PLASTIC SURGERY INSTITUTE OF DAYTON, INC.
Steven P. Schmidt, M.D. Matthew J. Fox, M.D. Jason Hedrick, M.D.
9985 Dayton Lebanon Pike
Centerville, OH 45458
937-886-2980
937-886-2982 fax

This letter will answer many of your questions and explain our policies.

Please call if you will be unable to keep your appointment. We would appreciate it if you would **arrive 10 minutes** prior to your scheduled time.

Please **fill in ALL the blanks on** the following forms, and bring them with you for the consultation. This will save you time.

We request that any applicable co-pays and / or deductibles be paid at the time of your visit. We will be happy to submit a claim for you for any non-cosmetic evaluations.
Cosmetic consultations are $75 and are payable at the time of service.

Your office visit is for CONSULTATION ONLY. It will be determined at this visit if surgery is necessary and when and where it will be accomplished.*

Please bring the following with you:

1. Current insurance cards for ALL your medical insurance plans.
2. Driver's license or other photo ID.
3. Utility bill or other correspondence showing current residence if the photo ID does not show the patient's current address.

If your insurance company requires a referral from your family doctor, it is YOUR responsibility to obtain this referral prior to your appointment.

If the patient is a minor, the patient's parent or legal guardian should bring the information listed above.

All patients under age 18 must be accompanied by a parent or legal guardian (due to new privacy standards mandated by the government). Patients 18 and over, but still covered by parent's insurance must be accompanied by a parent or legal guardian.

We request insurance information even though the current condition may not be covered by insurance. A number of patients want to add procedures that may be covered by insurance; however, if we do not have the insurance information, the patient may have a larger balance because we cannot meet pre-certification requirements or we may be out of network.

Written directions to the office are included in this patient packet. There is a map on the Home page of the website.

Thank you.

*For non-cosmetic patients: If surgery is necessary, you may incur separate charges from the hospital, PSI Surgery Center, anesthesiologist and / or pathologist in addition to the physician's fees. Physician fees and PSI Surgery Center fees will be billed to your insurance company by our office on your behalf. Hospital, anesthesiology, and pathology fees will be billed to your insurance company by the facility providing those services. Please feel free to contact our billing office with any questions you may have.

DIRECTIONS TO THE OFFICE OF
PLASTIC SURGERY INSTITUTE OF DAYTON, INC.

Steven P. Schmidt, MD Matthew J. Fox, MD Jason Hedrick, MD

9985 Dayton Lebanon Pike Centerville OH 45458 937-886-2980

FROM THE NORTH/DOWNTOWN DAYTON AREA:

Take I-75 South to Exit 41, Austin Blvd (2nd exit past Dayton Mall). Turn left onto Austin Blvd and follow to the fourth major intersection (approx. 4 miles; fire station on left corner). Turn left onto St Rt 48 and go approx. 1/2 mile to driveway just beyond pond; look for address sign **10001**. Turn left at this sign and then immediately turn right into our parking lot. Go to far door at end of lot.

FROM THE SOUTH/CINCINNATI AREA: Take I-75 North to Exit 41, Austin Blvd. Turn right onto Austin Blvd and follow to the fourth major intersection (approx. 4 miles; fire station on left corner). Turn left onto St Rt 48 and go approx. 1/2 mile to driveway just beyond pond; look for address sign **10001**. Turn left at this sign and then immediately turn right into our parking lot. Go to far door at end of lot.

FROM THE BEAVERCREEK/FAIRBORN AREA: Take I-675 South to Exit 4, Centerville/Kettering.
Turn left onto St Rt 48 and follow through 10 stop lights (approx 3 miles). Go thru the 10th light (Hibberd Dr - Nutt Rd intersection) and then immediately turn right into our parking lot. Go to far door at end of lot.

NOTE: Entering 9985 Dayton Lebanon Pike into GPS may not get you here. Please follow directions above. Thank you!

