

# INSTITUTE OF PLASTIC SURGERY

KRISHNA S. DASH, M.D.  
Board Certified



RUPESH JAIN, M.D.  
Board Certified

Welcome, and thank you for choosing the Institute of Plastic Surgery

To Whom It May Concern:

Thank you for scheduling with the Institute of Plastic Surgery. We are sending you an appointment slip confirming your scheduled time, and some paper work that will need to be completed and returned to us the day of your appointment. Please take note that if for any reason you are unable to keep the appointment that has been scheduled; we request that you call our office (719) 535-9990 at least 12 hours prior to your scheduled time. This will give the office staff time to move someone else into that consultation slot.

## **Cancellation Policy:**

Out of courtesy our cosmetic consultations are free and with that our physician's schedules fill rapidly. We allow one free rescheduled appointment. If you choose to reschedule your appointment for a second time there will be \$75.00 charge for that consultation. **If you do not cancel your appointment at least 12 hours prior to your scheduled time or you choose to be a "no-show", you will be billed \$75.00 for your missed appointment, and the physician's time spent waiting for you.** Our phone lines are open 24 hours per day and a message can be left at any time if you need to cancel. We pride ourselves with staying on time and getting you back to work or home as soon as possible, so if you're running more than 15 minutes late for the time scheduled we will reschedule that appointment when you come in.

## **Interpreters:**

If you require an Interpreter our office can provide one for you, at a cost to you, of \$40.00 per hour. You are welcome to bring your own, but they will need to be at least 18 years of age and FLUENT in both languages to insure nothing is lost in translation.

## **Insurance related procedures:**

Please call your referring physician or your PCP (primary care physician) to confirm that all referral authorizations for your insurance company have been completed. Bring YOUR current insurance card(s), and be prepared to make your co-payment at the time of your visit. We accept Visa, MasterCard, Discover, cash or check.

## **Do not bring children to your consultation:**

**With all consultation the physicians perform a physical exam and take photos. This takes approximately 45 minutes. Children may not accompany the patient into the exam room and cannot be left unattended in the reception area. Please make other arrangements for your children's supervision.**

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## **Location**

Our office is located at 7606 N. Union Blvd., Ste A, on the corner of Briargate Blvd and Union Blvd. We are located in the Northwest corner of that intersection just behind First Bank. We have enclosed a map and directions; if you need further assistance please call our office.

## **Directions**

From Interstate-25:

Take the Woodmen Exit (#149) and travel east (away from the mountains) for 2 miles. At the Intersection of Union Blvd and Woodmen, take a left (north) and stay in the left hand lane of Union Blvd. The next intersection is Briargate Blvd. Take a left at the light and then an immediate right into the parking lot. You will see the First Bank and the medical offices behind it. We are in the first building on the left, Suite A.

From N. Academy:

Turn on to Briargate Blvd. by the Chapels Hill Mall. Continue up the hill for approximately one mile. On the left hand side of the road, you will see the First Bank. Turn into the parking lot which is located before the light. If you miss the turn, do a u-turn at Union Blvd and make a right into the parking lot.

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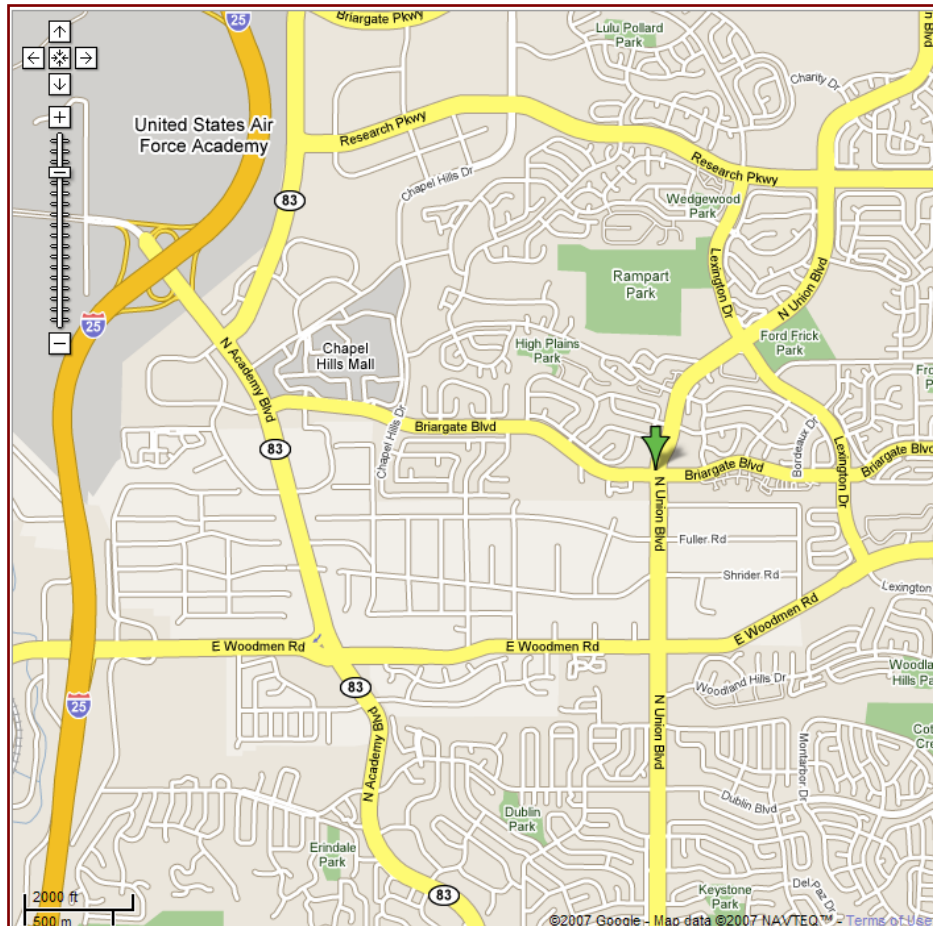
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## Map:



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7606 N. UNION BLVD, SUITE A | COLORADO SPRINGS, CO 80920 | TEL 719.535.9990 | FAX 719.535.9980  
[www.instituteofplastics.com](http://www.instituteofplastics.com)

**WELCOME**  
**INSTITUTE OF PLASTIC SURGERY, P.C.**

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**PATIENT INFORMATION**

Patient \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

May we send letters to this address? \_\_\_\_\_

Sex:  Male  Female **Birthdate** \_\_\_\_\_

**Patient SS#** \_\_\_\_\_

**Email:** \_\_\_\_\_

**PHONE NUMBERS**

**May we call?**

Home \_\_\_\_\_ **Y** **N**

Work \_\_\_\_\_ **Y** **N**

Cell \_\_\_\_\_ **Y** **N**

**HOW DID YOU HEAR ABOUT US?**

Magazine: Connect Colorado  Magazine: Local Value

Friend  Physician

Name \_\_\_\_\_ Name \_\_\_\_\_

Hospital  Yellow Pages: Verizon

Internet  Yellow Pages: DEX

Other \_\_\_\_\_

**WHY ARE YOU HERE?**

- Face Lift
- Brow Lift
- Eyelid Surgery
- Nose Surgery
- Breast Augmentation
- Breast Reduction
- Breast Reconstruction
- Tummy Tuck (Abdominoplasty)
- Liposuction
- Body Contouring (after major weight loss)
- skin care
- skin cancer
- scar revision
- Tissue Fillers
- Botox
- Facial Trauma

**Other:** \_\_\_\_\_

**MEDICAL HISTORY**

Date of Injury \_\_\_\_\_

Is this a work related issue?  Yes  No

Is there third party liability?  Yes  No

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

Employer's Phone \_\_\_\_\_

**CONTACT IN CASE OF EMERGENCY:**

Name \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Home phone \_\_\_\_\_

Work phone \_\_\_\_\_

**SPOUSE (if different than Emergency contact)**

Spouse's Name \_\_\_\_\_

**INSURANCE**

Who is responsible for the account? \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Co \_\_\_\_\_

ID # \_\_\_\_\_

Group # \_\_\_\_\_

Primary Care Physician? \_\_\_\_\_

Is the patient covered by additional insurance?

Yes  No

Subscriber name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Insurance Co \_\_\_\_\_

Group # \_\_\_\_\_ ID# \_\_\_\_\_

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I understand that although my insurance company may authorize my office visit or surgery, this does not necessarily mean that they will pay for the services rendered. I understand that this office will make every attempt to work with my insurance company to meet their requirements. **However, if the Institute of Plastic Surgery is unable to collect reimbursement from my insurance company, I will be responsible for all charges.**

I acknowledge that it is my responsibility to understand the particular details of my insurance policy. I will check with my insurer to verify that my surgery has been properly preauthorized and will do so prior to my date of surgery.

I understand that in the event that I am uninsured (self-pay patient), payment for services rendered will be due at the time of my office visit unless other arrangements have been made with this office in writing.

I also understand that I am responsible to pay interest on any outstanding balances at a rate of r 18% per year.

**If, for any reason, I do not pay on my account for two billing cycles (60 days), I understand that my account will be placed for collections with no further notice from this office. Our professional collection agencies are Transworld Systems and/or CMS. If your account is transferred to collection you will be responsible for any and all fees charged to IPS by the collections company to secure payment.**

I authorize the use of this form for all my insurance submissions and for the release of information to all my insurance companies.

I authorize Dr. Rupesh Jain and/or Dr. Krishna Dash to act as my agent in helping me to obtain payment from my insurance companies and I authorize my insurance companies to make payment directly to the Institute of Plastic surgery.

I permit a copy of this authorization to be used in the place of the original.

