Zieg Plastic Surgery Center & Lipo Spa
812-471-5476

401 Metro Ave *Evansville IN 47715*

Please fill out the following information:

Patient Name: (First, Middle Int., Last)
_____
Home Address: _____
City:_____ State:_____ Zip:_____
Contact Number: _____
Work Phone: _____
E-Mail Address: _____
Social Security Number: _____Sex: M F
Date of Birth: _____
Employer: _____
Occupation: _____
Marital Status: S M D W
Spouse Name: _____

*If Patient is a **MINOR**: Responsible Party needs to complete the following:*
Person's relationship to patient: SELF SPOUSE CHILD
Name of person responsible for account: _____
Address: (Street, City, State & Zip):_____
_____
Contact Number: _____
Work Phone: _____
Social Security #: _____
Employer: _____
Occupation: _____
Next of Kin:
Please list a name of the person responsible for the account if the patient will not be responsible for the account:
Name (First, Middle Int., Last): _____
_____
Relationship to patient: _____
Contact Number: _____
Work Phone: _____

Patient Name: _____Primary Physician:_____
Age: _____Sex: **M F** Referring Physician:_____

Patient's Medical History:

• Stroke	Y	N	Date:_____
• Angina/Heart Attack	Y	N	Date:_____
• Congestive Heart Failure	Y	N	
• Pneumonia/ Tuberculosis	Y	N	
• Emphysema/Bronchitis/Asthma	Y	N	
• Kidney Disease/Kidney Failure	Y	N	
• High Blood Pressure	Y	N	
• Diabetes:	Y	N	
Insulin:	Y	N	
• Peptic Ulcer Disease	Y	N	
• Liver Disease	Y	N	
• Thyroid Disease	Y	N	
• Seizures:	Y	N	
Medications for Seizures	Y	N	
• Cancer (Site the location of cancer)	Y	N	Site: _____

History of:

• Previous blood transfusions	Y	N	
• Bleeding Problem	Y	N	
• Will accept blood transfusions	Y	N	**(If Necessary)**
• Tobacco Use	Y	N	
• Alcohol Use	Y	N	

Previous Operations:

	Type:	Date:	Hospital:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Medications currently used:

_____

_____

Allergies (If any)	Reactions:
1._____	_____
2._____	_____
3._____	_____

Latex Allergy: Y N
Do you have a living will? Y N
Do you have a healthcare designate? Y N if yes: Name:_____
Patient Signature: _____Date:_____

OFFICE USE ONLY:

Information Reviewed By: _____Date:_____

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Patient Consent Form

I hereby consent to ZIEG PLASTIC SURGERY CENTER using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health services rendered to me or to carry out the practice's health care operations. I also consent to ZIEG PLASTIC SURGERY CENTER using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

I understand that I may request in writing that restrict how my private information (protected health information) is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

I understand that I may revoke this consent in writing at anytime, except to the extent that you have taken action relying on this consent.

I further acknowledge that ZIEG PLASTIC SURGERY CENTER has provided me a copy of it's Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my private information (protect health information).

_____

Signature of Patient or Parent/Guardian

_____

Name of Patient or Parent/Guardian (Print)

_____

Date

_____

Relationship to Patient if Minor

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Photograph and/or Videotape Consent

I _____, recognize that the results from the practice of medicine and surgery are not absolutely predictable, and I acknowledge that no guarantees or assurances have or can be made concerning the results of such treatment. I further acknowledge that there have specifically been no guarantees as to the cosmetic results from the procedure.

I consent to the taking of photographs and/or videotaping before, during and after the procedure. These photographs and/ or videotapes are important to document and follow my progress after surgery. I will not be identified by name on any photograph and /or videotape.

I expect no compensation for any such of these photographs and/or videotapes, and I waive all my rights to any claims for payment or royalties. I also release Dr. Paul M. Zieg and/or his associates/assistants from any liability in connection with the use of such photographs and/or videotapes. I recognize these photographs and/or videotapes are used to track and follow my progress before, during and after the procedure and will not be released for publication at anytime without my written consent on secondary photograph/videotape consent.

"I herby grant permission for the use of any of my medical records including illustrations, photographs, videotapes or other imaging records created in my case, for use in examination, testing, credentials, and/or certifying purpose by The American Board of Plastic Surgery, INC."

Patient Signature: _____

Witness Signature: _____

(Office Use Only)

Date: _____

Zieg
Plastic Surgery Center & Lipo Spa
Office Policies and Procedures

Pricing

After your consultation you will be given the prices for the procedure you are interested in. **The "Regular Price" is where the payment is made by Visa, Master Card, Care Credit.** Generally, Visa and Master Card Debit cards have a daily limit and cannot be run for large amounts. Please contact your bank before your pre-operative visit and let them know the amount you plan on running on your card the day of your pre-operative visit.

We do a 15% discount from the "Regular Price" which is considered the "Cash Price." **The "Cash Price" is where the payment is made by a bank issued cashier's check, or cash.**

Payments

To schedule a surgery, a **$1,000.00 deposit** will be collected to book a surgery. This deposit can be paid by personal check, cash, or Visa and Master Card. You may call the office to schedule a surgery and make a credit card deposit over the phone. This deposit does come off the total cost of the surgery, and is non-refundable. If you finance your procedure, the **$1,000.00** is included in the whole amount, and you will be put on the surgery schedule when your financing is approved.

At the Pre-Operative appointment that is scheduled a week prior to surgery, all procedures must be paid in full.

No personal checks over $1,000.00 will be accepted.

No amount will be refunded after the Pre-Operative visit.

Financing

Care Credit is the financial institution that is used through our office for financing. You can apply in the office, or on-line at **www.CareCredit.com** or over the phone at **1-800-365-8295.** A photo id and a major credit card will be necessary for final processing at the time of the pre-operative visit.

Appointments

All pre-operative appointments, follow-up appointments, and esthetic treatments must have a 48-hour cancellation notice. After a second missed appointment with no notice to the office a $100.00 deposit will be required to book another appointment, and deposited if a third appointment is missed with no notice to the office. The deposit will be secured with a Visa or Master Card.

It is imperative to come to all post-operative appointments for optimal results after any procedure. It is the patient's responsibility to rebook any missed appointments.

Patient Signature: _____

Date: _____

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Fees Only

I understand that I am responsible for all charges incurred for each and all treatments and Surgical Procedures. I also understand that at my Pre-operative visit my total balance is due and becomes 100% **NON-REFUNDABLE.**

Patient
Signature_____

Date_____