STACY L PETERSON MD

(316) 265-1441

Patient Information as of ________________ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name ____
Last First Middle

Address ____
Street & Apt # City State Zip

Home Phone ____________ Cell Phone ____________ Other Phone ____________

Any restrictions for contacting you? ❒ No ❒ Yes E-mail ____________

Contact Restrictions: ____________ Drivers License # (include State) ____________

Age ______ Birthdate __/__/____ SS# ___-___-____ Sex ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: ____________ ❒ Other: ____________

Patient's Employer ____________ Occupation ____________

Work Phone ____________ Ext: ______ Is it okay to call you at work? ❒ Yes ❒ No

Address ____
Street & Suite # City State Zip

Emergency Contact
(Not in your household) ____________ Relationship to Patient ____________

Home Phone ____________ Work Phone ____________ Other Phone ____________

Address ____
Street & Apt # City State Zip

Primary Health Insurance Company ____________

Policy # ____________ Group # ____________ Ins. Phone ____________

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ ______

Insured: Name ____________ DOB ____________ Employer ____________

Secondary Health Insurance Company ____________

Policy # ____________ Group # ____________ Ins. Phone ____________

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ ______

Insured: Name ____________ DOB ____________ Employer ____________

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Stacy L. Peterson to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Stacy L. Peterson and myself.

Signature ______________________________ **Date** ____________

HOW DID YOU HEAR ABOUT DR. PETERSON:_____Internet; ______Phonebook;________Other;
Friend/ Relative name: __________________________Doctor Name____________________________

Stacy L. Peterson, M.D. 818 N. Emporia S-305 Wichita, KS, 67214 (316)265-1441

PATIENT HEALTH HISTORY

Patient Name____ Date____________________

Reason for Visit____

Who is your Primary Care Physician?________________Referring_______________________________

Allergies * List ANY reactions you have had to medications and describe the symptoms.

Medications * Please list dosage/frequency. Include all prescriptions, over-the-counter and herbal supplements

Past Surgical History * List all previous surgery, include approximate date and any complications.

Past/Current History: Please check all that apply

__Lung Disease	__Heart Disease CHF	__Tuberculosis	__Joint Replacement	__Anemia
__Liver Disease	__High Blood Pressure	__Asthma	__Cancer	__Pulmonary Embolism
__Kidney Disease	__Chest Pain	__Emphysema	__HIV/Aids exposure	__Deep Vein Thrombosis
__Diabetes	__Mitral Valve Prolapse	__Chronic Cough	__Infection	__COPD
__Hepatitis Type__	__Heart Attack ____yr	__Recent Bronchitis	__Paralysis	__Thyroid Disorder
__Arthritis	__Bleeding disorder	__Recent Cold	__Psychological	
__Seizures	__Smoke	__Recent wt. change	__Personal or Family History of Malignant Hyperthermia	

Do you have any medical condition not listed?____

Personal or Family History of problems with anesthesia?____

Females Only: Are you pregnant? Yes No Are you trying to get pregnant? Yes No

Have you had any children? Yes No If yes, please specify____

Are you nursing? Yes No If you recently stopped nursing, when?___________________________________

Social History:

Do you smoke? Yes No If yes, how much? Light Moderate Heavy Social How long?_________ years

Have you ever smoked? Yes No When did you quit?________________________

Do you drink alcohol? Yes No How much? Light Moderate Heavy Social

Do you use recreational drugs? Yes No If yes, describe________________________

Have you ever used recreational drugs? Yes No If yes, describe______________________

Skin:

Do you have any problems with wound healing or keloid scarring? Yes No

Do you have a family history of skin cancer? Yes No If yes, please specify____

I hereby acknowledge that all of the above information has been answered honestly and to the best of my ability. I will update the doctor with any medical changes that may occur.

Signature:____

OFFICE USE ONLY BP_______ P________R_______T_______ HT_______ WT________

PATIENT QUESTIONNAIRE

1. Please list the family members or other persons, including all contact information, which we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

   ____

   ____

2. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

   Yes ______ NO ______

3. Please print the telephone number, if any where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number:
   (   ) ______________________________

   ☐ I am fully aware that a cell phone is not a secure and private line

4. Can confidential messages (i.e. Appointment reminders) be left on your telephone answering machine or voicemail?

   Yes_______ No______

   Patient Name _________________________________ (guardian if under 18 years)

   ____ ______________________
   Patient/Guardian Signature Date

FINANCIAL POLICY FOR STACY L. PETERSON, MD

FEES: Cosmetic consults and insurance co-pays, co-insurance and deductibles are to be paid in full at the time services are rendered. If your insurance company reimburse you directly for services billed; you are responsible for payment of all balances due. If our office receives a NSF check from you, you will be charged $30 and we will no longer be able to accept a check from you. Our office accepts cash, checks, money orders, cashier checks, VISA, MASTERCARD, DISCOVER and CARECREDIT (Call office to see which plans we except).

ADDITIONAL FEES: Extra items purchased such as Silicone Sheeting and garments are the responsibility of the patient and will not be billed to insurance. Payment is due at the time of purchase.

