and the topic or question, in the subject line of emails. This will serve to identify you as the sender of the email.
- Please acknowledge that you received and read the message by return electronic message to the sender.

I have read and understood the above description of the risks and responsibilities associated with electronic communication with Front Range Plastic and Reconstructive Surgery.
I acknowledge that commonly used text services and email services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information.
I have been given the opportunity to discuss electronic communication with a representative of FRPS and have had all my questions answered.
In consideration for my desire to use electronic communication as an adjunct ti in-person office visits with FRPS, I hereby consent to electronic communication via non-secure text and email services.
I understand that I may revoke my consent to communicate electronically at any time by notifying the practice in writing at the following address: Front Range Plastic and Reconstructive Surgery, 2500 Rocky Mountain Ave Ste 2130, Loveland, CO 80538. However, if I revoke my consent, the revocation will not have an effect on actions my doctor has already taken in reliance on my consent.
I agree and release my provider and Front Range Plastic and Reconstructive Surgery from any and all liability that may occur due to electronic communication over a non-secure network.
I further agree to be held accountable and to comply with the client responsibilities as outlines in this consent.

***CLIENT***

Client Authorized Email Address (Please Print)

Print Name

Client Signature Date

***PARENT/GUARDIAN (if client under 18 years of age)***

Client Authorized Email Address (Please Print)

Client Name (Print)

Client Signature Date

**Please check <u>all</u> procedures that you are interested in discussing with the doctor.**

**<u>Face</u>**

- ☐ Facelift
- ☐ Upper Eyelid Surgery
- ☐ Lower Eyelid Surgery
- ☐ Neck lift
- ☐ Nose Surgery
- ☐ Ear surgery
- ☐ Lip implants
- ☐ Cheek implants
- ☐ Chin implants
- ☐ CO2 Fractionated laser
  - ☐ Face
  - ☐ Neck
  - ☐ Chest
  - ☐ Hands

**<u>Injectables</u>**

- ☐ Botox
- ☐ Juvederm
- ☐ Facial fat transfer

**<u>Skin Care</u>**

- ☐ Facial
- ☐ Microdermabrasion
- ☐ Skincare products
- ☐ Jane Iredale make-up line

**<u>Breast</u>**

- ☐ Augmentation
- ☐ Lift
- ☐ Reduction
- ☐ Reconstruction

**<u>Abdomen</u>**

- ☐ Tummy Tuck

**<u>Arms</u>**

- ☐ Arm Lift

**<u>Hands</u>**

- ☐ Fat Grafting rejuvination

**<u>Thighs</u>**

- ☐ Thigh Lift

**<u>Buttock</u>**

- ☐ Buttock Lift

**<u>Liposuction</u>**

- ☐ Upper abdomen
- ☐ Lower abdomen
- ☐ Flanks (love handles)
- ☐ Back
- ☐ Axillary (arm pit area)
- ☐ Inner thighs
- ☐ Outer thighs
- ☐ Neck
- ☐ Arm

Print Name:_____

# Front Range Plastic and Reconstructive Surgery
# PATIENT MEDICAL HISTORY

Name:_____
Birth date_____ Appt. Date: _____

How did you hear about us?: _____

Who is your PCP?: _____ _____

Reason for your visit today:_____

Pharmacy Name and Location:_____

Height _____ Weight _____ BMI _____ BP _____ P _____

List any medical conditions for which you are presently being treated: _____

_____

_____

List all past major illnesses: _____

_____

List all drug/food/tape allergies (please explain reactions): _____

_____

_____

List all current medications (by mouth and topical) including prescription, over-the-counter, vitamins, herbal supplements, and creams:

| MEDICATION/DOSAGE | MEDICATION/DOSAGE |
|---|---|
| | |
| | |
| | |
| | |
| | |
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| | |
| | |
| | |

Have you taken any steroids within a year? □ Yes □ No When? _____ How long?_____ Why? _____

List all past surgeries (including cosmetic surgery) with dates:

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

Have you ever had a bad reaction with:

