

Patient Information

Full Name: _____ She/He/They (Circle One)

Date of Birth: ____ / ____ / ____ SSN: ____ - ____ - ____

Gender: _____ Height: _____ Weight: _____

Address: _____

Phone Number (Cell): _____ (Home): _____

Email Address: _____

Occupation: _____ Employer: _____

**For Office Use
Only:**

BMI _____

BSA _____

Schnur Scale

What is the reason for your upcoming consultation?:

Have you consulted any other physician/provider for this? **Yes** **No**

What additional services would you like to learn about? Please check all that apply.

FACE

- Brow lift
- Drooping eyelids
- Under eye bags
- Nose size or shape
- Facial fullness/drooping
- Mole removal
- Ear size/shape

BREAST

- Breast size
- Breast shape
- Breast implant correction
- Breast reconstruction

BODY

- Tummy tuck
- Upper arm lift
- Thigh lift
- Butt lift or enlargement
- Liposuction or fat transfer
- Vaginal rejuvenation
- Red or raised scars

OTHER: _____

MED SPA

- Facial fine line/wrinkles
- Thin lips
- Skin care products
- Brown spots/age spots
- Laser hair removal
- Facials
- Micro-needling
- Acne
- Dermal Filler
- Neurotoxin injection

Referral Information

Referred By: _____ May we thank them? **Yes** **No**

- Internet
- Word of mouth
- American Society of Plastic Surgery
- Physician: _____
- Magazine
- Other: _____

Primary Care Physician/Provider

Name: _____

Phone Number: _____

***Do you see any other specialist providers to manage your health? Yes No**

(Example: Cardiology, Endocrine, Neurology, Pain management, etc.)

Name: _____

Phone Number: _____

Name: _____

Phone Number: _____

Pharmacy Information

Name: _____

Phone Number: _____

Address: _____

***Do you consent for us to pull your medication history from all outside providers for your safety? Yes No**

Emergency Contact Information

Name: _____

Relationship to patient: _____

Phone Number: _____

Communication Authorization

Please contact me regarding my treatment and care at the following number(s):

Cell: _____

Home: _____

Please contact me regarding my treatment and care at the following email:

- YES, it is ok to leave information on: ____ Voicemail ____ Text Messages ____ Emails
- NO, do not leave information on voicemail or receive text messages/emails.

Health Habits:

Consumption of the following?

Aspirin	YES	NO	Amount Daily? _____
Alcohol	YES	NO	Amount Daily? _____
Tobacco	YES	NO	Amount Daily? _____
Have you smoked in the past?	YES	NO	Amount Daily? _____
			# of years smoked? _____
Recreational drugs	YES	NO	Amount Daily? _____

Patient Name (Print): _____

Date of Birth: _____

Plastic Surgical History

Operation	Date	Complications?

Other Surgical History

Operation	Date	Complications?

Medications, Vitamins, & Herbal Supplements (Prescribed and over-the-counter)

Medication Name	Dose	Taken How Often?

Do you take weight loss medication? ___ Y ___ N Name of medication: _____

Patient Name (Print): _____ **Date of Birth:** _____

Allergies (Medications, Substances, Foods, etc.) - Please list reaction with allergy

YES	NO	Aspirin	YES	NO	Demerol	YES	NO	Erythromycin
YES	NO	Iodine	YES	NO	Penicillin	YES	NO	Sulfa drugs
YES	NO	Tape	YES	NO	Latex	YES	NO	Morphine

Family History

	Family Member(s)	Explanation
Breast Cancer		
Other Cancer		
Diabetes		
Heart disease		
High blood pressure		
Bleeding disorders/blood clots		
Obesity		
Other		

Medical History

Have you ever taken Accutane? **Yes** **No** If so, how long ago? _____

Bleeding Problems (please circle)

Do you bruise or bleed easily? **Yes** **No**

Do you have a family history of bleeding problems? **Yes** **No**

Explain: _____

Have you ever had a blood transfusion? **Yes** **No**

Female Patients:

