Front Range Plastic and Reconstructive Surgery
Warren Schutte, MD

Legal Last Name_____ First Name_____MI_____

What name do you prefer to be called _____Email:_____

Male/Female Date of Birth_____ SSN_____

Address_____

City_____ State_____ Zip_____ Phone(_____)_____

Cell (____)_____ May we send you text message reminders: yes____ no ____

Emergency Contact_____Phone Number (____)_____

Spouse Name_____Phone Number (____)_____

Referral Information
Who referred you to our office_____

The following is information collected from all our patients and used it to track quality of care. This information goes into your medical record and it is confidential. It is a government requirement to monitor health care processes and outcomes for different population groups, target quality initiatives more efficiently and effectively, and provide patient-centered care.
Please circle or fill in one of the following:

Race: African-American Asian Caucasian Hispanic Other_____

Ethnicity: Non-Hispanic Hispanic Other_____

Primary Language: English Spanish Other:_____

IF Patient is a Minor
Guarantor Name_____DOB_____

Address_____

City_____State_____Zip_____SSN_____

Communication Authorization
I certify this information is true and correct to the best of my knowledge. I will notify the office of any changes in my status or the above information. I also acknowledge that I reviewed and received the practice privacy notice.

Signature:_____ Date:_____

Front Range Plastic and Reconstructive Surgery
Policies

Thank you for choosing Front Range Plastic and Reconstructive Surgery. We are dedicated to providing you the most efficient care and service possible. Your understanding of our policies is an essential element of your care and service. If you have any questions regarding any aspect of our policy, please feel free to present your question to any of our staff.

Front Range Plastic and Reconstructive Surgery and Dr. Schutte are affiliated with healthcare teaching institutions. We may participate in programs to teach resident doctors, medical students, nursing students, and other healthcare students. These healthcare workers in training may participate in your care and treatment including office evaluation and surgical procedure, under the guidance of Dr. Schutte.

Payments are due when services are rendered. If you are unable to make payment in full at the time of service, your appointment will be rescheduled to a more convenient time. We accept Visa, MasterCard, Discover, personal checks and cash. Please be aware that we will add a $30.00 charge to your account for returned checks. We reserve the right to send all accounts with balances over 60 days old to an outside collection agency. All accounts sent to collections will be charged a $50.00 processing fee and any additional fees associated. You may be responsible for all collections and attorney costs incurred.

Cosmetic procedures deposit
There is a non-refundable deposit required before the date selected can be reserved exclusively for you. The deposit is $500.00 or 10% of surgery cost whichever is greater. This is a non-refundable deposit. This fee is used to cover the booking and scheduling expenses involved with your surgery. This amount will be deducted from your total cost.

Surgery Final Payment
You will be expected to pay the remaining balance due on your account at your pre-op visit, generally two weeks prior to your surgery. We accept: Visa, MasterCard, Novus (Discover), Money Orders, Cashiers Checks and Cash. Personal checks are accepted only if paid two (2) weeks prior to surgery. No post-dated checks will be accepted. Please note if you plan to use a Bank DEBIT card for your final payment, they usually will not process over $500.00, please contact your bank in advance to make arrangements. We also accept Care Credit and United Medical Credit.

Surgery Cancellation
If for any reason, medical or personal, you cancel surgery two weeks or less than your scheduled surgery date you will be charged a cancellation fee: 14 days = 25% of total surgical fee, 7-13 days = 50% of total surgical fee; 2-6 days = 75% of total surgical fee, 1 day = 100% of total surgical fee

I acknowledge that I have received a copy of this policy. I agree to read this document and comply with the terms set forth for services rendered by Front Range Plastic and Reconstructive Surgery.

Patient Signature (Guarantor) Date

_____ _____

Front Range Plastic and Reconstructive Surgery

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____
have been informed that a copy of our offices Notice of Privacy Practices 2013 version is available in the waiting room(s) and online at www.frontrangeplasticsurgery.com. A copy of this Notice will be furnished to me upon my request.

