Thomas E. Kinney, M.D.

Greater Milwaukee
PLASTIC SURGEONS, S.C.

PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION *(Please print & complete all areas)*

Name_____ **SSN**____ - ____ - ____ **Age**____
(First MI Last)

Address_____ City_____ State____ Zip____

Home # (____)_____ **Work #** (____)_____ **Cell #** (____)_____
* List only numbers we have your consent to call

☐ Male ☐ Female **Date of Birth** ____/____/____ ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Ethnicity ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other **Email**_____

Employer_____ **Occupation**_____

Employer Address_____

Spouse's Name_____ **Spouse's SSN** ____ - ____ - ____

Spouse's Employer_____ **Date of Birth**____/____/____

Referring Doctor's Name_____ **Primary Doctor's Name** _____

Emergency Contact_____ **Phone #** (____)_____ **Relationship**_____

INSURANCE INFORMATION

Person Responsible for Account / Insured_____
(Last First MI)

Primary Insurance_____ **Secondary Insurance**_____

Policy Holder Name_____ **Policy Holder Name**_____

Subscriber #_____ **Subscriber #**_____

Group #_____ **Group #**_____

***** If patient is the CHILD OF THE INSURED, the parent's information must be completed below:***

SSN ____ - ____ - ____ DOB ____/____/____ Home # (____)_____ Relationship_____

Address_____ City_____ State____ Zip____

Employer_____ Work # (____)_____

ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage with aforementioned insurance carrier(s) and assign directly to my doctor all insurance benefits, if any, otherwise payable to me for services rendered. ***I understand that I am financially responsible for all charges whether or not paid by my insurance and accept responsibility for any balance remaining after payment of such benefits.*** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I further authorize the physician to release any information required in the course of my treatment as authorized according to HIPAA Privacy Rules.

_____ _____ _____
Signature of Insured or Guardian Relationship Date

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PATIENT MEDICAL HISTORY

Patient's Name: _____
First MI Last

Height: _____ Weight: _____ Age: _____ y/o

List your primary physician (or pediatrician if child): _____

List reason for visit or current medical problem(s): _____

_____

List medications you are currently taking: _____

_____

Do you have any known **ALLERGIES and/or DRUG SENSITIVITIES?** ☐ No ☐ Yes, please list: _____

_____

List any vitamins and/or herbal supplements that you currently take: _____

List previous operations with dates: _____

_____

Number of pregnancies: _____ Number of live births: _____

Circle "Y" for "Yes", "N" for "No" in response to the following:

Do you smoke? Y N How much per day? _____

Do you drink? Y N How often? _____

Do you bruise easily? Y N

Do you take aspirin, ibuprofen or similar over-the-counter medication? Y N

Family History: Diabetes Y N Cancer Y N

Heart Disease Y N Malignant Hyperthermia: Y N

Other: _____

Do you have now or have you ever had:

breathing problems	Y	N	kidney disease	Y	N
high blood pressure	Y	N	bladder infection	Y	N
heart disease	Y	N	arthritis	Y	N
epilepsy	Y	N	auto immune disease	Y	N
glaucoma or cataracts	Y	N	(AIDS/HIV, lupus, polyarthritis, etc.)		
stomach ulcers	Y	N	blood clots in leg	Y	N
hepatitis/jaundice	Y	N	pulmonary embolus (blood	Y	N
estrogen therapy	Y	N	clot in lung)		
psychiatric counseling	Y	N	diabetes	Y	N
gout	Y	N	cancer	Y	N

Have you ever had a blood transfusion? Y N If Yes, enter date or year _____

Would you accept a blood transfusion if needed in an emergency situation while under the physician's care? Y N

Date of last dental exam: _____ Normal? ☐ Yes ☐ No If no, please explain: _____

Are there any medical problems not listed above that you would like the physician to be informed about?

_____

I certify that the above information is correct to the best of my knowledge:

Patient Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

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HIPAA ACKNOWLEDGEMENTS AND AUTHORIZATIONS

I acknowledge that I have received from GREATER MILWAUKEE PLASTIC SURGEONS, S.C. (the "Practice") a written Notice of Privacy Practices concerning the confidentiality of my protected health information. I acknowledge that the written Notice contains a description of how medical information about me may be used and disclosed and how I may access this information. I acknowledge that the Notice also contains:

- A description of the types of uses and disclosure that the Practice is permitted to make for treatment, payment or healthcare operations with and without my written authorization.
- A description of each of the other purposes for which the Practice is permitted to be required to use or disclose PHI without my written authorization.
- A description of uses or disclosures that may be limited or prohibited by law.
- Descriptions that are in sufficient detail to make me aware of the uses or disclosures that are permitted or required by the federal privacy rules and other applicable laws.
- A statement describing my individual rights with respect to my health information and a description of how I may exercise these rights.
- A statement describing the Practice's duties under the federal privacy law.
- A statement describing how I may express concern to the Practice and the Secretary of the Federal Department of Health and Human Services if I believe my privacy rights have been violated.
- Information explaining how to contact the Practice for further information and the effective date upon which the Notice is first in effect.

