SunCoast Plastic Surgery

SWET CHAUDHARI, MD
DOUBLE BOARD-CERTIFIED PLASTIC SURGEON

Date: ______________ Account # ______________________ Reviewed by: ______________

NEW PATIENT INTAKE FORM

DEMOGRAPHICS

Name: ____ Age: _________ SEX: M / F
Last First Middle

DOB:_____________________ SSN: _____________________________

Mailing Address: ____
Street City State Zip

Mobile Phone: _____________________ Work Phone: ______________________ Home Phone: ______________________

Email Address: __________________________________ Driver's license # __________________________ State of DL:______

Preferred Method of Contact: ☐ Email ☐ Phone ☐ Text messages

Do you have: 1) a medical power of attorney? ☐ Yes ☐ No 2) Do you have a living will? ☐ Yes ☐ No
Have you had consultations with other plastic surgeons? ☐ Yes ☐ No If Yes, who? ____________________________________

EMERGENCY CONTACT - In case of a medical emergency, it's important for us to know who to contact.

Emergency Contact Person: ___________________________ Relationship to You: _______________________
Phone: _____________________________ Alternate Phone: ___________________________

HEALTH INSURANCE INFO (Optional for cosmetic surgery patients)

Primary Insurance Company & Plan:____
Policy holder's Name: _________________________________ Relationship to You: ___________________________
Policy holder's DOB: ____________________________ Policy holder's SSN: _____________________________
Insurance ID # __________________________________ Group # _______________________________________

MARKETING INFO - How did you hear about SunCoast Plastic Surgery and/or Dr. Chaudhari?

☐ Internet search (Google, etc.) ☐ Facebook ☐ Instagram ☐ Snapchat ☐ RealSelf ☐ Youtube ☐ Crisalix
☐ Referred by ________________________________ ☐ Print Ad in this Magazine ______________________________
☐ I got a printed flyer here ____________________________ ☐ Signage outside building or at street

FINANCIAL QUESTIONS

What are you expecting to pay for your plastic surgery?
☐ <$5000 ☐ $5000 to $10,000 ☐ $10,000 to $15,000 ☐ > $15,000 ☐ Other ________________
How do you plan to pay for your plastic surgery? ☐ Cash ☐ Credit card ☐ Financing ☐ Health Insurance
If you plan to finance, do you have an account with Care Credit? ☐ Yes ☐ No
If you plan to finance, what's the strength of your credit score? ☐ Bad ☐ Low ☐ Fair ☐ Good ☐ Great
If you plan to finance, what's your monthly household income? ☐ less than $2000 ☐ $2000-4000 ☐ $4000-8000 ☐ more than $8000

MEDICAL INFORMATION

WHAT IS THE PURPOSE OF YOUR VISIT? WHAT DO YOU WANT TO TALK TO DR. CHAUDHARI ABOUT?

____

PLEASE INDICATE ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING (include herbal and OTC)

1. ______________________ 5. ______________________
2. ______________________ 6. ______________________
3. ______________________ 7. ______________________
4. ______________________ 8. ______________________

HAVE YOU HAD AN ADVERSE REACTION OR ALLERGY TO ANY MEDICATION? ☐ Yes ☐ No

If yes, please explain: ____

PAST MEDICAL HISTORY

WHAT ONGOING MEDICAL PROBLEMS DO YOU HAVE?

____

____

PLEASE LIST ANY SURGERIES OR PROCEDURES THAT YOU HAVE HAD IN THE PAST, INCLUDING COSMETIC SURGERY

Type	Date	Type	Date

BESIDES THE SURGERIES, HAVE YOU BEEN IN THE HOSPITAL OR HAD ANY OTHER SERIOUS INJURIES?

