7971 Moorsbridge Rd
Portage MI 49024

3600 Capital Ave SW, Ste 102
Battle Creek MI 49015

SOUTHWEST MICHIGAN
PLASTIC AND HAND SURGERY

Raghu G. Elluru, M.D., F.A.C.S.
Office 269.329.0655
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SWMPHS.com

WELCOME TO OUR OFFICE!

Today's Date: _____

Patient's Name: First _____ MI _____ Last _____ Maiden _____

Date of Birth _____ Sex ☐ M ☐ F Soc Security No. _____ Marital Status S M W D

Patient Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____
to receive occasional announcements

Patient Employer _____ Employer Address _____

Patient Occupation _____

IF PATIENT IS A MINOR, name of person responsible for account: _____

Relationship _____ Date of Birth _____ Social Security No. _____

Employer _____ Work Phone _____ Home Phone _____

Home Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT INFORMATION

Contact Name #1 _____

Relationship to Patient _____

Home Phone _____

Work Phone _____

Contact Name #2 _____

Relationship to Patient _____

Home Phone _____

Work Phone _____

RELEASE OF INFORMATION

If at some time it becomes necessary to leave messages pertaining to my medical record, such as diagnostic testing or appointments with another individual , please refer to the persons listed below.

I, _____ hereby authorize Southwest Michigan Plastic and Hand Surgery to discuss my medical record and/or care with the following persons:

Name	Phone #	Relationship

☐ I do not wish to have information about my medical record given to anyone but myself.

This Release applies to all health information in my medical record as identified by HIPAA guidelines. I authorize medical treatment to be released as indicated above.

This Release will be in effect until _____ (date) and may be updated at anytime.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

SOUTHWEST MICHIGAN

PLASTIC AND HAND SURGERY

COSMETIC INTEREST QUESTIONNAIRE

Our practice offers you the safest, most advanced technologies for facial rejuvenation and overall physical rejuvenation.

Please check all of the following that you would like to discuss today.

- ☐ Laser Skin Resurfacing
- ☐ Cosmetic treatment for wrinkles (BOTOX, fillers)
- ☐ Medical Skin Rejuvenation / Skin Care advice
- ☐ Treatment for spider veins (leg and/or facial)
- ☐ Liposuction
- ☐ Tummy Tuck
- ☐ Thigh / Buttock Lift
- ☐ Upper Arm Lift
- ☐ Scar Revision
- ☐ Other _____
- ☐ Breast Augmentation (enlargement)
- ☐ Breast Reduction
- ☐ Breast Lift
- ☐ Nose Surgery
- ☐ Eyelid Surgery
- ☐ Facelift
- ☐ Neck Lift
- ☐ Forehead / Brow Lift
- ☐ Ear Pinning

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number:

- **When looking in the mirror, how concerned are you about the appearance of your face and neck?**

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

- **When looking in the mirror, how concerned are you about the appearance of your body?**

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

How did you hear about our practice (if known):

- ☐ Yellow Pages (name): _____
- ☐ Newspaper ad (name): _____
- ☐ Radio ad (name): _____
- ☐ TV ad (name): _____
- ☐ Other (please specify): _____
- ☐ Friend or family (name): _____
- ☐ Physician referral (name): _____
- ☐ Internet (list website or search engine): _____

Reorder from **One Source Inc.**
(269) 649-3600

SOUTHWEST MICHIGAN
PLASTIC AND HAND SURGERY

Patient History Form: Full Name (print): _____ DOB: _____

LUNGS:
__Bronchitis
__Emphysema
__Asthma
__Tuberculosis (TB)
__Sinusitis
__Cold/Respiratory infection
__Chronic cough
__Phlegm while coughing
__Other:_____

HEART:
__High blood pressure
__Heart attack
__Heart disease
__Heart murmur
__Chest pain
__Shortness of breath
__Chest discomfort during exercise
__Hearth thumping/racing
__Mitral valve prolapse
__Other:_____

VASCULAR:
__Circulatory problems
__Anemia
__Sickle cell
__Bleeding tendencies
__Leg pain
__Ankle swelling
__Blood clot(s)
__Blood transfusion
__Other:_____

SYSTEMIC:
__Diabetes
__Glandular trouble
__Thyroid/Hormone
__Night sweats
__Unusual lumps
__Nipple discharge
__Stomach/bowel problems
__Hepatitis
__Yellow, Jaundice
__Ulcers, Hiatal hernia
__Medication port
__Alcoholism
__AIDS
__Other:_____

KIDNEY/BLADDER:
__Urinate frequently
__Urinary pain/itching
__Urinary infections
__Leakage
__Kidney stones
__Bloody urine
__Gynecological disease
__Other:_____

MUSCULAR/SKELETAL:
__Muscle weakness
__Arthritis
__Back/Neck injury
__Broken bones
__Other:_____

NERVOUS SYSTEM:
__Headache
__Nervousness
__Fainting/Dizziness
__Epilepsy/Seizures
__Head injury
__Nerve injury/damage
__Stroke
__Psychological problems
__Other:_____

TEETH/MOUTH:
__Mouth sores
__Loose teeth
__Dentures: Upper:____ Lower:_____
__Other:_____

EYE/EAR/NOSE:
__Eye pain
__Glaucoma/cataract
__Hearing loss
__Ringing in the ears
__Other:_____

SKIN:
__Acne
__Psoriasis
__Dermatitis
__Bruise easily
__Skin disease/disorders
__Other:_____

Current Medications: please list below or provide us with a list.

