

7611 Forest Ave · Suite 210
Richmond, VA 23229
(804) 290-0909
Fax (804) 290-0333
www.DrSundin.com



1500 Cornerside Blvd · Suite 400
Vienna, VA 22182
(703) 740-8333
Fax (703) 740-8775
www.MyModernBody.com

Burton M. Sundin, M.D. / Reps B. Sundin, M.D

Date: _____

Name (Last, First, MI): _____

Address: _____

Zip, City, State: _____

Home#: _____ Work#: _____ Cell#: _____

Email address: _____

Patient Status: 1-Married 2-Single 3-Separated 4-Divorced 5-Widowed 6-Other

Birthdate: _____ Sex: _____ Social Security#: _____

Referred by: _____ Primary Care Dr: _____

Do you have a living will? No Yes

Emergency Contact: _____ Phone#: _____

***** GUARANTOR INFORMATION/SECONDARY ADDRESS:**

Name: _____ Phone#: _____

Address: _____ SS #: _____

Empl Status: 1-Empl FT 2- Empl PT 3-Retired 4-Not Empl 5-Student FT 6-Student PT

Employer's name: _____ Phone#: _____

Address: _____

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services. I also authorize the physician to release any information required to process this claim and in the course of my exam and treatment.

SIGNED: _____ DATE: _____

WOULD YOU LIKE TO RECEIVE EMAILS ON OUR UPCOMING EVENTS AND SPECIALS? YES/NO

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MEDICAL HISTOR/ REVIEW OF SYSTEMS: HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING CONDITIONS?

HEART DISEASE	Y	N	BLOOD CLOT (DVT)	Y	N	ASTHMA	Y	N
(including Heart Attack, Congestive Heart Failure, Congenital Heart Defect of Disorder)			PULMONARY EMBOLISM	Y	N	LUNG DISEASE	Y	N
HIGH BLOOD PRESSURE	Y	N	ANEMIA	Y	N	GLAUCOMA	Y	N
STROKE	Y	N	MENTAL HEALTH PROBLEMS	Y	N	CANCER	Y	N
KIDNEY DISEASE	Y	N	HIV/AIDS	Y	N	KELOIDS	Y	N
HEPATITIS	Y	N	ANY OTHER MEDICAL PROBLEMS	Y	N	EXCESSIVE SCARRING	Y	N
DIABETES	Y	N				EXCESSIVE BRUISING	Y	N
						BLEEDING/CLOTTING DISORDER	Y	N

PLEASE EXPLAIN ANY "YES" ANSWERS ABOVE:

PERSONAL PHYSICIAN: _____ LAST MEDICAL EXAM: _____
 HAVE YOU OR ANY OTHER RELATIVE HAD PROBLEMS WITH ANESTHESIA? Y N
 HAVE YOU EVER HAD CHEMOTHERAPY? Y N
 HAVE YOU EVER HAD RADIATION TREATMENT? Y N
 IF YES, WHAT PART OF YOUR BODY? _____

Number of term pregnancies: _____ History of weight loss? Y N amount of weight lost: _____ Maximum Weight _____

Do you have or have you ever had problems with:

General:			Eyes:			Musculoskeletal:		
Fever	Y	N	Irritation of the eyes/eyelids	Y	N	Joint Pain	Y	N
Weight Loss/Gain	Y	N	Blurred Vision	Y	N	Back Pain	Y	N
Endocrine:			Gastrointestinal:			Skin:		
Excess Thirst	Y	N	Diarrhea	Y	N	Itchiness	Y	N
Insomnia	Y	N	Constipation	Y	N	Skin Allergies	Y	N
Lungs/Respiratory:			Eating Problems	Y	N	Cold Sores	Y	N
Shortness of breath	Y	N	Lymph/Hematology:			Cardiovascular:		
Psychiatric:			Bleeding	Y	N	Chest Pains	Y	N
Depression	Y	N	Sweating	Y	N	Palpitations	Y	N
Suicidal Thoughts	Y	N	Allergy/Immunology:			Ankle Swelling	Y	N
Anxiety	Y	N	Dust	Y	N	Urinary:		
ENT:			Ragweed	Y	N	Difficulty Urinating	Y	N
Nose Bleeds	Y	N	Molds	Y	N	Frequency	Y	N
Ringing in Ears	Y	N	Other: _____			Burning	Y	N
Problems	Y	N	Pregnancy Issues:			Neurological:		
Swallowing			Currently Pregnant	Y	N	Headaches	Y	N
			If yes, due date: _____			Numbness	Y	N
			Currently Breast Feeding	Y	N	Seizures	Y	N
			Planning Pregnancy	Y	N			
			Miscarriage	Y	N			

