LEVI J. YOUNG, MD

ADVANCED COSMETIC SURGERY

Name _____
(Last) (First) (Middle)

Date of Birth _____/_____/_____ Social Security Number _____- _____ -_____ Marital Status - S M W D

Address _____
(Street) (City) (State) (Zip)

Age: _____ Gender: M F Phone No. (Residence) (_____) _____

(Cell No.) (_____) _____

Email Address _____

Employer_____ Occupation_____

Reason for Consultation _____

How did you hear about our office?

Friend (name)_____ Magazine _____

Facebook Instagram Genesis Health Club Radio Real Self Google

Spouse, Parent or Emergency Contact

Name _____ Relationship _____

Phone No. (____)_____

HIPAA acknowledgement

Pursuant to HIPAA policy, No information is given out about you on the phone or in person to anyone unless you authorize us to do so. If you anticipate your caregiver or loved one may need to discuss with us anything regarding your procedure or payment before or after your surgery please list that individual or individuals here so that we may discuss your care with them.

Name:_____ Relationship:_____

Ok to discuss the following with the person listed above: ☐ Medical information ☐ Financial Information

Payment Responsibility
I acknowledge that Advanced Cosmetic Surgery does not accept insurance of any kind and I am responsible for all fees to be paid in full two weeks prior to surgery. I authorize the release of any medical information necessary to process any fees that are processed on my behalf by the office of Levi J Young, M.D.

Signature: _____ Date: _____

Patients Personal History

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Confidential Information contained herein will not be releases except when you have authorized us to do so. Please answer all questions to the best of your knowledge. Your doctor, in his decisions regarding your care, will use the information provided by you.

Patient Name: _____
Height: _____ Ft: _____ In. Weight _____ BMI_____

WOMEN ONLY:
Date of last mammogram _____ Results _____
Have you had a breast MRI / Ultrasound Yes / No If yes, date _____
Do you have children: Yes / No Ages: _____ Breastfed: Yes / No

Do you have or have you had any of the following: (check all that apply)

____ Asthma / Shortness of breath
____ Back Problems
____ Bladder Infection
____ Bleeding Disorder / Blood Clots
____ Cancer
____ Chronic Hoarseness
____ Chest Pain / Heart Attack
____ Chronic Skin Conditions
____ Chronic Sinus Problems / Nasal Blockage
____ Diabetes
____ Easy Bruising
____ Eating Disorder
____ Epilepsy
____ Glaucoma or Blurry Vision
____ High Blood Pressure
____ Heart Problems
____ Hepatitis / HIV / AIDS
____ Hormone replacement therapy
____ Kidney Disease
____ Latex Allergy
____ Mental Illness
____ Paralysis of the face
____ Prednisone or Steroid Use
____ Recurrent Fever Blisters
____ Recurrent Severe Dizziness or Headache
____ Severe Dryness of the Eyes
____ Sleep Apnea
____ Stomach Ulcers / Acid Reflux
____ Stroke
____ Taking Birth Control
____ Tuberculosis
____ Wound Healing Problems / MRSA

Other serious illness or health condition: _____
_____

Previous Surgeries: _____
_____

List of current prescriptions and over the counter medications and supplements you are taking and the dosage:
_____
_____

Do you smoke? Yes / No How much?_____ Do you drink? Yes / No How Much?_____

Are you allergic to any food or medications? Yes / No (if yes, what?) _____
_____

Signature:_____ Date: _____

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Practice Policies

Thank you for giving Dr. Young and Advanced Cosmetic Surgery the opportunity to work with you as you reach your aesthetic goals. Dr. Young and his staff are committed to exceeding your expectations and look forward to creating a personalized plan for you, addressing your specific questions and concerns.

Your initial consultation is **$50**, due at the time of check in. The surgical quote provided at your consultation will include fees for the surgery center, anesthesia, Dr. Young's fee and all post operative follow up appointments. The Surgery Centers control their own fee schedules and may increase their fees at any time. Any prescription medication, labs, x-rays, or pathology samples are not included in our quote. Additional consultations will incur a **$100 office fee**. No-showed appointments will be charge a $50 fee.

Payment for surgery deposits or balance may be made by cash, check, cashier check, money order or all major credit cards. We also offer patients affordable financing options through, Care Credit. Payments for non-surgical treatments such as Botox, Juvederm or fillers, are made at the time of service. Advanced Cosmetic Surgery **does not accept any medical insurance**. In the event a sample is sent to pathology, your insurance provider would bill you for that service.

Should you pay for your procedure with a credit card and then for any reason need a refund, the refund credit will reflect a **5% processing fee** which is charged to our office by credit card companies for the initial transaction. Our office requires a **20% non-refundable deposit** to reserve and guarantee your surgery date. In the event you need to reschedule your surgery date, we require **a minimum of 30 days** and would allow you to reschedule within 90 days of the cancelled date. Full payment **+$500 rescheduling fee** is required before the rescheduled date will be secured. If you do not reschedule within 90 days, your deposit is **forfeited.** If a check is returned due to insufficient funds, the patient will be responsible for the amount of the check plus a $35 processing fee. Our office reserves the right to increase the processing fee pending bank charges.

We encourage you to contact us with any questions or concerns regarding our policies prior to scheduling any procedure.

Signature:

Patient_____ Date:_____

Witness_____ Date:_____