Medication	*Dosage*	*when do you take it.*

Allergies: Do you have any sensitivity? Yes ___ No ___

___To medications: (please list) _____

___To X-Ray Dye: (please explain) _____

___Other: (please list/explain) _____

Previous Surgeries: Have you had any surgeries? Yes___ No___

Reason: _____ Year: _____

Reason: _____ Year: _____

Reason: _____ Year: _____

Reason: _____ Year: _____

Additional comments: _____

Anesthesia: Have you had difficulty with anesthesia before? Yes_____ No_____

FOR HAND PATIENTS: Which hand is injured, R or L? _____ Date of injury: _____

Describe the type of work you do: _____

Personal History: Height: _____ **Weight:** _____

When was the last time you saw your primary care physician? _____

Have you ever had any type of cancer? If yes, what kind? _____ No_____

What is your daily consumption of: Caffeine/Coffee/Pop/Tea: _____

Do you smoke tobacco? Yes_____ How much? _____ No_____

Do you drink alcohol? Yes_____ How often? _____ No_____

Do you use drugs/mind altering substances/recreational marijuana? Yes_____ No_____

Family History: (please list any disease/health conditions & WHICH family member.)

_____

_____

Reason for today's visit:

_____

Answers to the above represent a true/complete history to the best of my knowledge:

Signature: _____ today's Date: _____

Southwest Michigan Plastic and Hand Surgery, P.C.

Elective Procedure Financial Policy

As patients approach surgery, they frequently need information about the various payment options and have questions about their potential insurance benefits. We hope the following information will be helpful.

Our Cosmetic Coordinators are readily available to meet with you personally to provide the specific information you desire. They are here to help meet your needs regarding surgical payment and insurance benefit options. As a general rule, cosmetic services are not normally paid for by insurance companies. We will do our best to coordinate the billing of procedures, services. and supplies in order to maximize prospective insurance reimbursement.

If we participate with your insurance, and if we are given preauthorization for services associated with your surgery, we will bill your preauthorized service according to our payer agreement. The benefits paid by insurance companies for corrective or cosmetic surgery vary greatly from carrier to carrier and plan to plan. Therefore, we make every effort to determine insurance coverage in advance. For carriers with which we participate, we will provide a projected insurance payment and the amount required for non-covered services. We do this because we believe you need to be informed as completely as possible before making a surgical decision. You are ultimately responsible for the full payment of your account, but we have found that our knowledge and experience can be an important factor in assisting you to collect your maximum benefits. You will be required to pay, in advance of surgery, for all services, devices, implants, garments, anesthesia and facility fees not preauthorized by your insurance carrier.

If we do not participate with your insurance, you will be required to pay, in advance of surgery, for all services, devices, garments, implants, anesthesia and facility fees. We will work with you to forward a completed bill to your insurance carrier for pre-authorized services provided by our physicians. We will request the carrier to make any benefit payments payable to you. In the event we receive the benefit payment, we will refund you, the amount of the benefit payment from your carrier within I O days of receipt..

Payment Options:

Payment for surgery is due in full a minimum of two weeks prior to your surgery date. This does include any applicable facility and anesthesia payments as well as the surgeon's fees. A surgical deposit of $250.00 is required to "hold" a surgical date for you. This is nonrefundable, but applicable to your surgical fee if you have surgery within 90 days of paying the deposit.

Your surgical quote is an estimate of surgical services. There may be additional or reduced charges depending upon such changes as: adding or deleting a procedure, using additional operating room and anesthesia time or changing to another facility.

- Cash or check: Personal check, cashier's check or cash
- Credit Card: Visa, MasterCard, Discover or Debit cards with Visa/MasterCard logos
- Financing Plans: We will be happy to assist you with applying for financing should you desire.

Cancellation Policy:

We understand that a situation may arise that could force you to postpone your surgery. Please understand that such changes affect not only your surgeon but other patients as well. Our surgeon's time, as well as that of the operating room staff is a precious commodity and we request your courtesy.

Southwest Michigan Plastic and Hand Surgery, P.C.

Elective Procedure Financial Policy

Surgical Fees:

If you need to cancel your surgery after your pre-operative visit but more than two weeks before surgery, you are entitled to a full refund minus a $250 .00 processing fee. Should you find it necessary to cancel your surgery after your pre-operative visit and less than two weeks before surgery, the following policy will apply;

We will refund 50% of your surgical fee when you give 5 business days notice prior to your surgery date. If you find it necessary to cancel your surgery with less than 5 business days notice there will be no refund given. However, if you can reschedule your surgery, we would be happy to discuss your options with you.

