Southwest Michigan
PLASTIC SURGERY + MED SPA

Raghu Elluru, MD, FACS
7971 Moorsbridge Road
Portage, MI 49024
269-329-0655

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 _____Sate _____Zip _____

Mobile Phone _____Home Phone_____

Work Phone _____Email _____

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 _____Sate _____Zip _____

Emergency Contact

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

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

Release of Information

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

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

☐ 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 released as indicated above.

This release will be in effect until _____(Date) may be updated at any time.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

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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
__Hearth 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:_____

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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:_____

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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 the patient revokes. This authorization may be updated at any time.

Patient 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 in 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 bull 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:_____ **Date:**_____

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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:** _____

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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 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 for 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 48-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 $100 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 $100 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**: _____