Richard K. Lee, M.D. 3550 South Tamiami Trail Suite 201

# Lee Institute of Plastic Surgery, Medical Corporation

Sarasota, FL 34239

941 340 4731

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| --- | --- | --- | --- |
| **TODAY’S DATE:** | | | |
| ***Patient Registration*** | | | |
| Patient’s *LEGAL* Name | | | Marital Status |
| DOB | Age | | Gender: Male  Female |
| Address City State Zip | | | |
| Cell Phone  ( )  Email | | Other Phone  ( ) | |
| Employer Occupation Work Phone ( ) | | | |

|  |  |  |
| --- | --- | --- |
| Please let us know the reason for your consultation | | |
| How did you hear about our office? (Check All that Apply)  Radio Friend (please specify) Online (circle one) YELP Google REALSELF  Other | | |
| ***In Case of Emergency*** | | |
| Name of Friend or Relative | Relation to You | Phone(s) |
| Pharmacy Name Phone Address | | |
|  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| ***Patient Health History*** | | | |
| Patient Name | | Date | |
| Height | Weight lbs | # of full Pregnancies  Planning more children? Y N | Last Pregnancy Delivery Date (mm/yy)  Did you breast feed? Y N |
| Do you wear glasses or contacts? Yes No If yes, please explain: | | History of Breast Infections (i.e. mastitis)? Yes No If yes, please explain: | |
| Are you legally blind? Yes No | | If yes: Right Eye Left Eye Both Eyes | |
| Date of last mammogram (if applicable): | | Date of last EKG (if applicable): | |
| Are you ***ALLERGIC*** to any ***MEDICATIONS, LATEX, ADHESIVES/TAPE/BAND AIDS,*** and/or ***FOODS (if YES, please list all)?*** Please specify your reaction to each. Yes No | | | |
| Do you take any prescribed or over-the-counter medications (for pain, anxiety/depression, blood pressure, thyroid, etc), diet pills, vitamins/supplements, tea, herbs, protein supplements (bars, shakes, etc.), sleep aids, energy drinks? Yes No  Aspirin Bayer Excedrin Bufferin Ibuprofen Advil Nuprin Naprosyn Motrin Arthritis Medications  ***If YES, please list ALL including dosage & frequency:*** | | | |
| What are your past, present, and chronic medical problems/conditions?  Please list all prior ***surgeries*** , ***traumas (including physical traumas: physical or mental abuse), accidents*** you have had: | | | |
| Please indicate any surgery complications you have had | | | |
| Did you have any significant childhood illnesses? | | | |
| Any family history of breast cancer? | | | |
| Are there any significant illnesses in your family? | | | |
| Do you use nicotine/tobacco products in any form (smoke, vape, e-cig, gum, patch, etc), marijuana, CBD, THC, edibles, hookah, other? Yes No If YES, how much per day?  Any past history of use of nicotine/tobacco products in any form (smoke, vape, e-cig, gum, patch, etc), marijuana, CBD, THC, edibles, hookah, other? Yes No If YES, how much per day, and when did you quit? | | | |
| Do you drink alcohol? Yes No If YES, how much per week? | | | |

