ASSOCIATES IN PLASTIC SURGERY, INC.

Jonathan S. Jacobs, DMD, MD, FACS John. S Alspaugh, MD, FACS Michael J. Denk, MD, FACS

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐	
Maiden Name:	Prefer/Nickname:	Social Security Number:	Birth Date: / /	Age:	Sex: ☐ M ☐ F	
Street address:		Email Address:			Do you wish to be on our email list? ☐ Yes ☐ No	
City:	Zip Code:	Best phone number to reach you: home ☐ cell ☐ work ☐			May we leave a message? ☐ Yes ☐ No	
Home Phone: ( )		Cell Phone: ( )			Work Phone ( )	
Employer:		Employer Address:			City:	Zip Code:
Primary Care Physician	**Phone:** ( )	Other Current Physician Name:			Phone: ( )	

INSURANCE INFORMATION

(Please give your insurance card to the secretary.)

Primary Insurance Company:	**Policy Number:**	Specialist Co-pay: $
Patient's relationship to subscriber : ❑ Self ❑ Spouse ❑ Child		
Subscriber's Name:	**Subscriber's S.S. Number:**	**Subscriber's DOB:**
Secondary Insurance (if applicable):	Address:	
Policy Number:	Group Number:	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑Other		

IN CASE OF EMERGENCY

Who may we speak to regarding your health/medical care:	Relationship to patient:	Home Phone Number: ( )	Work Phone Number: ( )

This certifies that the above information is correct and current as of this date. I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Associates In Plastic Surgery, Inc. in accordance to applicable HIPPA Law. _____ please initial

_____ _____

Patient/Responsible Party Signature ***Date*** *Witness*

***How did you hear about us (please check one box):**	☐ Dr.	☐ Friend	☐ Family
☐ Newspaper	☐ Facebook	☐ Email advertisement	☐ Promotional Event	☐ Attorney
☐ Radio	☐ TV	☐ Twitter	☐ Flyer	☐ Love Your Look	☐ Breast Implants USA	☐ Internet
☐ ER	☐ Other (please explain):					

****FOR EFFICIENCY PURPOSES, PLEASE COMPLETE ALL INFORMATION BEFORE SUBMITTING TO THE FRONT DESK.**

Associates in Plastic Surgery, Inc. Patient Consent

Consent for Treatment

I, the undersigned, as the patient or on behalf of the above named patient hereof, do hereby consent to and authorize all diagnostic and therapeutic treatment considered necessary or advisable in the judgment of the physician on duty or the referring physician, as well as any testing and/or treatment carried out by Associates in Plastic Surgery, Inc. staff under the direction of the Medical Director.

Opt-In Consent

I, the undersigned, consent to the use of text messages for the purpose of office communication regarding appointments and marketing. You have the right not to recieve unsolicited marketing communications via SMS.

_____ (pt. initials)

No Guarantee of Results

I understand that no guarantee or assurance has been made as to the results which may be obtained from the exam, testing, or treatment.

Release of Medical Information

I hereby authorize the release of any medical records to any company insuring the patient named above and assign all benefits from said insurance to Associates in Plastic Surgery, Inc. In the case of work related injury or illness, I hereby authorize Associates in Plastic Surgery, Inc. to release any information obtained by Associates in Plastic Surgery, Inc. to any employer or prospective employer when the medical exam, testing, or treatment is in accordance with the provisions of, and under the conditions prescribed by the Workers' Comp Act, any state of federal mandated exams, or company policy which requires a medical examination.

Blood borne Pathogen Exposure

As established in Virginia Law (Virginia Code Section 32.1-45.1) acknowledge that if a caregiver is exposed to my blood or bodily fluids in the course of my treatment, my blood will be tested for Human Immunodeficiency Virus (HIV) antibody, Hepatitis B or Hepatitis C viruses and the results will be released to me.

Payment

I understand that payment is due when services are rendered unless other arrangements have been made in advance. I understand that my medical insurance carrier will be billed as a courtesy, if requested. I understand and agree that I am responsible for all co-pays, deductibles and **co-insurance** (if applicable) **____ (pt. initial.)** and all balances due. I understand and agree to pay all reasonable attorney fees and collection fees, as well as court cost incurred by the practice(s) in the collection of any monies due by myself or dependents. ***Insurance must be presented at each time of service. If there are any changes to your insurance we must be notified immediately. All remaining balances are patient responsibility*** **_____ (pt. initial.)**

In case of work related injury or illness, employer requested medical services are usually paid by the employer of their insurance company. I understand that I will be responsible for services provided by Associates in Plastic Surgery, Inc. if arrangements have not been made, or arrangements have been negated for any reason.