____

____

ADDITIONAL MEDICAL PROBLEMS

GENERAL
- Weight gain or loss Y / N
- Weakness/fatigue Y / N
- Fever, chills, night sweats Y / N

EYES
- Glasses or contacts Y / N
- Pain or redness Y / N
- Cataracts Y / N
- Blurred vision Y / N
- Double vision Y / N
- Dry eyes Y / N

EARS/NOSE/MOUTH/THROAT
- Hearing difficulty Y / N
- Ringing Y / N
- Earaches Y / N
- Allergies/sinus Y / N
- Frequent colds Y / N
- Nose bleeds Y / N

RESPIRATORY
- Cough Y / N
- Wheeze Y / N
- Shortness of breath Y / N
- Pneumonia Y / N

CARDIAC
- Chest discomfort Y / N
- Palpitations Y / N

GASTROINTESTINAL
- Swallowing Y / N
- Nausea and vomiting Y / N
- Blood in stool Y / N
- Abdominal pain Y / N

MUSCULOSKELETAL
- Leg cramps Y / N
- Other muscle cramps Y / N
- Back pain Y / N
- Joint pain/stiffness Y / N
- Weakness Y / N
- Tingling/numbness Y / N
- Leg cramps w/ walking Y / N
- Pain in feet Y / N

URINARY
- Increased frequency Y / N
- Burning Y / N
- Urinating at night Y / N
- Incontinence Y / N
- Blood in urine Y / N
- Decreased force Y / N

SKIN
- Rashes Y / N
- Lumps Y / N

NEUROLOGIC
- Fainting Y / N
- Seizures Y / N
- Shaking Y / N
- Loss of memory Y / N
- Headaches Y / N
- Head injury Y / N
- Hand or leg weakness Y / N
- Numbness Y / N
- Facial droop Y / N
- Slurred speech Y / N
- Unilateral eye blindness Y / N
- Stroke Y / N

ENDOCRINE
- Thyroid trouble Y / N
- Diabetes Y / N
- Hormonal imbalances Y / N

HEMATOLOGIC/LYMPHATIC
- Anemia Y / N
- Bleeding problems Y / N
- Transfusion reaction Y / N
- Blood clots Y / N

ALLERGIES, IMMUNE PROBLEMS
- Food allergies Y / N
- Recurrent infections Y / N
- Wound healing problems Y / N

PSYCHIATRIC
- Anxiety Y / N
- Depression Y / N
- Mood swings Y / N

BREAST
- Lumps Y / N
- Nipple discharge Y / N
- Pain Y / N
- Date of last mammogram ___________

FEMALE REPRODUCTIVE HISTORY
- Age at 1st menstruation: _____ yo
- # Pregnancies: _____ # Live births: _____
- Age of children (if any): _________________
- Age at menopause: _____ yo
- Last menstrual period: ___________
- Last pap smear: ________________
- Birth control pills? Y / N
- Hormone supplementation? Y / N

If you answered yes to any of the above, please explain: ____
____
____

Have you ever had cancer? Y / N If Yes, provide details: ____________________________________
____

FAMILY HISTORY

	Living?	Medical Problems?
Father	Y / N	____________________
Mother	Y / N	____________________
Siblings	Y / N	____________________
	Y / N	____________________
Children	Y / N	____________________

SOCIAL HISTORY

Marital Status: ☐ Single; If Single, do you live alone? Y / N
☐ Married; If married, for how long? ____________________
Spouse's name: ____________________________
☐ Separated ☐ Divorced

Do you have family members that live nearby? Y / N Where? ____________________
Do you have family or friends that can help you recover if you need it? Y / N
Status of nicotine use (Cigarette smoking, Cigar smoking, Vaping)?
☐ I have never smoked/vaped ☐ I smoke/vape socially a few times a month
☐ I used to smoke/vape _______ packs per week for _______ years, but QUIT smoking/vaping _______ weeks/months/years ago
☐ I am still an Active smoker/vaper and I currently smoke/vape _______ packs per week for _______ years
Do you drink alcoholic beverages? Y / N How much and how often? ____________________
Do you use recreational drugs of any kind (including weed)? Y / N Which drugs and how often? ________________

EDUCATION & EMPLOYMENT INFO

Highest level of completed education? ☐ HS or GED ☐ Vocational school education ____________________
☐ College/University degree ____________________ ☐ Post-Graduate degree ____________________
Are you currently a student? Y / N If Yes, at what school? ________________ Academic interest? ______________
Employment status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired
Employer: ____________________ Position: ____________________ For how long?____________
How much physical activity does your job involve? ☐ Minimal ☐ Moderate ☐ Significant

******** S. T. O. P. ***********************************

VITAL SIGNS (to be completed by Staff only)

Height: ____feet _____inches Weight: ____________ lbs

Temp: ________ HR: _________bpm BP: _______/________

SunCoast Plastic Surgery

GENERAL SERVICE AGREEMENT

Dear Prospective Patient,

This General Service Agreement letter is to confirm our understanding of the terms and conditions of our services. Please read this letter carefully and sign below to demonstrate your acceptance of these terms.