_____ _____
Signature of Patient Date

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

It is our policy to not release confidential and/or unauthorized information except as defined in the Notice of Privacy Practices. If you would like to have information released to someone other than yourself please complete the following:

Please list names of people we can discuss your medical or skin care with:
Spouse Name _____ yes____ no____
Parent Name _____ yes____ no____
Other Name _____ yes____ no____
Please give name and relationship such as boyfriend, sister, etc.

I authorize the doctor's office to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them, in writing, whenever this information changes.

Home telephone	yes____ no ____	Voice mail	yes____ no____
Answering machine	yes____ no____	Cell phone/voice mail	yes____ no____
Work phone	yes____ no____	Text	yes____ no____

Preferred Contact (circle one) Home / Work / Cell / Email

May we fax medical records for referrals? yes____ no____

_____ _____
Signature of Patient/Guardian Date

CONSENT TO PHOTOGRAPH

I understand that photographs will be taken periodically throughout my treatments. These photographs will be used to monitor progress and other factors. I understand that failure to consent to these photos will give Front Range Plastic and Reconstructive Surgery the right to decline my treatment.

I hereby grant permission for the use of any of my medical records including: illustrations, photographs or other imaging records created in my case for the use in examination, testing, credentialing and/or certification purposes by The American Board of Plastic Surgery, Inc., AAAASF, and Dr. Warren Schutte.

_____ _____

(Patient Full Name – Please Print) (Patient Signature)

_____

(Date)

CONSENT TO USE PHOTOGRAPHS

I hereby give Dr. Warren Schutte and staff the absolute right and permission to copyright and/or publish, or use photographic portraits of me, or in which I may be included in whole or in part, or reproductions thereof in color or otherwise, for presentations, photo albums, display on the company's web site, art trade, news or any other lawful purpose whatsoever. I hereby waive any right that I may have to inspect and/or approve the finished product or the advertising copy that may be used in connection therewith, or the use to which it may be applied. Please check one below:

- ☐ Accept
- ☐ Decline

I understand that by signing below Front Range Plastic and Reconstructive Surgery need not approach me again for authorization on these photos.

_____ _____

(Patient Full Name – Please Print) (Patient Signature)

_____

(Date)

ELECTRONIC COMMUNICATION

Email, text, or other electronic communication provides a fast and easy way to communicate with Front Range Plastic and Reconstructive Surgery (FRPS) for those issues that are non-emergent, non-urgent or non-critical. It is not a replacement for the interpersonal contact that is the very basis of the client practice relationship; rather it can support and strengthen an already established relationship.

The following summarizes the information you need to determine whether you wish to supplement your experience at our practice by electronically communicating with FRPS staff.

General Considerations

- Electronic communication will be considered and treated with the same degree of privacy and confidentiality as written medical records.
- Standard electronic communication services, such as text or gmail, AOL, and hotmail email services are not secure. This mean that the electronic messages are not encrypted and can be potentially intercepted and read by unauthorized individuals.
- Your electronic addresses will not be used for external marketing purposes without your permission. You may receive a group emailing from the practice; however, the recipients email addresses will be hidden.

Provider Responsibilities

- Staff will attempt to electronically confirm your email address by requesting a return response to all email messages.
- Your provider may route your electronic messages to other members of the staff for information purposes or for expediting a response.
- Designated staff may receive and read your electronic messages
- Every attempt will be made to respond to your electronic message within 2 business days (Monday – Friday, non-holidays). If you do not receive a response from the practice within 2 business days, please contact the practice by phone.
- Copies of electronic messages sent and received from and to you could be incorporated into your medical record. You are advised to retain all electronic correspondence for your own files.

Client Responsibilities

- Electronic messages should not be used for emergencies or time-sensitive situations. In the event of an emergency, you should call 911. For emergent or time-sensitive situations, you should contact the practice by phone.
- Electronic messages should be concise. Please arrange for an office appointment if the issue is too complex of sensitive to discuss via electronic messaging.
- Please include your full name and the topic or question, in the subject line of emails. This will serve to identify you as the sender of the email.
- Please acknowledge that you received and read the message by return electronic message to the sender.

