MERIDIAN PLASTIC SURGEONS
PERKINS | VAN NATTA | SADOVE | KELLEY

Meridian Plastic Surgery Center
for Laser & Cosmetic Surgery
the medical art of face & figure™

History & Physical Data Sheet (Ages 0-16)

MPSC Sticker

Name: _____
Last First MI

Date of birth: _____/_____/_____ Age: _____ Height: _____ Weight: _____

Parent / Legal Guardian Name: _____

Reason(s) for seeing physician: _____

_____Rhinoplasty (nose)	_____Chin	_____Removal of Moles/Lesion
_____Protruding Ears	_____Laceration Repair	_____Removal of Birthmark, Hemangioma
_____Skin Resurfacing	_____Scar Revision	_____Craniofacial / Cleft Palate
Other:		

Have you consulted another physician in regards to this type of surgical procedure? **Y** **N**

If so, whom? _____

Family Physician: _____ Contact #: _____-_____-_____

Date of last physical exam: _____ May we notify him/her of upcoming surgery? **Y** **N**

If you are currently being treated by a psychiatrist/psychologist:

Name: _____ Contact #: _____-_____-_____

FEMALE PATIENTS ONLY OB/Gyn: _____ Contact #: _____-_____-_____

Are you pregnant? **Y** **N** Date of last menstrual period: _____

Are you a <u>SMOKER</u>? Y N Does anyone in your household smoke? **Y N**

Do you take **<u>ASPIRIN</u>** and/or **<u>BABY ASPIRIN</u>**, regularly? **Y N**

of Caffeinated drinks per day: _____

Have you ever taken **<u>Accutane</u>**? **Y N** If stopped, when: _____

Are your immunizations up to date? **Y N**

Do you realize every operation is followed by a period of healing before the tissues return to normal and a final result is apparent? ***Y N***

Do you understand that the objective of any cosmetic surgery is improvement in appearance, ***not perfection?*** ***Y N***

<u>Have you ever been treated for or diagnosed with any of the following? Mark all that apply.</u>

___Rheumatic Heart / MVP	___Lung / Chest Problems	___Migraines / TMJ	___Body Jewelry
___Heart Murmur	___Asthma	___Depression / Anxiety	___Contact Lens
___Angina / Chest Pain	___Anemia	___Psychiatric Problems	___Dentures – Upper/Lower
___Heart Attack	___Ulcers / Reflux	___Seizures / Convulsion	___Skin Condition, Infection, or Irritation/Shingles
___High Blood Pressure	___Lupus / Scleroderma	___Bleeding / Bruise Easily	___Alcohol / Drug Dependency
___Stroke	___HIV / AIDS	___Excessive Scarring	___Recreational Drugs: _____
___Cold Sores / Fever Blisters	___Diabetes / Hypoglycemia	___Staph Infections	_____
___Hay fever / Nasal Allergies	___Kidney Disease	___Eye Problems / Glaucoma	___Other: _____
___Hepatitis / Jaundice	___Cancer: _____	___Latex Allergy	
Type: A B C	___Sleep Apnea	___Cold, Cough, Fever, Flu	

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Do you have any other medical problems that have ***not*** been covered? Or list any additional information you think is or would be important for us to know about your medical/social history prior to surgery.

_____

_____

Surgical History

Surgical History: _____

_____

Have you ever received local anesthesia (Novacaine or Xylocaine)? **Y N**

Have you ever had any reaction (nausea) to local or general anesthesia (or a family history of problems)? **Y N**

If yes, please describe: _____

Describe any complications you may have experienced: _____

_____

Current Medication & Vitamin/Supplement Record

Medication	Strength	Dosage	Frequency	Medication	Strength	Dosage	Frequency

Allergies / Reactions: _____

_____

CONFIDENTIAL RECORD: Information contained here **will not be released** unless you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your doctor in making decisions regarding your care.

I authorize my physician and/or administrative and clinical staff to telephone or otherwise contact me (or responsible party) regarding appointments, treatment information, or any other details related to patient therapy and treatment.

