



Welcome to Kadlec Clinic!

We know that selecting a new provider is a big decision, and we thank you for choosing our practice. Our goal is simply to provide you with quality health care and personal attention.

We offer a wide range of medical, surgical and cosmetic services, and we will be happy to address concerns in any of these areas.

Enclosed you will find the necessary forms we ask new patients to complete before your scheduled appointment. This will ensure a more efficient and pleasant experience with us.

If you need special accommodations please call our office and we will do our best to make other arrangements.

We look forward to serving you and are committed to your continued good health.

Sincerely,

Kadlec Clinic Plastic Surgery

Follow us on www.kadlecclinics.org/plastics

Directions: We are located at 112 Columbia Point Dr. Suite 101, Richland, WA 99352
(To the left after you pass Winco, look for the blue and yellow Plastic Surgery flag)

KADLEC CLINIC, LLC

MISSED APPOINTMENT POLICY:

In an effort to better serve our patients, we ask that you give a minimum of 24 hours notice if you are unable to keep your appointment. We will be happy to reschedule your appointment for a time that is more convenient for you. This time has been reserved for you and your health care is important to us.

If you do not cancel your appointment with at least 24 hour advanced notice or you fail to keep your appointment, you could possibly receive a charge of \$50.00.

An excessive amount of missed appointments could result in being discharged from our practice.

LATE POLICY:

If you are 15 or more minutes late for your appointment, the receptionist will do the following:

- Check with the provider or staff and see if you can be seen without delaying other scheduled appointments.
- Reschedule for another day.
- Reschedule at the end of the morning or afternoon.

CELL PHONES AND PAGERS:

To insure that you have uninterrupted, quality time with your health care provider during your examination, we ask that you turn off your cell phone or your pager when you enter the examination room.

Thank You

Reason(s) for today's visit:

List Prescription and Non Prescription

Medication	Amt in mg/g	Frequency

Are you allergic to any medication? yes / no If yes, list below: Latex allergy Tape allergy

Have ever had dental or other local anesthesia (Novocaine, Lidocaine, et)? Yes / No

Any bad reaction? Yes / No _____

Anesthesia Reaction/Complication? Yes / No _____

Have you ever received a transfusion? Yes / No if yes, what year? _____ Hearing aid: Yes / No

Are you having ongoing Dental Work? Yes / No Dentures: Yes / No

Are you experiencing an ongoing infection? Yes / No _____

FEMALES: Are you pregnant Yes / No (due date _____) Are you nursing Yes / No

Are you planning on becoming pregnant with 1 year? Yes / No

Status of menstrual cycles: not yet begun regular irregular menopausal
 post-menopausal hysterectomy/tubal ligation (year _____)

REVIEW OF SYSTEMS: (Please check all that apply to you CURRENTLY)

General: all negative **Skin:** all negative **Neurologic/Psychiatric:** all negative

chills blistering new lesion/growths anxiety depressed mood

fatigue/weakness bruising thinning hair paralysis difficulty concentrating

fever nail changes scaling confusion suicidal ideation

night sweats cold sores sun sensitivity

weight gain dry lips pigment change

weight loss dry skin rash/itching

HEENT: all negative **Respiratory:** all negative **Cardiovascular:** all negative **Vascular:** all negative

blurred vision cough chest pain poor circulation

vision changes shortness of breath congestive heart failure varicose veins

decreased night vision cough blood leg swelling

dry eyes wheezing fast heart beat

nose bleeding

facial pain

Genitourinary: all negative **Gastrointestinal:** all negative **Metabolic/Endocrine:** all negative

dark urine abdominal pain jaundice cold intolerance

painful urination constipation diarrhea hair loss

change in appetite nausea/vomiting excess hair

excess sweating

Metabolic/Endocrine: all negative **Hematologic:** all negative **Immunological:** all negative

arthralgia/joint pain easy bruising frequent infections

arthritis anemia environmental allergies

muscle spasms blood clots food allergies

muscle weakness easy bleeding

enlarged lymph nodes

PAST MEDICAL/SURGICAL

- | | | | | |
|---|--------------------------------------|---|---|---------------------------------------|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Atrial Fib | <input type="checkbox"/> Fainting Spell | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Abnormal Clotting Disorder | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Gastrointestinal Disease | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Actinic Keratosis Disease | <input type="checkbox"/> Cancers | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Acid Regurgitation | <input type="checkbox"/> CHF | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Chemotherapy |

