DR. ROBERT HOUSER
COSMETIC & PLASTIC SURGERY OF COLUMBUS, INC

41 Commerce Park Drive · Westerville, OH 43082
Phone: 614.890.5565 · Facsimile: 614.890.5561

Patient Registration	**Today's Date:**
Patient Name: first mi last	Birth Date:
Address:	Age: / SS#:
City, State, Zip:	Sex: M F / Marital Status: M S D W Sep
Home Ph: ( )	Family Physician:
Work Ph: ( )	Occupation: FT PT
Cell/Other Ph: ( )	Patient Employer:

By filling out your email address, I give Dr. Houser permission to contact me via email with future communications or scheduling information. Email Address:

Referral Source:

As a referral is a great compliment for a physician, I would like to know how you found my practice, so I can express my gratitude.

__Patient __Word of Mouth	__www.drroberthouser.com __Internet	__Physician	Name of Referral (or specific source)

Spouse/Parent Name:	Home Ph: ( )
Address:	Work Ph: ( )
City, State, Zip:	Cell/Other Ph: ( )
Spouse/Parent Employer:	Occupation: FT PT

Emergency Contact:	Home Ph: ( )
Relationship to patient:	Cell/Other Ph: ( )

Emergency Contact needs to be a person we can contact who does not share the same home phone number.

Primary Insurance:	Insured SS#:
Insured name & relationship to patient:	Insured DOB:
Secondary Insurance:	Insured SS#:
Insured name & relationship to patient:	Insured DOB:

I authorize Cosmetic & Plastic Surgery of Columbus, Inc. to disclose information concerning medical findings and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Cosmetic & Plastic Surgery of Columbus, Inc.'s determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

I also agree to be responsible for all charges incurred if not covered by my insurance company or other agency. This office agrees to file my insurance claim, if any, providing that my coverage is current and accurate. All co-pays must be paid at the time of service. I authorize release of any medical information necessary to process any claims. I authorize payment of any benefits to Cosmetic & Plastic Surgery of Columbus, Inc.

Signature:_____ Date:_____
(subscriber, parent, guardian or patient if over 18 years of age)

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Medical History	**Today's Date:**
Patient Name:	Date of Injury/Onset of problem:
Describe the reason for your visit with Dr. Houser:	
Current Medications:	Do you take blood thinners or Aspirin? Y N
Preferred Pharmacy:	Phone Number: ( )
Current Vitamins/Supplements:	
Drug Allergies:	Other Allergies:

Social History:			
Do you have any children?	Y	N	If so, what ages?
Do you use alcohol?	Y	N	If so, how much/ how often?
Do you smoke or use tobacco products?	Y	N	If so, how much/ how often?
Do you use recreational drugs?	Y	N	If so, how much/ how often?

Previous Surgery:	Type	Year	Hospital	City/State

Previous Cosmetic Surgery:	Type	Year	Hospital	City/State

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	Personal History? If yes, explain.	**Family History?** If yes, which family member(s).
Diabetes	Y N	Y N
Cancer (indicate type)	Y N	Y N
Heart Trouble	Y N	Y N
Seizures	Y N	Y N
High Blood Pressure	Y N	Y N
Bruise/Bleed Easily	Y N	Y N
Blood Clotting Disorders/**DVT/PE**	Y N	Y N
Substance Abuse	Y N	Check Those Which You Have Had:
Heart Attack	Y N	__Tape Allergy __Depression
Stoke/TIA	Y N	__Latex Sensitive __Psychiatric Care
Keloid Scars	Y N	__Headaches __Chest Pain
Do you object to blood transfusion?	Y N	__Fainting Spells __Blindness
Anemia (low blood counts)	Y N	
Asthma	Y N	
Emphysema	Y N	
Sleep Apnea	Y N	
Cold Sores	Y N	
Restless Leg Syndrome	Y N	
Hepatitis	Y N	
Autoimmune Disease	Y N	
Weight Gain	Y N	
Weight Loss	Y N	
Other		

Have you had disorder of: __Bones/Joints __Brain/Nerves __Heart/Blood Vessels __Liver __Face __Eyes __Blood
__Reproductive Organs __Urinary System __Intestines/Stomach __Lungs __Ears __Nose __Throat

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ARTAS ROBOTIC HAIR TRANSPLANT
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Office Policies

Welcome to our practice. Please take a few moments to review some of our office policies. Refer to our practice literature for additional information. If you have any questions, please don't hesitate to ask. If you should have any changes in your personal data including medical history, please see that we are notified. In addition, be certain we have a current copy of your insurance card.