Are you /could you be pregnant? **Yes** **No**

of pregnancies? _____ # of children? _____ # of breastfed children? _____

Approximate date of last mammogram? _____ Normal? _____ Abnormal? _____

If considering breast surgery, what is current bra size? _____

Patient Name (Print): _____ **Date of Birth:** _____

Personal Medical History (please circle)

YES	NO	Abnormal bleeding	YES	NO	MRSA	YES	NO	Stomach ulcers
YES	NO	Heart murmur	YES	NO	Heart disease	YES	NO	Chest pain
YES	NO	Heart Attack	YES	NO	Heart Stents	YES	NO	Other stents
YES	NO	Artificial heart valves	YES	NO	High blood pressure	YES	NO	Glaucoma
YES	NO	Asthma	YES	NO	Abnormal clotting	YES	NO	Cancer
YES	NO	Post-op nausea/vomiting	YES	NO	Previous surgical infection	YES	NO	Chemo/Radiation
YES	NO	Diabetes	YES	NO	Pacemaker/ICD	YES	NO	HIV
YES	NO	COPD/Emphysema	YES	NO	Seizures	YES	NO	Hepatitis B or C
YES	NO	Excessive sweating	YES	NO	Sinusitis	YES	NO	Stroke
YES	NO	Fever blisters	YES	NO	Skin condition	YES	NO	Migraines
YES	NO	Sleep apnea	YES	NO	Neck injury/surgery	YES	NO	Depression/Anxiety

Please explain any of the selections above: _____

Please list below any other medical problems or medical conditions:

It is mandatory and medically necessary for patients who smoke to **QUIT A MINIMUM OF FOUR WEEKS PRIOR TO SURGICAL PROCEDURES AND A MINIMUM OF FOUR WEEKS AFTER THOSE PROCEDURES**; please discuss with surgeon if you cannot refrain from smoking or need assistance with cessation.

_____ YES, I can refrain from smoking _____ NO, I cannot refrain from smoking

I affirm that the information I have given is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ **Date:** _____

Patient Name (Print): _____ **Date of Birth:** _____

Patient Partnership Plan

Dear Patient,

Welcome to Coastal Cosmetic Center! We hope to provide you with the care and service that you expect and deserve. Achieving your best possible health requires a “partnership” between you and your doctor. As our “partner in health,” we ask you to participate in your care in the following ways:

By **initialing** below, you are stating that you have read and agree to the following:

_____ I will keep follow-up appointments and reschedule missed appointments.

_____ I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and do not reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

_____ I understand that my physician’s goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician’s office within the time specified, I will call the office for my test results.

_____ I will inform my doctor if I decide not to follow his recommended treatment plan.

_____ I understand that after examining me, my doctor may make certain recommendations based on his impression regarding what is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his recommendations so that he may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, seek an explanation, report symptoms, or discuss concerns. If you need more information about your health or condition, please ask.

Signature: _____ **Date:** _____

Authorization for disclosure of information: I authorize Coastal Cosmetic Center, PA/ Coastal Surgery Center, LLC to disclose complete information concerning medical findings and treatment of the patient for which this form is used, from the initial office visit until the date of the conclusion of such treatment, to those individuals who, in your physician’s sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

Signature: _____ **Date:** _____

Patient Name (Print): _____ **Date of Birth:** _____

INSURANCE CONSENT TO RELEASE INFORMATION

I _____ (**name of patient**), give Coastal Cosmetic Center, PA/Coastal Surgery Center permission to release my medical records and photos to my insurance company if needed to help my case get authorized and approved for billing purposes. I give permission to release any information concerning the status of my health care including appointments, test results, photos, and operative notes to them if needed for medical necessity.

Consent -- Patient Signature: _____ **Date:** _____

Insurance Information Questionnaire

Although your procedure may be cosmetic and not covered by insurance, Coastal Cosmetic Center requests to have your insurance information on file in the event you have a procedure eligible for insurance coverage in the future.