Local anesthesia? □ Never had □ No □ Yes- Reaction:_____

General anesthesia? □ Never had □ No □ Yes-Reaction:_____

Have you had an EKG? □ Yes □ No When? _____ Where? _____Why?_____

**FEMALES:** When was your last mammogram? _____

## FAMILY HISTORY

Check the following medical conditions that have occurred in your family (current or past):

| DISEASE | MOTHER | FATHER | BLOOD RELATIVE |
|---|---|---|---|
| Cancer | | | |
| Heart Disease | | | |

## SOCIAL HISTORY: Exercise Frequency: □ None □ 1x/week □ 2-3 x/week □ 4-6x week

Have you ever smoked, chewed, or used nicotine-containing products? (circle one) Yes No

When Quit? _____ Have you ever quit?_____ How long did you quit for?_____

Do you drink alcohol? (circle one) Yes No How much? _____

## REVIEW of SYSTEMS: **Please check <u>all</u> past and present medical conditions**

**CONSTITUTIONAL:**
□ Good general health lately
□ Recent weight gain
□ Recent weight loss
□ Night sweats
□ Headache
□ Fever
□ Fatigue
□ Stroke/TIA history
□ Other: _____

**CARDIOVASCULAR:**
□ High blood pressure
□ Heart attack(s) history
□ Pacemaker
□ Coronary artery disease
□ Heart murmur/Mitral valve prolapse
□ Irregular heartbeat/palpations
□ Stroke/TIA history
□ Chest pain/pressure/burning
□ Swelling of feet, ankles, or hands
□ Atrial fibrillation
□ High cholesterol
□ Tachycardia
□ SVT
□ CHF
□ Fainting episodes
□ Other _____

**RESPIRATORY:**
□ Asthma
□ Chronic cough
□ Shortness of breath
□ Wheezing
□ Spitting up blood
□ COPD
□ Sleep Apnea
□ Bronchitis
□ Other: _____

**HEMATOLOGY/LYMPHATIC:**
□ Blood transfusion history
□ Bleeding disorder
□ Slow healing
□ Easily bruise/bleeding
□ Anemia
□ Clotting disorder
□ Taking anticoagulants
□ DVT/PE history
□ Enlarged glands
□ Other: _____

**NEUROLOGICAL:**
□ Frequent or recurring headaches
□ Migraines
□ Dizziness
□ Numbness/Tingling sensation
□ Tremors
□ Seizure disorder/convulsions
□ Paralysis
□ Parkinsons Disease
□ Other: _____

**PSYCHOLOGICAL:**
□ Depression
□ Anxiety
□ Memory loss or confusion
□ Receive(d) psychiatric treatment
□ Sleeping problems
□ Bipolar disorder
□ ADHD
□ OCD
□ PTSD
□ Panic attack history
□ Other: _____

**EARS/NOSE/THROAT:**
□ Nasal allergies
□ Difficulty breathing by nose
□ Previous nasal injury
□ History of sinus infections
□ Hearing loss
□ Hoarseness
□ Nose bleeds
□ Sinus problems
□ Sore throat
□ Ringing in ears
□ Nasal deformity
□ Difficulty swallowing
□ Other: _____

**EYES:**
□ Dry eye
□ Blurred/double vision
□ Cornea problems
□ Glaucoma
□ Thyroid eye disease
□ Wear glasses/contacts
□ Eye pain
□ Eye disease/injury
□ Visual field obstruction
□ Macular degeneration
□ Decreased vision
□ Other: _____

**ENDOCRINE:**
□ Diabetes/Prediabetes
□ Thyroid disease
□ Excess thirst/urination
□ Other: _____

**GENITOURINARY:**
□ Dialysis
□ Burning/painful urination
□ Frequent urination
□ Incontinence/Dribbling
□ Blood in urine
□ Kidney stones
□ Indwelling catheter
□ BPH
□ Kidney disease
□ Other: _____