I, the undersigned, acknowledge that I have received a written Notice of Privacy Practices from GREATER MILWAUKEE PLASTIC SURGEONS, S.C.

_____ _____

(Signature of Patient or Personal Representative) (Date)

_____

(Print Patient Name)

If Personal Representative, describe relationship: _____

For Office Use Only:

☐ The patient's condition prevents the individual from signing an acknowledgement at this time. It will be obtained as reasonable practice after the patient's condition improves.

☐ Acknowledgement was unable to be obtained.

Reason: _____

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PHOTO RELEASE AND CONSENT

This is a consent document that has been prepared to help inform you concerning permission to take photographs, slides and/or videotapes and to use these images for a purpose as defined within this consent document. It is important that you read this information carefully and completely before giving your signature consent. ***Any sections below that do not apply or that you do not consent to may be crossed out. All sections crossed out must be initialed by the patient.***

Medical photographs, slides and/or videotapes may be taken before, during or after a surgical procedure or treatment. Consent is required to take such images. Additionally, patients may consent to release these medical photographs, slides and/or videotapes for a stated purpose.

1. **CONSENT TO TAKE PHOTOGRAPHS/SLIDES/VIDEOTAPES FOR TREATMENT PURPOSES**
   I authorize the physician and/or his associate to take pre-operative, intra-operative and post-operative (before, during and after procedure) photographs, slides and/or videotapes. I additionally consent to photographs, slides and/or videotapes of my interview with the physician and/or his associates. These photographs, slides and/or videotapes will become a permanent part of my medical record for treatment purposes.

2. **CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPE FOR EDUCATIONAL AND/OR SCIENTIFIC SETTINGS.**
   I understand and accept that I may be recognized from my likeness or case history.

   a. I authorize the physician and/or his associate to use my photographs, slides, videotapes and case information in **educational and scientific settings** including lectures and multimedia presentations for an audience of medical professionals, at which members of the press may be present, and medical, surgical and scientific journal articles.

   b. I authorize the use of my photographs, slides, videotapes and case information in the following **commercial/educational settings:** my physician's office patient education materials; my physician's file of pre- and post-operative patient photographs available to prospective patients for viewing in the office; newspaper and magazine articles in which my physician participates; television programs in which my physician participates; my physician's personal web site or web page; and lectures and multi-media presentations given by my physician for the general public.

   c. I authorize my physician's professional associations, the American Society of Plastic Surgeons and the American Society for Aesthetic Plastic Surgery, to use my photographs, slides, videotapes and case information **in fulfilling its mission of public education**, in any of the following settings: patient education brochures available for purchase; educational videotapes available for purchase; lectures and slide presentations available for purchase; information submitted by the Societies to consumer periodicals, magazines and web sites for press or Internet publication; television programs about plastic surgery; and case studies presented on the Societies websites.

Patient Signature: _____ Date: _____

Patient's Printed Name: _____

10/2018

Greater Milwaukee
PLASTIC SURGEONS, S.C.
13800 W North Ave | Suite 110
Brookfield, WI 53005

Philip L. Sonderman, M.D.
Thomas E. Kinney, M.D.

NOTICE TO PATIENTS OF GREATER MILWAUKEE PLASTIC SURGEONS

GREATER MILWAUKEE PLASTIC SURGEONS

NEW FINANCIAL POLICIES

EFFECTIVE 1/1/2022:

ACCOUNTS WITH PATIENT RESPONSIBILITY BALANCES WILL RECEIVE BILLING STATEMENTS FOR 2 CONSECUTIVE MONTHS. IF BALANCE IS NOT PAID IN FULL WITHIN 30 DAYS FOLLOWING THE 2ND STATEMENT, BALANCES WILL BE FORWARDED TO OUR OUTSIDE COLLECTION SERVICE. THE PATIENT WOULD THEN NEED TO MAKE PAYMENT ARRANGEMENTS THROUGH THAT AGENCY.

EFFECTIVE 6/1/2022:

A CONVENIENCE FEE OF 3.5% WILL BE ADDED TO ALL CREDIT CARD TRANSACTIONS.

***PLEASE NOTE** THAT THIS ADMINISTRATIVE FEE IS NOT A PORTION OF YOUR CO-PAYMENT, CO-INSURANCE OR DEDUCTIBLE, BUT A SEPARATE FEE THAT WILL BE ITEMIZED ON YOUR CREDIT CARD RECEIPT. PAYMENTS MADE WITH PERSONAL CHECKS OR CASH WILL NOT BE CHARGED THIS ADMINISTRATIVE FEE.
THANK YOU.

Member
AMERICAN SOCIETY OF PLASTIC SURGEONS

Thomas E. Kinney, M.D.

