Fox Valley Plastic Surgery, S.C. www.fvpsurgery.com

2400 Witzel Avenue, Suite A
Oshkosh, WI 54904
920-233-1540
920-651-6951 Fax

2500 E Capitol Drive, Suite 1500
Appleton, WI 54911
920-358-1810
920-358-1819 Fax

Name: _____

DOB:_____

BHRT HEALTH HISTORY - Male

History

1. What is your height? _____ Current weight? _____
2. Have you used or are you currently using male hormone replacement supplements or therapy? ☐ No ☐ Yes

   If yes, please describe (when, what you used and did it help?)_____

   _____
3. Have you tried any other supplements or medications to help with your symptoms? ☐ No ☐ Yes. If yes, please describe (when, what you used and did it help?)_____

   _____
4. Do you have a history of mumps? ☐ No ☐ Yes
5. Do you have currently or have you been treated for benign prostate hypertrophy (BPH)? ☐ No ☐ Yes
6. Do you have a **personal** history of testicular, colon or prostate cancer? ☐ No ☐ Yes. If yes, please describe (age, type, treatments):_____

   _____
7. Do you have a **family** history of testicular, colon, or prostate cancer? ☐ No ☐ Yes. If yes, please describe (relation, age, type):_____

   _____
8. When was your last testicular exam? _____
9. When was your last prostate exam? _____
10. When was your last Dexa scan (bone density test)? _____
11. When was your last colonoscopy? _____ Do you have regular colonoscopies? ☐ No ☐ Yes ☐ N/A
12. Do you have a primary care doctor you see regularly? ☐ No ☐ Yes

Are there any other comments or concerns of which we should be aware?

_____

_____

_____

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Symptoms

1. Do you have difficulty sleeping or disruptive sleep? ☐ No ☐ Yes. If yes, please describe: _____

   _____
2. Do you have memory loss? ☐ No ☐ Yes
3. Do you have a loss of energy? ☐ No ☐ Yes
4. Do you feel irritable? ☐ No ☐ Yes
5. Are you currently depressed or are you being treated for depression? ☐ No ☐ Yes. If yes, please describe treatments:

   _____
6. Have you struggled to keep weight off? ☐ No ☐ Yes
7. Have you noticed a change in fat distribution? ☐ No ☐ Yes
8. Do you find it more challenging to maintain muscle tone? ☐ No ☐ Yes
9. Do you have a decreased libido (interest in sex)? ☐ No ☐ Yes. If yes, please describe: _____

   _____
10. Are you currently sexually active? ☐ No ☐ Yes
11. Are you satisfied with your sex life? ☐ No ☐ Yes
12. Do you have trouble climaxing/orgasm? ☐ No ☐ Yes
13. Do you have difficulty maintaining an erection? ☐ No ☐ Yes
14. Other:_____

Patient Signature: _____ Date: _____

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Name: _____

DOB:_____

OPTIONAL: VIDEO AND PHOTOGRAPH RELEASE AND AUTHORIZATION

I hereby consent to and authorize the use and reproduction by Fox Valley Plastic Surgery, or anyone authorized by them, of any and all photographs, electronic images or video footage of me taken by FVPS, or that FVPS has in its possession, provided either by me or by a third party (collectively, Images) for the purpose of informing the medical profession and the general public about plastic surgery and plastic surgery procedures and techniques without compensation to me. Such use shall include, but not be limited to, distributing the Images via print, visual and electronic media, specifically including the FVPS website and social media sites such as YouTube, Facebook and Twitter. The Images (including any photographic negatives) shall be the sole property of FVPS.

I understand that the Images will not be identified by my name, but that such Images may reveal my identity. I understand and accept these terms.

I hereby waive any right to inspect or approve the finished product, photograph, video, DVD, CD-ROM or matter that may be used in conjunction therewith or to the eventual use that it might be applied.

I hereby release, discharge and agree to hold harmless FVPS and its affiliates and their respective representatives, assigns, and employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and the reproduction thereof as stated above, including any claim for payment in connection with distribution or publication of the video and/or photographs.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Fox Valley Plastic Surgery.

I understand that once content is posted on the web, it may remain on the web even after the content is deleted from the source.

I hereby warrant that I am at least eighteen years old, and competent to contract in my own name insofar as the above is concerned.

The purpose of this form is to obtain my prior written consent so that Fox Valley Plastic Surgery may photograph or film me for one or more of the following purposes listed below for which I do hereby consent.