Completed by: Patient Nurse/Medical Assistant MD

I hereby certify that the information provided above is true and accurate to the best of my knowledge. I recognize that the information provided above will be used in my medical care and has direct implications with regard to care including but not limited to selection of treatment and potential outcomes or complications.

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Printed name: _____ Signature: _____

CONSENT TO TREATMENT AND RESPONSIBILITY AGREEMENT

Please read each section carefully. You may request a copy of this form for you own records.

Patient name: _____

I, the undersigned, do hereby request and consent to an evaluation and treatment by Dr. Burton M. Sundin, Dr. Rebs B. Sundin, and/or the designated staff of Virginia Institute of Plastic Surgery/MBody. I wish to rely on Dr. Burton M. Sundin and/or Dr. Rebs B. Sundin to exercise judgement for my best interest me or that of my dependent, the above-named patient, during the course of treatment. I will inform Dr. Burton M. Sundin and/or Dr. Rebs B. Sundin or his assistant, who is treating me or my dependent of any sensitive areas or adverse conditions that I or my dependent may have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment.

I consent to the taking of photography by Dr. Burton M. Sundin and/or Dr. Rebs B. Sundin or his designee of me or parts of my body in connection with the plastic surgery procedure(s) or non-surgical procedures to be performed by Dr. Burton M. Sundin and/or Dr. Rebs B. Sundin or their employees.

I clearly understand and agree that all services rendered to me or to my dependent, the above-named patient, may be charged directly to me and that I am personally responsible for full payment. I understand that even if I suspend or terminate treatment, any fees for professional services rendered to me or to my dependent up to the point of termination will be immediately due and payable.

I acknowledge that Dr. Burton M. Sundin and/or Dr. Rebs B. Sundin and Virginia Institute of Plastic Surgery may not participate directly with my insurance carrier and that I am responsible for any outstanding fees for services provided to me or to my dependent, the above-named patient, by Dr. Burton M. Sundin and/or Dr. Rebs B. Sundin and/or Virginia Institute of Plastic Surgery that are not reimbursed through insurance or other third party payers; this includes all co-payments, deductibles, and out of pocket costs. I understand that a potentially refundable deposit to cover fees for uncovered services may be required at the time of service or follow up. I acknowledge that a 1.5% per month interest charge may be added to any balance unpaid after 90 days of aging. I further acknowledge that I will be held responsible for any and all expenses incurred by Dr. Burton M. Sundin and/or Dr. Rebs B. Sundin and/or Virginia Institute of Plastic Surgery for any fee collection process, including a 30% attorney fee on any balance referred to an attorney for collection as a result from my delay in payment for services rendered by Dr. Burton M. Sundin and/or Dr. Rebs B. Sundin and/or Virginia Institute of Plastic Surgery.

I agree that, I will not audio record, video record or take unauthorized photographs of the office, staff, consultation process or treatment process during my visits at Virginia Institute of Plastic Surgery/MBODY, or at facilities where they operate or see patients. Video or Audio recording is strictly prohibited without the explicit permission of Dr. Sundin

With regard to cosmetic or self-pay procedures: I understand that hospital fees, fees for laboratory tests or studies, cost of medications, anesthesia fees, and operating room fees related to cosmetic or self-pay procedures will likely not be covered by my insurance carrier. I understand that I will be responsible for all facility and anesthesia fees incurred for subsequent revision and/or emergency procedures performed on me or my dependent, the above named patient, as well as necessary supplies including but not limited to implants, unless otherwise specified by Dr. Burton M. Sundin, Dr. Rebs B. Sundin. I will also be financially responsible for any studies, Pathology, laboratory tests, medications, anesthesia and hospital fees related to cosmetic procedures or self-pay procedures or complications thereof. Any surgeon's fee that may be incurred for subsequent revision and/or emergency procedures will be addressed on a case by case basis. If any fees are waived, refunded, and/or paid by the physician or office; this action does not constitute an admission of guilt, malpractice, or wrongdoing.

