



## MEDICAL HISTORY

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Do you smoke?  Yes  No If so, how much? \_\_\_\_\_

Please list any serious illnesses: \_\_\_\_\_

Have you ever had any of the following? (Check those that apply)  allergy to adhesive tape  asthma

Bruise/bleed easily  cataracts  diabetes  glaucoma  heart disease  high blood pressure

keloids  kidney disease  lung disease  other \_\_\_\_\_

When was your last physical exam? \_\_\_\_\_ Physician's Name \_\_\_\_\_

List any medications taken on a daily basis such as blood thinner, aspirin, Bufferin, Advil, Birth Control, diuretics, blood pressure or heart medications, steroids, tranquilizers, hormones, Retin-A, Accutane, herbal drugs, Diet medications, Vitamins, etc. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Allergies to Medications:** \_\_\_\_\_ **Latex Allergy:** \_\_\_\_\_

Have you taken steroids, i.e. prednisone, cortisone, medrols, etc. in the past 12 months: \_\_\_\_\_

Do your experience cold sores or fever blisters: \_\_\_\_\_

HIV: \_\_\_\_\_

Previous Surgery: \_\_\_\_\_

Surgery complications: \_\_\_\_\_

Procedures/Services of Interest: \_\_\_\_\_

Questions to discuss: \_\_\_\_\_

\_\_\_\_\_

Is today's visit a result of an injury? \_\_\_\_\_ If so, date of injury: \_\_\_\_\_ Work related? \_\_\_\_\_

## PERMISSION TO PHOTOGRAPH AND/OR VIDEO TAPE

I HEREBY AUTHORIZE Dr. Lynch or any staff that she may engage for this purpose, to take such photographs/video tape of me as she desires before, during, and after surgery, which is to be performed on me. I authorize such photographs to be published in professional journals and medical books, to be used for educational/research purposes, or for advertising or in the event of legal action. I would not be identified by name if my photographs were published. Furthermore, this release is a general lifetime release, and I agree that no compensation will be given or sought for such use of my image.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship, if not patient

## **FINANCIAL POLICY**

1. All payments are due at the time of service
2. There is a cosmetic consultation fee of \$100 which is currently being waived. A fee of \$180 is charged for all breast revision second opinion consultations and may be applied to surgery fees. A fee of \$180 is charged for all breast reduction consultations and is eligible for insurance reimbursement.
3. A 10% deposit is required at the time surgery is posted.
4. All cosmetic surgeries must be paid in full two (2) weeks prior to the surgery date. Any surgery not paid in full is subject to cancellation. If are scheduling surgery less than two weeks in advance, full payment is required at that time.
5. Cancellation Policy: Surgery fees are refundable if surgery is rescheduled or cancelled no later than two (2) weeks before the scheduled surgery, less a \$250 non-refundable administrative fee. In the event that the surgery is cancelled less than 2 weeks in advance of the scheduled surgery date, the 10% deposit will be retained and the remainder refunded.
6. Surgery Rescheduling Policy: There is a \$50 rescheduling fee for all rescheduled surgeries.
7. The patient is financially responsible for the entire fee. We will only quote approximate patient responsibility, to the best of our ability. The balance for non-cosmetic procedures will be billed to the patient when applicable, according to the individual's insurance policy.
8. Postoperative visits relating to the original procedure are included in the surgical fee, for one calendar year. Consultation regarding unrelated procedures will be billed accordingly.
9. Cosmetic re-operations that involved minor revisions will be performed within a 12-month period from the original surgical date. The patient is responsible for 100% of the facility fee, anesthesia fee, and/or all supplies used.
10. Returned checks: a \$30.00 fee will be assessed should an unpaid check be returned.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **PRIVACY PRACTICES WILL BE PROVIDED ON ARRIVAL TO THE OFFICE**

I have read and understand Dr. Sheilah Lynch's notice of privacy practices (HIPAA).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you would like to take a copy of HIPAA please request one at the front desk.