Financial Policy For Stacy L. Peterson, MD

FEES: Cosmetic consults and insurance co-pays, co-insurance and deductibles are to be paid in full at the time services are rendered. If your insurance company reimburse you directly for services billed; you are responsible for payment of all balances due. If our office receives a NSF check from you, you will be charged $30 and we will no longer be able to accept a check from you. Our office accepts cash, checks, money orders, cashier checks, VISA, MASTERCARD, DISCOVER and CARECREDIT (Call office to see which plans we except).

ADDITIONAL FEES: Extra items purchased such as Silicone Sheeting and garments are the responsibility of the patient and will not be billed to insurance. Payment is due at the time of purchase.

PARTICIPATING PROVIDER INSURANCE PLANS: Our office will contact your plan a couple weeks before your procedure, surgery or consultation and get a cost analysis. Understand this is an estimate because deductibles and co insurance can change pending outstanding claims. We will collect all applicable co pays, co-insurance and deductibles as designated by your plan at the time of consult or office visit and if surgery is planned they will be due 2 weeks prior to surgery. Your claim will be submitted to your insurance company as a courtesy. Disputes with insurance companies, etc., are the responsibility of the patient.

WORKERS COMPENSATION: We will submit confirmed worker’s compensation claims for our patients. If you were injured at work, there is no guarantee your bill will be covered under workers compensation.

MOTOR VEHICLE ACCIDENTS/PERSONAL INJURY INSURANCE: If you are injured in a MVA or personal injury where another party could be liable, you are responsible to obtain the necessary information. Consult fee will be paid at time of service and we will provide you with a bill to turn into the proper insurance company. We will not submit consult fee.

UCR Statement: If any portions of our fees are not covered by your insurance company, we want our patients to be aware of the fact they are responsible for any balances due after the insurance payment. This balance due includes provisions set by your insurance company such as: co-insurance, deductible, and “usual and customary” or “reasonable and customary” allowances. The policy held by you or your employer is a contract between the policy holder and the insurance company. Please discuss your policy with your employer or insurance company prior to charges being incurred.

PREDETERMINATION/PRECERTIFICATION: Please inform our office if your insurance company will require a predetermination for surgery or has a preferred facility. If a predetermination letter is required, please provide the insurance company’s name, address, phone, group, identification numbers, and the contact person to whom we should address the letter.

FEE FOR COPIES OF PROTECTED HEALTH INFORMATION: If you request a copy of your health information, we will charge a fee for costs incurred to comply with your request. Kansas law prohibits charges that exceed the following: $20 handling fee, plus $.75 per page for pages 1-25; $.50 per page for pages 26-50; and $.25 per page for pages 51 or more. Requests for copies of protected health information must be in writing.

Completion of Disability Form or FMLA forms: Initial form is $15. Fee for subsequent forms are an additional $10. Fees are due in advance of forms being completed.

RELEASE/ASSIGNMENT: I hereby authorize the release to my insurance company or its representative any information, including diagnosis and/or records of any treatment or exam rendered to me during the course of such medical care. I also hereby assign all medical benefits including major medical benefits to which I am entitled from government sponsored programs, private insurance and/or any other health plan to: Stacy L Peterson, MD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original. I understand that I am financially responsible for all charges whether or not paid by insurance. I also agree to pay any additional charges or fees related to the cost of collection agency fees, court fees, certified letter fees and handling fees, in the event I fail to pay my bills in a timely manner. All accounts over 120 days old are subject to 1% interest penalty compounded monthly.

I acknowledge that I have read and understand the financial policy of Stacy L Peterson, MD.

Name: ____________________________ Date: ________________

Responsible Party: ____________________________
Hello!

Enclosed you will find new patient forms to be completed prior to your first visit. It is essential that these forms be completed before arriving for your appointment on:

____________________________________________

On the day of your appointment, please bring:

1. Completed “new information” forms
2. Your insurance card (s)
3. A list of medications that you are currently taking.

If you have insurance coverage that requires a referral from your primary care physician, it is your responsibility to obtain this prior to your appointment. Please come prepared to pay your insurance co-payment, co-insurance and deductibles; they are due at the time of service.

If you are seeing the doctor for a cosmetic consult, this is considered a “self-pay”, as most insurance companies will not pay for these services and the charge will be your responsibility at the time of your appointment.

We do accept VISA, MASTERCARD, DISCOVER, debit cards, personal checks, and cash as forms of payment.

If you are unable to keep your scheduled appointment, please kindly call our office and reschedule. Failure to do so could result in a $25.00 charge.

Your cooperation is greatly appreciated. We look forward to meeting you and serving your entire medical and aesthetic needs.

Dr. Stacy L. Peterson & Staff
Patient Information

Please Print Legibly & Fill in or Correct All Fields

PATIENT INFORMATION AS OF ____________________ (Enter today's date)

Patient Name: ____________________________________________

LAST   FIRST   MIDDLE

Address: __________________________________________________

STREET & APT #     CITY     STATE     ZIP

Home Phone: _____________________________ Cell Phone: _____________________________ Other Phone: _____________________________

Any restrictions for contacting you? □ Yes □ No  Contact restrictions: _____________________________

Email Address: ____________________________________________ Drivers License # w/state _____________________________

Age: _____  Date of Birth: ________________________  SSN: _____________________________  Sex: □ Male  □ Female

Martial Status: □ Single  □ Married To: ____________________________________________  □ Other: _____________________________

Patients Employer: ______________________________________  Occupation: _____________________________

Work Phone: _____________________________ Ex. _____________________________  Is it okay to contact you at work?: □ Yes □ No

Address: __________________________________________________

STREET & APT #     CITY     STATE     ZIP

Emergency Contact (Not in your household) ____________________________  Relationship To Patient: ____________________________

Home Phone: _____________________________ Cell Phone: _____________________________ Other Phone: _____________________________

Address: __________________________________________________

STREET & APT #     CITY     STATE     ZIP

Primary Insurance Company: ____________________________

Policy #: ____________________________  Group #: ____________________________  Ins. Phone: ____________________________

Referral Required? □ No □ Yes  Copay? □ No □ Yes, $ ____________________________

Insured: Name: ____________________________  DOB: ____________________________  Employer: ____________________________

Secondary Insurance Company: ____________________________

Policy #: ____________________________  Group #: ____________________________  Ins. Phone: ____________________________

Referral Required? □ No □ Yes  Copay? □ No □ Yes, $ ____________________________

Insured: Name: ____________________________  DOB: ____________________________  Employer: ____________________________

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. and myself.