Initial all that apply:

_____ **Medical Use:** Use or disclosure of image for medical specialty board in formulating its examination of applicant physicians, or in a professional presentation or journal publication

_____ **Office Use:** Use or disclosure of image for marketing or advertising purposes and patient education within the office

_____ **Website Use:** Use or disclosure of image for marketing or advertising purposes and patient education via print, visual and electronic media

Photo Limitations: _____

(For example: No face, no tattoo, etc.)

I have read and understand the foregoing release, authorization and agreement, before signing my name below, and enter into it knowingly and voluntarily.

Patient's Signature	Date

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Name: _____

DOB: _____

Demographics ~ <Appointment.Date>

First Name: _____ MI: _____ Last Name: _____ Former Name: _____

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

Home Phone: _____ Cell Phone: _____ Cell Carrier: _____ Work Phone: _____

DOB & Age: _____ Race: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Sex: _____ SSN: _____ Email Address: _____

Who is your primary care physician? _____
First Name Last Name

Preferred Pharmacy (name & location): _____

How did you hear about our practice?

☐ Patient: _____ ☐ Dr. Referral: _____
First Name Last Name

☐ Friend: _____

☐ Other: _____

Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

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Name: _____

DOB:_____

Consent to Communicate including Transmission of Protected Health Information by Non Secure Means (Email & Text Message)

In order to secure your Protected Health Information (PHI), it is always best to personally go to the office and talk to a representative of Fox Valley Plastic Surgery (FVPS). If this is not possible, the next best methods are to communicate by phone, fax, or U.S. mail. All these methods are secure means of transmitting PHI.

In spite of these secure options, it sometimes may become useful for during the course of treatment for the patient to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with FVPS, there is a reasonable chance that a third party may be able to intercept those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

FVPS has found that some patients prefer to message or email the office with photos or questions. These are not secure avenues of communication. If you wish the office to respond in kind to your inquiries, you must expressly give FVPS permission to communicate with you with these insecure methods instead of phoning, faxing, or writing you. Please mark the ways that you consent to us communicating with you.

Communication Method	OK to Leave Voicemail?	OK to Leave Message with Another Person?	Preferred Method(s)	Best Time to Call
☐ Call Work Phone <EmployerAddress.Phone>	☐ Yes	☐ Yes	☐	
☐ Call Cell Phone <PresentAddress.CellPhone>	☐ Yes	☐ Yes	☐	
☐ Call Home Phone <PresentAddress.HomePhone>	☐ Yes	☐ Yes	☐	
☐ Send Email <PersonalInfo.EmailAddress>	☐ Okay for appt reminder? ☐ Okay for medical/schedule information? ☐ Okay for special offers including patient surveys and newsletter? No spam. We do not sell our lists.			
☐ Send US Mail to <PresentAddress.Address> <PresentAddress.Apt#>, <PresentAddress.City>, <PresentAddress.State>, <PresentAddress.Zip>	Mail to ☐ present address, ☐ permanent address, ☐ employer address, ☐ emergency contact, ☐ responsible party			
☐ Send Text Message <PresentAddress.CellPhone> Cell Phone Carrier:	☐ Okay for appt reminder? ☐ Okay for medical/schedule information? ☐ Okay for special offers?			

FAMILY MEMBERS				
Name	Date of Birth	Relationship	Release Results	Expiration or Comments

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my PHI by unsecured means. I understand that message and data rates may apply. I understand that I am not required to opt into emails or texting, or sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Patient Signature: _____ Date: _____

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DOB: _____

Health History

Medical History from ThedaCare

☐ Yes ☐ No Are you a patient in the ThedaCare system?
☐ Yes ☐ No Do you give FVPS permission to access to your medical history from ThedaCare?

Section I: Surgery and Anesthesia History

1. List and describe your surgical history.

_____

_____

_____

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

_____

Section II: Specific Medical History

HEIGHT & WEIGHT: _____

Do you have a history of the following?	No	Yes	Description
2. Anemia	☐	☐	
3. Asthma	☐	☐	
4. Emphysema	☐	☐	
5. Bleeding tendency	☐	☐	
6. Blood clots	☐	☐	
7. Cancer	☐	☐	
8. CHF	☐	☐	
9. COPD	☐	☐	
10. Diabetes	☐	☐	
11. High Blood Pressure	☐	☐	
12. Heart disease	☐	☐	
13. Hepatitis	☐	☐	
14. Herpes/Cold Sores	☐	☐	
15. Kidney disease	☐	☐	
16. Melanoma	☐	☐	
17. Migraine headaches	☐	☐	
18. Periodontal disease – currently being treated	☐	☐	
19. Stroke	☐	☐	
20. Thyroid disease	☐	☐	
21. Problem Scarring	☐	☐	
22. Have you been advised to or had psychiatric care?	☐	☐	
23. Vein problems, such as venous reflux disease	☐	☐	
24. Others Not Listed			