I have read and understood the above description of the risks and responsibilities associated with electronic communication with Front Range Plastic and Reconstructive Surgery.
I acknowledge that commonly used text services and email services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information.
I have been given the opportunity to discuss electronic communication with a representative of FRPS and have had all my questions answered.
In consideration for my desire to use electronic communication as an adjunct ti in-person office visits with FRPS, I hereby consent to electronic communication via non-secure text and email services.
I understand that I may revoke my consent to communicate electronically at any time by notifying the practice in writing at the following address: Front Range Plastic and Reconstructive Surgery, 2500 Rocky Mountain Ave Ste 2130, Loveland, CO 80538. However, if I revoke my consent, the revocation will not have an effect on actions my doctor has already taken in reliance on my consent.
I agree and release my provider and Front Range Plastic and Reconstructive Surgery from any and all liability that may occur due to electronic communication over a non-secure network.
I further agree to be held accountable and to comply with the client responsibilities as outlines in this consent.

CLIENT

Client Authorized Email Address (Please Print)

First Name Last Name

Client Signature Date

PARENT/GUARDIAN (if client under 18 years of age)

Client Authorized Email Address (Please Print)

Client Name (Print)

Client Signature Date

Please check <u>all</u> procedures that you are interested in discussing with the doctor.

<u>Face</u>

- ☐ Facelift
- ☐ Browlift
- ☐ Upper Eyelid Surgery
- ☐ Lower Eyelid Surgery
- ☐ Neck lift
- ☐ Nose Surgery
- ☐ Ear surgery
- ☐ Lip implants
- ☐ Cheek implants
- ☐ Chin implants
- ☐ CO2 Fractionated laser
  - ☐ Face
  - ☐ Neck
  - ☐ Chest
  - ☐ Hands

<u>Injectables</u>

- ☐ Botox
- ☐ Juvederm
- ☐ Facial fat transfer

<u>Skin Care</u>

- ☐ Facial
- ☐ Chemical Peel
- ☐ Skincare products

<u>Breast</u>

- ☐ Augmentation
- ☐ Lift
- ☐ Reduction
- ☐ Reconstruction

<u>Abdomen</u>

- ☐ Tummy Tuck

<u>Arms</u>

- ☐ Arm Lift

<u>Hands</u>

- ☐ Fat Grafting rejuvination

<u>Thighs</u>

- ☐ Thigh Lift

<u>Buttock</u>

- ☐ Buttock Lift

<u>Liposuction</u>

- ☐ Upper abdomen
- ☐ Lower abdomen
- ☐ Flanks (love handles)
- ☐ Back
- ☐ Axillary (arm pit area)
- ☐ Inner thighs
- ☐ Outer thighs
- ☐ Neck
- ☐ Arm

- ☐ Coolsculpting
  Cellfina

Name:_____

THROMBOSIS RISK FACTOR
ASSESSMENT

CHOOSE ALL THAT APPLY

EACH RISK FACTOR REPRESENTS 1 POINT	EACH RISK FACTOR REPRESENTS 2 POINTS	EACH RISK FACTOR REPRESENTS 3 POINTS
☐ Age 41-60 years ☐ Minor surgery planned ☐ History of prior major surgery (<1 month) ☐ Varicose veins ☐ History of inflammatory bowel disease ☐ Swollen legs (current) ☐ (BMI > 25) ☐ Acute myocardial infarction ☐ Congestive Heart Failure (< 1 month) ☐ Sepsis (< 1 month) ☐ Serious lung disease including pneumonia (< 1 month) ☐ Abnormal pulmonary function (COPD) ☐ Medical patient currently at bed rest ☐ Other risk factors _____	☐ Age 60-74 ☐ Arthroscopic surgery ☐ Malignancy (present or previous) ☐ Major surgery (> 45 min) ☐ Laparoscopic surgery (> 45 min) ☐ Patient confined to bed (> 72 hrs) ☐ Immobilizing plaster cast (<1 month) ☐ Central venous access	☐ Age over 75 years ☐ History of DVT/PE ☐ Family history of thrombosis* ☐ Positive Factor V Leiden ☐ Positive Prothrombin 20210A ☐ Elevated serum homocysteine ☐ Positive lupus anticoagulant ☐ Elevated anticardiolipin antibodies ☐ Heparin-induced thrombocytopenia (HIT) ☐ Other congenital or acquired thrombophilia If yes: Type: _____ * Most frequently missed risk factor