Our Service Commitment to You

At SunCoast Plastic Surgery, Dr. Swetanshu Chaudhari and his staff are dedicated to providing outstanding patient care and helping you fulfill your goals for enhanced aesthetics or improved function. Our guiding principle is to treat you with the utmost respect, help you make an educated decision, and to provide you with the finest medical services in a safe, comfortable, and professional environment.

We provide a wide variety of services, including but not limited to, consultations for all kinds of cosmetic surgery or skin care, wound and scar management, and management of traumatic wounds to the face or hands. In order to provide our services to you, we will request personal information regarding your health, conduct an interview with a physical examination, provide education about your treatment options, discuss and agree upon a treatment plan, and assist you with obtaining pre-authorization for medical services from your insurance company, if needed.

Our Responsibilities to You

As a patient of SunCoast Plastic Surgery, you can expect:

- Quality health care delivered with respect and compassion
- Protection of your health information in compliance with HIPAA
- A fairly accurate estimate of the costs of your medical care
- A detailed explanation of your treatment plan and subsequent medical bill
- Prompt and courteous customer service

Patient Responsibilities to Us

As a patient of SunCoast Plastic Surgery, you are responsible for:

- Providing complete and accurate health and medical information on the New Patient Intake Form
- Following the treatment plan for your health care, as detailed by Dr. Chaudhari
- Keeping your appointments or promptly notifying us if you will be unable to
- Being polite and considerate to Dr. Chaudhari and his staff
- Providing prompt payment of all fees and charges for our services
- Reviewing and signing the HIPAA Notice of Privacy Practices and this General Service Agreement
- Assisting us in expediting the claims process with your insurance company, if applicable

Authorization for Treatment

In order to provide you with quality medical care, your authorization for treatment is required. By signing below, you hereby grant permission to Dr. Swetanshu Chaudhari and his staff at SunCoast Plastic Surgery to perform such medical and/or surgical procedures on me as they deem in their judgment advisable or necessary for the treatment or care of (1) any condition now recognized or contemplated, and (2) any conditions, not now recognized or contemplated, which are revealed or arise during the course of such treatment or care.

Treatment of a Minor

A minor is defined as an individual under 18 years of age that is not married nor self-supporting. An emancipated minor is a minor under 18 years of age that is not under the specific care of a legal guardian either because they have married or for other legal reasons. As defined by Texas State Law, doctors may notify or involve legal guardians of care provided in our office except in the case of an emancipated minor. Minors may make certain decisions in their medical care, but it varies depending on the situation. Doctors may, however, notify the legal guardian without the minor's consent in the event that the doctor feels the minor's health is being jeopardized by non-compliance of care. Doctors may also speak directly with the legal guardian if the minor is mentally disabled and/or unable to speak or comprehend verbal communication.

Assignment of Benefits

In order to provide you with quality medical care, it is essential that the information that you provide regarding your health be true and correct. By signing below, you certify that the information you are providing Dr. Chaudhari and his staff is true and correct to the best of your knowledge and promise to pay Dr. Chaudhari and SunCoast Plastic Surgery, PLLC all charges due by you as assigned by either Dr. Chaudhari or by your insurance company. By signing below, you authorize Dr. Chaudhari to send photocopies of any and all of your personal and medical records to your insurance company in order to process your claim, if requested. You also authorize you insurance company to send payment directly to Dr. Swetanshu Chaudhari at SunCoast Plastic Surgery, PLLC. If payment is sent to you from your insurance carrier, you understand that you are responsible for forwarding all applicable payments due to Dr. Chaudhari within 10 business days of receiving the payment. You also understand that failure to do so will result in legal action being filed against you by Dr. Chaudhari and SunCoast Plastic Surgery, PLLC, and possibly your own insurance carrier. You understand that it is a federal offense to tamper with any insurance payments that are incorrectly sent to you. Finally, you also understand that it is a federal offense to falsify any information in order to have a claim paid by your insurance carrier on your behalf.