Signature: _____ **Date:** _____

OFFICE USE ONLY

Weight:		Age:		BD:		Sex:	**M F**
Pulse:		Resp:		BP:		Temp:	

Medication Reviewed with Patient: **Y N**	Advance Directive: **Y N** ☐ Copy to MPSC	
H.E.E.N.T.:	Mental Assessment:	
Heart:	Lungs:	Neck:
Neuro:	Trunk:	ABD:
Abnormal Findings:	Patient Condition Acceptable for Anesthetic Admin: **Y N**	
Impression:	Plan:	

M.D. Signature: _____ **Date:** _____

Patient: _____

Medical Record #: _____ DOB: _____

Physician: _____

DOS:	☐ **No Changes** ☐ **Updated**
Date:	**M.D. Signature:**

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Patient Information

Name: _____ Sex: M F
Last First MI

Home Address: _____
Street Apt. City State Zip Code

Phone: _____ _____ _____
Home Work Cell

E-Mail: _____ Social Security: _____

Birth Date: _____ Age: _____ Marital Status: S M D W Name of Spouse: _____

Referral Information

How were you referred? (Check all that apply)

☐ Patient: Name: _____ ☐ Friend: Name: _____

☐ Physician/Dentist: Name: _____ ☐ Nurse: Name: _____

☐ Newspaper ☐ Radio ☐ Yellow Pages ☐ Magazine: Name: _____

☐ Other Source: _____

Patient Employment Information

Employers Name: _____ Occupation: _____

Employer's Address: _____

Employer's Phone: _____

In case of emergency

Please list name, phone number, and relationship of person to contact:

Name: _____ Phone numbers: _____

Relationship to Patient: _____

Family Physician: _____ Address: _____ Phone #: _____

I recognize and accept full financial responsibility for all professional services rendered, regardless of the amounts covered by any applicable insurance coverage. In the event Perkins Van Natta Sadove Kelley or the Meridian Plastic Surgery Center is required to collect my account after default, I will be responsible for all attorney fees and cost of collection. If insurance is to be filed, I authorize release of medical information including photographs necessary to process any claim for services provided by Perkins Van Natta Sadove Kelley, and the Meridian Plastic Surgery Center. I further authorize an insurance company to pay benefits directly to Perkins Van Natta Sadove Kelley, and/or the Meridian Plastic Surgery Center.

Date: _____ _____
Signature of Patient/Responsible Party

_____
Relationship to Patient

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Patient Information

Insurance Information Part 1

As a courtesy to our patients, we will file your charges with your insurance company. However, the following information must be filled out completely for your procedures to be filed with your insurance carrier. Insurance deductibles which have not been met may require payment prior to your surgery. If this form is incomplete, you will be billed directly.

If your insurance requires that you have a referral from you Primary Care Physician, you must handle this by calling your Primary Care Physician. Please check to be sure that our Physicians and the Meridian Plastic Surgery Center are contracted with you insurance company. This is especially important if you have an HMO policy. Some Primary Care Physicians may refer you to Physicians not contracted with your insurance company, which poses a problem for you. If we are not a network provider for you, then check to see if you have out-of-network benefits. If so, out-of-network coverage is provided at a reduced rate. Refer to the phone number on your insurance card.

In order for our facility to give you the most information regarding you insurance benefits, you must supply us with a CURRENT insurance card including the billing address and phone number. Our medical assistants can help you with any question you may have if you call during our regular business hours, Monday through Friday, 9:00 a.m. to 5:00 p.m.

Primary Insurance Information

Primary Insurance _____

Address to Mail Claims _____

Phone _____ ID _____ Group _____

Member's Name _____

Member's SSN _____ Member's Birth Date _____

Member's Employer _____

Relationship to Member: Self Spouse Child Other _____

Secondary Insurance Information

Secondary Insurance _____

Address to Mail Claims _____

Phone _____ ID _____ Group _____

Member's Name _____

Member's SSN _____ Member's Birth Date _____

Member's Employer _____

Relationship to Member: Self Spouse Child Other _____

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Patient Information

Insurance Information Part 2

If your procedure will require anesthesia, you need to know if your insurance requires you to use a specific group. The group that we use is North Side Anesthesiologist Service, LLC. Their phone number is (317) 802-6316.

Our facility uses Ameripath for any pathology testing. If you are having a procedure that is going to require pathology testing, you need to know if your insurance company will accept this lab. The phone number for the lab is 275-8112 or 1-866-635-1917.