EACH RISK FACTOR REPRESENTS 5 POINTS	FOR WOMEN ONLY (EACH REPRESENTS 1 POINT)
☐ Elective major lower extremity arthroplasty ☐ Hip, pelvis or leg fracture (< 1 month) ☐ Stroke (1 < month) ☐ Multiple trauma (< 1 month) ☐ Acute spinal cord injury (paralysis) (< 1 month)	☐ Oral contraceptives or hormone replacement therapy ☐ Pregnancy or postpartum (< 1 month) ☐ History of unexplained stillborn infant, recurrent spontaneous abortion (>=3), premature birth with toxemia or growth-restricted infant

Total Risk Factor Score = _____

Age: Sex:

Weight:

Front Range Plastic and Reconstructive Surgery - Medical History Form

Name:_____ Date: _____

Birth date: **«Person_Birth_Date»** Age:_____ Height _____ Weight _____ Occupation_____

How did you hear about us?: _____

Reason for your visit today: _____

Physicians that care for you: (PCP/Specialists)_____

Pharmacy Name _____Location:_____

Do you have a responsible adult available to assist you during a recovery period? □ Yes □ No

CURRENT MEDICAL CONDITIONS for which you are presently being treated: _____

_____

_____

PAST MAJOR ILLNESSES: _____

_____

ALLERGIES: □ NONE

Allergy: (Drug, Food, Tape, Latex)	Reaction

MEDICATIONS: List All Prescription, Over-the-counter, Supplements, and topical creams

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQENCY

Have you taken any steroids within a year? □ Yes □ No When? _____ How long?_____ Why? _____

PAST SURGERIES (including cosmetic surgery) with dates:

Have you had an EKG? □ Yes □ No When? _____ Where? _____Why?_____

ANESTHESIA HISTORY:

Local anesthesia? □ Never had □ No complications □ Severe Reaction:_____

General anesthesia? □ Never had □ No complications □ Severe Reaction:_____

FEMALES ONLY: Have you had a mammogram? □ Yes □ No When last:_____

Where? _____Results: □ Normal □ Abnormal_____

Number of Past Pregnancies:____ Future pregnancies planned: □ Yes □ No Are you lactating? □ Yes □ No

FAMILY HISTORY: *Have any blood relatives ever had any of the following problems:*

Office Use: Ht_____ Wt_____ BMI_____ BP_____ P _____
Notes:

Measurements:_____

□ Abnormal bleeding or clotting □ Cancer □ Problems with Anesthesia □ Heart disease □ Other serious illness:
Please describe:_____

SOCIAL HISTORY: Exercise Frequency: □ None □ 1x/week □ 2-3 x/week □ 4-6x week

Do you ever use nicotine-containing products? (Smoke/Chew/ E Cig) □ No □ Quit □ Yes Amount_____

If Quit: When? _____ Have you ever quit?_____ For how long?_____

Do you drink alcohol? (circle one) No Yes How much? _____

REVIEW of SYSTEMS: **Please check <u>all</u> past and present medical conditions**

CONSTITUTIONAL:
□ Good general health lately
□ Recent weight gain
□ Recent weight loss
□ Night sweats
□ Headache
□ Fever
□ Fatigue
□ Other: _____

