LANSDALE INSTITUTE OF PLASTIC SURGERY
Dr. Floyd Herman MD, MS
Board Certified by the American Board of Plastic Surgery
1101 S. Broad Street, Suite 100 Lansdale, PA 19446
P: 215-855-1122 F: 215-855-1988
info@lansdaleplasticsurgery.com
lansdaleplasticsurgery.com

PATIENT INTAKE FORM

Dear Patient,

Thank you for contacting us regarding our services at Lansdale Institute of Plastic Surgery and for scheduling your upcoming appointment. While we work with you to create your perfect plan, you can feel confident that our staff is committed to not only meeting your needs, but exceeding your expectations.

At Lansdale Institute of Plastic Surgery we strive to provide the most up to date, safe and effective procedures available today. By combining procedures that have stood the test of time with newly proven advances in technology, our office is able to provide you with the best cutting edge options available.

In order to minimize your wait time, please complete the enclosed New Patient forms prior to your visit and bring them with you to your appointment. In the meantime, if you have any questions at all, please feel free to call our office. We are committed to providing you with the best possible experience.

If for any reason you are unable to keep your appointment, please contact us at least 24 hours prior to your scheduled appointment to cancel or reschedule. Appointments that are not cancelled 24 hours prior to your consult may be subject to a $100.00 charge. We understand that some delays are unavoidable but please be aware that if you are 30 minutes later or more, we will do our best to fit you in but you may have to wait or reschedule.

Thank you for choosing Lansdale Institute of Plastic Surgery!

Sincerely,

Dr. Floyd Herman, M.D. and Staff

CONTACT US
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PATIENT INTAKE FORM

Date:_____/_____/_____
First Name:_____ M.I.:____ Last Name:_____ Male Female
Address:_____ Apt:_____ Age:_____ DOB:_____/_____/_____
City:_____ State:_____ Zip:_____ Home Tel:_____
Social Security.#:_____ Driver's License #:_____ Work Tel:_____
Marital Status: ☐ Single ☐ Married ☐ Other
E-mail:_____ Cell:_____

SPOUSE CONTACT [If applicable]

First Name:_____ Last Name:_____ Spouse's Cell:_____
Spouse's Employer:_____ Spouse's Work Tel:_____

EMPLOYMENT INFORMATION

☐ Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Other Occupation:_____
Employer/School:_____ Work Tel:_____
Work/School Address:_____ City:_____ State:_____ Zip:_____

EMERGENCY CONTACT

First Name:_____ Last Name:_____ Home Tel:_____
Relationship to Patient:_____ Work Tel:_____
Address:_____ City:_____ State:_____ Zip:_____ Cell:_____

INSURANCE INFORMATION

Primary Insurance Company Name:_____ Telephone:_____
Name of Insured: First:_____ Last:_____ DOB:_____/_____/_____
Policy#:_____ Group#:_____ Co-pay? ☐ Yes ☐ No If Yes, Amount:$_____
Secondary Insurance Company Name:_____ Telephone:_____
Name of Insured: First:_____ Last:_____ DOB:_____/_____/_____
Policy#:_____ Group#:_____ Co-pay? ☐ Yes ☐ No If Yes, Amount:$_____

I understand that co-pays and deductibles are my responsibility on the day service is rendered. I authorize Floyd Herman, M.O. of Lansdale Institute of Plastic Surgery to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Floyd Herman and myself.

Signature: *(Patient, Parent or Guardian)*:_____ Date:_____/_____/_____

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REFERRAL INFORMATION

Referring Physician or Patient:_____
How did you hear about Dr. Herman?_____
Have you been to our website *(www.lansdaleplasticsurgery.com)*? ☐ Yes ☐ No
If yes, was our website helpful? ☐ Yes ☐ No If No, please list reason:_____

PROCEDURE INFORMATION

What is the reason for your visit today? *(Check all applicable procedures below)*