It is our goal to help you obtain the maximum benefits from your insurance company, however, failure to follow through with verification of the above information could cause your coverage for these services to be denied and your benefits to be waived. **If you have a deductible that has not been met, you may be responsible for payment at the time of service.** Please keep in mind: ***Your insurance contract is between you and your insurance company, making it your responsibility to know your benefits.***

Please don't hesitate to call our office for any concerns you may have.

Ultimately, the patient is the only person who can effectively work out any disagreements related to reimbursement with the insurance company. The patient will be billed and expected to pay the portion of the total bill their insurance company does not pay. The only exceptions are in situations where a certain insurance plan has an agreement with the surgeon and/or the facility to accept the predetermined usual and customary allowance.

Note:
Because of the many changes occurring with insurance plans, it is very important for you to find out if your policy requires a second opinion, referral from your primary physician, or pre-certification for the procedure and/or an overnight observation. Failure to determine this information will result in a markedly reduced insurance payment.

I have read and understand the above stated insurance information.

Please initial: _____

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Patient Insurance Checklist

As patients approach surgery, they frequently need information regarding insurance benefits. As a courtesy to our patients, we would like to inform you of several things that are important to you when having any procedure that involves your insurance company. It is the patient's responsibility to check on the following:

1. *If your insurance requires that you have a referral from your Primary Care Physician (PCP), you must obtain the referral by calling your PCP. Please verify that both* ***physician(s) and Meridian Plastic Surgery Center*** *are contracted with your insurance company. This is especially important if you have an HMO policy. If we are not a network provider for you, please verify if you have out-of-network benefits.*

2. *If your procedure is going to require anesthesia at the Meridian Plastic Surgery Center, you will need to know if your insurance requires you to use a specific group. The group that we use is the North Side Anesthesiologist Service, LLC. Billing for North Side Anesthesia is handled by Susan J. Taylor Billing Service at phone number (317) 567-2179. You should ask to speak to Jennifer Walker at extension 106. Hours for the billing service are 8 am - 5 pm Monday through Thursday and 8 am - 2:30 pm on Friday.*

3. *The Meridian Plastic Surgery Center uses Ameripath of Indiana Laboratory for any pathology testing. If you are having procedures that will require pathology testing, you will need to verify that your insurance company will accept this lab. The telephone number for the Ameripath is (317) 275-8112 or 1-866-635-1917.*

In order for our facility to give you the most information regarding your insurance benefits, you must supply us with your **most current** insurance card(s) with the billing address(es) and phone number(s).

It is our goal to help you get the maximum benefits from your insurance company, but your failure to follow through with the above information could result in denial of coverage and cause your benefits to be waived. If you have a deductible that has not been met, you may be responsible for payment at the time of service. Please keep in mind that your insurance contract is between you and your insurance company, making it your responsibility to know your benefits.

Please be advised that the average waiting period for insurance benefit information is 7-14 working days. The average waiting period for predetermination for approval for small procedures is 8-12 weeks. The process can vary with different insurance companies. Please contact Cornella Scott with any questions or concerns you may have regarding precertification, predetermination, or insurance benefits. (317) 575-0336 ext 103.

I have been informed that Dr. Perkins and Dr. Van Natta are not in network health providers. Therefore, the amount covered by insurance for their services may be reduced due to their status as out of network health providers.

Please initial to confirm receipt of this information. _____

Patient Contact Authorization Form

Patient Name: _____

How may we contact you and/or leave a message? (Please circle)

HOME	YES	NO	FAX HOME	YES	NO
WORK	YES	NO	FAX WORK	YES	NO
CELL	YES	NO	EMAIL HOME	YES	NO
			EMAIL WORK	YES	NO

Can we send mail to you at: (Please circle)

HOME	YES	NO
WORK	YES	NO

To WHOM may we speak about your appointments, treatments, insurance, or billing?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ **Date:** __ _____

Witness: _____ Date: __ _____

(This form is valid for one year unless revoked or changed by the patient.)

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HIPPA Acknowledgement

I hereby acknowledge that I have been made aware of the above-identified provider's Notice of Privacy Practices and that I may read a copy of it by my request.

Signature of Patient: _____

Printed Name: _____

Date: _____

Please return this page to the provider.