Primary Insurance Company: _____ **Ph #** _____

Policy #: _____ **Group #:** _____

Name of the Insured: _____ **Relationship:** _____

Subscriber's Birthday: _____

***Secondary Insurance Company:** _____ **Ph #** _____

Policy #: _____ **Group #:** _____

Name of the Insured: _____ **Relationship:** _____

Subscriber's Birthday: _____

ACCIDENTS/INJURIES

Is your visit due to an injury? (circle one) **YES** **NO**

If yes (circle one): **Work Injury** **Auto Accident** **Other** (please specify): _____

Where did your injury occur? Home Work Other (please specify): _____

Date of Injury: _____ **Type of Injury:** _____

Claims #: _____ **Auto Adjuster:** _____ **Ph #** _____

Workman's Comp Carrier: _____ **Ph #** _____

Workman's Comp Address: _____

Patient Name (Print): _____ **Date of Birth:** _____



Cancellation Policy for Office Procedures and/or Surgery

As of January 1, 2024 the cancellation policy is updated as follows:

Non-surgical procedures: Coastal Cosmetic Center requires **24 hours' notice** for cancelling your appointment. Patients who do not show up for their appointment without notifying the office 24 hours prior are considered a **NO SHOW**. In either case, a **\$100 cancellation/no show fee** will be applied to your next visit. Arriving to your appointment more than 30 minutes late, could result in rescheduling the appointment. We will work with you the best we can if such a situation arises but we cannot compromise on the quality and timely care provided to our other patients.

Coolsculpt

- A non-refundable deposit of \$100.00 will be collected upon scheduling your treatment.

Skin Care

- Credit card information will be taken and kept in your file the day of your appointment.

Surgical procedures: Scheduling your surgery takes careful planning and coordination between our office and the surgery center. Please understand the importance of respecting our **Two (2) Week Cancellation Policy**.

- A \$750.00 **non-refundable** deposit will be collected to secure your surgical date.
- **Cancelling** your surgery within 15 calendar days of your scheduled procedure date will result in 50% of the remaining balance of your surgical cost to be refunded.
- **Rescheduling surgery-** if you reschedule your surgery more than twice, there will be a non-refundable rescheduling charge of \$500 for each time surgery is rescheduled. This will be due at the time of rescheduling.

***Payment for surgery must be received in full on the date of your preoperative appointment. All payment types are accepted.**

***The \$100 consult fee is non-refundable and used to hold your appointment date and time. It will be applied to your surgical balance when you schedule surgery or to any other service in-office.**

Thank you for your cooperation and understanding,
Coastal Cosmetic Center

I have read, understand, and accept the above policies.

Patient/Guardian Signature: _____ **Date:** _____

Patient Name (Print): _____ **Date of Birth:** _____

Financial Disclosure and Authorizations

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

Patient Identification

A current government issued photo ID, secondary ID with name, and insurance card (if you are requesting us to bill insurance) must be present at the initial visit. Failure to provide either of these may require us to collect our standard billed charges accrued on the day the services were rendered rather than the patient's out of pocket fees. It is our practice policy to photo copy your ID and insurance card(s) for our files. Patients must fill out a patient information forms prior to seeing the physician.

Referrals

If your insurance plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, you will be required to pay for the services rendered at the time of service.

Expected Amount Due

By law we must collect your carrier designated co-pay/co-insurance and/or deductible. This payment is expected at the time of service. Please be prepared to pay the expected amount due at each visit. We will not bill an insurance company if we do not have a copy of your current card and valid photo ID at the time of visit. We bill primary and secondary insurances only, as a courtesy. If we are unable to verify your benefits, then you will be responsible for following up with your insurance company.

Medicare

We will submit claims to Medicare for covered services. The patient will be responsible for the deductible and the 20% co-insurance for covered services, which can be billed to a secondary insurance if you have one.

Medicaid Recipients

Our practice does not participate with these programs; therefore, you are responsible for the services rendered.

Consult Photos

Photos of the patient will be taken at consultation of the area in which you are requesting a consult. These photos are specifically for before and after purposes and will not be used unless approved by you, the patient, during your preoperative visit should you choose to pursue surgery with Dr. Timothy Fee, MD, FACS or Dr. Jordan Bilezikian, MD.