Electronic Communication

We may engage in email communication with you regarding scheduling or rescheduling your appointments, providing financial estimates related to your medical care, assistance with third-party financing, distribution of education material, and notification of upcoming promotions or educational events. On occasion, we may send you an email notifying you of any office policy changes, or questions about your health insurance.

You are responsible for providing us with a private, secure email address. If you do not want your information viewed by anyone else, you must make sure that no one else can access your email. We cannot be held responsible for who views your email once we have emailed it to the address you provided. By providing your email address, we assume that you are giving us consent to email you at anytime. We recommend that you do not use your work email address because your employer may be able to view your emails. If your email address changes, you are responsible for notifying us either in person or in writing by either mail or fax.

We do not provide consultations, or detailed results of abnormal lab results via email or by telephone. If any of your testing requires additional attention due to abnormal results, you will be notified via telephone that you must come in for an office visit. You will be required to make an appointment to discuss the results and your treatment plan. If you have a co-payment for office visits, you will be required to make payment at the time of service.

If the patient is a minor, the only acceptable email address that will be used is that of the legal guardian.

Fees and Payment Terms

Dr. Swetanshu Chaudhari and SunCoast Plastic Surgery, PLLC are NOT in-network with any health insurance companies, which means that we have not contracted a reimbursement schedule for any provided health services and are not part of any health insurance referral network. For all the health insurance companies, we are considered out-of-network and you will be responsible for following your own insurance company's guidelines regarding payment and reimbursement for health care. If necessary, we are able to work with the out-of-network benefits of your health insurance plan.

Cosmetic Surgery and Cash-Pay Patients

We charge a $75 non-refundable consultation fee for all cosmetic surgery consultations. Certain promotions or discounts may apply. This consultation fee is applied towards the cost of any cosmetic surgery that results from the consultation. No payment plans are available for office visits and this fee is due at the time services are rendered. If you are NOT using your health insurance to help cover the costs of health care provided by Dr. Chaudhari, there are no fees or charges associated with post-operative visits related to your cosmetic surgery. There are no fees or charges for non-surgical consultations. Once you have accepted a surgery quote and are ready to proceed, we require a $500 non-refundable deposit, which is included in your estimate and will lock in the surgeon's fees only for 1 year from the time of payment and will serve as a booking fee for your planned operative procedure. We expect payment in full for all fees and charges for cosmetic surgery at least 2 weeks in advance of the scheduled operative date. In the event that the treatment plan is changed in the operating room, any unapplied amounts will be refunded back to you after completion of your surgery. In the event of cancellation of a procedure before full payment has been received, we will retain the $500 non-refundable deposit, while the remaining collected fees and charges can either be credited to your account for future use or can be refunded to you upon request. If a scheduled operative procedure has to be re-scheduled by the patient within 24 hours of the operative date, then a $500 re-scheduling fee will be assessed to cover the administrative costs of the surgery center. If an operative procedure is cancelled after full payment has been received and the procedure has been scheduled at the surgery center, then we will retain 25% of the surgeon's fees on top of the $500 non-refundable deposit and the $500 cancellation fee charged by the surgery center, as payments for administrative work associated with your planned procedure.

Insurance and Medicare Patients

If you are using your health insurance or Medicare to help cover the costs of health care provided by Dr. Chaudhari, you are expected to cover your own office co-payments for all office visits, regardless of whether you are examined or not. If your insurance company does not pay your claim because of reasons that can be resolved by you, you are responsible for getting the requested information to them. This includes filling out paperwork requested by your insurance and/or employer, paying premiums, notifying them of other insurance policies, etc. If the claim is not paid due to lack of information from our office, you will NOT be held responsible. We will correct our mistake and re-file the claim. You will be asked at each and every visit to present your insurance card. This is done to ensure that we have the correct information to file your claim. Even though your insurance company may not change, they frequently change group numbers and claims addresses. The front office staff is required to check the information every visit, so we appreciate your cooperation. If you are in a dispute with your insurance company regarding claims that have not been paid, you will still be held responsible for paying your balance within 90 days. You will need to get reimbursed from your insurance company for any payments you make to our office.