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Section III: Social History

1. Do you smoke? ☐ No ☐ Yes, how much? _____
2. Do you drink? ☐ No ☐ Yes, how much? _____
3. Do you have children? ☐ No ☐ Yes, how many? _____
4. Do you exercise? ☐ No ☐ Yes, how much? _____

Section IV: Family History

Do your blood relatives have any of the following?	No	Yes	Description
1. Asthma	☐	☐	
2. Bleeding Tendency	☐	☐	
3. Blood Clots	☐	☐	
4. Cancer	☐	☐	
5. Chronic Lung Disease	☐	☐	
6. Depression	☐	☐	
7. Diabetes	☐	☐	
8. Heart Disease	☐	☐	
9. High Blood Pressure	☐	☐	
10. Kidney Disease	☐	☐	
11. Melanoma	☐	☐	
12. Mental Illness	☐	☐	
13. Migraine Headaches	☐	☐	
14. Obesity	☐	☐	
15. Stroke	☐	☐	
16. Thyroid Trouble	☐	☐	

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Name: ______________________________

DOB:______________________________

Section V: Medications

List any medications, and oral or topical vitamins or herbal supplements you are taking.

Name of Medication	Strength (mg)	How many times a day?

Do you have a Pain Contract with another physician? ☐ **No** ☐ **Yes**

Section VI: Allergies and Sensitivities

List all allergies and sensitivities:

Allergy:	Severity:	Reaction: (list #'s from bottom)
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	

Reaction List: 1) Arthralgia, 2) Chills, 3) Cough, 4) Fever, 5) Headache, 6) Hives, 7) Malaise/Fatigue, 8) Myalgia, 9) Nasal Congestion, 10) Other, 11) Pain/Soreness at injection site, 12) Rash, 13) Rhinorrhea, 14) Shortness of breath/Difficulty breathing, 15) Sore Throat, 16) Swelling, 17) Unknown

Are you allergic to medical adhesives such as tape, steri-strips, bandaids? ☐ No ☐ Yes, please list:
Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

Section VII: Women Only

Date of last mammogram: ______________________ Number of pregnancies: ______________

Do you do regular breast self-exams?	☐ Yes	☐ No
Do you breast feed?	☐ Yes	☐ No
Breast lump or discharge?	☐ Yes	☐ No
Are you pregnant or trying to get pregnant?	☐ Yes	☐ No
Are you on birth control pills or hormone replacement therapy?	☐ Yes	☐ No

I have read this questionnaire and disclosed my medical history to the best of my knowledge.
Patient Signature: ______________________________ Date: ______________________

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HIPAA Information and Consent

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

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HIPAA NOTICE OF PRIVACY PRACTICES **(signature page of 8 page document)**

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Fox Valley Plastic Surgery to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would no apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Fox Valley Plastic Surgery may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Fox Valley Plastic Surgery send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Fox Valley Plastic Surgery not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Fox Valley Plastic Surgery amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Fox Valley Plastic Surgery for the six years prior to the date of the request, beginning with disclosures made after April 14th, 2003. We are not required, however, to record disclosures we make pursuant to signed consent or authorization.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with Fox Valley Plastic Surgery and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Fox Valley Plastic Surgery, please contact the Privacy Officer at Fox Valley Plastic Surgery.

It is the policy of Fox Valley Plastic Surgery that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

I, <PersonalInfo.FullName>, have been given the opportunity to read, review, obtain a hard copy and ask questions about Fox Valley Plastic Surgery's **HIPAA Notice of Privacy Practices**, and how Fox Valley Plastic Surgery uses and discloses my information and my rights concerning my information.

Patient or **Personal Representative**
Signature: _____ Date: _____
If Personal Rep, describe relationship _____

☐ The patient's condition prohibits the individual from signing an acknowledgement at the time. It will be obtained as reasonably practicable after the patient's condition improves.

