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: _____ Marital Status: S M W D
Home Address: _____
City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone:_____
Work Phone: _____ Email:_____
Employer: _____ Occupation: _____
Employer Address: _____
City: _____ State: _____ Zip Code: _____

If Patient is Minor: Person Responsible for Account: _____
Relationship: _____ Date of Birth: _____
Employer: _____ Work Phone: _____ Home Phone: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____

Emergency Contact

Contact Name #1: _____ Contact Name #2: _____
Relationship to Patient: _____ Relationship to Patient: _____
Home Phone: _____ Home Phone: _____
Mobile Phone: _____ Mobile 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 people 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 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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Skin Care Consultation

Today's Date: _____

Name:_____ DOB:_____ Referred By: _____

What would you like to achieve from your treatment today?

_____

_____

Previous Skin Care and Treatment History

1) Have you ever had any of the following? (Please list when and what type if known)
   - □ Chemical Peel _____
   - □ Facial _____
   - □ Filler _____
   - □ Botox/Dysport _____
   - □ TruSculpt/CoolSculpt_____
   - □ Microneedling _____
   - □ IPL _____
   - □ Skin Resurfacing_____
   - □ Microdermabrasion _____
   - □ Body Sculpting (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
   - □ Retinal/Vitamin A
9) Have you used 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:

   _____

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Skin Care Consultation *Continued*

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

(Please circle) Shaving Waxing Electrolysis Tweezing Stringing

Current Skin Care Regime

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
- ☐ Sunspot/liver spot/brown spot
- ☐ Other_____
- ☐ Dark Circles
- ☐ Other:_____

Eyes: (Please check any that apply and explain)

- ☐ Dehydrated
- ☐ Wrinkles
- ☐ Puffiness

_____

_____

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).

Cosmetic	Pollen
Medicine	Fragrance
Food	Sunscreen's
Animals	Shellfish
AHA's	Iodine
Drugs	Other: _____

Explanation: _____

_____

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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: _____

For 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:

_____

_____

For Male Patients Only

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

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

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

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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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Full Name: _____ DOB: _____

Patient Medical History Form – Please Circle any Conditions you may have

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 thumbing or 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 issues
- 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: _____

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Health History Continued:

Full Name: _____ DOB: _____

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: _____

Previous Surgeries: Have you had any surgeries? Yes _No_

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

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Health History Continued:

Full Name: _____ DOB: _____

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: _____
Which is your dominant Hand: Right or Left
Describe what type of work you do: _____

Personal History:
Do you drink alcohol? Yes or No How often? _____Amount_____
Do you use drugs/mind altering substances/recreational marijuana? Yes No
Do you smoke tobacco? Yes No If yes how much? _____
Have you ever had cancer? Yes or No *If yes,* what kind? _____
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:_____pre

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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 $100 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 rescheduling made less than 48 hours will result in a cancellation fee. The amount of the fee will be $100.00. 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:** _____

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Southwest Michigan Plastic and Hand Surgery

Patient: _____

Patient Photographic Authorization

I, authorize Dr. Elluru and/or Southwest Michigan Plastic and Hand Surgery, and/or (his, her, their) representative(s), to take photographs, slides, or videotapes of my or parts of my body for the following procedure(s) and for medical purposes to be used for my care, medical presentations and/or articles.

In addition, I authorize the use of these images, without compensation to me for the following specific purposes: **(Please initial in the boxes marked with yes or No for each item).**

Yes	No	Medium
		In the office photo album for prospective patients
		In office seminars for prospective patients
		On our website for prospective patients
		Advertising/Social Media
		On television

Additional Comments:

I understand that:

1. Such photographs, slides or videotapes may be published by Dr. Elluru/Southwest Michigan Plastic and Hand Surgery in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and internet websites, the purpose of informing the medical profession or the greater general public about plastic surgery methods. I understand that such uses may also include marketing on behalf of Dr. Elluru, for which Dr. Elluru may receive direct or indirect remuneration.

2. I will not be identified by name in any of the media described above: however, I also understand that in some circumstances the photograph, slides, or videotapes may display features that identify me.

3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to Office Manager at 7971 Moorsbridge Road. A revocation shall not affect any release of information made prior to the revocation in reliance upon this authorization. If I do

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not revoke this authorization, it shall expire on the following date, event or condition: When patient revokes. If I fail to specify an expiration date, event, or condition, this authorization shall expire in (State Law Dictates Seven (7) years), except to the extent action has been taken thereon.

4. I may refuse to sign this authorization without such refusal affecting the medical treatment I received from Dr. Elluru and/or Southwest Michigan Plastic and Hand Surgery.

5. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or federal Health Insurance Portability and Accountability Act of 1996 ("HIPPA"). Any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by applicable federal and/or state confidentiality rules.

6. A copy of the Authorization is valid as the original. I have received a copy of this authorization, as provided by feral and/or state law.

I release and discharge Dr. Elluru and Southwest Michigan Plastic and Hand Surgery from all liability, including liability for negligence that in any way arises out of:

Any and all rights that I may have or may have had in the photographs slides or videotapes of me that I have authorized to be used and disclosed in this authorization.

Any claim that I may have or may have had relating to such use and disclosure of those photographs, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This authorization is made as a voluntary contribution in the interest of public education and certify that I have read this Authorization and Release carefully and fully understand these terms.

If I have any questions about the use or disclosure of my photographs, slides, or videotapes, I can contact the Office Manager at 269-329-0655.

Signature: _____ Date: _____

Witness: _____ Date: _____