_____ _____

Patient Signature Date

_____ _____

Responsible Party Date

_____ _____

Witness Date

January 22, 2016

Associates in Plastic Surgery, Inc.
1037 First Colonial Road, Virginia Beach, Virginia 23454
Phone: 757-491-3535 Fax: 757-422-4750
Dr. Jonathan S. Jacobs
Dr. John S. Alspaugh
Dr. Michael J. Denk

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: 1037 First Colonial Road

City: Virginia Beach State: VA Zip Code: 23454

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Right to terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Associates in Plastic Surgery, Inc. You should contact the Privacy officer to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it was sent. It may not be possible to ensure your right to the protection of the privacy of this information once Associates in Plastic Surgery, Inc. discloses it to another party.

Rights of the Individual

- You may inspect or copy information used or disclosed under this authorization.
- You may refuse to sign this authorization

Effect of Refusing Authorization

If you refuse to sign this authorization, Associates in Plastic Surgery, Inc. will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others, including:

_____ (treatment conditioned on authorization)

Patient Signature: _____ Date Signed: _____

Copying document fees: $10.00 service charge, plus $.50 per page for the first 50 pages and $.25 per pager thereafter. Please allow 7-10 business days for your records to be processed.

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

June 28, 2013

Associates in Plastic Surgery, Inc. Office Financial Policy

Thank you for choosing us as your health care provider. Our staff and physicians are committed to providing you the best service we can. The following is a statement of our office policy which we request you read and sign.

All patients are required to complete our registration form, provide us with a valid **medical insurance card and a photo ID**, as well as new insurance cards as they become available.

We accept assignment of insurance benefits as a courtesy to our patients; however the balance is your responsibility. Deductibles applied by your insurance, not covered by another insurance, will also be your responsibility. Please be aware that some services provided may not be covered and may not be considered medically necessary, under Medicare and other insurances. Patients will be responsible for payment in full at the time of visit, unless valid insurance is presented.

All copayments, deductibles and co-insurance amounts are to be paid at the time service is rendered. Insurance processing can take up to six months or more. If you are due a refund for some or all of your deductible or co-insurance payments made at the time of service, refunds will be reviewed by Associates In Plastic Surgery and then processed through our billing company. This process does not take place until AFTER all insurance payments have been satisfied. Your EOB or explanation of benefits documents that you receive from your insurance company will help you understand and track the payments. Insurance refunds are processed through our billing company are only run on a monthly basis. If you have questions or concerns you can speak with our Authorization Business Associate (757-491-3535 ext. 344) at your convenience. _____ Patient's initials

Some visits are performed by the nursing staff, without seeing a doctor, are considered an office visit and fees will be charged accordingly.

We ask 24-48 hours to process prescription requests and prescription refills.

If you are calling to make an appointment from a referring physician and your insurance requires a referral to be seen, please allow at least 3 business days prior to appointment to assure we receive the authorization. If you choose to be seen without proper authorization, you will be given a waiver to sign stating you aware authorization has not been received and would like to be seen. You will be responsible for any charges your insurance denies because of un-authorized visit.

There is a fee for copied medical records. We will notify you of the records fee and will require payment in full prior to the release of records. We require at least 5 business days to receive records and make copies.

Should you arrive late to your appointment, you may be asked to reschedule or you may have to wait to be seen between or after other patients who have arrived on time.

Unless canceled at least 24 hours in advance, we reserve the right to charge a No Show/Late cancellation fee of up to $50.00. Please help us better serve you better by keeping your scheduled appointments.

I, _____ have read, understand and agree to the

Office Financial Policy of Associates in Plastic Surgery, Inc.

_____ _____
Patient Signature Date

_____ _____
Responsible Party Date

_____ _____
Witness Date

ASSOCIATES IN PLASTIC SURGERY
Appointment, Payment & Credit Card Policy

Thank you for choosing our office for your medical care. We have written these policies to keep you informed of our current office policies.

Office Hours: Our office is open Monday – Friday, 8:30 am – 5:00 pm

Appointments: We see patients by appointment only. Same day appointments are usually available for urgent Patients.
Please arrive at least 15 minutes prior to your scheduled appointment to allow us adequate time to properly check you in. If you have any changes to your demographic information (such as a change of address or insurance), please arrive 15 minutes prior to your scheduled time.

After-hours, Emergencies, and Holidays: If you have a life-threatening emergency, call 911 immediately. Our answering service is available after hours, weekends, and holidays for your convenience. You will have the opportunity to either leave a message or the answering service will page the physician on call.

Cancellations/Rescheduling: Appointments for physicians are in high demand. If you cannot keep an appointment, we require your cancellation notice no later than 48 hours prior to your scheduled appointment.