I authorize Virginia Institute of Plastic Surgery to submit all precertifications and claims directly to the insurers on my behalf. I hereby authorize the release of my medical records and other information necessary to process insurance claims. I understand and agree that any and all monies/funds received from insurance companies and/or other third-party payers as reimbursement for services rendered to me or to my dependent, the above-named patient, by Dr. Burton M. Sundin and/or Dr. Rebs B. Sundin and Virginia Institute of Plastic Surgery. Any other arrangements that may involve insurance billing, reimbursement, payment plan, or payment deferral, must be made in writing with the office manager and/or Dr. Burton M. Sundin and/or Dr. Rebs B. Sundin. Verbal agreements are not acceptable.

Relationship to patient: _____

Signature: _____ Date _____

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CANCELLATION POLICY FOR COSMETIC OR SELF-PAY PROCEDURE

By signing this document, I agree to the following cancellation policy of Virginia Institute of Plastic Surgery, PC. (abbreviated in this document as "VIPS")

- I. To secure a cosmetic of self-pay procedure or surgery date, a \$1000 nonrefundable deposit per procedure is required.
- II. All fees due to Dr. Burton or Dr. Reps Sundin are due 30 days prior to the surgery or procedure date and are nonrefundable.
- III. All fees to Virginia Institute of Plastic Surgery, PC are due and nonrefundable after the calendar date 30 days prior to the date of surgery. There will be no refunds given for procedures cancelled after the calendar date 30 days prior to the day of surgery.
- IV. If a surgery or procedure is booked within a period less than or equal to 14 days prior to the surgery or procedure date, all fees are immediately nonrefundable.
- V. In the event of cancellation, nonrefundable fees paid to Virginia Institute of Plastic Surgery, PC may be utilized for future services or products. These credits will expire 365 days past the initial payment date, unless other arrangements are agreed upon by the patient and Virginia institute of Plastic Surgery, PC in writing. These Credits are non-transferable and may only be utilized by the patient personally.
- VI. Cancellation or rescheduling of a surgery within 30 days of the surgery date are subject to a rescheduling fee of 25% of the total cost of the surgery. Additional cancellations or rescheduling will be subject to an additional 25% fee.
- VII. Cancellation secondary to: acts of God, fire, electrical outage, weather events, mandatory shutdown by the government, disease outbreak, epidemic, pandemics, quarantine, acts of terrorism or war, hospital or surgery center closure, cancellation by the hospital or surgery center, office building closure, death or illness of the physician, death or illness of the patient, delay in transportation of the physician or patient will NOT result in any refunds.
- VIII. Dr. Sundin will make a reasonable attempt to reschedule the procedure or surgery. A second cancellation of a procedure or surgery by the patient for whatever reason will result in no further scheduling of that procedure and forfeit of all funds paid to Virginia Institute of Plastic Surgery, PC.
- IX. I further acknowledge that I will be held responsible for any and all expenses incurred by Dr. Burton M. Sundin or Dr. Reps B. Sundin and/or Virginia Institute of Plastic surgery for any fee collection process, including a 30% attorney fee on any balance referred to an attorney for collection as a result from my delay in payment for services rendered by Dr. Burton M. Sundin or Dr. Reps B. Sundin and/or Virginia Institute of Plastic Surgery, PC.
- X. All transactions-payments are nonrefundable 48 hours after payment. If payment is not applied to originally planned services, payment may be rendered for other goods and services available at VIPS.
- XI: All financial credits will expire and be forfeited 365 days post payment unless an exception is provided in writing to the patient.