*Please circle the appropriate response*

***Y****=Yes* ***N****=No* ***U****=Unsure*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***Airway*** |  |  |  | ***Abdomen*** |  |  |  |
| Capped Chipped Broken Teeth (circle all that apply) | Y | N | U | Hiatal hernia, frequent regurgitation, heartburn | Y | N | U |
| Difficulty opening mouth fully | Y | N | U | Ulcers, Vomiting Blood | Y | N | U |
|  |  |  |  | Hepatitis, Jaundice | Y | N | U |
| ***Respiratory*** |  |  |  | Liver disease, Cirrhosis | Y | N | U |
| Used tobacco products within the last year | Y | N |  | Kidney Disease | Y | N | U |
| Used marijuana products within the last year (CBD, THC) | Y | N |  |  |  |  |  |
| Persistent cough | Y | N | U | ***Genitourinary*** |  |  |  |
| Sputum, Phlegm, Mucus production | Y | N | U | Could you be pregnant? | Y | N | U |
| Asthma, Wheezing | Y | N | U | Difficulty passing urine? | Y | N | U |
| Bronchitis, Emphysema, COPD | Y | N | U | At risk for AIDS or Venereal Disease | Y | N | U |
| Tuberculosis | Y | N | U |  |  |  |  |
| Shortness of breath climbing 2 flights of stairs? | Y | N | U | ***Musculoskeletal*** |  |  |  |
| Recent cold? | Y | N | U | Physical limitations, Prosthetic devices | Y | N | U |
|  |  |  |  | Arthritis of jaw, neck or back? | Y | N | U |
| ***Heart*** |  |  |  | Phlebitis | Y | N | U |
| Chest pain, Angina, MI, Heart Attack | Y | N | U |  |  |  |  |
| Leg swelling, Edema, CHF | Y | N | U | ***Neurological/Psychiatric*** |  |  |  |
| Paralysis | Y | N | U | Seizures, Convulsions, Prosthetic Devices | Y | N | U |
| Heart murmur | Y | N | U | Stroke, Fleeting Blindness, Weakness | Y | N | U |
| Prolapsed mitral valve | Y | N | U | Psychiatric treatment | Y | N | U |
| Legs cramp when walking | Y | N | U | Family history of postpartum depression? | Y | N | U |
|  |  |  |  | Family history of psychiatric problems? | Y | N | U |
| ***Skin*** |  |  |  | Anxious about possible surgery? | Y | N | U |
| Problems with wound healing? | Y | N | U |  |  |  |  |
| Poor scarring | Y | N | U | ***General*** |  |  |  |
| Excessive bleeding | Y | N | U | Headaches, Unexplained weight loss | Y | N | U |
| Allergic reaction to adhesive tape? | Y | N | U | Steroid use within the last year | Y | N | U |
| Prior Infection (MRSA, etc.)? | Y | N | U | Glaucoma | Y | N | U |
|  |  |  |  | Chemotherapy within the last 6 months | Y | N | U |
| ***Endocrine*** |  |  |  | Recreational drug use | Y | N |  |
| Diabetes? Type | Y | N | U | History of any recreational drug use | Y | N |  |
| Low blood sugar | Y | N | U | Specify |  |  |  |
| High blood sugar | Y | N | U |  |  |  |  |
| Thyroid problems | Y | N | U |  |  |  |  |
| Intolerance to heat or cold | Y | N | U | ***Hematological*** |  |  |  |
|  |  |  |  | Blood transfusions | Y | N | U |
|  |  |  |  | Anemia | Y | N | U |
|  |  |  |  | History of excessive bleeding | Y | N | U |
|  |  |  |  | History of blood clots | Y | N | U |

***Please clarify any YES answers:***

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**THROMBOSIS RISK FACTOR**

**ASSESSMENT**

**CHOOSE ALL THAT APPLY**

**EACH RISK FACTOR REPRESENTS** I **POINT EACH RISK FACTOR REPRESENTS 2 POINTS** I ' ' • ' ' I

:, Age Al-60 years

**:J** Minor surgery planned

**:J** Hislory of prior major surgery (< l monlh)

::l Vorioos.e veins

**:J** Hislory of inflammalory bowel disease

**:J** Swollen legs (currenl)

:, Obesily **(BMI** > 25)

::l Acute myocardial infarction

**:J** Congestive hear! failure (<l manlh)

:, Sepsis (<l month)

::l Serious lung diseas.e including pneumonia

(d monrh)

**:J** Abnormal pulmonary funclion (COPD)

**:J** Medical patienl currenrly al bed resl

:J Orher risk laclors

:, Age 60-7*A* years

:J Arthroscopic surgery

:l Malignancy (present or previous)