Cosmetic/Self-Pay Payment Policy for Surgical Procedures and Hair Restoration:

- Consultation fees are due at the time of service.
- For surgical procedures, there is a $1000.00 deposit required that becomes non-refundable 30 days prior to the scheduled date.
- For hair restoration procedures, there is a $1000.00 non-refundable deposit due once the procedure is scheduled.
- Payments are due in full two (2) weeks prior to surgery. If payment is not received by the deadline, your surgery will be removed from our schedule and will need to be rescheduled.
- If you cancel OR RESCHEDULE your surgery or hair restoration within 5 business days of your procedure date, we will charge you 25% of your quoted amount as an inconvenience fee at our discretion.

Revision Policy for Cosmetic/Self-Pay Payment Surgical Procedures:

Occasionally, a surgical procedure may require a revision for the treatment of unexpected complications or for optimal results. In such cases, it is the patient's responsibility for any cost incurred in relation to the revision. These costs include but are not limited to the surgical facility, supplies or implants, and anesthesia fees. Professional fees MAY be waived if the required revision is within the first 12 months after surgery.

Insurance Payment Policy:

- Please be certain we have a current copy of your insurance card.
- If Dr. Houser feels your procedure will considered for insurance coverage, your copayment will be expected at the time of service.
- If we have been provided with proper insurance information, we will gladly submit your claim for services to both your primary and secondary insurance companies (if applicable).
- Most surgical cases involving insurance will be done at Mount Carmel St. Ann's Hospital. You will be responsible for any copayment or amount applied to your deductible.
- Occasionally, minor surgical procedures are done in our office-based operating suite. Professional services will be submitted to your insurance company. If you request anesthesia services, you will be quoted and charged a minimal out-of-network fee to cover these expenses. This portion of your claim would not be covered or submitted to your insurance company. You will have to sign to consent to this if it is an option for you, and this payment will be expected the day of service.

Payment can be made by personal check, cash, VISA, MasterCard, Discover, American Express and CareCredit.

Please sign below as indication that you have read, understand and accept these office policies.

Name: _____ Date: _____

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PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, _____, consent to the taking of photographs or videotapes of me or parts of my body, by Cosmetic & Plastic Surgery of Columbus, Inc. or a designee, in connection with any plastic surgery procedure(s) deemed necessary. I further consent to the release by Cosmetic & Plastic Surgery of Columbus, Inc. to the American Society for Aesthetic Plastic Surgery, Inc. ("ASAPS"), the American Society of Plastic Surgeons ("ASPS"), or the American Board of Plastic Surgery ("ABPS") of such photographs, videotapes or case histories for use in examination, testing, credentialing and/or certifying purposes.

I understand that such photographs, videotapes or case histories may be published by Cosmetic & Plastic Surgery of Columbus, Inc., ASAPS, ASPS, ABPS and/or any party acting under their license and authority in any print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations, and teaching courses, for the purpose of informing the medical profession or the general public about plastic surgery methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) years from the date written below.

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Cosmetic & Plastic Surgery of Columbus, Inc.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because ASAPS, ASPS, and ABPS are not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA and may be redisclosed by ASAPS, ASPS or ABPS.

I release and discharge Cosmetic & Plastic Surgery of Columbus, Inc., ASAPS, ASPS, ABPS, and all parties acting under their license and authority from all rights that I may have in the photographs, videotapes or case histories and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these materials in any medium.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____
Patient *Date*

WITNESS/PHYSICIAN:_____
I have read the above Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

_____ _____
Patient/Guardian *Date*

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Why Stop Smoking?

Studies have shown that surgery patients who smoke are 12 times more likely to develop healing problems than non-smokers. In particular, patients who smoke and who have cosmetic surgery, such as breast reductions, tummy tucks, facelifts or other procedures that create skin "flaps," are more prone to healing complications.

The carbon monoxide in cigarette smoke greatly reduces the blood's ability to carry oxygen, which is essential for wound healing. Smoking slows healing, and if a skin "flap" was used, the wound may not heal at all.

Anesthesiologists are responsible for keeping you alive while you are under general anesthesia. Countless studies have shown that smokers have a tendency to develop harsh coughs and an elevated heart rate. **Smoking decreases the proper functioning of the lungs and airways and your body's ability to fight infection. It also affects the blood vessels, the heart, and the blood pressure. Additionally, there is a higher incidence of blood clots in smokers after surgery.**

There are many plastic surgeons who will not even think about performing surgery on a smoking patient. ***Dr. Houser has instructed you to cease smoking two weeks prior to and two weeks following surgery.***

If you cannot give up smoking for two weeks before and after the operation, you may want to rethink your decision to have plastic surgery. People choose to have plastic surgery to improve their looks and sense of well-being, so it makes little sense to jeopardize the results by failing to forego smoking for several weeks. If you are a smoker trying to quit, this may be an excellent opportunity to give up the habit altogether.

- **I have read the above information and my signature confirms that I understand that smoking may jeopardize my results and Dr. Houser may cancel my surgery.**

Signature: _____ Date: _____