Follow Up Care

If you have a surgical procedure that is billed to your insurance company, that procedure could include up to 90 days of follow-up care dependent on the performed treatment. If you are seen for a condition other than the one treated, your insurance company may be billed for this added condition and in turn, you could be billed for the out-of-pocket fees.

Out-Of-Network Plans

You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges, if the UCR is in accordance with the American Medical Associations Guidelines. Most patients will be responsible for their co-pay, co-insurance, and deductible. If we do not "participate" with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 90 days; you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the appropriate provider's office.

Patient Balances

Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. All arrangements made for services will require an agreement signed by both patient and administrative staff. In the event you default your account, collection proceedings will begin and you will be responsible for any additional collection charges incurred.

Patient Name (Print): _____ **Date of Birth:** _____

Short-Term Disability (STD) or Family Medical Leave Act (FMLA) Paperwork

Effective November 1st 2012, there will be a \$25.00 fee for each disability and FMLA paperwork that requires our physician and/or staff to complete on your behalf. Unfortunately, due to the time consuming nature of these forms, we have no choice but to impose this fee. Please feel free to speak with one of our staff members if you have questions regarding this matter.

Plastic and Reconstructive Procedures

Your insurance company requires that we bill our services to you using a coding system known as a CPT (Current Procedural Terminology). Many codes that surgeons use to describe the services performed are found in the "surgery" section of the CPT code book. This does not mean that you had an operation. This is merely the way the CPT book is organized for ease of use by both the insurance companies and physicians. Your Insurance Company may cover the care rendered for "surgical" codes differently than for office visits. Therefore, your insurance explanation of benefits may reflect that the service was paid as a surgical procedure, with deductible and co-insurance guidelines applied. We encourage all of our patient's to check with your insurance company and verify your benefits. If a service is not covered by your insurance and you are billed for the service, your timely response to the bill is imperative due to filing limits. Should you request further appeal by our office, you acknowledge that our collection efforts are a courtesy and that you are ultimately responsible for the services rendered. You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges incur as a result of this.

We accept **cash, checks, Master Card, Visa, American Express, Discover, Care Credit** and **Alphaeon Credit**. **REFUNDS:** payments made with cash or checks are refunded by check. Payments made by credit card are refunded to the same credit card used for payment. When using **Care Credit** or **Alphaeon** you can only make changes to the purchase within **30** days of the purchase date.

Thank you for taking the time to review our policies, please feel free to ask any questions or share with us any concern you might have.

I have read and fully understand the above and authorize payment of the insurance benefits directly to Coastal Cosmetic Center/Coastal Surgery Center and my surgeon. I realize that I am responsible for any charges not covered by insurance. The signature furnished below shall suffice for all insurance forms on a continuing basis.

Patient/Guardian Signature: _____

Date: _____

Ownership Notice to Patients

Because of concerns that there may be a conflict of interest when a physician refers a patient to a healthcare facility in which the physician has an ownership interest, Florida passed a law (the "Patient Self-Referral Act of 1992," FL Statute Section 455.654). Under this law, I must disclose my ownership in this facility and tell you about alternative places, where you may go to obtain these services. This disclosure is intended to help you make a fully informed decision about your health care. You have the right to obtain health care items or services at a location or from a provider or supplier of your choice, including the facility in which I am an owner. I assure you that you will not be treated differently if you do not choose the facility listed below in which I have an ownership interest.

Dr. Timothy E. Fee, M.D. ownership interest in:
Coastal Surgery Center, LLC

Patient Name (Print): _____

Date of Birth: _____

Notice of Policy Regarding Advanced Directives

Advanced directives **are not honored** at this facility and in the event of an emergency of life-threatening situation, advanced cardiac life support procedures **will be instituted** in every instance and patients will be transferred to a higher level of care.

Signature: _____

Date: _____

Use of Photographs

The use of photographs is essential to the planning and evaluation of cosmetic or reconstructive surgery. These photographs are a permanent part of your medical record and will never be shown to anyone else without your consent.