:J Major surgery (> *AS* minules)

:J laparoscopic surgery (> *AS* minules)

:J Patient confined lo bed (> 72 hours)

:J Immobilizing plaster casl (< l month)

:l Central venous access

**EACH RISK FACTOR REPRESENTS 3 POINTS**

:J Age over *75* years

:, History of DVT/PE

:J Family hislory of lhrombosis•

::JPositive Factor V Leiden

:J Positive Prothrombin 20210A

::JElevated s.erum homocysleine

::JPositive lupus anticoagulant

:J Elevaled anticardiolipin antibodies

:J Heparin-induced lhrombocytopenia (HIT)

::JOther congenital or acquired thrombophilia

II yes:

Type: \_

* *roost lreq,ently missed risk foct0<*

::JElective major lower extremity arthroplosly

:, Hip, pelvis or leg lrocrure (< l month)

:J Slroke (< l monlh)

:J Multiple lrauma (< l month)

:J Acule spinal cord injury (paralysis) (< l month)

**FOR WOMEN ONLY (EACH REPRESENTS**

I **POINT)**

Cl Oral contraceptives or hormone replacement therapy

* Pregnancy or poslporrum (< l month)
* Hislory of unexplained stillborn inion!, recurrent spontaneous abortion ), premature birth with toxemia or growth-reslricled infonl

□

**TOTALRISK FACTOR SCORE**

*2005 Caprini* ***Risk*** *Assessment Model Reprinted with permission from Joseph* ***A.*** *Caprini,* ***MD***

PATIENTS' NAME:

AGE: SEX:

WEIGHT:

|  |
| --- |
| **ASPS VTE TASK FORCE**  **RISK ASSESSMENT AND PREVENTION**  **Approved by the ASPS Executive Committee in July 2011**  Disclaimer: The recommendationswere developed to provide strategies for patient management and to assist physicians in clinical decision making. The recommendations should not be construed as a rule, nor should it be deemed inclusive of all proper methods of careor exclusive of other methods of care reasonably directed at obtaining  the appropriate results. The recommendations are not intended to define or serve as the standard of medical care. The ultimate judgment regarding the care of a particular patient must be made by the physician in light of all thecircumstances presented by the patient, the diagnostic and treatment options available, and available resources. |
| **STEP ONE: RISK STRATIFICATION**  **PATIENT POPULATION RECOMMENDATION** |
| **In-patient** adult aesthetic and reconstructive plastic surgery **Should complete** a 2005 Caprini risk factor assessment tool in order to stratify who undergo general anesthesia patients into a VTE risk category based on their individual risk factors. **Grade B**  **or**  **Should complete** a VTE risk assessment tool comparable to the 2005 Caprini  RAM in order to stratify patients into a VTE risk category based on their individual risk factors. **Grade D** |
| **Out-patient** adult aesthetic and reconstructive plastic surgery **Should consider** completing a 2005 Caprini risk factor assessment tool who undergo general anesthesia in order to stratify patients into a VTE risk category based on their individual  risk factors. **Grade B**  **or**  **Should consider** completing a VTE risk assessment tool comparable to the 2005 Caprini RAM in order to stratify patients into a VTE risk category based on their individual risk factors. Grade D |
| **STEP TWO: PREVENTION**  **PATIENT POPULATION 2005 CAPRINI RECOMMENDATION The scores listed apply to the 2005 Caprini**  **RAM and were notintended for use with**  **RAM SCORE\* alternative VTE risk assessment tools.** |
| **Elective Surgery Patients** adult aesthetic **7 or more Should consider** utilizing risk reduction strategies such as limiting OR times, and reconstructive plastic surgery who undergo weight reduction, discontinuing hormone replacement therapy and early  general anesthesia postoperative mobilization. **Grade C** |
| **Patients undergoing the following 3to6 Should consider** the option to use postoperative LMWH or unfractionated  **major procedures when the procedure** heparin. **Grade B**  is performed under general anesthesia lasting more  than 60 minutes:   * Body contouring, **3 or more Should consider** the option to utilize mechanical prophylaxis throughout * Abdominoplasty, the duration of chemical prophylaxis for non-ambulatory patients. **Grade D** * Breast reconstruction, * Lower extremity procedures, * Head/neck cancer procedures **7 or more Should strongly consider** the option to use extended LMWH   postoperative prophylaxis. **Grade B** |
| **For the full task force report and prophylaxis medication, dosage, and timing protocol examples, visit plasticsurgery.org/vte** |