Greater Milwaukee
PLASTIC SURGEONS, S.C.

FINANCIAL PATIENT POLICY

Thank you for choosing Greater Milwaukee Plastic Surgeons, S.C. (GMPS) for your care. We will provide medical services to you provided that you understand and agree to the following financial policies of our practice. If you have any questions, please discuss them with our billing staff or office manager.

SUBMISSION OF INSURANCE CLAIMS

YOUR HEALTH INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR HEALTH INSURANCE PLAN. You are responsible for understanding and following your health plan's required procedures and policies. It is your responsibility to provide us with accurate and up-to-date insurance information, so that we can file an insurance claim on your behalf for services rendered. If we do not receive payment within 60 days from the date the claim is filed with your health plan, you are responsible for the unpaid balance and we may request immediate payment from you. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. It is your responsibility to contact your health plan regarding benefits or coverage issues.

REFERRALS AND PRIOR AUTHORIZATIONS

If your health plan requires you to have a referral from your primary care physician in order to be seen by our practice, it is your responsibility to verify that a referral has been received by our office prior to your visit. FAILURE TO HAVE A VALID REFERRAL AUTHORIZATION MAY RESULT IN YOUR APPOINTMENT BEING RESCHEDULED UNTIL A VALID REFERRAL IS OBTAINED. If you request to be seen without a valid referral, you will be responsible for payment of services rendered and payment will be due in full at the time of the appointment. If your health plan requires preauthorization for a procedure, our billing staff will assist you in obtaining a prior authorization. Pre-authorization does NOT guarantee payment of your surgery costs. If payment is denied, you may be responsible for payment of the balance in full. Approval does not indicate payment at 100%. It is your responsibility to understand your benefit levels. Your insurance carrier can assist you in mapping out what you may owe, which we highly recommend prior to surgery so there are no surprises.

CO-PAYMENTS AND NON-COVERED SERVICES

If your health plan requires a co-payment, we are required to collect it at the time of your visit. We cannot waive co-payments, deductibles or co-insurance amounts, which are the patient's responsibility. Co-payments and non-covered services are collectable at the time of your visit. If you cannot make the required payment, your appointment will be rescheduled. If you do not have health insurance coverage or request a service that is not covered by your health plan (i.e., cosmetic in nature), we require payment to be made in full at the time services are rendered. For your convenience, we accept cash, personal or cashier's checks and all major credit cards.

ELECTIVE SURGERY

If you are scheduled for surgery that is cosmetic in nature and not covered by your health plan at a facility other than Greater Milwaukee Plastic Surgeons, S.C., we require that payment be made in full 21 calendar days prior to surgery. For your convenience, we accept cash, personal or cashier's checks, all major credit cards and Cosmetic Fee Plan payments. Prepayment is also required by the facility and anesthesiologist; however, these are separate billing entities and you will be informed of their payment policies when you schedule your surgery. We are not responsible for any charges or billing practices of a facility, anesthesiologist or any healthcare providers, as they are not affiliated with Greater Milwaukee Plastic Surgeons, S.C. If you elect to move forward cosmetically, you do so with the understanding that GMPS will not accept assignment of benefits, nor will GMPS submit for coverage thereafter or assist in the patient submission process.

PATIENT RESPONSIBILITY FOR BILLED AMOUNTS

We will send you a statement of any remaining balance on your account after health plan payments are applied. Payment is due in full within 30 days from the date that appears on your billing statement. If we do not receive payment from you within 60 days from the date of the first billing notice, your account may be turned over to our collection agency. IF YOUR ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY, YOU WILL BE RESPONSIBLE FOR ALL COLLECTION COSTS AND LEGAL FEES INCURRED.

CONVENIENCE FEE

Effective 6.1.2022, a convenience fee of 3.5% will be added to all credit card transactions.

REFUNDS

Refunds will be processed in the same manner with which the payment was made (i.e., if payment was made by credit card, then the refund will be done by credit card, etc).

HSA ACCOUNTS

GMPS will not accept HSA payments for payments of elective/cosmetic surgeries per IRS guidelines.

MINORS

A parent or legal guardian must accompany a minor and consent to treatment. Parents or legal guardians must comply with the terms of this financial policy. The parent or legal guardian that accompanies the minor will be held responsible for payment of services.

MISSING, INACCURATE OR INCOMPLETE BILLING INFORMATION

You are responsible for notifying our office of any health plan or billing information changes. Failure to notify us of changes may result in your being responsible for any remaining balance on your account. Our practice will not be responsible for any billing errors, lack of coverage or payment due as a result of missing, inaccurate or incomplete information that you have provided us, including inaccurate information on secondary or third party payment coverage.

I have read and understand the Patient Financial Policy for Greater Milwaukee Plastic Surgeons, S.C. and accept all the terms and conditions as stated above. I have received a copy of this policy.

Signature of Patient	Date
Signature of Minor patient's parent or legal guardian	Relationship to patient