PATIENT INFORMATION

PATIENT'S NAME: LAST	FIRST		MIDDLE INITIAL	
PREFERRED NAME:	PREFERRED PRONOUNS:		GENDER:	
HOME ADDRESS:				
CITY:	STATE:	ZIP CODE:	DATE OF BIRTH:	Age:
EMAIL:				
SOCIAL SECURITY #:	HOME PHONE #:		CELL PHONE #:	
RACE/ ETHNICITY:	MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐SEPARATED ☐PARTNER ☐OTHER			
OCCUPATION:	WORK #:	EMPLOYER:		

EMERGENCY CONTACT

NAME:	RELATIONSHIP TO PATIENT:
HOME PHONE #:	CELL PHONE #:

GUARANTOR INFORMATION

NAME:		RELATIONSHIP TO PATIENT:	
STREET ADDRESS:		PHONE #:	
CITY:	STATE:	ZIP CODE	

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:	POLICY #:	GROUP #:
PATIENT'S RELATIONSHIP TO INSURED:	SUBSCRIBER'S NAME (IF OTHER THAN PATIENT):	
SOCIAL SECURITY #:	SUBSCRIBER'S DATE OF BIRTH:	
SECONDARY INSURANCE COMPANY:	POLICY #:	GROUP #:
PATIENT'S RELATIONSHIP TO SUBSCRIBER:	SUBSCRIBER'S NAME:	
SUBSCRIBER'S SOCIAL SECURITY #:	SUBSCRIBER'S DATE OF BIRTH:	

REFERRING PHYSICIAN'S INFORMATION

NAME:	PHONE #:	FAX #:

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: _____ Date: _____/_____/_____

For patients under the age of 18:

Parent / Guardian Signature: _____ Date: _____/_____/_____

Medical History Form

General information:

Full Name: _____ Birth Date: _____
Address: _____
Contact Number: _____

Family Physician and/or Primary Health Care Provider:

Doctor/Other: _____ Phone: _____
Adress: _____ City/State: _____

A copy of your visit/labs will be sent to your physician or primary health care provider:

Past Medical history:

Comments:

_____
_____

Surgeries:

Type of surgery and specific date or your age at surgery:

_____
_____

Medications:

List any prescription medications (with dosage and frequency of use you are currently taking.

_____
_____

List any self-prescribed medications, dietary supplements, or vitamins (with dosage and frequency of use) you are currently taking:

_____
_____

Allergies:

List any drug or medical materials (i.e., Latex) allergies and reactions:

_____
_____

Family History:

_____
_____

Health and Lifestyle: (Circle One)

Do you smoke? YES or NO

If you smoke, how many per day? _____ Age Started? _____

Do you drink alcohol? YES or NO

If so, how often do you drink? _____

Do you use marijuana or any other type of drug? YES or NO

Do you vape? YES or NO

If so, how often? _____

Symptoms:

Are you currently having, or have you recently had any of the following symptoms? Check those questions to which you answer yes (leave the others blank).

- Fevers
- Night Sweats
- Unexplained weight loss/gain
- Fatigue
- Headaches
- Vision problems
- Hearing problems
- Dizziness
- Ringing in ears
- Eye pain
- Ear pain
- Nosebleeds
- Abdominal Pain
  - Nausea
  - Vomiting
  - Diarrhea
- Rectal Pain
  - Change in bowel habits.
  - Blood in stool
  - Black stool
- Muscle, bone, or joint pain
- Leg cramps
- Skin color changes
- Persistent bruising
- Inability to sleep flat.
- Sore throat
- Difficult swallowing
- Hoarse voice
- Persistent cough
- Coughing up blood
- Chest pain
- Palpitations/irregular heartbeat
- Swelling of extremities
- Shortness of breath
- Lightheadedness
- Change in appetite.
- Change in size/color of mole.
- Numbness of extremities
- Muscle weakness
- Tremor
- Urinary Symptoms
  - Blood in urine
  - More frequent urination
  - Incontinence/loss of urine
  - Pain
- Sexual dysfunction
- Mood changes
- Difficulty sleeping

Vegas Plastic Surgery Institute – General Financial Policy & Agreement

Thank you for choosing Vegas Plastic Surgery Institute. Please review the following policy regarding your financial responsibility.

Insurance Patients

As a courtesy, we verify medical benefits; however, final claim decisions are made by your insurer and may differ from quoted benefits.

- You must provide accurate insurance details and referrals, if required.
- Co-pays are due at the time of service.
- Authorization is not a guarantee of payment.
- If there are coverage discrepancies, you will be treated as self-pay until resolved**.**

Out-of-Network Patients

We will submit claims to your insurance if your plan allows out-of-network services (*Medicaid excluded*).