Payment Policy

We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.**
2. **Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.**
3. **Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.**
4. **Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to**

provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.**
6. **Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.**
7. **Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payment plans are possible when negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.**
8. **Credit Card payments: Our policy is to accept credit cards. We require identification and use of the cvv code. If for some reason the card is declined or processes a charge back, we have the right to bill and collect the balance through other payment or collection efforts. These charges will be your responsibility and billed directly to you. If you have any questions about your services please ask for more information. Please help us to serve you better by keeping your regularly scheduled appointment.**

Our practice is committed to providing the best treatment to our patients.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

Associates in Plastic Surgery, Inc.

Dear Patient:

Many changes have recently occurred in the insurance industry. We would like to clarify our role as your Health Care Provider.

- We recognize how difficult it is for the patient to collect from his/her insurance company; therefore, Associates in Plastic Surgery, Inc. provides a service on behalf of their patrons to process all insurance claims, even the most minor claims.
- We understand that your insurance policy is a binding contract between you and your carrier.
- Because of your contract, you are **obligated** to pay any *cost shares, copays*, and *deductibles* as outlined in your individual policy.
- We comply with all **FEDERAL** and **STATE** laws which define our responsibility to collect balances on your account due Associates in Plastic Surgery, Inc.
- "PARTICIPATION" – If your physicians "participate" with your particular insurance carrier, we will then accept as payment in full the amount allowed by your carrier as long as you have met all *cost shares, copays*, and *deductibles*.
- "ASSIGNMENT OF BENEFITS" – allow your insurance carrier to pay benefits directly to Associates in Plastic Surgery, Inc.

Thank you for allowing us to provide your care. We hope this information is helpful. Please feel free to contact our Business Office if you have any questions.

_____	_____
Patient Signature	Date
_____	_____
Responsible Party	Date
_____	_____
Witness	Date

Associates in Plastic Surgery, Inc.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage, such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care operations: Your health information may be used as necessary to support the day-to-day activities and management of Associates in Plastic Surgery, Inc. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to public health angencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require you authorization: Disclosure of your health information or its uses for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminder: Your health information will be used by our staff to notify of your upcoming appointment.

Information about treatments: Your health information may be used to send you information that may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Associates in Plastic Surgery, Inc. Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.
We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recent revised notice of any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Physician's secretary or the Privacy Practice Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Associates in Plastic Surgery, Inc.
1037 First Colonial Road
Virginia Beach, VA 23454

If you believe your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.
You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

Practice Administrator
1037 First Colonial Road
Virginia Beach, VA 23454
757-491-3535

Effective Date
This notice is in effect as of April 14,2002.

Associates in Plastic Surgery, Inc.
PHOTOGRAPHS / FILMS / VIDEO CONSENT

I authorize _____ and associates or assistants of his or her choice, to take photographs, films, or videos of the treatment site for record purposes on _____.
(Patient Name)

Patient's Initials

_____ Details of the photographing, filming, videotaping have been explained to me in terms I understand.

_____ I understand that the photos, films, or videos are the property of the above-mentioned physician, and that upon request with my signature, I may obtain a copy.

_____ I agree and authorize use of the photos, films, or videos for teaching purposes, which includes being shown to other patients. ***I am aware that my name and identity will not be disclosed.***

-OR-

_____ I DO NOT authorize the use of these photos, films, or videos for teaching purposes.

_____ I agree and authorize use of the photos, films, or videos in the advertisements of the above-mentioned physicians. ***I am aware that my name and identity will not be disclosed.***

-OR-

_____ I DO NOT authorize the use of these photos, films, or videos for advertising purposes.

_____ I agree and authorize the above-mentioned physician to use my photos, films, or video on his professional website. ***I am aware that my name and identity will not be disclosed.***

-OR-

_____ I DO NOT authorize the use of these photos, films, or videos on any website.

_____ I agree and authorize the above-mentioned physician to use my photos, films, or videos for social media advertising (e.g., Facebook, LinkedIn or Twitter) and as part of an office E-mail for marketing of services and/or specials. ***I am aware that my name and identity will not be disclosed.***

-OR-

_____ I DO NOT authorize the use of these photos, films, or videos on any social media site.

_____ The physician has answered all of my questions to my satisfaction.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature.

_____ _____
Patient or Legal Representative Signature / Date **Relationship (self, parent, etc.)**

_____ _____
Print Patient or Legal Representative Name **APSI Witness Signature/Date**

FOR APSI STAFF:
I certify that I have explained the nature and purpose for the proposed photographs, films, videos to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the *patient/legal* representative fully understands what I have explained.
(Circle one)

_____
Physician Signature / Date

_____ copy given to patient
Initials
_____ original placed in chart
Initials
Updated: 2/28/2014

**This consent expires in 30 years unless otherwise stated

ASSOCIATES IN PLASTIC SURGERY, INC. Today's Date:_____

Name:_____ Date of Birth:_____
Occupation:_____ Sex: M☐ F☐
Age:_____ Height:_____ Weight:_____ BMI_____
HISTORY OF PROBLEMS OR CONCERNS:_____
_____
_____