History and Physical for Dayton Plastic Surgery Institute of Dayton & PSI Surgery Center (Drs. Schmidt, Fox & Hedrick)

9985 Dayton Lebanon Pike, Centerville, Ohio 45458 Phone: 937-886-2980 FAX: 937-886-2982

Patient's Name: _____, Date _____, Birthday _____, Age _____, Height _____, Weight _____

History of Present Illness: Where and what is the problem/diagnosis?_____

How long has problem been present?_____ Has it changed and how (bigger/smaller)? _____

How painful or severe 1-5____? Color/change?_____ Bleeding?___ Scaly?___ Crusty?___ Past treatments?_____

What makes it better or worse?_____

□ Accident? □ Work related Injury? Date of injury? _____ Referring Doctor? _____

_____

Would you like information on cosmetic surgery or procedures? □ yes □ no

If yes, which procedures are you interested in? _____

Current Medication: Please include non-prescription drugs; Aspirin, Advil, Motrin, Ibuprofen, Excedrin, Aleve, Naprosyn, Midol, Pamprin, Vitamins, Herbal remedies. Please list drug name, dosage and schedule. (example: Tylenol 325mg 2 pills three times a day)

1) _____ 5) _____ 9) _____

2) _____ 6) _____ 10) _____

3) _____ 7) _____ 11) _____

4) _____ 8) _____ 12) _____

Drug Allergies: Circle all that apply: None, Penicillin, Sulfa, Codeine, Aspirin, Erythromycin, LATEX, other**?**_____

Please list reactions; hives, rash, nausea, vomiting, sick, breathing problems, swelling, other? _____

Past Medical History: **(**check all that apply) □ NONE

□ Autoimmune Disorder	□ AIDS/HIV	□ Alcoholism	□ Kidney Disease	□ Anesthesia Problem	□ Ulcers
□ Heartburn/acid reflux	□ Gastric Bypass	□ Diabetes	□ Bleeding Problem	□ Psychiatric Care	□ Cancer
□ Pacemaker/Defibrillator	□ Heart Attack	□ Skin Cancer	□ Transfused	□ Depression/Anxiety	□ Asthma
□ Stents/Heart surgery	□ Heart Disease	□ Hepatitis	□ Heart Murmur	□ Healing Problems	□ TB
□ High Blood Pressure	□ Sleep Apnea	□ Anemia	□ Liver Disease	□ High Cholesterol	□ COPD
□ Radiation Therapy	□ Melanoma	□ Arthritis	□ Substance Abuse	□ Thyroid Problem	□ Stroke
□ Chest Pain/Tightness	□ Glaucoma	□ Dentures	□ Other_____		

Females only: □ Menopause □ Fibrocystic Disease □ BRCA Gene □ Breast Cancer □ Ovarian Cancer □ Tubal Ligation

□ Hysterectomy □ C-section Last Mammogram Date: _____ □ Currently Pregnant □ Plan on becoming pregnant? □ #of Pregnancies ____

□ # of Live Births ____ Ages of Children? _____ Bra Size _____

Past Surgical History: 1) _____ 2) _____3) _____

4) _____ 5) _____6) _____ 7)_____

Family History: Has any family member had any of these conditions? (circle) Heart, Lung, Liver, Kidney, Brain Disease, Cancer & Type, Diabetes, High cholesterol, Hypertension, Other:_____

Social History: **Profession**:_____, Status:□ Married, □ Single, □ Widowed, □ Divorced

of **Alcoholic drinks**____per day/week/month. **Smoking #** of cigarette packs per day _____ **#** of years smoking _____ □ caffeine

□ **History of drug/alcohol abuse**? □ Recreational Drugs?_____ **Exercise**? cardio/weights □ dieting □ weight loss

Ethnicity: (circle); African American, Hispanic, Asian, Caucasian, Native American, other: _____

System Review: (Circle all that apply)