FACE	BREAST	BODY	SKIN
☐ Facelift	☐ Breast Augmentation	☐ Liposuction	☐ Botox
☐ Cheek lift	☐ Breast lift (Mastopexy)	☐ TummyTuck	☐ Facial Fillers
☐ Brow Lift	☐ Breast Revision/ Repair	☐ Mommy Makeover	☐ Juvederm
☐ Neck Lift	☐ Breast Implant Exchange	☐ Body Lift	☐ Restylane/Perlane
☐ Liquid Facelift	☐ Breast Capsulectomy	☐ Buttock Augmentation	☐ Prevelle
☐ Facial Fat Transfer	☐ Breast Reduction	☐ Arm Lift (Brachioplasty)	☐ Radiesse
☐ Facial Implants	☐ Breast Asymmetry	☐ Thigh Lift	☐ Fat Injections
☐ Lip Augmentation	☐ Breast Reconstruction	☐ Fat Transfer	☐ Skin Resurfacing
☐ Chin Augmentation	☐ Male Breast	☐ Cellulite Reduction	☐ Skin Tightening Laser
☐ Ear Reshaping	☐ Other _____	☐ Other _____	☐ Hand Rejuvenation
☐ Upper Eyelids			☐ Hyperhidrosis
☐ Lower Eyelids			☐ Skin Care
☐ Rhinoplasty			☐ Latisse
☐ Other _____			☐ Other _____

Please describe why you are interested in having the procedure(s) listed above:_____
Have you consulted with other physicians about procedure(s) indicated above? ☐ Yes ☐ No
If No, please list reason:_____
Is this procedure a revision from a pievious surgery? ☐ Yes ☐ No
If Yes, how many previous surgeries?_____

SURGERY SCHEDULING QUESTIONNAIRE

To help us understand your particular needs and time preferences for your surgery, please provide us with the following information:

What is your tih1e preference for your Procedure?
Within the next: ☐ Month ☐ 3 Months ☐ 6 Months ☐ 1 Year

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HEALTH INFORMATION

PATIENT INFORMATION

First Name:_____ M.I.:____ Last Name:_____DOB:____/____/__
Employer/School:_____ Work Tel:_____ Cell:_____
Primary Care Physician:_____ Internist:_____ Cardiologist:_____
Age:_____ Weight:_____ Height:_____ B/P *(May be taken in office)*:_____

PERSONAL PAST HISTORY

Do you have any chronic medical problems? *(Fill in box for those that apply)*

☐ High Blood Pressure	☐ Diabetes	☐ HIV or AIDS
☐ Heart Disease	☐ Kidney Disease	☐ Stroke
☐ Heart Failure	☐ Psychiatric Diagnosis	☐ Hepatitis
☐ Seizures	☐ Bleeding Problems	☐ Emphysema
☐ Heart Attack	☐ Liver Disease	☐ Stomach Problems
☐ Chest Pain	☐ Gastric Reflux	☐ Other _____
☐ Asthma	☐ Cancer	☐ Other _____

Is there a personal or famtly of complications with anesthesia or malignant hyperthermia? ☐ Yes ☐ No
If yes, please explain?_____

FAMILY HISTORY

Do you have a family history of any medical problems? *(Check box of those that apply)*
Please indicate Family member(s):_____

☐ High Blood Pressure	☐ Diabetes	☐ HIV or AIDS
☐ Heart Disease	☐ Kidney Disease	☐ Stroke
☐ Heart Failure	☐ Psychiatric Diagnosis	☐ Hepatitis
☐ Seizures	☐ Bleeding Problems	☐ Emphysema
☐ Heart Attack	☐ Liver Disease	☐ Stomach Problems
☐ Chest Pain	☐ Gastric Reflux	☐ Other _____
☐ Asthma	☐ Cancer	☐ Other _____

Please list all prior Operations	Date	List any Complications
1._____	____/____/____	_____
2._____	____/____/____	_____
3._____	____/____/____	_____

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Please list All medications and/or dietary supplements:
(This Includes: Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil and St. John's Wort)

*1.*_____ *2.*_____
*3.*_____ *4.*_____
*5.*_____ *6.*_____
*7.*_____ *8.*_____
*9.*_____ *10.*_____

Please list ALL allergies and describe reactions: (I.e. Shellfish, Latex, Penicillin, etc.):_____

SOCIAL HISTORY

Do you use Aspirin or medications containing Aspirin? ☐ Yes ☐ No

Do you use Blood Thinners? (i.e. Coumadin, Heparin, Aspirin or Ibuprofen) ☐ Yes ☐ No
If Yes, medication name:_____

Have you used Diet Pills in the last two (2) weeks? ☐ Yes ☐ No
If Yes, medication name:_____

Have you taken Steroids within the last year? ☐ Yes ☐ No
If Yes, medication name:_____

Have you ever smoked tobacco products? ☐ Yes ☐ No
If Yes,# of packs per day:_____ # of years:_____
If you quit, when?_____

