ASPS Member Surgeon

Sheilah A. Lynch, M.D.
LYNCH PLASTIC SURGERY

TOP DOCTOR WASHINGTONIAN

INFORMATION FOR CASE HISTORY

Today's Date: _____

Salutation: Dr. ❒ Mr. ❒ Mrs. ❒ Ms. ❒ Miss ❒

Patient's Name: _____
First Middle Last

Social Security #: _____ Date of Birth: _____ Age: ____ Sex: M / F

Home Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____

E-mail: _____ **Would you like to be on our mailing list for specials? Y / N**

Preferred method of being contacted: ❒Email ❒ Home Address ❒ Phone cell / home

Occupation: _____ Employer: _____

Permission to call you at work, if necessary: **Y / N** Work Phone: _____

Work Address: _____
Street City State Zip Code

EMERGENCY CONTACT

Emergency Contact: _____
First Last

Relationship: _____ Phone: _____

How were you referred to our office?
□ Friend: Name_____ □ Doctor: Name _____
□ Internet □ Yellow Pages □ Google □ Other: _____
□ BreastImplantsByMentor.com □LynchPlasticSurgery.com □ Staff _____
Magazine: □ Your Health □ Washingtonian □ Bethesda

Is today's visit a result of an injury? _____ If so, date of injury: _____ Work related? _____
**Please provide any necessary documentation to be completed by physician.*

PERMISSION TO PHOTOGRAPH AND/OR VIDEO TAPE

I HEREBY AUTHORIZE Dr. Lynch or any staff member that she may engage for this purpose, to take such photographs/video tape of me as she desires before, during, and after surgery, which is to be performed on me. I authorize such photographs to be published in professional journals and medical books, to be used for educational/research purposes, or for advertising or in the event of legal action. I would not be identified by name if my photographs were published. Furthermore, this release is a general lifetime release, and I agree that no compensation will be given or sought for such use of my image.

_____ _____ _____
Patient's Signature Date Relationship, if not patient

MEDICAL HISTORY

Height: _____ Weight: _____

Do you smoke? ☐ Yes ☐ No If so, how much? _____

Do you consume alcohol? ☐ Yes ☐ No If so, how much? _____

Please list any serious illnesses: _____

_____

Have you ever had any of the following? (Check those that apply) ❒asthma ❒bruise/bleed easily ❒cataracts

❒diabetes ❒glaucoma ❒heart disease ❒high blood pressure ❒keloids ❒ kidney disease ❒ lung disease

❒other _____

When was your last physical exam?_____ Physician's Name _____

Physician's Telephone # _____ Physician's Address (city/state) _____ –

Pharmacy: _____ Pharmacy Phone # _____

List any medications taken on a daily basis such as blood thinner, aspirin, Bufferin, Advil, birth control, diuretics, blood pressure or heart medications, steroids, tranquilizers, hormones, Retin-A, Accutane, herbal drugs, diet medications, vitamins, etc:

_____

_____

ALLERGIES

❒Aspirin ❒Penicillin ❒Codeine ❒Percocet ❒Sulfur ❒Latex ❒Adhesive Tape ❒Other ❒None

If other, please explain: _____

Have you taken steroids, i.e. prednisone, cortisone, medrols, etc. in the past 12 months: Y / N

Do your experience cold sores or fever blisters: Y / N If yes, please explain: _____

HIV: _____ Hepatitis: _____

MRSA (Methacillin Resistant Staphalococcus aureus) History: _____

Previous surgery: _____

_____

Surgery complications: _____

_____

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Name: _____ Date: _____

Please review the many services we offer. If you have interest in any of these please check √ all that apply

SURGICAL

[ ] Fat Transfer
[ ] Breast Enlargement
[ ] Breast Lift (Mastopexy)
[ ] Buttock Enhancement
[ ] Breast Reduction
[ ] Correction of Protruding Ears (Otoplasty)
[ ] Face or Neck Lift
[ ] Male Body Contouring
[ ] Male Breast Reduction (Gynecomastia)
[ ] Chin/Cheek Implants
[ ] Tummy-Tuck (Abdominoplasty)
[ ] Eyelid Rejuvenation (Blepharoplasty)
[ ] Brow Lift
[ ] Nasal Surgery (Rhinoplasty)
[ ] Body Contouring/Liposuction

NON-SURGICAL

[ ] Botox Cosmetic / Dysport
[ ] Juvederm, Restylane
[ ] Radiesse, Voluma
[ ] Sun Spots / Sun Damage
[ ] Photo Rejuvenation
[ ] Reducing Wrinkles
[ ] Treatment for Leg Veins
[ ] Microdermabrasion
[ ] Hair Removal
[ ] Glycolic/ TCA/ Salicylic Peels
[ ] Vi Peel

Other_____

Other_____

Questions to discuss: _____

_____

_____

_____

5530 Wisconsin Ave, Suite 1440
Chevy Chase, Maryland 20815
301.652.5933

lynchplasticsurgery.com

8615 Commerce Drive, Suite 5
Easton, Maryland 21601
410.822.1222

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FINANCIAL POLICY

Please take a moment to review our financial policy, as a clear understanding of the policy is important to our professional relationship. Changes to the financial policy may subject to change without advanced notification. All payments are due at the time of service.

Cosmetic Consultation Fees are as follows:

- Cosmetic Consultation $100
- Breast Revisions, Buttock Augmentation, Minor Surgery Consultation $150

Consultation fees will be applied towards treatment or surgery within (6) six months from your original consultation date. The consultation fee includes a secondary consultation within 60 days of original consult date, if needed.