General	None; Fever, Chills, Weight Loss, Weakness
HEENT	None; Vision changes, Blind, Double vision, Dry Eyes, Sinus Problem, Nasal Congestion, Ringing, Headache, Head Injury, Snoring, Dental disease, Sore Throat, Broken Nose/Face, Blocked Nose, Nose bleeds, Swollen glands, Dentures, Neck Pain, Hearing Loss, Hard to Swallow, Jaw Pain, Tearing, Seasonal Allergies
Cardiology	None; Chest pain, Heart Failure/Fluid in Lungs; Palpitations (racing heart), Short of breath w/activity, Fainting, Irregular Heart Rate, Waking Up Short of Breath, Rheumatic Fever, A-fib
Pulmonary	None; Asthma/Wheezing, Bronchitis, Cough, Coughing up Blood, Shortness of Breath, Pneumonia
GI	None; Heartburn, Poor Appetite, Nausea/Vomiting, Diarrhea, Constipation, Bloody Stool, Jaundice, Belly Pain, Hernia
GU/Renal	None; Dialysis, Kidney Stones, Kidney/Bladder Infections, Bloody Urine, Incontinence, Pain or Freq. Urination
Vascular	None; Heart/Vascular Disease of Artery/Veins, Vasculitis, Leg Swelling, DVT, Clot, Embolism, Calf Pain
Neurological	None; Headache, Epilepsy/Seizures, Date of last seizure_____ , Spinal Cord Injury, Paralysis, Brain/Nerve Tumor, Head injury, Dizzy, Nerve Pain, Sciatica, Numbness, Weakness
Hematological	None; Leukemia, Sickle cell, Anemia, Bleeding, Blood clots, Bruising, Radiation, Chemotherapy
Endocrine	None; Swollen Lymph Nodes, Diabetes Type I, II # yrs___; Chronic Steroid Use ___yrs.; Always Hot/Cold, Hypo or Hyper Thyroid, Excessive thirst, Fluid Retention, Hot flashes, Menopause, Hairy, Hair Loss

Skin	None; Acne, Cellulitis, Pressure Ulcers, Difficulty Healing, Basal Cell, Squamous Cell, Keloid, Melanoma, Eczema, Warts, Growths, MRSA, Pressure relief, Orthotics, Scaly, Rash, Itching, Bleeding Lesions, Skin Cancer, Ulcer, Frequent Sunburn, Dry Skin
Musculoskeletal	None; Weakness, Fractures, Arthritis, Immobility, Osteomyelitis, Gout, Muscle/Joint/Back Pain
Infectious Disease	None; MRSA, TB, Hepatitis A, B,C, AIDS / HIV, Herpes, Immunizations, Tetanus Shot, Zoster Shot
Psych	None; Disorientation, Unusual thoughts, Depression, Anxiety, Addiction, Insomnia

Please, it is *important* that you fill in all the blanks:

Referred by _____ Phone_____
Address_____ City_____ Zip _____
Family Physician_____ Phone_____
Address_____ City_____ Zip_____
Other physician (example: specialist)_____ Phone_____
Address_____ City_____ Zip_____

STATEMENT OF RELEASE: May we leave a message concerning **your health information and appointments** with a family member or other designated person(s) or on your answering machine? □ yes □ no.
FAMILY MEMBER OR DESIGNATED PERSON(S):
Name_____ Relationship _____ Phone _____
Name_____ Relationship _____ Phone _____
Patient Signature_____ Date_____

Authorization for Disclosure of Information: I authorize Drs. Schmidt, Fox & Hedrick to disclose complete information concerning his/their medical findings and treatment of the undersigned, from the initial office visit until the date of conclusion of such treatment, to those individuals who, in my physician's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