Surgical Deposits:

When you reschedule your surgery before your pre-operative visit, we will be happy to apply your $250.00 surgical deposit to your new date if it is within the next three months. This will apply to only one rescheduling. If you cancel your surgery the surgical deposit will not be refunded.

Refund Policy:

Having cosmetic surgery is not a decision to enter into lightly. Our board certified surgeons will meet with you to discuss your procedures and anticipated results. We will make every effort to assist you in achieving your desired surgical goals. However, occasionally cosmetic surgery can result in patient disappointment. Due to the nature of your services we regret that we cannot refund surgical fees. Should you experience an outcome that does not meet your expectations, our surgeons will discuss with you the various options available for refinement or revision. Your satisfaction is our ultimate goal. If you have questions or need assistance, please ask your Cosmetic Coordinator to assist you.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

SMOKING/SECONDARY SMOKE/TOBACCO PRODUCTS AND THEIR AFFECTS OF WOUND HEALING

All procedures in plastic surgery are performed to improve form and, in some cases, function. Our goal as Plastic Surgeons is to have a perfect form and scar. Unfortunately, smoking and secondary smoke affect wound healing in a potentially devastating way. Any exposure to smoke, either direct.(y, or indirectly can result in poor wound healing, delayed wound healing, skin loss necessitating skin grafting, increased risk in wound infection and loss of skin and deeper tissues. Decreased blood supply to those areas is the cause of these complications. Nicotine is the root cause of the decreased blood supply in that is causes constrictions of the capillaries and small blood vessels that feed the skin with oxygen. Nicotine patches, therefore can NOT be used as an alternative to smoking.

The following procedures and accompanying complications that may result from the use of tobacco products are:

Face Lifting operations: There can be actual skin loss of the face in front of and behind the ear.

Forehead Lifting: There can be hair loss, poor wound healing and scarring.

Blepharoplasty: There can be infection, loss of skin, poor wound healing, edema, and prolonged swelling.

Rhinoplasty: There can be infection, loss of skin, poor wound healing.

Breast Reduction, Mastopexy, and ***Breast Augmentation*** operations: There can be delayed wound healing resulting in unsightly scarring and skin loss and potential nipple loss necessitating skin grafting. There can be infection around the implant requiring its removal. In all cases of patients exposed to smoke or directly smoking, wound do not heal within the expected time frame. Wound healing can be prolonged, as long as 3-4 months.

Abdominoplasty: Smoking or exposure to smoke will decrease the ability of the skin to heal properly resulting in unsightly scarring and higher risk for infection and more importantly, skin loss in the central abdomen, sometimes requiring a skin graft.

Reconstructive Surgery: Smoking can result in failure of skin flaps, skin grafts or muscle flaps to "take" or live. This would result in delayed wound healing or large open wounds requiring months of wound care or additional operations to heal. Complete loss of a flap or graft will require additional and multiple reconstructive operations. All of these will require prolonged or repeated hospitalizations, home nursing care and prolonged time off work.

Bone Healing: Can significantly slow or prevent bone healing.

As your physician I am advising you, if you are smoking, using nicotine patches or gum or in contact with secondary smoke within <u>three weeks</u> of any surgical procedure, your surgery may be cancelled depending on the procedure. Testing for nicotine levels and its longer lasting byproduct , continine, are occasionally performed as part of our routine per- surgery lab work, and if this test is positive for nicotine or continine your surgery will be cancelled. Slow wound healing taking months instead of weeks, skin loss resulting in scabbing and prolonged need for dressing changes and infection usually involving the need for antibiotics (and sometimes another surgery to drain the infection) all are complications that can occur if you smoke, are exposed to secondary smoke, use nicotine patches or gum. Please be honest with us so we can take good care of you and help prevent problems.

I have read the above information and have been informed of the issues of primary and secondary smoke and nicotine effects on wound healing.

SIGNATURE_____

DATE_____

SOUTHWEST MICHIGAN
PLASTIC AND HAND SURGERY

Acknowledgment of Receipt of Notice of Privacy Practice

By signing below, I acknowledge that I was offered a copy of Southwest Michigan Plastic and Hand Surgery Notice of Privacy Practices.

WITNESS:

Date_____ _____
Printed Patient Name

_____ _____
Witness Signature Patient Signature

PHOTOGRAPHY CONSENT

I consent to the taking and use of pictures for training and educational purposes pursuant to the guidelines listed in the HIPAA Regulations

WITNESS:

Date_____ _____
Printed Patient Name

_____ _____
Witness Signature Patient Signature

DOCUMENTATION OF FAILURE TO OBTAIN SIGNED ACKNOWLEDGMENT

On _____, _____presented this Acknowledgement of
(date) (employee name)

Receipt of Notice of Privacy Practices Form to _____.

The Patient refused to provide a signature when requested.