Initials _____

NOTICE REGARDING NEED FOR EMERGENCY PROCEDURES AND/OR FUTURE REVISIONS

I understand that I will be responsible for all facility and anesthesia fees incurred for subsequent revision and/or emergency procedures performed on me or my dependent, the above named patient, as well as necessary supplies including but not limited to implants, unless otherwise specified by Dr. Burton M. Sundin or Dr. Reps B. Sundin. Any surgeon's fee that may be incurred for subsequent revision and/or emergency procedures will be addressed on a case-by-case basis. If any fees are waived, refunded or paid by the physician or office, this does not constitute an admission of guilt, malpractice or wrongdoing.

Initials _____

PATIENT NAME (PLEASE PRINT) _____

PATIENT SIGNATURE _____ DATE _____

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Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information

PATIENT NAME _____

DATE _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Virginia Institute of Plastic Surgery may use or disclose my protected health information for treatment, payment or health care operations – which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Virginia Institute of Plastic Surgery has a detailed document called the '**Notice of Privacy Practices**'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the '*Notice*' before signing the agreement. If I ask, Virginia Institute of Plastic Surgery will provide me with the most current *Notice of Privacy Practices*.

My signature below indicated that I have been given the chance to review such a copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Virginia Institute of Plastic Surgery to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Virginia Institute of Plastic Surgery has taken action relying on this content.

SIGNATURE _____

DATE _____

Relationship to patient if signed by another party _____

DATE _____

You may obtain a copy of our *Notice of Privacy Practices*', including any revisions of our '*Notice*' at any time by contacting: Virginia Institute of Plastic Surgery, 7611 Forest Avenue, Suite 210, Henrico, VA 23229, 804-290-0909.

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**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
TO INDIVIDUALS
(FAMILY MEMBERS, NEXT OF KIN, SPOUSE, CARETAKERS)**

I, _____, hereby authorize the below individuals to receive information regarding my medical treatment and condition. I recognize that in accordance with HIPAA no other individuals will receive information about my medical treatment or condition unless this form is updated appropriately.

Printed name: _____

Signature: _____

Date: _____

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NOTICE OF DEEMED CONSENT TO HIV AND HEPATITIS BLOOD TESTING

A law was enacted in Virginia in 1989 which authorizes health care providers to test their patients for HIV and Hepatitis antibodies when the health care provider is exposed to the body fluids of a patient in a manner which may, according to certain medical authority, transmit human immunodeficiency virus (HIV), the virus that causes Acquired Immunodeficiency Syndrome (AIDS) related disorders, and Hepatitis. Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the health care provider who may have been exposed. However, if such an exposure occurs, you will be informed before any of your blood is tested for HIV and Hepatitis antibodies. Pursuant to the provision, the testing will be explained to you, and you will be given the opportunity to ask any questions you might have.

The law also provides that if you should be exposed to body fluids of a health care provider in a manner which may, according to certain medical authority, transmit HIV and Hepatitis, the health care provider is deemed to have consented to such testing and to the release of the test results to you.

I have read and understand the above "Notice of Deemed Consent to HIV and Hepatitis Blood Testing".

Patient's Signature: _____

Date: _____

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INSURANCE RELEASE FORM

I authorize to any holder of medical or other information about me to release to my insurance carrier any information needed for this or any related item.

I hereby authorize, request, and assign payment directly to Virginia Institute of Plastic Surgery, PC for bills rendered by this office covering Dr. Sundin's services and any past and future treatments if related to the incident or condition giving rise to carriers with whom I have coverage or settlements or judgment flowing from the incident for which I am receiving treatment. This authorization shall include all benefits specified and/or master medical benefits otherwise payable to me.

I permit a copy of this authorization to be used in place of the original.

Name:

Signature:

Date:

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Informed Consent: COVID-19 RISK

I _____ (patient name) understand that I am opting for an elective

treatment/procedure/surgery that is not urgent and may not be medically necessary. I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that Dr. Sundin and all the staff at Virginia Institute of Plastic Surgery/MBody are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for Dr. Sundin and all the staff at Virginia Institute of Plastic Surgery/MBody to proceed with the same. I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus, or I may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure/surgery can lead to a higher chance of complication and death. I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital. I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself. I have been given the option to defer my treatment/procedure/surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery.

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

Patient's Signature: _____ Date: _____