- Consultations are $150; follow-up or post-op visits outside global periods are $75 — due at time of service.
- If insurance pays, this amount will be applied to your balance.
- You are responsible for securing any required referrals or authorizations.
- Cost estimates are provided prior to treatment.

Self-Pay / Cosmetic Patients

Patients without insurance or choosing not to use insurance.

- Consultations are $150 due at the time of booking
- Follow-up or post-op visits outside global periods are $75. – due at time of service.
- These services will not be billed to any insurance.

No Show / Late Cancellation Fees

If you fail to show for your scheduled appointments or cancel the same day as your appointment, except in rare conditional circumstances approved by management, there will be a fee amount due:

- Office visit: $50 | In-office procedure: $150
- Self-pay/cosmetic fees and surgery deposits are forfeited**.**

Other Fees

- Returned check: $35
- FMLA/forms: $25 (prepaid)
- Custom letters: Fee varies by complexity
- Balances >90 days may incur collections and interest fees.

Payment Responsibility

- You are responsible for any portion of the balance not covered by your insurance.
- Unpaid balances over 90 days may be referred to collections.

I have read and understand the financial policy above.

Print Name:_____

Signature: _____ Date: _____

Relationship: □ Self □ Parent □ Guardian

Authorized Representative Designation

I authorize Vegas Plastic Surgery Institute to act on my behalf in all insurance matters, including appeals, claims, and communication with my health plan. This remains valid until revoked in writing**.**

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Relationship: □ Self □ Parent □ Guardian

Vegas Plastic Surgery Institute

Location: 341 N. Buffalo Drive. Suite B. Las Vegas, NV 89145

Phone : 702.727.8500 **Fax :** 702.487.9600 **Email :** info@vegaspsi.com

Vegas Plastic Surgery Institute – Insurance Surgery Financial Policy & Agreement

Insurance Based Surgery

Pre-Surgical Financial Responsibilities
To reserve your surgical date, a **non-refundable deposit** is required based on the estimated length of your procedure:

- **Procedures under 4 hours:** $250.00 deposit
- **Procedures 4 hours or longer:** $500.00 deposit

If your estimated deductible and/or co-insurance exceeds the required deposit amount, the deposit will be applied toward your estimated portion of your deductible, copay and or co-insurance which will be collected prior to your surgery date.

Please note:

- The deposit is **non-refundable** and **will only be applied** to your surgical balance if the procedure is completed.
- If your surgery is **cancelled for any reason**, the deposit **will not be refunded** and **will not be applied** to any rescheduled procedures or future services, except in rare conditional circumstances approved by management.
- For **untimely cancellations or rescheduling**, a **new deposit** will be required to confirm a new surgery date.

Initial_____

Post-Surgical Insurance Balances
We strive to obtain accurate benefits however we are limited to the benefits provided by your insurance. Should your claim process be different from the benefits quoted, the insurance claims determination supersedes the benefits quoted by Vegas Plastic Surgery Institute. After your insurance claim is processed, any remaining patient responsibility is due promptly.

- The benefits quoted and payments collected by Vegas Plastic Surgery Institute apply only to the physician's services. You may receive separate bills and have additional financial responsibility for services provided by the hospital, surgical facility, or anesthesiologist.

Initial_____

Cancellation Policy
Patients are required to provide five (5) business days prior cancellation notice to avoid forfeiture of surgery deposit.

No Show / Late Cancellation Fees
If you fail to show for your scheduled surgery or provide less than a 5 days cancellation notice your surgery deposit will be forfeited, except in rare circumstances approved by management.
Initial_____

Patient Name: _____ DOB: _____
Signature: _____ Date: _____
Relationship: □ Self □ Parent □ Guardian

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Vegas Plastic Surgery Institute – Cosmetic Surgery Financial Policy & Agreement

Cosmetic Based Surgery

Patients Cosmetic Acknowledgement:
By signing this form, I acknowledge and agree that _____ is not medically necessary and is of cosmetic nature. By signing this form, I also acknowledge that this service will not be billed to my insurance, and I will not seek reimbursement from my insurance.
Initial_____
Planning for cosmetic surgery involves significant time and resource commitments well before the actual procedure takes place. Your surgical fee covers more than just the time spent in the operating room, it also includes the cost of securing operating room time at the facility, reserving an anesthesiologist, and ordering customized surgical supplies and implants specific to your case. These arrangements require coordination, advance payment, and are often non-transferable.
For this reason, deposits are non-refundable and full payment is collected in advance to confirm and hold your surgical date. This policy ensures that we can provide you with the highest level of care and properly allocate the resources required for a safe and successful procedure.