## ASSIGNMENT & RELEASE OF INSURANCE PAYMENT

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to **Institute of Plastic Surgery, P.C.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

## MEDICARE AUTHORIZATION FOR INSURANCE PAYMENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Institute of Plastic Surgery, P.C.** for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

**My signature indicates that I have read each paragraph, and agree to the terms and conditions of this form in its entirety, and that I understand the HIPPA compliance disclosure. I understand that a compliance form is not given to me, but I may request one if I so desire.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Revised 4/28/2006

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## General Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Last Mammogram \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ / \_\_\_\_\_

Where was the last Mammogram done? \_\_\_\_\_

What is the main reason for your visit today? Please describe in detail. \_\_\_\_\_

Please list any medications along with dosage and frequency? \_\_\_\_\_

Please list any allergies to medications and the reaction to those medications. \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If so, how much and for how long? \_\_\_\_\_

Please list any medical problems. \_\_\_\_\_

Have you had any previous surgeries? Please list with dates. \_\_\_\_\_

Have you had any problems with previous surgeries? \_\_\_\_\_

Do you have a family history of disease or illness (such as heart disease, diabetes, cancer, etc.)? \_\_\_\_\_

Do you now or have you had in the past any problems related to the following. **Please check if Yes.**

### **Allergic/Immunologic**

- Drug Allergies
- Hay Fever
- Lupus
- Scleroderma
- Other \_\_\_\_\_

### **Cardiovascular**

- Chest Pain
- Heart Murmur
- High Blood Pressure
- Pacemaker
- Heart Attack
- Other \_\_\_\_\_

### **Constitutional Symptoms**

- Chills
- Fever
- Weight Loss
- Weight Gain
- Other \_\_\_\_\_

### **Ears/ Nose/ Throat/ Mouth**

- Frequent Ear Infections
- Dental Work
- Nosebleeds
- Sinus problems
- Other \_\_\_\_\_

### **Endocrine**

- Diabetes
- Excessive Thirst
- Thyroid problems
- Tired/Sluggish
- Too hot/cold
- Other \_\_\_\_\_

### **Eyes**

- Blurred Vision
- Cataracts
- Double Vision
- Frequent Dry Eyes
- Glaucoma
- Pain
- Other \_\_\_\_\_

### **Gastrointestinal**

- Abdominal Pain
- Indigestion/ Heartburn
- Liver Disease
- Nausea or Vomiting
- Special Diet
- Stomach Ulcers
- Other \_\_\_\_\_

### **Genitourinary**

- Kidney Stones
- Painful Urination
- Urinary Frequency
- Urinary Retention
- Other \_\_\_\_\_

### **Hematologic/Lymphatic**

- Bleeding Tendency
- Blood Clotting
- Hepatitis
- HIV/AIDS
- Swollen Glands
- Other \_\_\_\_\_

### **Integument**

- Boils
- Keloids/ Thick Scar
- Skin Rash
- Other \_\_\_\_\_

### **Musculoskeletal**

- Arthritis
- Back Pain
- Gout
- Joint Pain
- Neck Pain
- Osteoporosis
- Other \_\_\_\_\_

### **Oncologic (Cancer)**

- Breast Cancer
- Skin Cancer
- Other \_\_\_\_\_

### **Neurological**

- Alzheimer's
- Multiple Sclerosis
- Numbness/ Tingling
- Seizures
- Tremors
- Weakness
- Other \_\_\_\_\_

### **Psychological**

- Anxiety
- Bipolar Disorder
- Depression
- Schizophrenia
- Other \_\_\_\_\_

### **Respiratory**

- COPD
- Chronic Coughing
- Pulmonary Embolism
- Shortness of Breath
- Other \_\_\_\_\_

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## Breast Reduction Information Form

Name \_\_\_\_\_ Date: \_\_\_\_\_

### Please check any of the below problems that you are experiencing:

- Headache       Backache       Neck Pain       Shoulder Pain  
 Breast Pain       Hand Pain       Rashes under Breasts       Other \_\_\_\_\_

Are you taking any pain medication now for the above systems?    No    Yes: \_\_\_\_\_

Current Bra Size \_\_\_\_\_       Desired Bra Size \_\_\_\_\_

### Documentation of failed conservative treatment:

Chiropractic:      From \_\_\_\_\_ to \_\_\_\_\_ Group or Facility \_\_\_\_\_

Massage Therapy: From \_\_\_\_\_ to \_\_\_\_\_ Group or Facility \_\_\_\_\_

Physical Therapy: From \_\_\_\_\_ to \_\_\_\_\_ Group or Facility \_\_\_\_\_

### Family History of Cancer:

Do you have any history of breast cancer? \_\_\_\_\_

Is there a history of breast cancer in your family? If so, please list which relatives.

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Date of last Mammogram: \_\_\_\_\_ Facility: \_\_\_\_\_ Normal? \_\_\_\_\_

Do you smoke now?    No       Yes, how much? \_\_\_\_\_       Quit, year \_\_\_\_\_

**\*\* Please fill out this form completely. This information is required by your insurance company to help us pre-authorize your surgery. Missing information will only delay pre-authorization.**

### For Office Use Only

Measurements:	<u>Right Breast</u>	<u>Left Breast</u>	
N→ IMF	_____	_____	Weight: _____ lbs
SN→ N	_____	_____	Height: _____ inches
Number of Grams to be removed from each side: (RT) _____ (LF) _____			

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