CHASE LAY, MD & ASSOCIATES INC

FACIAL PLASTICS ◊ EYELID SURGERY

DOUBLE BOARD CERTIFIED FACIAL PLASTICS & OTOLARYNGOLOGY
DIPLOMATE AMERICAN ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY

Date________________

Name(**Last**)_________________________(**First**)______________________

Address_____________________**City**______________**State**____ **Zip** ________

Phone __________________ **Cell Phone** _________________

E-mail ______________________ Preferred method of contact: ⦿ **Email** ○ **Phone**

DOB:________**Age**: ____Sex: ○**M** ⦿**F** Marital Status: ⦿**Single** ○**Married** ○ **Divorced**

Employer: ______________________Occupation: _________________________

Emergency contact:___________________ Relationship:_ Spouse _

Phone: __________________

How did you hear about us? ○**Web search** ○ **Yelp** ⦿**Realself.com** ○**FB** ○**IG**
Referral: ___________ **Other**:_______________

Procedures & Health History

What are you being seen for today? ____________________________________
What procedures are you interested in?__________________________________
Are you in good health? ○**YES** ○ **NO** If NO, provide reason:
____
____

List **all medications** which you are on currently or have taken in the last 6 months (prescription & non-prescription - **ESPECIALLY ASPIRIN, COUMADIN, WARFARIN, PLAVIXX, LOVENOX)**: Amount & Frequency- attach list if needed

1)_____________________________ 2)_________________________________

3)_____________________________ 4)_________________________________

List all herbal supplements or Vitamin C, E, Fish oils currently taking **(especially Gingko, Ginger, Garlic, St. John's Wort)**____

List ALL drug ALLERGIES and reactions:

____

Are you a smoker? ◯ **YES** ◯ **NO** If YES, how much: none Quit? How long ago?_________

How much alcohol do you drink? __ i don't drink Caffeine?_______________

Is there any possibility that you may be pregnant at this time? ◯ **YES** ◯ **NO**

List **all surgeries** that you have had (include Plastic Surgery) and year performed (month if performed this year):

____

____

Have you or anyone in your family ever had unusual reactions to anesthesia? ◯ **YES** ◯ **NO**

Have you ever undergone chemotherapy, radiation, or treatment for autoimmune disease? ◯ **YES** ◯ **NO**

For what and when?____

Chest Pain	◯ YES ◯ NO	Rheumatic Fever	◯ YES ◯ NO	Heart Disease	◯ YES ◯ NO
Diabetes	◯ YES ◯ NO	Thyroid Disorder	◯ YES ◯ NO	Asthma	◯ YES ◯ NO
Emotional Problems	◯ YES ◯ NO	Eye Burning	◯ YES ◯ NO	Heart Murmur	◯ YES ◯ NO
Palpitation	◯ YES ◯ NO	High Blood Pressure	◯ YES ◯ NO	Cancer	◯ YES ◯ NO
Hepatitis	◯ YES ◯ NO	Seizures	◯ YES ◯ NO	Eye Disease	◯ YES ◯ NO
Dryness of Eyes	◯ YES ◯ NO	Mitral Valve Prolapse	◯ YES ◯ NO	Shortness of Breath	◯ YES ◯ NO
Anemia	◯ YES ◯ NO	Breast Disease	◯ YES ◯ NO	Kidney Problems	◯ YES ◯ NO
Scarring	◯ YES ◯ NO	Eye Itching	◯ YES ◯ NO	Bleeding Disorders	◯ YES ◯ NO

Have you recently or are you about to undergo significant life changes? **(Wedding, Divorce, Career or job change, Death of a loved one?)**_________ None ___

NOTE: Please stop aspirin products and other blood thinners 2 weeks prior to surgery or discuss with the doctor. Initials______________ Date:___________

General & Financial Agreement

I recognize that the practice of medicine and surgery is not an exact science. I understand and accept that fees are paid for performance of the procedure(s) only, and not a guaranteed result. I acknowledge that although a good outcome is expected, and a reasonable effort has been made to establish realistic expectations, there cannot be any warranty, expressed or implied, as to the results that may be obtained.