Pre-Surgical Financial Responsibilities
To reserve your surgical date and time at the hospital, a **non-refundable deposit is required.**

- **Booking Deposit:** $500.00 deposit

Please note that if you book your surgery within (30) days of your consultation, your consultation fee will be applied towards the deposit.
Initial_____

Payment Timelines:
Surgery within (1) month:

- If surgery is scheduled in the same month as your consultation, you will have 7 days to submit full payment for surgery.

Surgery scheduled beyond (30) days

- Payment is full is required (30) days prior to the scheduled surgery date, or the surgery will be cancelled, and you will forfeit your deposit.
- If you cancel less than 5 business days prior to your surgery, you will forfeit 50% of the amount paid for surgery.

Initial_____

The practice of medicine and surgery is not an exact science, and individual outcomes can vary. While we are committed to delivering the highest standard of care, no specific results can be guaranteed, and some procedures may not achieve or maintain the degree of improvement you anticipate. It's important to understand that all services are non-refundable. In the event that complications arise, or surgical revisions are required, additional fees may apply.

Initial_____
Patient Name: _____ DOB: _____
Signature: _____ Date: _____
Relationship: □ Self □ Parent □ Guardian

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VPSI
VEGAS PLASTIC SURGERY INSTITUTE

HIPAA Release Form

Patient Information
Name: _____
Date of Birth: _____ Phone: _____

I, the undersigned, hereby authorize Vegas Plastic Surgery Institute to release my health information to the individual(s) listed below:

Authorized Individual(s):

1. Name: _____
   Relationship: _____
   Phone: _____
2. Name: _____
   Relationship: _____
   Phone: _____

☐ **DECLINED**

Information to be Released (Check all that apply):
☐ Appointment details (date, time, reason)
☐ Billing and insurance information
☐ Medical records (including test results, notes, surgery information)
☐ All of the above
Expiration of Authorization:
This authorization will remain in effect until the patient submits a request in writing.

Patient Rights:

- I understand that I have the right to revoke this authorization at any time in writing.
- I understand that information disclosed may be subject to redisclosure by the recipient and no longer protected by HIPAA.
- I understand I am not required to sign this authorization to receive treatment.

Patient Signature: _____
Date: _____

Witness Signature (if needed): _____
Date: _____

VPSI
VEGAS PLASTIC SURGERY INSTITUTE

Your Privacy Matters

We care about your privacy. The Health Insurance Portability and Accountability Act (HIPAA) protects your personal health information (PHI). This notice explains how we use and protect your information.

How We Use Your Information

We may use your health information to:

- Provide you with care and treatment
- Work with other healthcare providers and labs
- Bill your insurance and manage payments
- Run our office and improve services

We only share your information when necessary and with individuals or organizations authorized to access it.

Your Rights

You have the right to:

- See and obtain a copy of your health records
- Request corrections to your records
- Ask us not to share certain information (we'll do our best to accommodate)
- Receive a list of who we've shared your information with
- File a complaint if you believe your privacy rights were violated

Our Responsibilities

By law, we are required to:

- Keep your health information private
- Provide you with this notice
- Follow the terms of this notice

Acknowledgment

By signing below, you acknowledge that you have received and reviewed this notice.

Print Name: _____ Date: _____

Signature: _____

Relationship to Patient (if applicable): _____

VPSI
VEGAS PLASTIC SURGERY INSTITUTE

PATIENT PHOTOGRAPH AND VIDEO RELEASE

At **Vegas Plastic Surgery Institute**, we love celebrating transformations and educating others about our work! If you're comfortable, we kindly ask for your permission to take photos and/or videos before, during, and after your procedure. These may include images of you or specific areas of your body ("my images"). Dr. Joshua Goldman and Dr. John Brosious may share these with staff, other healthcare professionals, and the public for **educational and marketing purposes**.

We want you to know that once images are shared, they may be seen in different places beyond our control. Online images may be saved, reshared, or found in searches, and while we do our best to protect your privacy, we cannot guarantee how they may be used by others.

I'm happy for my images to be used in:

(Please initial ONE option)

☐ **ALL MEDIA –** My images and medical details may be used across print and broadcast media. This includes pamphlets, educational films, the internet (including all social media platforms), journals (both print and digital), and television.

☐ **WEBSITE ONLY –** My images and medical details may be used on my surgeon's official website.

☐ **ALBUM ONLY –** My images and medical details may be included in printed and/or digital albums, used only to privately show other patients' examples of my surgeon's work.

OR

☐ **I PREFER TO OPT OUT –** I do not give permission for my images to be used in any form.

By signing this consent form, you acknowledge and agree that any photographs, videos, or other media featuring you may be used on our website and other promotional materials. You understand that no compensation, monetary or otherwise, will be provided for the use of your likeness in any form. We appreciate your trust in us and your willingness to help others by sharing your journey!

Patient Name: _____
Date: _____
Patient or Guardian Signature: _____