PERSONAL PAST HISTORY: Have you had:

Hypertension:	Y☐	N☐	Asthma:	Y☐	N☐	Abnormal Bleeding:	Y☐	N☐
Sleep Apnea:	Y☐	N☐	Diabetes:	Y☐	N☐	Abnormal Clotting:	Y☐	N☐
Snoring:	Y☐	N☐	Reflux/GERD:	Y☐	N☐	DVT or PE:	Y☐	N☐
COPD	Y☐	N☐	Heartburn:	Y☐	N☐	Blood clot legs	Y☐	N☐
Angina:	Y☐	N☐	Hyperthermia	Y☐	N☐	Cancer:	Y☐	N☐
Wt Change past 12 mo.:	Y☐	N☐	Hepatitis:	Y☐	N☐	Anemia:	Y☐	N☐
Heart Disease:	Y☐	N☐	Malignant	Y☐	N☐	Other serious illness:	Y☐	N☐
MRSA	Y☐	N☐	Hyperthermia:			High Temp After Anesthesia:	Y☐	N☐

Are you currently taking oral contraceptives (birth control pills) or hormone replacements? Y☐ N☐
PLEASE DESCRIBE QUESTIONS WITH A "YES"ANSWERED:_____
_____
_____

FAMILY HISTORY: Have any blood relatives ever had the following problems:

Abnormal Bleeding:	Y☐	N☐	Coronary Surgery:	Y☐	N☐	Kidney Disease:	Y☐	N☐
Abnormal Clotting:	Y☐	N☐	Diabetes:	Y☐	N☐	Tuberculosis:	Y☐	N☐
Heart Disease:	Y☐	N☐	Hypertension:	Y☐	N☐	Cancer:	Y☐	N☐
Other Serious Illness:	Y☐	N☐	Anesthetic problems	Y☐	N☐	High temp for exercise:	Y☐	N☐
Muscle or Neuro-muscular disorders	Y☐	N☐	Hx of Malignant -Hyperthermia or unexpected death following general anes or exercise:				Y☐	N☐

MEDICATIONS: List dose or number of pills per day.
Prescription Drugs: Non Prescription Medications (including vitamins and herbs):
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
Drug Allergy: Y☐ N☐ List drug(s) and type of reaction for each medication listed:_____
_____
Latex Allergy: Y☐ N☐ Tape Allergy: Y☐ N☐ Food Allergy:_____
SOCIAL HISTORY:
Smoke: Y☐ N☐ Amount:_____ Alcohol: Y☐ N☐ Amount:_____
Have you ever received a blood transfusion? Y☐ N☐ If yes, what year?_____
Have you ever been tested for HIV? Y☐ N☐ If yes, what year?_____ Test results ☐positive ☐negative
PREVIOUS SURGERY: List year and type of procedure:
_____ _____
_____ _____
_____ _____
Has an anesthesiologist ever told you that you have a difficult airway? Y☐ N☐
Indicate the type(s) of anesthesia received in the past, list any complications or reactions you experienced:
_____
Primary Care Physician (name)_____ telephone_____
(address)_____
WOMEN PATIENTS ONLY: Number of pregnancies:_____ Number of children:_____
Last menstrual period: _____

NAME:_____ DATE OF BIRTH:_____

TO BE COMPLETED BY PHYSICIAN:

REVIEW OF SYSTEMS:

Loose Dental Devices	Y ☐	N ☐	Chest Pain	Y ☐	N ☐	Obesity	Y ☐	N ☐
Neck Mobility Problem	Y ☐	N ☐	Irregular Heart Beat	Y ☐	N ☐	Black Out	Y ☐	N ☐
Short Neck	Y ☐	N ☐	Vomiting	Y ☐	N ☐	Seizures	Y ☐	N ☐
Shortness of Breath	Y ☐	N ☐	Difficulty Voiding	Y ☐	N ☐	Stroke	Y ☐	N ☐
Recent Upper Resp. Infection	Y ☐	N ☐	Current Pregnancy	Y ☐	N ☐	Cough	Y ☐	N ☐
Abnormal Menstrual Cycle	Y ☐	N ☐						

Comments:_____
_____
_____
_____

PHYSICAL EXAM:
Height:_____ Weight:_____ BMI:_____ BP:_____ Pulse:_____ Temp:_____ Resp:_____

GENERAL STATUS COMMENT:
HEENT:_____ Vision:_____
Pulmonary: Clear to auscultation _____
Heart: RRR without murmur _____
Abdomen:_____
Breast:_____
Extremity:_____
Neurologic: Alert and oriented X 3 _____

Comments:_____
_____
_____
_____

PATIENT IS CLINICALLY READY FOR SURGERY:_____

DIAGNOSIS:
1._____
2._____
3._____
4._____

PLAN:
1._____
2._____
3._____
4._____

Physician Signature:_____ Date:_____