SUMMIT PLASTIC SURGERY
MAXIMILIAN MALOTKY, MD, INC.
1800 Buenaventura Blvd., Ste. 200, Redding, CA 96001
Phone (530) 638-8868 Fax (530) 638-8870
E-mail office@drmalotky.com

Dear Patient,

Welcome to Summit Plastic Surgery. We look forward to meeting you. New patients and returning patients who have not been seen within the past 3 years will be required to complete new patient registration paperwork.

Please read the following carefully:

1. Fill in **ALL** the blanks of this paperwork. If anything doesn't apply to you, please write N/A.

2. **Please keep this page and the next 2 pages of our Office and Financial Policies for your records**.

3. **The Patient Registration Forms must be returned to our office no later than 3 days prior to your appointment or we will have to reschedule you for another time.** You may submit your paperwork by mail, email, fax, or deliver it in person. Our physical address, fax number, and email address are located at the top of this form.

4. Bring your insurance card(s) and a government issued photo ID with you (i.e., driver's license, State ID card, military ID).

5. We ask that you be prepared to pay your copay, coinsurance, and/or deductibles. Due to the influx of high deductible insurance plans, insurances will no longer be providing payment until these deductibles are met. If you require surgery, we will request you pre-pay the portion of your deductible and coinsurance at your pre-operative appointment. Our financial coordinator will contact you with an estimate of your patient responsibility.

6. **New Cosmetic Consultations** are $100. This fee is non-refundable and is collected at the time of scheduling. However, this fee is credited toward any cosmetic service that is provided to you. Cosmetic treatments and procedures are not considered medically necessary and will not be billed to insurance. Payment in full is required from you prior to a treatment and/or procedure. Additionally, another $100 will be charged if 3 months have passed since your last visit, cancelled appointment, or a new discussion about a cosmetic procedure or treatment is desired.

Thank you for choosing Summit Plastic Surgery. We look forward to providing you with excellent service and exceptional results.

SUMMIT PLASTIC SURGERY

OFFICE AND FINANCIAL POLICIES

Please keep this page for your records

FOR ALL PATIENTS

1. ***No-Show, Late Cancellations, and Surgery Rescheduling:*** A minimum 24-hour cancellation notice for office visits or consultations. A 2-week notice for surgery and or in-office procedure cancellation or rescheduling is mandatory. We are a specialty practice, and our doctor is usually scheduled for surgeries and consultations weeks in advance. When a patient fails to notify us within these cancellation or rescheduling times or doesn't show for their appointment or procedure, we have lost an opportunity to fill that time slot for another patient. The following fees will apply for late cancellations, no-show appointments, and surgery cancellations:

   - **$50.00 to $100.00 for an office visit or consultation.**
   - **$100.00 per hour for an in-office procedure (based on the length of the scheduled procedure)**
   - **$500.00 for a medical surgery cancellation or rescheduling**
   - **10% of the total Doctor Fee for a cosmetic surgery cancellation or rescheduling (please note: this is separate and in addition to the 25% booking fee.)**

   These fees cover lost revenue as well as prepared supplies that must be discarded and/or loss of reserved time and/or staffing at an inpatient or outpatient facility. Insurance does not reimburse for these fees. Payment of these fees will be billed directly to the patient and is due immediately upon receipt. These fees will also need to be collected prior to rescheduling another appointment.

2. ***Form Fee and Records Request*****:** Please note, our fee for completing outside agency forms such as disability and other miscellaneous forms will incur a $15 charge for each form. The records request fee maybe up to $25.

3. ***Copayment/Coinsurance/Deductible/Account Balance/Returned Check*****:** All copayments, coinsurance, and deductible amounts due will be expected at the time of service. If you have a balance on your account, please be prepared to pay that as well. We reserve the option to reschedule your appointment if numerous attempts to collect these payments are unsuccessful. We may also utilize an outside collection agency to assist us in recoupment of past due account balances. Returned checks will incur a $35.00 service charge**.**

4. ***Children:*** We kindly request that you arrange for childcare prior to your appointment. If you must bring your child/children with you, we ask that you bring an adult to supervise them in the waiting room. Our exam rooms are equipped with medical instruments, containers, and other necessary machinery used by the doctor and his medical staff. It may prove hazardous to a child should he or she become overly curious and acquainted with these items. Your visit is very important to us, and we expect to provide you with a thorough discussion about your health or cosmetic needs.

