- 7971 Moorsbridge Rd.
  Portage, MI 49024
- 3620 Capital Ave. SW Suite B
  Battle Creek, MI 49015

Southwest Michigan
PLASTIC & HAND SURGERY

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

www.SWMPHS.com
Office: 269-329-0655
Fax: 269-329-0622

WELCOME TO OUR OFFICE!

TODAY'S DATE: _____

Patient's Name: First_____MI_____Last_____Maiden_____
Date of Birth _____ Sex M F Marital Status S M W D
Patient Address_____City_____Sate_____Zip_____
Mobile Phone_____Home Phone_____
Work Phone_____Email_____
Patient Employer_____Employer Address _____
Patient Occupation _____ _____

If Patient is Minor: Person Responsible for Account: _____
Relationship _____ Date of Birth _____
Employer_____Work Phone_____Home Phone _____
Home Address_____City_____Sate_____Zip _____

EMERGENCY CONTACT INFORMATION

Contact Name #1 _____ Contact Name #2 _____
Relationship to Patient _____ Relationship to Patient _____
Home Phone _____ Home Phone _____

Work Phone_____Work Phone _____

RELEASE OF INFORMATION

If at some point in time it becomes necessary to leave messages pertaining to my appointments with another individual, please refer to the persons listed below.

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

Name_____Phone No._____Relationship_____
Name_____Phone No._____Relationship _____

This release applies to all health information in my medical record as identified by HIPPA guidelines. I authorize medical treatment to be release as indicated above.
This release will be in effect until_____(Date) may be updated at any time.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Skin Care Consultation

Name:_____DOB:_____Date: _____

Referred By: _____

What would you like to achieve from your treatment today?

_____

_____

Previous Skin Care/Treatment/History

1) Have you ever had any of the following? (Please list when and what type if known)
   - □ Chemical Peel- _____
   - □ Facial-_____
   - □ Filler- _____
   - □ Botox- _____
   - □ TruSculpt/CoolSculpt- _____
   - □ Microneedling- _____
   - □ IPL- _____
   - □ CoolSculpting-_____
   - □ Skin Resurfacing- _____
   - □ Microdermabrasion-_____
   - □ BodySculpting (Emscuplt/Transform)_____
2) Do you have a history of skin cancer? ☐No ☐Yes, when? _____
3) Do you have a history of cold sores? ☐No ☐Yes
4) Do you have any history of Keloid or Hypertrophic scarring? ☐No ☐Yes, Please specify: _____
   _____
5) Do you take any blood thinners? ☐No ☐Yes, Please specify: _____
   _____
6) Does your job require you to work outside? ☐No ☐Yes
7) Do you have any skin problems or concerns pertaining to your face or body? ☐No ☐Yes, Please specify:_____
   _____
8) Have you ever used any of the following in the past 3 months?
   - □ Retin-A
   - □ Renova
   - □ Adapalene Hydroxyl Acid
   - □ Retinol/Vitamin A
9) Have you used an acne medication? ☐No ☐Yes, Please specify what drug and when:_____
   _____
10) Have you recently used any self-tanning lotions, creams or treatments? ☐No ☐Yes, Please specify:
   _____

11) Have you used any of the following hair removal methods in the past 6 weeks? (Please circle)

Shaving Waxing Electrolysis Tweezing Stringing Depilatories

Current Skin Care:

12) What skin care products are you currently using? _____

_____

13) What areas of concern do you have regarding:

Skin: (Please check any that apply and explain)

- □ Breakouts/ acne
- □ Blackheads/ whiteheads
- □ Excessive oil/shine
- □ Rosacea
- □ Broken Capillaries
- □ Redness/ruddiness
- □ Sun spot/liver spot/brown spot
- □ Other_____

Eyes: (Please check any that apply and explain)

- □ Dehydrated
- □ Wrinkles
- □ Puffiness
- □ Dark Circles
- □ Other:_____

Lips: (Please check any that apply and explain)

- □ Dehydrated
- □ Cracked/Chapped
- □ Other: _____

14) Have you ever had an allergic reaction to any of the following? (Please check any that apply and please explain).

- □ Cosmetics_____
- □ Medicine_____
- □ Food_____
- □ Animals_____
- □ AHA's_____
- □ Drugs_____
- □ Pollen_____
- □ Fragrance_____
- □ Sunscreens_____
- □ Shellfish_____
- □ Iodine_____
- □ Other_____

15) What SPF do you use on your face?_____How often? _____

16) What SPF do you use on your body?_____How often? _____

17) Have you had any recent tanning bed or sun exposure that changed the color of your skin?

☐No ☐Yes, Please specify: _____

_____

Female Clients ONLY-

18) Are you taking oral contraceptives? ☐No ☐Yes, Please specify _____

_____

19) Any recent changes to or from your contraceptive treatment? ☐No ☐Yes, If so, what and when? _____

20) Are you pregnant or do you plan to become pregnant? ☐No ☐Yes

21) Are you lactating or breast feeding? ☐No ☐Yes

22) Any menopause problems? ☐No ☐Yes, Please specify _____

_____

23) Are you undergoing any hormone replacement therapy? ☐No ☐Yes, Please specify _____

_____

Male Clients ONLY

24) What is your current shaving system? (Please circle) Wet Shave Electric Shave

25) Do you experience irritation from shaving? ☐No ☐Yes

26) Do you experience any Ingrown Hairs from shaving? ☐No ☐Yes

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature:_____Date: _____

Witness Signature:_____Date: _____

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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:

- Patients with outstanding balances will receive monthly statements. The statement will indicate what, if any, of the outstanding balance is patient responsibility. 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, American Express).
- 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.
- 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 provider/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:** _____

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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.

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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 aesthetician's time more efficiently. Please arrive 5 minutes early for established 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 aesthetician's discretion. Remember to bring a current medication list, current skin care products being used, and photo ID 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 understand that sometimes, unexpected delays can occur, making schedule adjustments. If you need to cancel your appointment, we respectfully request at least 48 notice. This courtesy makes it possible to give your reserved time to another patient who would like it.

No-Show

A No-Show is defined as missing an appointment without calling and cancelling the appointment within 48-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. Repeated no-show appointments may result in your aesthetician sending you a letter discharging you from the practice.

Our Policy

Any cancellation or reschedule made less than 48 hours will result in a cancellation fee. The amount of the fee will be $50.00. If you are more than 10 minutes late for your service, we may not be able to accommodate you. In this case, the same cancellation fee will apply. We will do our very best to reschedule your service for another time that is convenient to you. We require a credit card to hold your appointment. Cancellation fees will be charged to your card on file. In the event of a true, unavoidable emergency, all or part of your cancellation fee may be applied to future services.

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**: _____