I hereby acknowledge that I am aware Dr. Lay's **Notice of Privacy Practices** (**HIPAA)** is available to me at any time at **http://www.chaselaymd.com/resources/HIPAA-Notice-to-Patients-00115667.pdf.** I further acknowledge that a copy of the current notice will be posted in the reception area and a copy is available to me on request. **INITIAL** __________

Problems and Complications

I understand and accept that problems relating to or complications of my surgery may result in additional costs to me. These costs may include additional anesthesia and facility fees, hospital costs, physician's fees or other unspecified charges that may not be covered, or only partially covered, by my health insurance. Lost time at work, social dates and wages due to prolong healing or perceived inability to present one's self to the public is a possibility as is missed. **INITIAL** ____________

Revisions and Touch-ups

I understand and accept that on occasion "touch-ups" or revisions of surgery are necessary. I acknowledge that in such cases I am responsible for all operating room and anesthesia charges. I am also aware and accept that a surgeon's fee may also be charged, at my surgeon's discretion. I understand and accept that the need for, and timing of, revisions and touch-ups will be determined solely by my surgeon, as will the amount of the surgeon's fee. **INITIAL** ____________

Aesthetic Surgery Payment and Cancellation

A nonrefundable fee of $750 will be collected at the time of booking in order to schedule and secure a date and time in the operating room. Full payment will be required 7 days prior to the scheduled surgery date. Cancellation and refund policies will be provided to me with my quote and when I schedule my procedure. If my surgery must be cancelled because I fail to provide requested preoperative lab work, X-rays, medical evaluation, history and physical, letter of medical clearance, or other requested medical information, my payment will be refunded less a non-refundable surgery deposit fee of $750. This will be forfeited and retained as a processing fee and not returned to me. If, for any reason, I fail to show for scheduled surgery without providing notice, I will forfeit the non-refundable surgery deposit fee of $750 and the aftercare fee (if any). These will be retained as processing fees and not returned to me. If surgery must be rescheduled, all fees will be applied to the new procedure date, and the cost will remain the same, provided it is within 6 months of the original date. After 6 months, fees can still be applied, but there may be additional costs for anesthesia, facility, or surgeon's fees. If a refund is needed, it will be issued in the form of a check even if a credit card payment was made. Please allow one to two weeks for processing. **INITIAL**_________

Declaration: I certify I have read and understand the financial agreement and I accept and agree to all of the above.

Signature_____________________ **Patient Printed Name:** ____________________**Date:** _________

Witness signature:_____________________________ **Date**________________

Cancelled and Missed Appointment Policy

Our goal is to provide quality, individualized, medical and cosmetic care in a timely manner. Please remember that we have reserved appointment times especially for you. In an effort to provide prompt service, we request at least a 24-hour advanced notice in order to reschedule your appointment.

Cancellation of an Appointment

If you are unable to show up for an appointment, please call Dr. Lay's office promptly. This time will be re-allocated to someone who is in need of treatment. If it is necessary to cancel or reschedule your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will allow another patient access to timely care. In the case that the office is notified of the cancellation with less than 24 hour's notice, it will be considered a No-Show.

How to Cancel or Reschedule Your Appointment

To cancel or reschedule your appointment, please call (408) 358-3888 or email scheduling@chaselaymd.com. If you do not reach the front office, you may leave a detailed message on our voicemail box. If you would like to reschedule your appointment, please leave your name and phone number. We will return your call promptly.

No Show Policy

A "no show" is a patient who misses an appointment without cancelling it. A failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". There will be a fee of $25 charged to the patient for a "no-show" appointment and added to your future visit. This charge is not covered by insurance and is the responsibility of the patient. After the 3rd occurrence, the patient may be discharged and removed from the practice.

Declaration

I certify I have read and understand the financial agreement and I accept and agree to all of the above.

Signature_______________________ **Patient Printed Name:** _______________

Date: ________________