Do you use Recreational Drugs? ☐ Yes ☐ No
If Yes, list type:_____

Do you Exercise?_____If Yes, how often?_____ ☐ Yes ☐ No
How long?_____ Type of Exercise?_____

Is your Level of Activity related to health limitations? ☐ Yes ☐ No
If Yes, please explain:_____

Do you have caps, bridges, dentures, or loose teeth? ☐ Yes ☐ No
If Yes, please explain:_____

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Review of Systems: Please answer the following Yes or No questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

CARDIOVASCULAR High Blood Pressure

Heart Attack	☐ Yes	☐ No
Angina/chest pain	☐ Yes	☐ No
Heart Bypass surgery	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Heart Failure	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Comments:_____	☐ Yes	☐ No

NEUROLOGICAL

Stroke	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Sciatica	☐ Yes	☐ No
Herniated disc	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Rheumato	☐ Yes	☐ No

RESPIRATORY

Abnormal Chest X-ray	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Recent Chest Infection	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Shortness of Breath at night	☐ Yes	☐ No
Shortness of Breath on exertion	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Cough with Sputum	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No
Use a C-PAP Machine	☐ Yes	☐ No

HEMOTOLOGIC/ONCOLOGIC

Bleeding Tendency	☐ Yes	☐ No
Easy Bruising	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Sickle Cell Disease	☐ Yes	☐ No
Blood clots in legs	☐ Yes	☐ No
Blood clots in lungs	☐ Yes	☐ No
Radiation Therapy	☐ Yes	☐ No

PSYCHIATRIC

Depression	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Obsessive Compulsive Disorder	☐ Yes	☐ No

ENDOCRINE

Diabetes	☐ Yes	☐ No
Hyperthyroidism	☐ Yes	☐ No
Hypothyroidism	☐ Yes	☐ No
Hypoglycemia	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No

GASTROINTESTINAL

Jaundice	☐ Yes	☐ No
Gallstone	☐ Yes	☐ No
Liver Disease (Cirrhosis)	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Hiatal Hernia	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No

EYES

Cataracts	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Dry Eyes	☐ Yes	☐ No

SKIN

Cancer	☐ Yes	☐ No
Radiation	☐ Yes	☐ No
Atypical Skin Lesions	☐ Yes	☐ No

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Do you wear Contact Lenses?

Please list any other medical conditions that are not listed above:_____

_____

_____

Have you had blood drawn in the past month? ☐ Yes ☐ No Location:_____

Have you had an EKG done in the last year? ☐ Yes ☐ No Location:_____

Have you had a chest x-ray done recently? ☐ Yes ☐ No Location:_____

Have you had a recent medical evaluation by your Internist, Cardiologist or Family Practitioner? ☐ Yes ☐ No Location:_____
Doctor's Phone Number:_____

Thank you for providing this important information!

Signature: (Patient, Parent or Guardian):_____ Date:____/____/____

Comments:

_____

_____

_____

_____

_____

_____

Reviewed by:_____ Date:____/____/____

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PATIENT INFORMATION

For all cosmetic patients during your visit, you will be given a fee estimate for your proposed aesthetic procedure(s). This quote will include fees for the Surgery Center and fees for the Anesthesiologist, as well as any special equipment fees or Assistant fees. Please note that Dr. Herman's portion of the quote is good for 90 days only. If you choose to schedule the procedure more than 90 days in the future, it is possible that the fee will be different than the original quote. The hospitals and surgery centers control their own fee schedules and may increase their fees at any time. Payment for surgery may be made by cash, major credit card, or personal check. Payment of non-surgical treatments such as Botox© Cosmetic and fillers are made at the time of service by cash or credit card; we are unable to accept personal checks for these treatments. At times, a revision or "touch up" procedure may be desired. Should that be the situation, you the patient will be responsible for additional fees including but not limited to Operating Room or Anesthesia.

In regards to procedures that may or may not be covered by medical insurance, there may be situations in which part of your surgery would be considered functional or medically necessary. In that case, your insurance may pay part of the surgery fee. As a courtesy to you, our office will pursue prior authorization for this procedure. You wlll be responsible for the Surgeons fee, deductible and/or copayments prior to the procedure. You will be responsible for your deductible and co-payments for the operating room & anesthesia, as well as payments for the cosmetic portion of your procedure. Purely cosmetic services wlll not be billed to any third party Insurer.