ALL BALANCES PAST 90 DAYS WILL BE SENT TO OUR COLLECTION AGENCY. THIS INFORMATION IS REPORTED ON YOUR CREDIT REPORT. THERE WILL BE ADDITIONAL COLLECTION AGENCY CHARGES ADDED TO YOUR BALANCE IF WE ARE FORCED TO TURN YOUR ACCOUNT OVER.

Payment Options

All payments are to be made to SunCoast Plastic Surgery, PLLC. We accept cash, cashier's check, credit cards (MasterCard, Visa, American Express, and Discover), and payments using third-party financing companies, including Care Credit, Chase Health Advance, United Medical Credit. These financing companies cover all cosmetic surgery, and non-surgical procedures (Botox, fillers, and skin care products). A finance fee will be charged by our office for using any third-party financing company. For more information regarding these financing options, please ask our staff or visit our website, www.suncoastplasticsurgery.net. We DO NOT accept personal checks, check/debit cards, or post-dated checks. We will not schedule any future appointments until your balance has been paid in full. All estimates given for plastic surgery services are for payments in cash or using a cashier's check, and a 4% processing fee will be charged for using any of the credit cards listed above.

At times, it may be necessary for us to obtain verbal authorization over the phone to process electronic payments, either by a major credit card (MC/Visa/AMEX/Discover) or by a medical financing company (CareCredit or MyMedicalLoans). Your signature below constitutes a legally-binding signed authorization for any of these electronic payments in the future.

Violation of this Agreement and Termination of Doctor-Patient Relationship

Dr. Chaudhari will work with you to create a health care treatment plan that will provide you with the best results. However, you have the right to refuse the health care treatment plan prescribed to you by Dr. Chaudhari either by (1) notification in person in the office or (2) by certified mail, and this refusal will be documented in your medical record. If Dr. Chaudhari cannot create a treatment plan to your liking, then the doctor-patient relationship can be terminated by either party. If you are felt to be non-compliant with your responsibilities (as listed above) and this non-compliance puts your health at increased risk, Dr. Chaudhari will have grounds to terminate the doctor-patient relationship and may do so without discussion. In this event, a termination letter will be sent by certified mail to your mailing address, with a return receipt request. Similarly, if you feel that Dr. Chaudhari is not fulfilling his responsibilities to you, you have the right to bring this to his attention and/or terminate the doctor-patient relationship, as well.

The doctor-patient relationship can be terminated for a variety of reasons, including but not limited to, you moving to another location, your dissatisfaction with delivered health care, you cannot afford the fees for health care, Dr. Chaudhari is unhappy about your non-compliance with the treatment plan, and/or personality conflicts. Regardless of the reason of termination, Dr. Chaudhari and his staff will be happy to provide you with a copy of your medical records, after you have signed the appropriate release of medical records form and provided the proper payment for copying services. Our staff will make every attempt to find you an equally knowledgeable plastic surgeon who you can contact to continue your health care treatment, but you understand that this may not be possible. If the doctor-patient relationship is terminated for any reason, we will remain courteous and respectful to you, and we will have no hard feelings and wish you the best with your new plastic surgeon.

Welcome

We appreciate the opportunity to provide you with outstanding health care in the field of plastic and reconstructive surgery. At SunCoast Plastic Surgery, Dr. Chaudhari will give you his undivided attention and then use his skill, talent, and many years of training to help you bring out the young spirit that lies within you or improve your function towards your pre-injury state.

At SunCoast Plastic Surgery, we treat each patient like a family member, and welcome you to join our family.

Yours truly,

Swetanshu Chaudhari, MD
Double Board-Certified Plastic Surgeon
President, SunCoast Plastic Surgery, PLLC
2508 Westminister St.
Pearland, TX 77581
832.398.0112
www.suncoastplasticsurgery.net

The foregoing is in accordance with my understanding of our relationship. The terms described in this letter are acceptable and are hereby agreed to.