Signature: ____________________________  Date: ____________________________

How did you hear about Dr. Peterson?: □ Internet  □ Phone Book | Yellow Pages □ Other: ____________________________

□ Friend | Relative Name: ____________________________  Doctor Name: ____________________________
Patient Health History

Patient Name: __________________________ Date: ______________

Reason for visit: __________________________

Who is your Primary Care Physician? __________________________

Allergies - List ANY reactions you have had to medications and describe the symptoms:

Medications - Please list dosage/frequency and reason for taking. Include all prescription, over-the-counter & herbal supplements.

Past Surgical History - List all previous surgery; include approximate date and any complications

Past /Current History - Please check all that apply

- Lung Disease
- Liver Disease
- Kidney Disease
- Diabetes
- Hepatitis Type ____
- Arthritis
- Seizures

- Heart Disease-CHF
- High Blood Pressure
- Chest Pain
- Mitral Valve Prolapse
- Heart Attack ____ Yr.
- Bleeding Disorder
- Smoke

- Tuberculosis
- Asthma
- Emphysema
- Chronic Cough
- Recent Bronchitis
- Recent “Cold”
- Recent wt Change

Do you have any medical condition not listed? ______________

Do you have any history of problems with anesthesia? ______________

Females Only: Are you pregnant? □ Yes □ No  Are you nursing? □ Yes □ No  Are you trying to get pregnant? □ Yes □ No

Social History

Do you smoke? □ Yes □ No  If yes, how much? _________ ppd  How long? _______ years

Have you ever smoked? □ Yes □ No  When did you quit? __________________________

Do you drink alcohol? □ Yes □ No  How much? □ Light □ Moderate □ Heavy □ Social

Do you use recreational drugs? □ Yes □ No  If yes, please describe: __________________________

Skin

Do you have any problems with wound healing or keloid scarring? □ Yes □ No

Do you use tanning beds? □ Yes □ No

Do you use sunscreen? □ Daily □ Occasionally □ Seldom □ Never

Are you interested in starting a skin care program to improve the condition of your skin? □ Yes □ No

I hereby acknowledge that all of the above information has been answered honestly and to the best of my ability. I will update the doctor with any medical changes that may occur.

SIGNATURE: __________________________

OFFICE USE ONLY  BP ________  P ________  R ________  T ________  HT ________  WT ________
Patient Questionnaire

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis. (Including treatment, payment and health care operations).

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

3. Please print the address of where you would like your postcards and/or correspondence from our office to be sent if other than your home.

   Address: ____________________________________________

   City: ____________________________ State: _______________ Zip: __________

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked “CONFIDENTIAL”

   ☐ Yes ☐ No

5. Please print the telephone number, if any, where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number:

6. Can confidential messages (ie. Appointment reminders) be left on your telephone answering machine or voicemail?

   ☐ Yes ☐ No

   * I am fully aware that a cell phone is not a secure and private line

Patient Name: (Guardian if under 18 years) ____________________________________________

Patient/Guardian Signature ____________________________ Date ____________________________
Patient Photograph Release Form

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before & after surgery. The photographs will be taken by one of the members of Stacy L Peterson’s staff. I hereby give my consent for Stacy L Peterson, MD to use the photographs under the following circumstances:

PLEASE INITIAL ALL THAT APPLY:

______ EDUCATIONAL MEDIA
Photographs taken of me or parts of my body as well as details regarding medical services I have received from Dr. Stacy L Peterson, MD may be used in any educational media including, presentations developed for patients &/or other audiences with the intention of sharing information about procedures, surgery methods &/or potential outcomes. Further, I release & discharge Stacy L Peterson, MD, the facility used and the American Society of Plastic Surgery, & all parties acting under their license & authority from any & all claims or actions that I have or may have relating to such use & publication; & all rights, if any , that I may have in such photographs & details regarding medical services rendered to me, including any claim for payment, in connection with any such use or publication. I give my consent as voluntary contribution in the interest of public education & consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

______ WEBSITE (www.stacypetersonmd.com)
Photographs taken of me or parts of my body as well as details regarding medical services I have received from Stacy L Peterson, MD, may be used on our internet website in order to inform the public about plastic surgery methods. Further, I release & discharge Stacy L Peterson, MD, the facility used and the American Society of Plastic Surgery, & all Parties acting under their license & authority from any & all claims or actions that I have or may have relating to such use & publications; & all rights, if any, that I may have in such photographs & details regarding medical services rendered to me, including any claim for payment in connection with any such use or publication. I give my consent as voluntary contribution in the interest of public education & consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

______ MEDICAL CARE
Photographs taken of me or parts of my body may be used for the purpose of my medical care with Stacy L Peterson, MD. The photographs & all details regarding medical services rendered to me will be kept confidential within my personal history file at the office of Stacy L Peterson (unless otherwise approved upon this release) or with the exception for use in the examination, testing, credentialing &/or certifying purpose by the American Board of Plastic Surgery, INC.

Patient/Guardian Signature

Date

Witness