Richard K. Lee, M.D.
Lee Institute of Plastic Surgery, Medical Corporation

3550 South Tamiami Trail Suite 201
Sarasota, FL 34239
941-340-4731

TODAY'S DATE:_____

Patient Registration

Patient's ***LEGAL*** Name_____ Marital Status_____

DOB_____ Age_____ Gender: ____Male ____Female

Address_____

City_____ State_____ Zip_____

Cell Phone (_____)_____ Other Phone (_____)_____

Email_____

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) FACEBOOK INSTAGRAM 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

<u>If YES, please list ALL including dosage & frequency:</u>

_____

_____

What are your past, present, and chronic medical problems/conditions?

_____

_____

Please list all prior ***<u>surgeries , traumas (including physical traumas: physical or mental abuse), accidents</u>*** 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
Capped Chipped Broken Teeth (circle all that apply) Y N U
Difficulty opening mouth fully Y N U

Respiratory
Used tobacco products within the last year Y N
Used marijuana products within the last year (CBD, THC) Y N
Persistent cough Y N U
Sputum, Phlegm, Mucus production Y N U
Asthma, Wheezing Y N U
Bronchitis, Emphysema, COPD Y N U
Tuberculosis Y N U
Shortness of breath climbing 2 flights of stairs? Y N U
Recent cold? Y N U

Heart
Chest pain, Angina, MI, Heart Attack Y N U
Leg swelling, Edema, CHF Y N U
Paralysis Y N U
Heart murmur Y N U
Prolapsed mitral valve Y N U
Legs cramp when walking Y N U

Skin
Problems with wound healing? Y N U
Poor scarring Y N U
Excessive bleeding Y N U
Allergic reaction to adhesive tape? Y N U
Prior Infection (MRSA, etc.)? Y N U

Endocrine
Diabetes? Type_____ Y N U
Low blood sugar Y N U
High blood sugar Y N U
Thyroid problems Y N U
Intolerance to heat or cold Y N U

Abdomen
Hiatal hernia, frequent regurgitation, heartburn Y N U
Ulcers, Vomiting Blood Y N U
Hepatitis, Jaundice Y N U
Liver disease, Cirrhosis Y N U
Kidney Disease Y N U

Genitourinary
Could you be pregnant? Y N U
Difficulty passing urine? Y N U
At risk for AIDS or Venereal Disease Y N U

Musculoskeletal
Physical limitations, Prosthetic devices Y N U
Arthritis of jaw, neck or back? Y N U
Phlebitis Y N U

Neurological/Psychiatric
Seizures, Convulsions, Prosthetic Devices Y N U
Stroke, Fleeting Blindness, Weakness Y N U
Psychiatric treatment Y N U
Family history of postpartum depression? Y N U
Family history of psychiatric problems? Y N U
Anxious about possible surgery? Y N U

General
Headaches, Unexplained weight loss Y N U
Steroid use within the last year Y N U
Glaucoma Y N U
Chemotherapy within the last 6 months Y N U
Recreational drug use Y N
History of any recreational drug use Y N
Specify _____

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:

_____

_____

_____

_____

_____

AMERICAN SOCIETY OF PLASTIC SURGEONS®

THROMBOSIS RISK FACTOR ASSESSMENT

VTE
ASPS CAMPAIGN FOR AWARENESS

CHOOSE ALL THAT APPLY

EACH RISK FACTOR REPRESENTS 1 POINT

- ❒ Age 41-60 years
- ❒ Minor surgery planned
- ❒ History of prior major surgery (< 1 month)
- ❒ Varicose veins
- ❒ History of inflammatory bowel disease
- ❒ Swollen legs (current)
- ❒ Obesity (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

_____

EACH RISK FACTOR REPRESENTS 2 POINTS

- ❒ Age 60-74 years
- ❒ Arthroscopic surgery
- ❒ Malignancy (present or previous)
- ❒ Major surgery (> 45 minutes)
- ❒ Laparoscopic surgery (> 45 minutes)
- ❒ Patient confined to bed (> 72 hours)
- ❒ Immobilizing plaster cast (< 1 month)
- ❒ Central venous access

EACH RISK FACTOR REPRESENTS 3 POINTS

- ❒ 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

- ❒ 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)

FOR WOMEN ONLY (EACH REPRESENTS 1 POINT)

- ❒ 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 ☐

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 recommendations were 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 care or 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 the circumstances 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 who undergo general anesthesia	**Should complete** a 2005 Caprini risk factor assessment tool in order to stratify 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 who undergo general anesthesia	**Should consider** completing a 2005 Caprini risk factor assessment tool 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 RAM SCORE*	RECOMMENDATION
Elective Surgery Patients adult aesthetic and reconstructive plastic surgery who undergo general anesthesia	**7 or more**	**Should consider** utilizing risk reduction strategies such as limiting OR times, weight reduction, discontinuing hormone replacement therapy and early postoperative mobilization. **Grade C**
Patients undergoing the following major procedures when the procedure is performed under general anesthesia lasting more than 60 minutes: ▶ Body contouring, ▶ Abdominoplasty, ▶ Breast reconstruction, ▶ Lower extremity procedures, ▶ Head/neck cancer procedures	**3 to 6**	**Should consider** the option to use postoperative LMWH or unfractionated heparin. **Grade B**
	3 or more	**Should consider** the option to utilize mechanical prophylaxis throughout the duration of chemical prophylaxis for non-ambulatory patients. **Grade D**
	7 or more	**Should strongly consider** the option to use extended LMWH postoperative prophylaxis. **Grade B**

The scores listed apply to the 2005 Caprini RAM and were not intended for use with alternative VTE risk assessment tools.

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, III, or IV	Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.
B: Recommendation	Levels: II, III, 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, III, 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.

**The 2005 Caprini VTE Risk Assessment Model has been validated in the plastic surgery population.*
Source: Pannucci CJ, Bailey SH, Dreszer G, et al. Validation of the Caprini risk assessment model in plastic and reconstructive surgery patients. J Am Coll Surg. 2011 Jan; 212(1):105-12.

Richard K. Lee, M.D.
The Lee Institute of Plastic 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.*

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 _____

Richard K. Lee, M.D.

The Lee Institute of Plastic Surgery
HIPAA PRIVACY INFORMED CONSENT

***None of your personal or medical information will be used or shared without your prior written consent.**

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: _____ Phone #: _____

Person/Facility: _____ Phone #: _____

INFORMATION TO BE DISCLOSED:

_____ Appointment information _____ Medical information _____ Billing information

_____ **Initial here if you <u>DO NOT</u> want your information to be released to anyone.

DO WE HAVE PERMISSON TO?

_____ TEXT information to you (appointment reminders etc..)
_____ EMAIL information to you (please note that emailing may not be a secured method of communication)
_____ MAIL information to you
_____ Use email/mailing address for the purpose of satisfaction surveys

_____ Leave appointment information on your PERSONAL voicemail
_____ Leave billing information on your PERSONAL voicemail
_____ Leave medical information on your PERSONAL voicemail

_____ Leave appointment information on your WORK voicemail
_____ Leave billing information on your WORK voicemail
_____ Leave medical information on your WORK voicemail

<u>*I verify that I have read and understand this form</u>

_____ _____
Patient Signature Date

REVOCATION:

I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company Medicaid and Medicare.

Acknowledgment of Receipt of Summary of Notice of Privacy Practices

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.

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"