Out-of-Network Insurance Consultation: A fee of **$250** is charged for all breast reduction and eyelid consultations. **Please note: Dr. Lynch is not a participating provider with any medical insurance plan including Medicare and Medicaid.* Dr. Lynch will provide all necessary documentation and paid receipts for you to submit to your medical insurance company for possible insurance reimbursement. (A separate insurance form will be issued to you.)

Scheduling Surgery: A **10% deposit** of the estimated quote total is required at the time surgery date is reserved. The deposit is credited towards the amount of surgeon's fee only. The remaining balance of the surgeon's fee is payable in full two (2) weeks (14 days) prior to your scheduled surgery date, usually coincides with your pre-operative appointment Any surgery not paid in full will be subject to cancellation. If you are scheduling surgery less than two (2) weeks in advance, payment in full is required at the time of your consult/pre-operative appointment.

We will only quote approximate and current estimates to the best of our ability. The patient is financially responsible for the total cost of surgery.

Cancellation Policy: If you cancel your surgery for elective reasons greater than two (2) weeks prior to your scheduled surgery date, we will refund your deposit less a $250 administrative fee. If you cancel your surgery for elective reasons less than two (2) weeks (14 days or less) before your scheduled surgery date, your deposit is forfeited and we will retain the initial ten percent (10%) deposit.

Rescheduling Surgery Policy: There is a $100 rescheduling fee for all rescheduled surgeries. If you need to reschedule your surgery for any reason, the deposit will be applied to your new surgery date if your surgery is rescheduled within six (6) months of original surgery date. If you reschedule your surgery more than six (6) months after original scheduled surgery date, your deposit if forfeited.

Postoperative visits relating to the original procedure(s) are included in the surgeon's fee for one (1) calendar year the date of surgery. Consultation regarding unrelated procedures will be billed a $100 cosmetic consultation fee. A series of *Kenalog* (steroid) injection treatments to help reduce redness and flattening of the scar are sometimes administered to patients who are prone to hypertrophic scarring. The series are usually three (3) treatments at $140 per from treatment. Patient is financially responsible for the cost of triamcinolone (*Kenalog*) prescription and the cost of each treatment.

Cosmetic re-operations that involve minor revisions will be performed within one (1) year from the original surgery date The patient is responsible for 100% of the facility fee, anesthesia fee, and supplies used.

In-Office revisions require a $100 deposit at the time of scheduling which will be applied to the quoted supply fee. In the event that the in-office revision is cancelled one (1) week or less, the $100 deposit will be forfeited.

Returned checks: A $35.00 fee will be assessed should an unpaid (NSF) check be returned.

Signature: _____ Date: _____

NOTICE to PATIENTS

This notice describes how medical information about you may be used and disclosed. We are required by law to protect the privacy of your protected health information. This document also explains how you can gain access to your medical information and who to contact should you have any complaint. Please read the document carefully and sign the bottom of the form to acknowledge that you have received it.

A. The general consent for release of medical records that you sign authorizes Sheilah Lynch, M.D. d/b/a Lynch Plastic Surgery to disclose the information in your medical record for treatment, payment and health care operations:

1. For the purpose of providing treatment to you. Your information may be shared with e.g. employees and contractors of the provider, or with other healthcare providers who are treating you or consulting in your care.

2. For the purpose of arranging payment for your care. Your information may be shared with your insurer or other third-party payer who is responsible for paying all or part of the cost for your care.

3. For the purpose of health care operations. We may use and disclose information that is necessary for our operations e.g. internal quality assessments, contacting other health care providers about treatment alternatives. We may also disclose information to doctors, nurses, technicians or other practice personnel who are involved in your medical care and treatment. Different areas of the practice also may share medical information about you in order to coordinate the different things you need, such as prescriptions and lab work. We may also disclose medical information about you to people outside the practice who may be involved in your medical care after you leave our office, such as family members or others we may rely upon or ask to assist us in caring for you. We may use information about you to provide you with appointment reminders such as voicemail messages, postcards or letters.

Please provide the name and phone number of a family member or friend that is permitted to receive messages/mail from our office pertaining to you in the event that we cannot get touch with you:

NAME (FAMILY MEMBER OR FRIEND) PHONE NUMBER

NOTICE to PATIENTS

B. You may be asked to sign a specific authorization for release of medical records, which will authorize us to make a specific disclosure that is not covered under Section A above. The specific information, the entity to whom it will be disclosed to, and the purpose for which it will be used will be documented for your review before signing.

C. You may revoke any consent or authorization provided to us by giving a written notice of revocation.

D. We may be required by law to disclose your records that you have not authorized. For example if we receive a subpoena for the records. We will keep all disclosure of your medical records to the minimum necessary.

E. Your rights regarding health information about you:

1. You have the right to inspect and copy your health information.

2. If you feel that the health information we have about you is incomplete or inaccurate you have the right to request an amendment to your medical records. The request must be made in writing with the reason that supports your request.

3. You have the right to find out how your health information is used and to whom it is disclosed. You may request an accounting of your medical records disclosures made by us except for disclosures made for treatment, payment and health care operations.

4. You have the right to receive a paper copy of this notice.

F. We are required by law to maintain the privacy of your protected health information and if you believe that your rights have been violated you may complain to the Secretary of The U.S. Department of Health and Human Services or complain to us by talking to us, calling us, or writing us with details. Please ask to speak to our Office Manager who is our Privacy Contact person.

G. If you have an advanced directive, please provide us a copy. If you need additional information on advanced directives, please visit www.Medicare.gov and search advanced directives.

H. When necessary, these policies will be modified to ensure compliance with practice operations and with State and Federal privacy regulations.

Please acknowledge receipt and review of this notice by signing below.

SIGNATURE OF PATIENT OR LAWFULLY AUTHORIZED PERSON DATE