5. **All patients under the age of 18 must be accompanied by a parent or legal guardian.**

6. ***Cell phones and other Electronic Devices:*** As a courtesy to our doctor, staff, and other patients; cell phones and electronic gaming devices should be set to silence. If you must make or receive a call, please utilize an area away from the waiting room.

OFFICE AND FINANCIAL POLICIES – CONTINUED
Please keep this page for your records

1. ***Cosmetic Surgery:*** Cosmetic surgery scheduling requires a non-refundable 25% payment of the surgeon's fees. The remaining balance of the surgeon's fee is due at your pre-operative appointment unless other arrangements have been made with our billing department. The surgery and anesthesia fees are separate and are based on information that we receive directly from the facility and the anesthesiologist. These fees are collected at your pre-op appointment at the facility.
   In- Office Procedures: Payment in full is due at the time of scheduling and is non-refundable.

2. ***Revision Surgery at Additional Cost:*** Although we strive for the best result possible, sometimes less-than-ideal results occur. Working with living tissue can have unexpected or inconsistent results and the aging process continues regardless of what we do. Should concerns about your results arise, please discuss this with Dr. Malotky. A second operation may be needed to improve your outcome which may incur additional fees, including that for the facility, anesthesia, and possible surgeon's fees.

   This issue is especially relevant for those who have experienced massive weight loss, such as followed by a gastric bypass procedure. As much as we wish for a perfect result, some patients will wish to further improve their results through revisions at additional costs. In addition, if you had pre-operative body weight to be considered for revisions as weight changes will affect results. If you fail to keep follow-up appointments during your post-op period, you will forfeit your right to revisions under our policy.

3. ***Follow-up Appointments:*** Surgery requires follow-up appointments to ensure you are recovering as expected and to allow interventions where they may be beneficial to you in your recuperation. If you fail to follow up as scheduled and miss these appointments, you will forfeit your right regarding revisions and your relationship with Dr. Malotky may also be terminated, preventing you from seeing him again in the future. This is very important so please do not miss your appointments.

4. ***Failure to Disclose Prior Treatments or Procedures:*** Failure to disclose previous cosmetic treatments or procedures to Dr. Malotky will result in immediate discharge from Summit Plastic Surgery and forfeiture of scheduled follow-up appointments.

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PATIENT REGISTRATION INFORMATION

Patient Name _____Date of Birth _____S.S.#_____

Mailing Address_____

City, State, and Zip Code_____

Home Phone _____Cell Phone _____Work Phone_____

E-mail _____ Consent to E-mail **YES NO**

Marital Status: (please circle**) Married / Partner / Single / Divorced / Widow / Widower**

Race _____ Decline to Specify ☐ Ethnicity _____ Decline to Specify ☐ Language _____

Primary Care Provider/Phone Number: _____

Emergency Contact/Phone Number: _____

How did you hear about us? _____

Preferred Pharmacy and Location: _____

Preferred Laboratory and Location: _____

Preferred Imaging Facility: _____

Please initial the following:

- By initialing here _____, I give Summit Plastic Surgery permission to leave messages on my home/cell phone voicemails regarding appointment or clinical information.
- By initialing here _____, I agree to receive text messages regarding appointment or clinical information.
- By initialing here _____, I agree to receive automated calls for appointment reminders, and/or other office information.
- By initialing here _____, I give consent to the taking of photographs of me or parts of my body in connection with the medical services which I am receiving from Dr. Malotky. The photographs shall become a part of my medical record and will be used only for the purpose of my medical care unless otherwise notified.
- By initialing here _____, I acknowledge that I have read, received copies and understand Summit Plastic Surgery's Office and Financial Policies and agree to accept responsibility as described.

  A copy of Summit Plastic Surgery's Notice of Privacy Practices is available in our office.