For various reasons, Timothy E. Fee, M.D. and Jordan Bilezikian, MD, are often asked to show before and after photos of patients. Many patients have given permission to use their photos anonymously. We now ask that you do so as well.

Consent for use of Before & After Photos

I understand pre- and post- treatment pictures will be obtained for medical records. **Initial:** _____

I hereby authorize Coastal Cosmetic Center to use my photos in their before and after presentation to other patients interested in the same procedures including but not limited to showing these images in-office, print, internet, social media, and electronic digital networks. I understand that every attempt will be made to represent me and the physician accurately and with integrity and dignity in all representations, including patient discretion by removing any identifying marks / features to maintain anonymity.

Consent Signature: _____

Date: _____

Refusal Signature: _____

Date: _____

Patient Name (Print): _____ Date of Birth: _____

Summary of Patient's Bill of Rights & Responsibilities

For copies, please see the front desk
Section 381.026, Florida Statutes

The patient has the right to:

- Be treated with courtesy and respect, with appreciation of his/her dignity, and with protection of privacy
- Receive a prompt and reasonable response to questions and requests
- Know who is providing medical services and is responsible for his/her care
- Know what patient support services are available, including if an interpreter is available if the patient does not speak English
- Know what rules and regulations apply to his/her conduct
- Be given by the health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis
- Refuse any treatment, except as otherwise provided by law
- Be given full information and necessary counseling on the available of known financial resources for care
- Know whether the health care provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare
- Receive prior to treatment, a reasonable estimate of charges for medical care
- Receive a copy of a understandable itemized bill and, if requested, to have the charges explained
- Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment
- Receive treatment for an emergency medical condition that will deteriorate from failure to provide treatment
- Know if medical treatment is for the purpose of experimental research and to give his/her consent or refusal to participate in such research
- Express complaints regarding a violation of his/her rights

The patient is responsible for:

- Giving the healthcare provider accurate information about present complaints, past illness, hospitalizations, medications, and any other information about his/her health
- Reporting unexpected changes in his/her condition to the healthcare provider
- Reporting to the healthcare provider whether he/she understands a planned course of action and what is expected of him/her
- Following the treatment plan recommended by the health care provider
- Keeping appointments and, when unable to do so, notifying the healthcare provider or facility
- His/her actions if treatment is refused or if the patient does not follow the healthcare provider's instructions
- Making sure financial responsibilities are carried out
- Following health care facility conduct rules and regulations

Filing Complaints

If you have a complaint against a hospital or ambulatory surgical center, call the Consumer Assistance Unit at 1-888-419-2456 (press 1) or write to the address below:

Agency for Healthcare Administration
Consumer Assistance Unit
2727 Mahan Drive, Building 1
Tallahassee, FL 32308

If you have a complain about a healthcare professional and want to receive a complaint form, call the Consumer Services Unit at 1-888-419-3456 (press 2) or write to the address below:

Agency for Healthcare Administration
Consumer Assistance Unit
PO BOX 14000
Tallahassee, FL 32317-4000

Patient Name (Print): _____ **Date of Birth:** _____

Patient Health Information Authorization and Disclosures

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communications of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Information Disclosure Authorization

I _____ (name of patient) hereby give authorization to Coastal Cosmetic Center/ Coastal Surgery Center for the release of information concerning the status of my health care including appointments, test results, and operative status on surgery day.

- | | |
|--|-------------------------|
| 1) _____ | _____ |
| Name of authorized individual (i.e. friend or family member) | Relationship to patient |
| 2) _____ | _____ |
| Name of authorized individual (i.e. friend or family member) | Relationship to patient |
| 3) _____ | _____ |
| Name of authorized individual (i.e. friend or family member) | Relationship to patient |

Acknowledgement of Notices

(Please see [Important Patient Information and Notices](#) manual in lobby for documents.)

By initialing on each line item, I acknowledge that I have read a copy of the following notices:

_____ Patient's Bill of Rights and Responsibilities

_____ Ownership Notice to Patients

_____ Privacy Practice/HIPPA

Patient/Guardian Signature: _____

Date: _____

For Office Use Only: Staff Witness Signature - _____