Patient Signature_____ Date_____
Witness_____ Date_____

DOCTORS ONLY: General: well developed, well nourished, obese anorexic, emaciated, oriented, confused, depressed, anxious
PHYSICAL EXAM: Vitals: Temp._____ Pulse_____ Resps._____ BP_____
HEENT: □ NCAT, AOx3, CN II-XII, PERRLA, EOMI, MMM, Nl Hearing, Nl Vision, Ø mass, Ø bruits, Ø Nodes_____
Heart: □ RRR , nl s1/s2 Ø GRM Ø JVD _____
Chest: □ CTAB, no WRRC, BS = , AE good, Ø breast mass, Ø nodes _____
Abdomen: □ Soft, NT ND BS+, ØHSM, Ø mass, □hernia_____
Skin: Location_____ Size_____ Reg/Irreg Border, Color: Br/Bk/Bl/Red/Tan, Mac/Pap, Scaly, Irritated, Itches
Location_____ Size_____ Reg/Irreg Border, Color: Br/Bk/Bl/Red/Tan, Mac/Pap, Scaly, Irritated, Itches
Location_____ Size_____ Reg/Irreg Border, Color: Br/Bk/Bl/Red/Tan, Mac/Pap, Scaly, Irritated, Itches
Other/X-RAY/path/lab:_____-_____ □ ***see pictogram***
IMPRESSION/PLAN: _____
_____
_____
_____
Time spent counseling patient_____.□The dx, procedure, risks, complications, tx options, expected post-op course, and questions were fully d/w pt.
Time needed for excision: _____ Anticipated repair length_____ Simple, Intermediate, Complex
Implant Style/Size: _____ □ ***see pictogram***
Functional: Y N, Insurance: Y N, Prior Auth. Needed: Y N, Pre-Cert Needed: Y N, High Deductible: Y N_____
Tiers: Y _____ N , Office in Network: Y N, PSI in Network Y N, Cosmetic: $_____Paid:_____ Due:_____

Patient Needs: □CBC □BMP □PT/PTT □EKG □CXR □Mammogram, **Facility**: □ MVH, □ KMC, □ SYC □ CMC, □ PSI, □ other:_____ **CLEARANCE**: □medical □cardiac □ No need for medical testing □ Patient is able to tolerate surgery
Anesthesia: □ general □ local □ IV Sed **OPERATIVE TIME REQUIRED:**_____
Equipment:_____
Preop RX:□ZPack □Cipro □Vicodin □Valtrex □Emend □Ativan □Bactrim □Percocet □Clonadine □Augmentin □Doxycycline□ other

DOCTOR'S SIGNATURE:_____DATE:_____

PATIENT REGISTRATION ***Black or Blue Ink Pen Only***

Patient's Name _____ Employer_____

Address _____ Address _____

City _____State _____Zip _____ City _____ State _____ Zip _____

Home phone (_____)_____ Employer phone (____)_____

Cell phone (_____)_____ Best # to reach you at _____

Birthday _____ Age _____ Sex_____ Emergency contact _____

Social security # _____ Relationship _____Phone (_____)_____

Would you like to receive emails regarding promotions, discounts and special offers? Yes No

Email address _____ Email address _____

Responsible party (if not the patient)_____ Relationship _____

Address _____ Social security # _____

City _____ State _____Zip _____ Employer _____

Home telephone (_____)_____ Address _____

Employer telephone #_____ City _____ State_____ Zip_____

INSURANCE INFORMATION: If we have a COPY OF YOUR CARD and the patient is the policy holder, skip this section.