PARTICIPATING PROVIDER INSURANCE PLANS: Our office will contact your plan a couple weeks before your procedure, surgery or consultation and get a cost analysis. Understand this is an estimate because deductibles and co insurance can change pending outstanding claims. We will collect all applicable co pays, co-insurance and deductibles as designated by your plan at the time of consult or office visit and if surgery is planned they will be due 2 weeks prior to surgery. Your claim will be submitted to your insurance company as a courtesy. Disputes with insurance companies, etc., are the responsibility of the patient.

WORKERS COMPENSATION: We will submit confirmed worker's compensation claims for our patients. If you were injured at work, there is no guarantee your bill will be covered under workers compensation.

MOTOR VEHICLE ACCIDENTS/ PERSONAL INJURY INSURANCE: For auto or homeowner related charges: We will collect fee upfront from you. Our office will provide receipt for your services and you may file with your insurance and payment will be paid directly to you. We will not submit fees unless you are our trauma patient. If your benefits are exhausted please provide us with Exhaust letter and provide us with your health insurance and we will then file charges.

UCR Statement: If any portions of our fees are not covered by your insurance company, we want our patients to be aware of the fact they are responsible for any balances due after the insurance payment. This balance due includes provisions set by your insurance company such as: co-insurance, deductible, and "usual and customary" or "reasonable and customary" allowances. The policy held by you or your employer is a contract between the policy holder and the insurance company. Please discuss your policy with your employer or insurance company prior to charges being incurred.

PREDETERMINATION/PRECERTIFICATION: Please inform our office if your insurance company will require a predetermination for surgery or has a preferred facility. If a predetermination letter is required, please provide the insurance company's name, address, phone, group, identification numbers, and the contact person to whom we should address the letter.

FEE FOR COPIES OF PROTECTED HEALTH INFORMATION: If you request a copy of your health information, we will charge a fee for costs incurred to comply with your request. Kansas law prohibits charges that exceed the following: $20 handling fee, plus $.75 per page for pages 1-25; $.50 per page for pages 26-50; and $.25 per page for pages 51 or more. Requests for copies of protected health information must be in writing.

Completion of Disability Form or FMLA forms: Initial form is $15. Fee for subsequent forms are an additional $10. Fees are due in advance of forms being completed.

RELEASE/ASSIGNMENT: I hereby authorize the release to my insurance company or its representative any information, including diagnosis and/or records of any treatment or exam rendered to me during the course of such medical care. I also hereby assign all medical benefits including major medical benefits to which I am entitled from government sponsored programs, private insurance and/or any other health plan to: Stacy L Peterson, MD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original. I understand that I am financially responsible for all charges whether or not paid by Insurance. I also agree to pay any additional charges or fees related to the cost of collection agency fees, court fees, certified letter fees and handling fees, in the event I fail to pay my bills in a timely manner. All accounts over 120 days old are subject to 1% interest penalty compounded monthly.
I acknowledge that I have read and understand the financial policy of Stacy L Peterson, MD.

Name____ Date____________________________________

Responsible Party____

Stacy L. Peterson, MD
Patient Photograph Release Form

Patient Name:
I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before & after surgery. The photographs will be taken by one of the members of Dr. Stacy L. Peterson's staff. I hereby give my consent for Stacy L. Peterson, MD to use the photographs under the following circumstances:
PLEASE INITIAL ALL THAT APPLY:

______EDUCATIONAL MEDIA
Photographs taken of me or parts of my body as well as details regarding medical services I have received from Stacy L. Peterson, MD may be used in any educational media including, presentations developed for patients &/or other audiences with the intention of sharing information about procedures, surgery methods &/or potential outcomes. Further, I release & discharge Stacy L. Peterson, MD, the facility used and the American Society of Plastic Surgery, & all parties acting under their license & authority from any & all claims or actions that I have or may have relating to such use & publication; & all rights, if any, that I may have in such photographs & details regarding medical services rendered to me, including any claim for payment, in connection with any such use or publication. I give my consent as voluntary contribution in the interest of public education & consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

______WEBSITE (www.stacypetersonmd.com)
Photographs taken of me or parts of my body as well as details regarding medical services I have received from Stacy L. Peterson, MD, may be used on our internet website in order to inform the public about plastic surgery methods. Further, I release & discharge Stacy L. Peterson, MD, the facility used and the American Society of Plastic Surgery, & all Parties acting under their license & authority from any & all claims or actions that I have or may have relating to such use & publications; & all rights, if any, that I may have in such photographs & details regarding medical services rendered to me, including any claim for payment in connection with any such use or publication. I give my consent as voluntary contribution in the interest of public education & consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

______MEDICAL CARE
Photographs taken of me or parts of my body may be used for the purpose of my medical care with Stacy L. Peterson, MD. The photographs & all details regarding medical services rendered to me will be kept confidential within my personal history file at the office of Dr. Stacy L. Peterson (unless otherwise approved upon this release) or with the exception for use in the examination, testing, credentialing &/or certifying purpose by the American Board of Plastic Surgery, INC.

Patient/Guardian Signature Date

Witness