Patient / Parent / Guardian **(PLEASE PRINT PATIENT'S NAME)**

SIGNATURE TODAY'S DATE

SUMMIT PLASTIC SURGERY
INSURANCE AND BILLING INFORMATION

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY_____

NAME OF INSURED / EMPLOYEE _____ **DOB** _____

ID# _____ GROUP# _____

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY _____

NAME OF INSURED / EMPLOYEE _____ **DOB** _____

ID# _____ GROUP# _____

ASSIGNMENT OF INSURANCE INFORMATION

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment(s) directly to Summit Plastic Surgery for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Summit Plastic Surgery to release any medical or incidental information that may be necessary to secure the payment of benefits.

CONTACT INFORMATION AND INSURANCE CERTIFICATION

I certify that the information given to me in applying for payment is correct.
I authorize the release of all records to my insurance company upon their request.
I request that payment of authorized benefits be made on my behalf.
I further agree that a photocopy of these assignments shall be as valid as the original.
I agree to be responsible for any costs associated with collection of funds owed to the practice, including but not limited to, collection agency fees, attorney fees, and court costs.
In the event the account becomes delinquent and is assigned to a collection agency, I hereby authorize Summit Plastic Surgery and/or their agent to obtain a copy of my credit report from the national credit bureaus, including but not limited to TransUnion, Equifax, and Experian.

Patient / Parent / Guardian – **(PLEASE PRINT PATIENT'S NAME)**

_____

SIGNATURE TODAY'S DATE

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Notice of Privacy Practices and Release of Protected Health Information

A copy of Summit Plastic Surgery Notice of Privacy Practices is available in our office.

Under the Patient Privacy Act, otherwise known as HIPPAA, our office cannot release or discuss patient information with anyone other than the patient, custodial parent, or legal guardian, unless we have written authorization from the patient, custodial parent, or legal guardian.

If you would like us to be able to speak to family members, caregivers, to other entities regarding your healthcare, please complete the following indicating the person(s), **BY FULL NAME**, to whom we may speak.

I, _____, authorize Summit Plastic Surgery to release or discuss my Private Health Information with the following person(s):

Name:_____ Relationship:_____ Phone#:_____

Name:_____ Relationship:_____ Phone#:_____

Name:_____ Relationship:_____ Phone#:_____

☐ **Entire Record** **or** ☐ **Specific Information Only: _____**

This authorization shall remain in effect until which time I have revoked this authorization in writing and/or completed a new form. My written revocation must be submitted to:

Summit Plastic Surgery, Privacy Officer, 1800 Buenaventura Blvd., Suite 200, Redding, CA 96001

Print Patient Name: _____

Signature: _____

Date: _____ Relationship other than Patient: _____

SUMMIT PLASTIC SURGERY
PATIENT HEALTH HISTORY

PATIENT NAME _____ DOB _____

REASON FOR VISIT _____

ALLERGIES / ADVERSE REACTIONS

Drug Name _____ What happens? _____

Drug Name _____ What happens? _____

Drug Name _____ What happens? _____

Anesthesia Problem? **YES / NO** – If yes, please indicate _____

_____

PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING:

Medications: _____

_____

_____

SURGICAL HISTORY (What surgeries have you had in the past?)

Type _____ Year_____

Type _____ Year_____

Type _____ Year_____

Type _____ Year_____

GYN HISTORY

Bra Size _____ Date of last mammogram _____ BRCA Gene? _____

History of Breast Cancer? _____ Gynecologic Cancer? _____

LMP _____ Currently pregnant? _____ Plan on becoming pregnant? _____

Children (how many?) _____ Did you breastfeed? _____

SOCIAL HISTORY

Do you exercise? _____ What kind of exercise? _____ How often? _____

Have you ever, or do you currently smoke cigarettes? _____ If you are a current smoker, how many cigarettes do you smoke per day? _____ If you were a former smoker, how long did you smoke? _____

Do you drink alcohol? _____ If yes, how many per day? _____ per week? _____ per month? _____