CARDIOVASCULAR:
□ High blood pressure
□ Heart attack(s) history
□ Pacemaker
□ Coronary artery disease
□ Heart murmur/Mitral valve prolapse
□ Irregular heartbeat/palpations
□ Stroke/TIA history
□ Chest pain/pressure/burning
□ Swelling of feet, ankles, or hands
□ Atrial fibrillation
□ High cholesterol
□ Tachycardia
□ SVT
□ CHF
□ Fainting episodes
□ Other _____

RESPIRATORY:
□ Asthma
□ Chronic cough
□ Shortness of breath
□ Wheezing
□ Spitting up blood
□ COPD
□ Sleep Apnea
□ Bronchitis
□ Other: _____

HEMATOLOGY/LYMPHATIC:
□ Blood transfusion history
□ Bleeding disorder
□ Slow healing
□ Easily bruise/bleeding
□ Anemia
□ Clotting disorder
□ Taking anticoagulants
□ DVT/PE history
□ Enlarged glands
□ Other: _____

NEUROLOGICAL:
□ Frequent or recurring headaches
□ Migraines
□ Dizziness
□ Numbness/Tingling sensation
□ Tremors
□ Seizure disorder/convulsions
□ Paralysis
□ Parkinsons Disease
□ Other: _____

PSYCHOLOGICAL:
□ Depression
□ Anxiety
□ Memory loss or confusion
□ Receive(d) psychiatric treatment
□ Sleeping problems
□ Bipolar disorder
□ ADHD
□ OCD
□ PTSD
□ Panic attack history
□ Other: _____

EARS/NOSE/THROAT:
□ Nasal allergies
□ Difficulty breathing by nose
□ Previous nasal injury
□ History of sinus infections
□ Hearing loss
□ Hoarseness
□ Nose bleeds
□ Sinus problems
□ Sore throat
□ Ringing in ears
□ Nasal deformity
□ Difficulty swallowing
□ Other: _____

EYES:
□ Dry eye
□ Blurred/double vision
□ Cornea problems
□ Glaucoma
□ Thyroid eye disease
□ Wear glasses/contacts
□ Eye pain
□ Eye disease/injury
□ Visual field obstruction
□ Macular degeneration
□ Decreased vision
□ Other: _____

ENDOCRINE:
□ Diabetes/Prediabetes
□ Thyroid disease
□ Excess thirst/urination
□ Other: _____

GENITOURINARY:
□ Dialysis
□ Burning/painful urination
□ Frequent urination
□ Incontinence/Dribbling
□ Blood in urine
□ Kidney stones
□ Indwelling catheter
□ BPH
□ Kidney disease
□ Other: _____

GASTROINTESTINAL:
□ Colitis
□ GERD
□ Stomach ulcers
□ Loss of appetite
□ Change in bowel movement/habits
□ Nausea/Vomiting
□ Frequent diarrhea
□ Blood in stool
□ Stomach pain
□ IBS
□ Crohns
□ Gastric bypass history
□ Other: _____

MUSCULOSKELETAL:
□ Scoliosis
□ Osteoporosis
□ Joint pain
□ Joint stiffness or swelling
□ Muscle or joint weakness
□ Muscle pain or cramps
□ Back pain
□ Difficulty walking
□ Paraplegic
□ Fibromyalgia
□ Gout
□ Arthritis
□ Other: _____

ALLERGIC/IMMUNOLOGIC/INFECTIOUS DISEASES:
□ Environmental allergy
□ HIV/AIDS
□ Hepatitis
□ TB
□ RA
□ Lupus
□ History of MRSA
□Psoriatic arthritis
□ Autoimmune disorder
□ Other: _____

DERMATOLOGICAL:
□ Excessive sweating
□ Cold sores/herpes
□ Acne
□ Rosacea
□ Eczema
□ Psoriasis
□ Radiation to face/neck
□ Scarring/keloid formation
□ Skin lesion
□ Mass
□ Hidradentitis
□ Rash or itching
□ History of skin cancer
□ Skin excess
□ Wound/abscess
□ Other: _____