Have you ever had any of the following? (list the year if known)

- | | | |
|--|--|--|
| <input type="checkbox"/> Appendectomy_____ | <input type="checkbox"/> Defibrillator _____ | <input type="checkbox"/> Organ Transplant_____(organ_____) |
| <input type="checkbox"/> CABG_____ | <input type="checkbox"/> Liver Biopsy _____ | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Vasectomy_____ | <input type="checkbox"/> Hysterectomy _____ | <input type="checkbox"/> Tubal Ligation_____ <input type="checkbox"/> Tonsillectomy_____ |

List any other pertinent diseases or conditons:-

SKIN CANCER HISTORY:

Have you ever had the following? I have never been diagnosed with skin cancer, precancers or atypical moles

	Year	Treatment	Location	Comments
<input type="checkbox"/> Atypical/Dysplastic Moles	_____	_____	_____	_____
<input type="checkbox"/> Malignant Melanoma	_____	_____	_____	_____
<input type="checkbox"/> Actinic Keratosis/Precancers	_____	_____	_____	_____
<input type="checkbox"/> Basal Cell Carcinoma	_____	_____	_____	_____
<input type="checkbox"/> Squamous Cell Carcinoma	_____	_____	_____	_____
<input type="checkbox"/> Cutaneous T Cell Lymphoma	_____	_____	_____	_____
<input type="checkbox"/> Unknown Type	_____	_____	_____	_____

FAMILY HISTORY

adopted unobtainable (reason:_____)

Please check all the apply and circle affected relative (M=mother, F=father, B=brother S=sister, C=child, G=grandparent)

- | | | | |
|---|-------------|---|-------------|
| <input type="checkbox"/> Abnormal Moles | M F B S C G | <input type="checkbox"/> Diabetes | M F B S C G |
| <input type="checkbox"/> Abnormal bleeding | M F B S C G | <input type="checkbox"/> Glaucoma | M F B S C G |
| <input type="checkbox"/> Abnormal Clotting | M F B S C G | <input type="checkbox"/> Hepatitis | M F B S C G |
| <input type="checkbox"/> Anesthetic Problems | M F B S C G | <input type="checkbox"/> High Cholesterol | M F B S C G |
| <input type="checkbox"/> Arthritis | M F B S C G | <input type="checkbox"/> High Blood Pressure | M F B S C G |
| <input type="checkbox"/> Asthma | M F B S C G | <input type="checkbox"/> Inflamm Bowel Dz | M F B S C G |
| <input type="checkbox"/> Basal Cell Carcinoma | M F B S C G | <input type="checkbox"/> Malignant Melanoma | M F B S C G |
| <input type="checkbox"/> Blood Disease | M F B S C G | <input type="checkbox"/> Psoriasis | M F B S C G |
| <input type="checkbox"/> Heart Disease | M F B S C G | <input type="checkbox"/> Kidney Disease | M F B S C G |
| <input type="checkbox"/> Cancer | M F B S C G | <input type="checkbox"/> Rosacea | M F B S C G |
| <input type="checkbox"/> COPD | M F B S C G | <input type="checkbox"/> Seizures | M F B S C G |
| <input type="checkbox"/> Stroke | M F B S C G | <input type="checkbox"/> Squamous Cell Cancer | M F B S C G |
| <input type="checkbox"/> Depression | M F B S C G | <input type="checkbox"/> Thyroid Disorder | M F B S C G |
| <input type="checkbox"/> Dermatitis | M F B S C G | <input type="checkbox"/> Other: | M F B S C G |

SOCIAL HISTORY:

unobtainable (reason:_____)

Primary language: English Spanish Other:_____

Employer:_____

Occupation:_____

Marital Status:_____

Smoking/tobacco: Yes / No former packs per day___ years smoked___ year quit___

Alcohol: yes former daily (#___) weekly (___) socially occasionally rarely

COSMETIC INTEREST QUESTIONNAIRE

WHAT ARE YOUR AREAS OF CONCERN?