Agreed To and Accepted:

______________________________	______________________________	__________
Printed Name of Patient	Signature of Patient	Date
______________________________	______________________________	
Printed Name of Legal guardian	Signature of Legal guardian	

HIPAA NOTICE OF PRIVACY PRACTICES

Effective: May 1, 2019

At SunCoast Plastic Surgery, Dr. Swetanshu Chaudhari and his office staff understand that health information about you is very personal and we are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to protecting your health information. We create a record of the care and services you receive from us, and this record helps to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by us, and informs you about the ways in which we may use and disclose information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

* Make sure that health information that identifies you is kept private
* Give you this Notice of our legal duties and privacy practices with respect to health information about you
* Follow the terms of the Notice that is currently in effect

How we may use and disclose health information about you:

* For Treatment
* For Payment
* For Healthcare operations
* For appointment reminders
* As required by law
* Public Health risks
* Health oversight activities
* Lawsuits and disputes
* Law enforcement
* To avert a serious threat to health and safety
* As required by the Military or Veterans and Workers Compensation
* Coroners, health examiners and funeral directors
* National Security and Intelligence activities
* Protective Services for the President and others
* Security Officials for Inmates
* For med spa services by Pearland Med Spa

Your rights regarding Health Information about you:

* Right to inspect and copy
* Right to Amend
* Right to Accounting of Disclosures
* Right to Request Restrictions
* Right to Request Confidential Communication

Your Medical Records: The original copy of your and/or electronic medical record is the property of SunCoast Plastic Surgery, PLLC and Dr. Swetanshu Chaudhari. You may request a copy of your records to be transferred by completing a medical records release form. As allowed by Texas state law, there will be a fee for providing you with this service. We require 14 business days from the date of your request to prepare and send your records unless the records are for urgent of life threatening health issues.

Changes to this Notice: We reserve the right to change this Notice. We will post a copy of the current notice in our facility with the current effective date.

Complaints: If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint.

For complete, detailed information regarding privacy laws, visit www.cms.gov/hipaa

Permission to Share your Health Information: We are required to follow certain federal guidelines and laws regarding the confidentiality of your personal health information. One of these prevents us from discussing anything in your medical file with anyone other than yourself or other medical personnel involved in your care. If you would like us to discuss lab results or other personal information with your significant other, family members, or any other individuals, please fill in their name and relationship to you in the section listed below.

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Acknowledgement of Receipt of the SunCoast Plastic Surgery HIPAA NOTICE OF PRIVACY PRACTICES: We request that you sign this form acknowledging you have received, read, and reviewed the SunCoast Plastic Surgery HIPAA Notice of Privacy Practices. If the patient is a minor, the legal guardian is automatically appointed by law to provide/receive protected information on behalf of the patient. I will notify Dr. Chaudhari and/or his staff of any changes or updates to this record.

This acknowledgement will become part of your records.

Printed Name of Patient	Signature of Patient	Date
Printed Name of Legal guardian	Signature of Legal guardian	

SunCoast Plastic Surgery

CONSENT FOR PHOTOGRAPHY

Date: _______________

Patient Name: ____

At SunCoast Plastic Surgery, we are committed to following the requirements mandated by the **Health Insurance Portability and Accountability Act (HIPAA)** and we do our best to maintain patient confidentiality. You photographs will not be used without your permission, unless ordered by a court.

In plastic surgery, photographs are a vital part of the medical record and documentation of the pre-operative state and the aesthetic and functional outcome of an operative intervention. Dr. Chaudhari requires your permission to obtain photographs to be used in your medical record.

“I hereby grant permission to Dr. Chaudhari and SunCoast Plastic Surgery, PLLC to obtain photographic images to be ...

(initial all that apply)

_________ ... used to complete my medical record, to document my pre-operative state and the aesthetic and functional outcome of the operative intervention, and post-operative care. ”

_________ ... used for publication in medical journals or presentation before an audience of medical professionals to further medical education.”

_________ ... used in brochures, website, or other literature for marketing purposes. I understand that every effort will be made to hide my identity and maintain patient confidentiality, as required by HIPAA rules. ”

Patient/Legal guardian signature: ____

Witness signature: ____