Dr. Herman is not responsible for refunding any surgical fees or rescheduling fees that result from a patient's non-compliance. This icludes the failure to follow pre-surgical instructions including nicotine, alcohol, or drug use, failure to avoid or to take specific medications as instructed, and failure to follow day of surgery instructions. Any surgical procedure rescheduled by the patient less than fourteen days prior to surgery or as the result of patient non-compliance, will incur a surgeon's rescheduling fee; this does not include fees that may be charged by the surgical facility. All fees must be paid prior to confirming any new surgical date.

Should you pay for your procedure with a credit card and then for any reason receive a credit, this credit will reflect a usage fee of 5% of the initial amount charged, due to usage fees that have been assessed to our account by the credit card company to process the initial transaction. Our office requires a non-refundable $1,000.00 scheduling fee to guarantee your surgery date and time. Surgery fees are due in full 20 days before your surgery date. There will be a $1,000.00 fee if you cancel or reschedule your procedure up to 14 days before your procedure. This fee increases to 50% of your surgery fee if you cancel between 10 and 14 days of your procedure. If you cancel within one week (7 days) of your procedure, you will forfeit 100% of your surgery fee. These penalties do not apply to Illness related cancellations where a doctor's note is provided. If a check is returned from the bank, the patient will be responsible for the amount of the check plus a $30.00 processing fee.

We encourage you to contact our office staff for any questions that you may have about this policy so that it may be clarified for you prior to scheduling any procedures. We have found that most patients are pleased to have all details known prior to scheduling.

Statement of Financial Responsibility

"I, the undersigned, have read the above and understand that I am responsible for all medical and surgical charges incurred by myself or my dependents. I authorize the release of any medical Information necessary to process any claims that are processed on my behalf by Dr. Herman and Lansdale Institute of Plastic Surgery. I understand that my medical insurance contract is between my insurance company and myself and that the failure of the insurance company to pay my claim does not absolve my financial responsibility to Dr. Herman. All court and attorney fees or other fees associated with the collection of my account are my financial responsibility."

Signature: *(Patient, Parent or Guardian)*:_____ Date:_____/_____/_____

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PHOTOGRAPHIC AUTHORIZATION

I consent to the taking of photographs or videotapes of myself or parts of my body by Lansdale Institute of Plastic Surgery in connection with any and/or all plastic surgery procedure(s) to be performed by Dr. Floyd Herman.

I understand that photographs may be required by my insurance company for the purpose of prior authorization and consent to the release of any requested images for this purpose.

I understand that such photographs, videotapes or case histories may be published by Dr. Floyd Herman and/or any party acting under his license and authority with Lansdale Institute of Plastic Surgery in any print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and internet websites, 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 Lansdale Institute of Plastic Surgery.

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 release and discharge Dr. Floyd Herman and Lansdale Institute of Plastic Surgery including all parties acting under his 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 Signature	Date	Physician/Witness Signature

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.

_____	____/____/____	_____
Parent, Guardian or Conservator Signature	Date	Physician/Witness Signature

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PATIENT PARTNERSHIP PLAN

Dear Patient,

Welcome to Lansdale Institute of Plastic Surgery. We hope to provide you with the care and service that you expect and deserve. Achieving your best possible health requires a "partnership" between you and your doctor. As our "partner in health", we ask you to participate in your care in the following ways:

- **I WILL KEEP FOLLOW-UP APPOINTMENTS AND RESCHEDULE MISSED APPOINTMENTS**
- **I WILL CALL THE OFFICE WHEN I DO NOT HEAR THE RESULTS OF LABS AND OTHER TESTS**
- **I WILL INFORM MY DOCTOR IF I DECIDE NOT TO FOLLOW HIS RECOMMENDED TREATMENT PLAN**

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, seek an explanation, report symptoms, or discuss concerns. If you need more information about your health or condition, please ask.

_____	____/____/____	_____
Patient Signature	Date	Physician/Witness Signature

At the practice of Lansdale Institute of Plastic Surgery, your privacy is a very important part of our mission and plays a very big factor in your experience. Dr. Herman and his staff adhere to the highest standards of respecting and protecting patient privacy and the confidentiality of your health care information. Additionally, the team complies with all state and federal regulations regarding the privacy of individual health care information, including HIPAA (Health Care Insurance Privacy and Protection Act), enacted on April 14, 2003.

Our "Notice of Privacy Practices" is available upon request.