(Please check all that apply)

- | | | | |
|--|--|--------------------------------------|--|
| <input type="checkbox"/> Frown lines between the brows | <input type="checkbox"/> Fine lines and wrinkles | <input type="checkbox"/> Acne | <input type="checkbox"/> Abdominalplasty |
| <input type="checkbox"/> Lines around nose and mouth | <input type="checkbox"/> Rough skin texture | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Breast Augmentation |
| <input type="checkbox"/> Tired-looking skin | <input type="checkbox"/> Sagging skin | <input type="checkbox"/> Freckles | <input type="checkbox"/> Breast Lift |
| <input type="checkbox"/> Dark circles under eyes | <input type="checkbox"/> Hyperpigmentation | <input type="checkbox"/> Facial Hair | <input type="checkbox"/> Breast Reduction |
| <input type="checkbox"/> Face Lift | <input type="checkbox"/> Neck Lift | <input type="checkbox"/> Eye Lift | <input type="checkbox"/> Liposuction |

ARE YOU INTERESTED IN LEARNING MORE ABOUT THE FOLLOWING?

(Please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> BOTOX Cosmetic (Botulinum Toxin Type A) | <input type="checkbox"/> JUVEDERM Injectable gel |
| <input type="checkbox"/> Alpha hydroxyl acid and glycolic peels | <input type="checkbox"/> Skin Rejuvenation |
| <input type="checkbox"/> Retin-A or Renova | <input type="checkbox"/> Radiese |
| <input type="checkbox"/> Latisse | <input type="checkbox"/> VIVITE Advanced skin care |
| <input type="checkbox"/> other skin care products | <input type="checkbox"/> Birthmarks |
| <input type="checkbox"/> Liver spots/age spots | <input type="checkbox"/> Sun protection |
| <input type="checkbox"/> Skin Medica Skin Care | <input type="checkbox"/> Clinique Medical Skin Care |
| <input type="checkbox"/> other, please specify: _____ | |

When looking at my face in the mirror,
I believe I look younger than, the same as,
Or older than my true age

Younger Than True Age Older Than

When looking at my face in the mirror,
I am not concerned, somewhat concerned
Or very concerned about the appearance
Of my wrinkles

Not Somewhat Very
Concerned Concerned Concerned

How did you hear about us?

- Friend or family member
 Physician or other provider
 Ad or Article
 Internet (Web site)
 Seminar or event (When)
 Other (please specify)



Yes, I authorize you to send me Kadlec Clinic monthly newsletter a
(Please print all information clearly)

My e-mail address is _____

Please print your name _____

*When you sign up to become a **BEAUTY INSIDER** you will, from time to time, receive free e-letters filled with special offers and discounts on medical-grade cosmetics, injectables and services with your safety in mind.*

Kadlec Clinic, LLC

DISCLOSURE/AGREEMENT

Date: _____

Patient's Name: _____

Date of Birth: _____

Reason for today's visit:

- Routine Preventive Exam (I have no medical complaint or significant problem/abnormality that I am aware of.)
- Routine exam for reproductive assessment.
- I have a problem/complaint that I wish evaluated/treated by the doctor. My chief complaint is: _____
- Pregnancy

- My Insurance plan covers Preventive Medicine Services.
- My Insurance plan does not cover Preventive Medical Services.
- I don't know if my Insurance plan covers Preventive Medical Services.
- My Insurance plan covers Reproductive Services.
- My Insurance plan does not cover Reproductive Services.
- I don't know if my Insurance plan covers Reproductive Services.

I recognize that I am responsible for providing my Insurance coverage information to Kadlec Clinic at the time of service. If I do not have this information with me, I recognize it is my responsibility to provide a Billing Representative with this information within 5 business days from the date of service.

_____ (initials)

I agree to pay for any and all medical services I receive from the doctors/providers of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim in my behalf. However, if my insurance company denies payment for any reason (e.g. non-covered services, insurance does not pay for preventive medicine visits), I will pay for same upon written/verbal notice of their refusal. Failure to pay within 45 days of filing is, for the purpose of this agreement, a refusal to pay.

_____ (initials)

I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical record. Thus, to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.

_____ (initials)

Patient or responsible party

Date

Kadlec Clinic, LLC

Kadlec Clinic – Plastic Surgery

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- ❖ A basis for planning my care and treatment
- ❖ A means of communication among the many health professionals who contribute to my care
- ❖ A source of information for applying my diagnosis and surgical information to my bill
- ❖ A means by which a third-party payer can verify that services billed were actually provided
- ❖ And a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a *Privacy Notice/Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in the reliance thereon.

I request the following restrictions to the use or disclosure of my health information.