PRIMARY COVERAGE

Insurance Company _____

Policy holder name _____

Policy ID # _____

Policy holder SS # _____

Policy holder birthday _____

Group name or number _____

Insurance address _____

City _____ State _____Zip_____

Telephone _____

SECONDARY COVERAGE

Insurance Company_____

Policy holder name_____

Policy ID # _____

Policy holder SS # _____

Policy holder birthday _____

Group name or number_____

Insurance Address _____

City _____State _____ Zip _____

Telephone _____

WORKERS COMPENSATION CLAIMS: Date of injury _____ BWC Claim # _____

Managed Care Organization _____ Telephone _____

Address _____ City _____ State _____ Zip _____

I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES.
I AUTHORIZE PAYMENT DIRECTLY TO PLASTIC SURGERY INSTITUTE OF DAYTON, INC.
I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR MY BILL.
I UNDERSTAND THAT IF I EXPECT ANY PORTION OF MY BILL TO BE REIMBURSED OR PAID BY INSURANCE OR A PREPAID HEALTH PLAN, IT IS MY RESPONSIBILITY TO ENSURE THAT MY DOCTOR HAS MET MY CARRIER'S REQUIREMENTS.
I AUTHORIZE THE USE OF THIS INFORMATION ON ALL MY INSURANCE CLAIM SUBMISSIONS TO OBTAIN PAYMENT FROM MY INSURANCE COMPANY.
I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PRECERTIFICATION FROM MY INSURANCE COMPANY AND TO OBTAIN PAYMENT FROM MY INSURANCE COMPANY.
I AUTHORIZE MY DOCTOR TO PHOTOGRAPH ME WITH RESPECT TO MY MEDICAL CARE FOR MEDICAL EDUCATION, TEACHING PURPOSES, PRESENTATION TO LAY PERSONNEL; AND THE USE OF MY MEDICAL RECORDS AND PHOTOS FOR EXAMINATION, TESTING, CREDENTIALING AND CERTIFICATION PURPOSES AND RELEASE TO MY INSURANCE COMPANY IF REQUESTED.

Signature _____ Date _____

PAYMENT POLICY FOR PLASTIC SURGERY INSTITUTE OF DAYTON, Inc.

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed card insurance programs. Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know exactly what those guidelines are at **each** time of service.

We are please to be able to provide this service to you, but it is extremely difficult for us to keep track of all the individual requirements of the plans. Each one has different stipulations regarding how often services may be rendered and, even more importantly, where those services may be performed. Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated. We will do our best to obtain pre-certification for you, but it is **your responsibility** to know your contract. If pre-certification is required, please inform us so we may obtain prior approval for you.

Many managed care plans require a written authorization or referral from your primary care physician for each visit. It is **your responsibility** to obtain this written authorization or referral **before each visit** or to be sure that follow up visits are covered under your primary referral.

Unfortunately, if you do not inform us of any special requirement in your contract or obtain your referral, and we subsequently order services, such as lab work, biopsies, and surgical specimen examinations by laboratory pathologists that **are not covered** under your contract, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then **your responsibility**.

Copayments and deductibles are **your responsibility** and payment is requested at the time of service. In order to help you meet those requirements, we accept cash, personal checks, Mastercard, Visa, American Express, and Discover. There is a $25.00 penalty for returned checks.

Patients with no insurance should contact our Business Office. It is necessary to arrange a satisfactory payment plan **before** your first visit, or you will be responsible for the entire balance within 30 days from the date of your treatment.

Financial Hardship cases are determined on an individual basis and should be directed to our Business Office.

Any questions or concerning regarding your account or insurance should be directed to our Business Office. We have a highly qualified business office staff available to assist you with your account.

With your cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on caring for your medical needs.

* * * * *

I have read and understand the office policy stated above and agree to accept responsibility as described.

_____ _____

Signature Date

PLASTIC SURGERY INSTITUTE OF DAYTON, INC.
PSI SURGERY CENTER, LLC.
9985 Dayton Lebanon Pike
Centerville, OH 45458
937-886-2980

Insurance Disclaimer

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs. **Providing quality medical care for our patients is our primary concern.** It is impossible to know if Plastic Surgery Institute of Dayton, Inc. and/or PSI Surgery Center, LLC. are participating providers for each and every insurance company and/or network. **It is the insured's responsibility to confirm with the insurance company that these entities are enrolled in your particular plan.** If your insurance company/network has changed recently or you have not been seen in our office in the last 3 months we strongly recommend you contact your insurance company to confirm we are a provider for your plan.

In addition, some insurance companies pay different levels of benefits depending on where care is provided. Again, **it is the insured's responsibility to know where the highest level of benefits will be provided.** (Employees of Miami Valley Hospital and Premier Health Partners who have United Health Care are examples of this type of reimbursement.)

I acknowledge that I have read the above statement and understand it is my responsibility to confirm with my insurance company/network that Plastic Surgery Institute of Dayton Inc. (Dr. Schmidt/Dr.Fox/Dr. Hedrick) and PSI Surgery Center, LLC. are participating providers for my plan. I will be provided a copy of this statement upon request.

Signature_____

Printed Name_____

Date_____

TRADITIONAL ANTHEM PATIENTS **DO NOT NEED TO CONTACT YOUR INSURANCE COMPANY—WE ARE CONTRACTED PROVIDERS FOR THIS PLAN (however we are not providers for Anthem Senior Advantage)