**GRADE QUALIFYING EVIDENCE IMPLICATIONS FOR PRACTICE**

|  |  |  |
| --- | --- | --- |
| A: Strong Recommendation | Level: I evidence or consistent findings from multiple studies of levels II, Ill, or IV | Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present. |
| B: Recommendation | Levels: II, Ill, or IV evidence and findings are generally consistent | Clinicians should follow a recommendation but should remain alert to new information and sensitive to patient preferences. |
| C: Option | Levels: II, Ill, or IV evidence, but findings are inconsistent | Clinicians should be flexible in their decision-making regarding appropriate practice, although they may set bounds on alternatives; patient preference should have a  substantial influencing role. |
| D: Option | Level: V little or no systematic empirical evidence | Clinicians should consider all options in their decision-making and be alert to new  published evidence that clarifies the balance of benefit versus harm; patient preference should have a substantial influencing role. |
| *\*Tlie 2005 Cap,ini vrE Risk Assessment Model has been -.olidated in the plastic svrge,y population.*  *Source: Pannvcci CJ, Bailey SH, Dreszer* G, *et* al. *Validation of the Cap,ini risk* assessment *model in plastic and reconslrvcfive surgery patients. J Am* Coll *Surg. 2011 Jan; 212/1/:105-12.* | | |

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# Richard K. Lee, M.D.

The Lee Institute of Palstics Surgery

*Authorization For The Taking and Release of Medical Photographs, Slides, Videotapes or Digital Photos*

I, (patient name) hereby authorize Richard K. Lee, M.D. and his associates to the taking and use of photographs, slides, videotapes or digital photographs of me pertaining to my procedure(s) for professional medial purposes, including submission to my insurance carrier(s) and/or for prior authorization (if applicable), and for medical record documentation.

I consent to the use of my photographs for medical education, insurance or lay groups, and/or patient education. I understand that all necessary steps will be taken to protect my identity.

## I understand that my photographs will not be published for purposes of public or commercial television, lay publications, or for use on the doctor’s website except when authorized by me by completion of a separate, special and specific authorization form.

I hereby grant permission for the use of any of my medical records including illustration, photographs or other imaging records created in my case for use in examination, testing, credentialing and/or certifying purposes by the American Board of Plastic Surgery, Inc.

I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of the photographs, slides, videotapes or digital photographs pertaining to my procedure(s).

To assure high quality of care, some patient charts in this facility are reviewed by outside physicians. I hereby consent to this peer review process.

I have read and understand the above information and give my consent with the above changes. I understand that I may cancel this agreement in writing at any time. If I do cancel this agreement, all photographs taken will be stored by the physician for purposes of medical record documentation.

Patient Signature Date Witness’ Initials

*(or signature of minor patient’s parent or guardian, or signature of guardian to incapacitated adult patient)*

***Confidentiality*** is of the utmost importance to us. Your name will not be used along with the display of the medical photographs, slides, videotapes or digital photographs without your consent. *(Photographs taken usually do not include your face unless you are consenting to or have undergone a procedure involving your head or neck areas.*

**Richard K. Lee, M.D.**

**The Lee Institute of Plastic Surgery**

**Patient Financial Responsibility and Assignment of Benefits**

## Patient Name: Record Number Private Pay

I have elected to consult and/or have surgery performed by Richard K. Lee, M.D., regardless of whether it may be

covered by my insurer, employer or health plan. I want to have these services provided privately, and I understand that I may be given a discount from the regular fee charged by my physician or other provider of service. I agree, in advance, to pay my physician’s fees and all related costs including, but not limited to, anesthesia, hospital and/or surgical center charges, supplies, laboratory work, pathology, and radiology. I agree that, even if in the future my insurer, employer or health plan determines that these charges would be payable under the terms of the plans, I will not send, nor request my physician or other provider of service to send, an operative report or list of charges to the insurer, employer or health plan, and my physician will not be obligated to either seek reimbursement from any third party on my behalf, or accept any fee from any person or entity other than myself, regardless of any other arrangements my physician or I have made with my insurer, employer or health plan. I agree to abide by the terms of this agreement and pay the fees and charges as set forth and on the terms disclosed. Furthermore, my signature below acknowledges my understanding and consent to the following policy:

**CANCELLATION POLICY:** A non-refundable deposit of $500.00 is required at the time of scheduling your surgery. Deposits are non-refundable for all circumstances. The remaining balance is due at your Pre- Operative appointment (usually scheduled 3-4 weeks before surgery). If you **RESCHEDULE** your surgery for any reason (including sickness, family issue, etc.) an additional rescheduling charge of $500 will be incurred which is not included in the fees quoted here. If you **CANCEL** your surgery after full payment, we reserve the right to retain 50% of all fees paid plus an additional $250.00 for administrative costs. All refunds are subject to processing fees.

**HMO, PPO, Private Insurance, Medicare and Medi-Cal, Trauma (EA)**

I acknowledge that I may have financial responsibility arising from services provided by Richard K. Lee, M.D. and agree to pay all charges applied to my insurance copay (co-insurance), deductible, or any other charges deemed non-covered by my insurer, excluding those amounts determined as contractually adjustable by the insurer. I acknowledge my responsibility for assisting Richard K. Lee, M.D. in obtaining necessary referrals and authorizations for my care and I agree to keep Richard K. Lee, M.D. informed of any changes in my insurance. I acknowledge that prior authorization from my insurer is not a guarantee of payment. I acknowledge that it is my responsibility to confirm if the doctor is a contracted provider with my insurer. I acknowledge that charges related to my care with Richard K. Lee, M.D. can be incurred for services from outside providers and that Richard K. Lee,

M.D. is not responsible for these charges and cannot quote fees or estimates for these outside providers. I agree to pay these outside providers under the terms of agreement with my insurer and that provider. I acknowledge my responsibility in assisting Richard K. Lee, M.D. in any way possible in his reimbursement from my insurer. I hereby authorize my insurer to issue payment directly to and in the name of Richard K. Lee, M.D. I acknowledge that my account may be subject to additional charges including but not limited to finance charges and collection fees.

If Medicare is the insurer, I acknowledge that Medicare will only pay for services that it determines to be “Reasonable and Necessary” under sections 1862 (A)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is “not reasonable and necessary” under Medicare program standards, Medicare will deny payment for that service and that I will be personally responsible for any and all charges incurred. I hereby authorize Medicare to issue payment directly to and in the name of Richard K. Lee, M.D.

**Patient Signature**

## Acknowledgment of Receipt of Summary of Notice of Privacy Practices and Medical Licensing

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

Therefore, I (printed name of patient), acknowledge that Richard K. Lee, M.D. or his duly authorized representative has provided a written copy of his Summary of Notice of Privacy Practices for Protected Health Information to myself.

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California

(800) 633-2322

[www.mbc.ca.gov](http://www.mbc.ca.gov/)

***If you are signing as a personal representative, documentation of your legal right to do so must be provided.***

Signature Date Printed Name

## This section is for the use of the office of Richard K. Lee, M.D. only

We made a good faith attempt to provide the above-named patient with a copy of our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reason:

Signature Date Printed Name

Title

This form is to be filed in the patient’s medical record under “consent”