**GASTROINTESTINAL:**
□ Colitis
□ GERD
□ Stomach ulcers
□ Loss of appetite
□ Change in bowel movement/habits
□ Nausea/Vomiting
□ Frequent diarrhea
□ Blood in stool
□ Stomach pain
□ IBS
□ Crohns
□ Gastric bypass history
□ Other: _____

**MUSCULOSKELETAL:**
□ Scoliosis
□ Osteoporosis
□ Joint pain
□ Joint stiffness or swelling
□ Muscle or joint weakness
□ Muscle pain or cramps
□ Back pain
□ Difficulty walking
□ Paraplegic
□ Fibromyalgia
□ Gout
□ Arthritis
□ Other: _____

**ALLERGIC/IMMUNOLOGIC/INFECTIOUS DISEASES:**
□ Environmental allergy
□ HIV/AIDS
□ Hepatitis
□ TB
□ RA
□ Lupus
□ History of MRSA
□Psoriatic arthritis
□ Autoimmune disorder
□ Other: _____

**DERMATOLOGICAL:**
□ Excessive sweating
□ Cold sores/herpes
□ Acne
□ Rosacea
□ Eczema
□ Psoriasis
□ Radiation to face/neck
□ Scarring/keloid formation
□ Skin lesion
□ Mass
□ Hidradentitis
□ Rash or itching
□ History of skin cancer
□ Skin excess
□ Wound/abscess
□ Other: _____

# THROMBOSIS RISK FACTOR
# ASSESSMENT

**CHOOSE ALL THAT APPLY**

| EACH RISK FACTOR REPRESENTS 1 POINT | EACH RISK FACTOR REPRESENTS 2 POINTS | EACH RISK FACTOR REPRESENTS 3 POINTS |
|---|---|---|
| ☐ Age 41-60 years<br>☐ Minor surgery planned<br>☐ History of prior major surgery (<1 month)<br>☐ Varicose veins<br>☐ History of inflammatory bowel disease<br>☐ Swollen legs (current)<br>☐ (BMI > 25)<br>☐ Acute myocardial infarction<br>☐ Congestive Heart Failure (< 1 month)<br>☐ Sepsis (< 1 month)<br>☐ Serious lung disease including pneumonia (< 1 month)<br>☐ Abnormal pulmonary function (COPD)<br>☐ Medical patient currently at bed rest<br>☐ Other risk factors<br>_____ | ☐ Age 60-74<br>☐ Arthroscopic surgery<br>☐ Malignancy (present or previous)<br>☐ Major surgery (> 45 min)<br>☐ Laparoscopic surgery (> 45 min)<br>☐ Patient confined to bed (> 72 hrs)<br>☐ Immobilizing plaster cast (<1 month)<br>☐ Central venous access | ☐ Age over 75 years<br>☐ History of DVT/PE<br>☐ Family history of thrombosis*<br>☐ Positive Factor V Leiden<br>☐ Positive Prothrombin 20210A<br>☐ Elevated serum homocysteine<br>☐ Positive lupus anticoagulant<br>☐ Elevated anticardiolipin antibodies<br>☐ Heparin-induced thrombocytopenia (HIT)<br>☐ Other congenital or acquired thrombophilia<br>If yes:<br>Type: _____<br><br>* Most frequently missed risk factor |

| EACH RISK FACTOR REPRESENTS 5 POINTS | FOR WOMEN ONLY (EACH REPRESENTS 1 POINT) |
|---|---|
| ☐ Elective major lower extremity arthroplasty<br>☐ Hip, pelvis or leg fracture (< 1 month)<br>☐ Stroke (1 < month)<br>☐ Multiple trauma (< 1 month)<br>☐ Acute spinal cord injury (paralysis) (< 1 month) | ☐ Oral contraceptives or hormone replacement therapy<br>☐ Pregnancy or postpartum (< 1 month)<br>☐ History of unexplained stillborn infant, recurrent spontaneous abortion (>=3), premature birth with toxemia or growth-restricted infant |

**Total Risk Factor Score = _____**

Patient Name:

Age: Sex:

Weight: