

- 7971 Moorsbridge Rd
Portage MI 49024
- 3620 Capital Ave SW
Battle Creek MI 49015



Raghu G. Elluru, M.D., F.A.C.S.
Office 269.329.0655
Fax 269.329.0622
www.SWMPHS.com

WELCOME TO OUR OFFICE!

TODAY'S DATE: _____

Patient's Name: First _____ MI _____ Last _____ Maiden _____

Date of Birth _____ Sex M F Social Security No. _____ Marital Status S M W D

Patient Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____
to receive occasional announcements

Patient Employer _____ Employer Address _____

Patient Occupation _____

IF PATIENT IS A MINOR, name of person responsible for account _____

Relationship _____ Date of Birth _____ Social Security No. _____

Employer _____ Work Phone _____ Home Phone _____

Home Address _____ City _____ State _____ Zip _____

Primary Physician _____ Referring Physician _____

Is your visit work related? yes no Date Accident Occurred _____

Is your visit auto related? yes no Date Accident Occurred _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Secondary Insurance Co. _____

Insurance Co. Address _____ Insurance Co. Address _____

Insurance Co. Phone _____ Insurance Co. Phone _____

Policy No. _____ Policy No. _____

Group No. _____ Group No. _____

Subscriber Social Security No. _____ Subscriber Social Security No. _____

Subscriber Date of Birth _____ Subscriber Date of Birth _____

Employer _____ Employer _____

Employer Address _____ Employer Address _____

EMERGENCY CONTACT INFORMATION

Contact Name #1 _____ Contact Name #2 _____

Relationship to Patient _____ Relationship to Patient _____

Home Phone _____ Home Phone _____

Work Phone _____ Work Phone _____

PLEASE COMPLETE BACK SIDE



ASSIGNMENT AND RELEASE

I, the undersigned, hereby authorize the release of any surgical and/or medical information necessary for the processing of insurance benefits payable to myself or the Southwest Michigan Plastic and Hand Surgery, including medical and/or major medical benefits. I am financially responsible to the Southwest Michigan Plastic and Hand Surgery for services not covered by this assignment. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signature of Patient or Guardian

Date

I hereby give my permission to Southwest Michigan Plastic and Hand Surgery and Dr. Raghu G. Elluru to administer treatment and to perform such minor operative procedures as may be deemed necessary in the diagnosis and treatment of my condition.

Signature of Patient or Guardian

Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Southwest Michigan Plastic and Hand Surgery for any services furnished me by said provider. I authorize any holder of surgical and/or medical information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If 'other health insurance' is indicated in item 9 of the HCFA-1500 or CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releases of the information to the insurer or agency shown.

Signature of Patient or Guardian

Date

Patient History Form: Full Name (Print): _____ DOB: _____

Lungs:

- Bronchitis
- Emphysema
- Asthma
- Tuberculosis (TB)
- Cold/Respiratory Infection
- Chronic cough
- Phlegm while coughing
- Other: _____

Heart:

- High blood pressure
- Heart disease
- Heart murmur
- Chest pain
- Shortness of breath
- Chest discomfort during exercise
- Heart thumping/Racing
- Mitral Valve Prolapse
- Other: _____

Vascular:

- Circulatory problems
- Anemia
- Sickle Cell
- Bleeding tendencies
- Leg pain
- Ankle swelling
- Blood clot
- Blood transfusion
- Other: _____

Systemic:

- Diabetes Type: _____
- Thyroid/hormone
- Night sweats
- Unusual lumps
- Nipple discharge
- Stomach/bowel problems
- Hepatitis Type: _____
- Yellow/Jaundice
- Ulcers/ Hiatal hernia
- Medication Port
- Alcoholism
- AIDS
- Other: _____

Kidney/Bladder:

- Urinate frequently
- Urinary pain/Itching
- Urinary infections
- Leakage
- Kidney stones
- Bloody urine
- Gynecological problems or disease
- Other: _____

Musculoskeletal:

- Muscle weakness
- Arthritis
- Back/Neck injury
- Broken bones
- Other: _____

Nervous System:

- Headache
- Nervousness
- Fainting/Dizziness
- Epilepsy/Seizures
- Head injury
- Nerve injury/Damage
- Stroke
- Psychological problems Type: _____
- Other: _____

Eye/Ear/Nose

- Eye pain
- Glaucoma/Cataracts
- Hearing Loss
- GERD
- Ringing in the ears
- Other: _____

Skin:

- Acne
- Psoriasis
- Dermatitis
- Shingles
- Bruise easily
- Skin disease/disorders
- Other: _____

Raghu Elluru, M.D., F.A.C.S.

Previous Surgeries: Have you had any surgeries? Yes ___ No___

Procedure: _____ **Year:** _____

Procedure: _____ **Year:** _____

Procedure: _____ **Year:** _____

Procedure: _____ **Year:** _____

Procedure: _____ **Year:** _____

Anesthesia: Have you had any difficulty with anesthesia before? ___Yes ___No

If yes, what happened? _____

Family History: (Please list any disease/health condition & which family member)

Current Medications: Please list below *or* provide us with a list.

Medication	Dosage	How often you take it

Allergies: Do you have any sensitivities: Yes ___ No ___

___To medications: (Please list)_____

___To X-Ray Dye: (Please list)_____

___Other:(Please list/explain)_____

FOR HAND PATIENTS: Which hand is injured? Right___ or Left___ Date of Injury?_____

Right___ or Left___ dominant?

Describe what type of work you do: _____

Personal History:

Do you drink alcohol? Yes ___ How often? _____ No ___

Do you use drugs/mind altering substances/recreational marijuana? Yes ___ No___

Do you smoke tobacco? Yes ___ How much? _____ No ___

Have you ever had cancer? *If yes, what kind?* _____ No ___

When was the last time you saw your primary care physician? _____

Height:_____ Weight:_____

Reason for today's visit:_____

Answers to the above represent a true/complete history to the best of my knowledge:

Signature:_____ Date:_____

Release of information

If at some time it becomes necessary to leave messages pertaining to my medical record such as diagnostic testing or appointment with another individual, please refer to the persons listed below.

I, _____ hereby authorize Southwest Michigan Plastic & Hand Surgery to discuss my medical record and/or care with the following persons:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

I do not wish to have my information about my medical records given to anyone but myself.

This release applies to all protected health information in my medical record as identified by HIPPA guidelines. I authorize medical treatment to be released as indicated above.

This release will be in effect until patient revokes. This authorization may be updated at anytime.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Raghu Elluru, M.D., F.A.C.S.

Southwest Michigan Plastic & Hand Surgery, P.C.

Financial Policy

We are committed to providing you with the best possible medical care. If you have special needs we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Our office participates with a variety of insurance plans. If you are a member of these plans, our business office will submit a claim for services.

It is your responsibility to:

- Bring your insurance card at every visit.
- Be prepared to pay your copay at each visit.
- Pay any balance not covered by your insurance plan.
- If you have insurance for which we are not a contracted provider, we will bill the insurance company, as a courtesy. You will assign the benefits to the practice so that payment will come directly to the practice.
- Patients with outstanding balances will receive monthly statements. The statement will indicate what, if any, of the outstanding balance is patient responsibility and what is pending to the insurance. Payment of outstanding patient balance is expected within 30 days of receipt of statement. Patient balances over 90 days will be sent to a collection agency.
- Payment for professional services can be made with cash, check or credit card. (Visa, Mastercard, Discover).
- Special Authorizations: It is your responsibility to ensure that any required authorizations for treatment are provided to the practice prior to your visit. If you do not have the authorization, your visit will be rescheduled or you may be financially responsible.
- You must provide us with current insurance information and bring your insurance card each visit.
- If the patient is a minor (17 years and younger), the parent or legal guardian must sign this form. The parent, or legal guardian of any unaccompanied minor is responsible for any payment due at the time of service, bringing any authorization and insurance card, as needed.
- Some services, such as preventative or cosmetic services, may not be a covered benefit under your insurance plan or under Medicare benefit guidelines. It is your responsibility to pay any balance not covered by your insurance plan.
- If you have any questions about your insurance plan, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member service department (number is listed on your insurance card).
- A charge of \$25.00 will be assessed for all returned checks and patients will be expected to pay this charge by credit card, money order or in cash upon receipt of a statement.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about our financial arrangements should be directed to the physician's office.

Patient Signature: _____ **Date:** _____

Parent/Legal Guardian

Signature: _____ **Date:** _____

Raghu Elluru, M.D., F.A.C.S.

Smoking/Secondary Smoke/Tobacco Products and their effects on wound healing

All procedures in plastic surgery are performed to improve form and, in some cases, function. Our goal as Plastic Surgeons is to have a perfect form and scar. Unfortunately, smoking and secondary smoke will affect wound healing in a potentially devastating way. Any exposure to smoke, either directly or indirectly can result in poor wound healing, delayed wound healing, skin loss necessitating in skin grafting, increased risk of wound infection, and loss of skin and deeper tissues. Smoking and exposure to second-hand smoke causes decreased blood supply to those areas which leads to those complications. Nicotine is the root cause of the decreased blood supply in that it causes constriction of capillaries and small blood vessels which are responsible for feeding the skin with oxygen. Nicotine patches, vapors, and gum therefore are NOT to be used as an alternative to smoking.

The following procedures and accompanying complications that may result from the use of tobacco products are:

Face Lifting operations: There can be actual loss of skin to the face in the front and behind the ear.

Forehead Lifting operations: There can be hair loss, poor wound healing and scarring.

Blepharoplasty: There can be infection, loss of skin, poor wound healing, edema, and prolonged swelling.

Rhinoplasty: There can be infection, loss of skin, poor wound healing.

Breast Reduction, Mastopexy, and Breast Augmentation operations: There can be delayed wound healing resulting in unsightly scarring and skin loss and potential nipple loss necessitating in skin grafting. There can be infection around the implant requiring its removal. In all cases of patients exposed to smoke or directly smoking, wounds don't heal within the expected time frame. Wound healing can be prolonged, as long as 3-4 months.

Abdominoplasty: Smoking or exposure to smoke will decrease the ability of the skin to heal properly resulting in unsightly scarring and higher risk for infection and more importantly, skin loss in the central abdomen, sometimes requiring a skin graft.

Reconstructive Surgery: Smoking can result in failure of skin flaps, skin grafts, or muscle flaps to "take" or live. This would result in delayed wound healing or large open wounds requiring multiple months of wound care or additional operations to heal. Complete loss of flap or graft will require additional and multiple reconstructive operations. All of these will require prolonged or repeated hospitalizations, home nursing and prolonged time off work.

Bone Healing: Can significantly slow or prevent bone healing.

As your physician I am advising you, if you are smoking, use nicotine patches, vapors, gum or in contact with secondary smoke within three weeks of any surgical procedure, your surgery may be cancelled depending on the procedure. Testing for nicotine levels and its longer lasting byproduct, cotinine, are occasionally performed as part of our routine pre-surgery lab work, and if this test is positive for nicotine or cotinine, your surgery will be cancelled. Slow wound healing takes months instead of weeks, skin loss resulting in scabbing and prolonged need for dressing changes and infection usually involving the need for antibiotics (and sometimes another surgery to drain infection) all are complications that can occur if you smoke, are exposed to secondary smoke, use nicotine patches, vapors or gum. Please be honest with us so we can take good care of you and help prevent problems.

I have read the above information and have been informed of the issues of primary, secondary smoke and nicotine effects on wound healing.

Patient Signature: _____ **Date:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I was offered a copy of Southwest Michigan Plastic and Hand Surgery Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Printed Name: _____

Witness Signature: _____ Date: _____

Photography Consent

I consent to the taking and the use of pictures for training and educational purposes pursuant to the guidelines listed in the HIPAA regulations.

Patient Signature: _____ Date: _____

Printed Name: _____

Witness Signature: _____ Date: _____

Documentation of failure to obtain signed acknowledgement

On _____, _____ presented this Acknowledgement of Receipt of
(Date) (Employee Name)

Notice of Privacy Practices Form to _____ (the "Patient"). The patient refused to provide a signature when requested.

Appointment/ Cancellation/No-Show Policy

Appointments

Office visits are by appointment only. Please call 269-329-0655. The front desk administrator may ask about the reason for your visit. This helps us schedule the physician's time more efficiently. Please arrive 5-10 minutes early for routine appointments and 15-30 minutes early for new patient appointments to give our office enough time to update your records. Patients who are late for any appointment may be asked to reschedule their appointment at the physician's discretion. Remember to bring a current medication list, photo ID, and insurance cards to every appointment, as we may need to update this in our system.

Cancellation

We would like to thank you for being a patient in our office. We value all of our patients and strive to provide the best care. Please understand that when we schedule you an appointment, we are reserving time for your particular needs. We kindly ask that if you must change or cancel an appointment, that you give us at least a 24-hour notice. This courtesy makes it possible to give your reserved time to another patient who would like it. We know that your time is valuable however when your appointment is made, a room is reserved, your records are prepared and special instruments/ equipment are readied for your visit. To avoid multiple cancellations, we do ask that you do your very best to reschedule and make it to your next appointment. You may be asked to put a \$50 deposit down on your next appointment if you cancel and reschedule multiple times.

**For all Cosmetic patients, if you have to cancel and reschedule a consultation more than two times, we will kindly ask that you put a \$250 non-refundable deposit on your next scheduled appointment.

No-Show

A No-Show is defined as missing an appointment without calling and cancelling the appointment within 24-hours before your scheduled time. We understand that the occasional missed appointment can occur for a variety of reasons. When you miss an appointment without cancelling, someone else who could have been seen in your place is delayed unnecessarily. There will be a charge for a no-showed appointment of \$50 non-refundable. Please note insurance will not cover charges for no-show fees. Repeated no-show appointments may result in your physician sending you a letter discharging you from the practice. We will provide 30 days of emergent care only and we will gladly transfer your medical records to the provider of your choice.

You will receive a bill for this no-show fee or you can pay it the next time you are in our office. Non-payment will result in collections. We greatly appreciate your cooperation and understanding in our office policy and we look forward to caring for you.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____