Signature of Patient or Legal Representative

DOB: _____

Witness

SS# _____

Date

April 14, 2003
Notice Effective Date or Version

Kadlec Clinic, LLC

Authorization to Verbally Communicate Health Information with Friends or Family

Patient's Name: _____

Former Name: _____

Date of Birth: _____

Phone: _____

This is to authorize: **Kadlec Clinic, LLC**

TO COMMUNICATE INFORMATION TO:

(Please initial all selections.)

NAME:

RELATIONSHIP TO PATIENT:

TYPE OF INFORMATION:

ALL	Scheduling/Appt	Medical	Billing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specific Instructions or Limitations: _____

Validation Code: *The Validation Code is the last four digits of your social security number. Please provide this code to any individual who may be involved in coordinating your care or payment of care. They will be asked for this code before information will be released over the phone.*

We will continue to rely on the information on this form when communicating with family members or others involved in your care until the expiration date provided. If you wish to request changes before the expiration date, please notify Kadlec Clinic, LLC.

This form is valid and information may be communicated with the parties listed above from:

Date _____ **EXP. (date)** _____ **Initial** _____

After this expiration date, the parties listed above will not have access to protected health information of any kind over the phone.

If expiration date is not specified, authorization will be valid for 1 YEAR from the date of signature.

AUTHORIZATION TO COMMUNICATE HEALTH INFORMATION

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records department of Kadlec Clinic, .L.L.C. 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 when the law provides my insurer with the right to contest a claim under my policy. I understand that this release does not account for the release of medical records, only discussion of health information over the telephone. I understand that by initialing either of the boxes labeled "medical" or "all", information regarding birth control, alcohol or drug abuse, and pregnancy will be discussed with the listed names. This will be done unless specific instructions are given to do otherwise. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact *Lisa Mallory, Privacy Officer*.

Signature of Patient

Parent or Legal Representative Patient (if needed)

Date

BILLING INFORMATION

What you need to bring to ALL of your appointments in our office.

1. Your current insurance card(s) or medical coupons.
2. Your insurance co-pay. We accept Visa and MasterCard.
A \$10.00 charge will be added to co-pays NOT paid at the time of service.
3. Insurance subscriber (cardholder) name, date of birth, and social security number.
4. Your medical history.
5. List of your current medications.

What you need to know before your visit with our office.

1. Call your insurance company and make sure that we are a preferred provider with your plan. If we are not, you will be liable for paying Non-preferred rates. You will also need to know what lab your insurance company is preferred with. We generally use Medical Lab Associates for any tissue or pap tests. For blood work we use Tri-City Labs. You are responsible for telling your nurse or doctor if your insurance company is not contracted with either of these labs.
2. Currently we do not accept assignment with Tri-Care, and are not on plan with some state aid programs. Please call if you have any further questions regarding any of these insurances.
3. Cash Pay patients are required to pay their balances at time of service. In extreme cases this may be extended by the office manager.
4. Elective procedures including; infertility treatment/visits, laser hair removal, as well as vascular/pigmented lesion removal need to be paid on the date of service. When a package is purchased on any laser service you are offered an option of three payments to better accommodate this expense. If you have any questions you may ask billing for assistance.

Payment Options

Your account is due in full 30 days from the date of your first statement for services rendered. We have recently restructured our billing office in an effort to keep your health care costs to a minimum. As a result, our office no longer accepts partial payments on accounts. We do however have many payment options including Visa/MasterCard, Debit, Check draft, check, cash. Coming soon you will also be able to pay your account balance online via our website. As an additional reminder, your co-pay is due at the time of service. This is a contract between our office and your insurance company; therefore if you neglect to pay the co-pay at your visit we will add an additional \$10.00 handling fee to your account. Communication is the key to keeping your account in good standing with our office. If you do not take responsibility for your past due account balance it will be turned over promptly to our financial service. At this point you will risk being discharged from our practice for unpaid medical debt. If your account is turned over to collection but you have not been discharged, you will need to call NCMI at (509) 783-1919 to make payment arrangements before you are seen in our office again.

Billing Your Insurance

We will bill your primary insurance company for any services rendered. When your insurance company processes your claim and we receive payment, you may receive a bill with the amount that your insurance company considered as your balance. If you have a secondary insurance we will bill them as a courtesy to you. Please remember that just because you have primary and secondary coverage this does not mean that you will not receive a bill and be financially responsible for the balance.