Do you drink Coffee? _____ Other caffeinated beverages? _____

Recreational Drugs? _____ If yes, what type? _____ How often? _____

Are you right-handed or left-handed? _____

PERSONAL MEDICAL HISTORY (Please check and / or circle if the following applies to you):

- ❑ AIDS, HIV, MRSA, TB, Hepatitis (A, B, C), Herpes, HPV, Other _____
- ❑ ANEMIA – Leukemia, Sickle Cell, Bleeding, Bruising, Transfusion, Other _____
- ❑ ARTHRITIS – Fractures, Osteomyelitis, Gout, Muscle / Joint / Back Pain, Weakness, Other _____
- ❑ ASTHMA – Wheezing, Bronchitis, Cough, Coughing up blood, Shortness of breath, Pneumonia, Other _____
- ❑ AUTOIMMUNE DISORDER, Type? _____
- ❑ CANCER, TYPE? _____
- ❑ DEPRESSION / ANXIETY, Unusual thoughts, Insomnia, Addiction, Disorientation, Other _____
- ❑ DIABETES (Type I, II, # of years _____) – Swollen lymph nodes, Excessive thirst, Fluid retention, always hot / cold, Hairy, Hair loss, Chronic steroid use, # of years _____
- ❑ GASTROINTESTINAL DISORDER – Heartburn, Nausea/Vomiting, Diarrhea, Constipation, Bloody Stool, Jaundice, Belly pain, Ulcer, Hernia, Gastric Bypass, Liver Disease, Other _____
- ❑ HEART CONDITION / DISEASE / VASCULAR – Heart Attack, Chest Pains, Heart Failure / Fluid in lungs, Palpitations, Pacemaker / Defibrillator, A-Fib, Irregular Heart Rate, Shortness of breath, Murmur, Stents, Rheumatic Fever, High Cholesterol, Hypertension, DVT, Blood clots, Stroke, Calf pain, Leg swelling, Vasculitis, Embolism, Other _____

PERSONAL MEDICAL HISTORY – CONTINUED:

- ❑ HEAD, EARS, EYES, NOSE, THROAT – Vision changes, Blind, Double Vision, Dry Eyes, Tearing, Glaucoma, Sinus Problems, Nasal Congestion, Ringing of the ears, Hearing Loss, Headache, Head Injury, Snoring, Dental Disease, Dentures, Sore Throat, Broken Nose, Blocked Nose, Nose Bleeds, Swollen Glands, Neck Pain, Jaw Pain, Hard to swallow, Seasonal Allergies, Other_____
- ❑ KIDNEY (RENAL) AND GENITOURNARY – Dialysis, Kidney Stones, Kidney / Bladder Infections, Bloody Urine, Incontinence, Pain or Frequency of Urination, Other _____
- ❑ NEUROLOGICAL DISORDER – Epilepsy / Seizures (date of last Seizure _____), Paralysis, Tumor, Sciatica, Numbness, Weakness, Dizzy, Head Injury, Nerve Pain, Other _____
- ❑ SKIN – Acne, Cellulitis, Pressure Ulcers, Difficulty Healing, Eczema, Warts, Growths, Dry Skin, Itching, Scaly, Rash, Bleeding Lesions, Frequent Sunburn, Melanoma, Basal Cell, Squamous Cell, Keloid, MRSA, Pressure Relief, Orthotics, Other _____
- ❑ THYROID PROBLEM - Hypothyroid, Hyperthyroid, Other _____

FAMILY HISTORY – has a member of your family had any of these conditions?
Other than Mother, Father, Brother, and Sister - Please indicate MATERNAL (mother side of the family) or PATERNAL (father side of the family) for Aunt, Uncle, Grandmother, and Grandfather:

- ❑ Heart – Relationship _____
- ❑ Cancer – Relationship _____
- ❑ Lung – Relationship _____
- ❑ Liver – Relationship _____
- ❑ Kidney – Relationship _____
- ❑ Brain Disease – Relationship _____
- ❑ Diabetes – Relationship _____
- ❑ High Cholesterol – Relationship _____
- ❑ Hypertension – Relationship _____