☐ Acknowledgment was unable to be obtained. Reason:

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FINANCIAL POLICY

Appointment scheduling requires careful planning and coordination between our office, surgery centers and contracted staff. Special medical instrumentation and supplies may be ordered and are sterilized for each individual procedure. Please consider the importance of this policy before scheduling a procedure.

SURGERY SCHEDULING

A $1,000 down payment is required to secure a scheduled surgery time. **Full payment is due 21 days prior to a scheduled surgery date.** This includes complete payment of deductibles, co-insurance and copays for insurance cases. Immediately upon scheduling, patients have a **24-hour grace period** to make changes including cancelling the surgery without incurring a rescheduling/cancellation charge.

SURGERY RESCHEDULING / CANCELLATION FEES

Patients who wish to change the surgery date or cancel surgeries, will incur a fee. Patients, who **fail a cotinine test**, are considered patient cancellations. Adequate notice of cotinine testing is always given, so there is no reason for a failed test. A rescheduling/cancellation fee will be assessed on failed cotinine tests. Fees are first withheld from any down payments already paid before invoicing the patient. The fee schedule is as follows:

Days Prior to Surgery	Rescheduling Fee	Cancellation Fee
Over 21 days	$200.00	$300.00
15-21 days	$400.00	$500.00
8-14 days	$600.00	$700.00
1-7 days	$800.00	$900.00
24 hours or less	$1000.00	$1000.00

NON-SURGERY RESCHEDULING / CANCELLATION FEES

Generally, full payment is due on the day of service for non-surgical procedures such as those in the Renaissance Medispa and the Laser Institute of Wisconsin™. Some procedures have a non-refundable $250 fee payable at the time of booking. The booking fee will be applied to the cost of the actual procedure, or used to cover the cost of consumables and room setup, if the patient cancels the appointment without adequate notice. You will be notified if your service requires a booking fee.

If you must cancel or change your non-surgical appointment, please notify us at least **24 hours** prior to your appointment time so that we can try to fill your slot with another patient. Without this advance notice, you will either forfeit your $250 booking fee, if applicable, or be charged a **$50 service fee**. This also applies to **no-shows**.

It is your responsibility to call us if you wish to reschedule. Your appointments, such as in veins, may have a sequential and cumulative sequence that must be followed. If one appointment is missed, the rest are timed incorrectly and must be rescheduled. If we cannot contact you, or you do not contact us, then all your remaining appointments will be cancelled.

If you arrive late for your treatment, you may be asked to reschedule, so as not to delay the next scheduled client.

ALLOWABLE FORMS OF PAYMENT

Our office accepts payment by cash, check, money order and credit cards from Visa, Mastercard, Discover and American Express. We also offer patient financing through Care Credit and Alphaeon Credit. Not all patients will qualify for financing, and not all procedures are eligible to be financed.

INSURANCE, CO-PAYS, DEDUCTIBLES

The patient or his/her legal representative is ultimately responsible for all charges incurred. Our office accepts assignment of benefits for many insurance companies. However, we are not preferred providers with all of them. It is your responsibility to **contact your insurance as to whether we are in your plan**, obtain your individual benefits and to be prepared to pay for any out-of-pocket expenses such as co-pays, deductibles and co-insurance before any surgery or office procedure is done. **Co-pays and past due balances are due at time of check-in**.

Your health care policy is a contract between you and your insurance company. If your insurance company does not cover your surgery, you will be liable for the payment. For example, Medicare does not have a pre-authorization process. If it is determined that your surgery was not medically necessary, you will then be billed for the surgery. It is ultimately **your responsibility to pay for all services** provided by Fox Valley Plastic Surgery.

If part or all my treatment is an insurance case, I verify that I have current insurance coverage, and directly assign to Fox Valley Plastic Surgery all medical benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for any out-of-pocket expenses such as, but not limited to co-pays, deductibles and co-insurance.

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BILLING

Statements are mailed monthly and expected to be paid in full within 60 days after your insurance has settled your claim. If you have financial difficulties, please contact our Financial Supervisor as soon as you are aware of the situation. The worst thing that you can do is to ignore the bill. Doing so will make you ineligible for any further service. If payment is not received within 90 days, your account may be referred to a collection agency.

DISPUTES

Performed services that are paid with a credit card, debit card or with financing, are not eligible for post-care payment challenges. Fox Valley Plastic Surgery encourages a complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy. I agree that this credit, debit card or financing challenge agreement is irrevocable.

I have read the above Financial Policy. I understand and agree to this.

Patient Signature: _____ Date: _____