Dr. Christine Rodgers
DENVER PLASTIC SURGERY

Patient Registration Information

Patient Legal Name: _____ Today's Date: _____
Preferred Name: _____ Gender at birth: ☐ M ☐ F ☐ Prefer not to say ☐ Other: _____
Age: _____ Date of Birth: _____ Last 4 digits of SS #: _____
Cell Phone: _____ E-Mail: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Employer: _____ Position: _____
Relationship Status: ☐ Single ☐ Married/Domestic Partner ☐ Divorced ☐ Widowed
Partners Name: _____ Partner Phone: _____

Responsible Party Information (Complete this section if someone other than yourself is financially responsible)

Responsible Party: _____ Relationship to Patient: _____
Date of Birth: _____ E-Mail: _____ Phone Number: _____
Address: _____ City: _____ State: _____ Zip Code: _____

Health Insurance Information

Insurance Company Name: _____ Insurance Phone: _____
Insurance Address: _____ City: _____ State: _____ Zip Code: _____
Name of Insured: _____ Insured Date of Birth: _____
Insurance ID #: _____ Insurance Group #: _____ Relationship to Patient: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Authorization to Obtain Medical Records:

I hereby authorize the release of any of my medical records to Denver Plastic Surgery Associates. This includes but is not limited to, mental health records, records related to drug and alcohol treatment as protected by law, and HIV/AIDS test results.

Releasing Provider/Office Name: _____ Office Phone: _____
This authorization is effective immediately and will remain in effect until _____ (date or event) or until I revoke it in writing in writing.

Patient/Responsible Party Signature: _____ Date: _____

Communication Consent

By choosing to communicate via email or text with Denver Plastic Surgery Associates, I understand that these methods are not fully secure and should not be used for medical emergencies or as the primary form of communication. I acknowledge that sending sensitive information, including photos, may put my health information at risk. Denver Plastic Surgery Associates cannot be held liable for any breach of confidentiality when using non-secure networks.

Patient/Responsible Party Signature: _____ Date: _____

Patient Acknowledgement

I understand and acknowledge that I am personally responsible for all expenses incurred during evaluation and treatment by Denver Plastic Surgery Associates. I acknowledge that a photocopy of this agreement will hold the same validity as the original.

Patient/Responsible Party Signature: _____ Date: _____

Dr. Christine Rodgers
DENVER PLASTIC SURGERY

History and Physical

Patient's Name: _____ Date of Birth: _____

Do you have an adult to assist you with surgery recovery? **Y** ☐ **N** ☐ **NA** ☐ Relationship: _____

Name of Primary Care Physician: _____

PCP Phone Number: _____ Date last seen by Primary Care Physician: _____

Preferred Pharmacy: _____ Phone: _____

Name of Internist/Gynecologist: _____ Phone: _____

Name of Dermatologist: _____ Phone: _____

Social

Smoke: **Y** □ **N** □ Amount: _____

Alcohol: **Y** □ **N** □ Amount: _____

Drugs: **Y** □ **N** □ Amount: _____

Caffeine: **Y** □ **N** □ Amount: _____

Daily Exercise: **Y** □ **N** □ Amount: _____

Ever abused drugs or alcohol? **Y** □ **N** □

Medications (Please list Name, dosage, and frequency pills per day. **If none, write N/A**)

Prescription Drugs

_____

_____

_____

Vitamins, Herbal Supplements, etc.

_____

_____

_____

Regular Aspirin Use? **Y** □ **N** □ Dosage & frequency: _____

NSA? (Advil, Motrin, Ibuprofen): **Y** □ **N** □ Dosage & frequency: _____

Cortisone Injections Past Year? Y □ **N** □ Date(s) and injection location: _____

Allergies/Drug Reactions

Food or Drug Allergy? **Y** □ **N** □ List allergies and type of reaction. Note if tested by an allergist:

_____

Latex Allergy? **Y** □ **N** □ Tape Allergy? **Y** □ **N** □

Anesthesia Reaction/Complication? **Y** □ **N** □ If yes, describe: _____

Family Medical History Please check all that apply to any blood relatives:

□ Anemia
□ Anesthetic Problems
□ Autoimmune Disease
□ Bleeding Disorder
□ Blood Clots
□ Cancer
□ Diabetes
□ Fibromyalgia
□ Heart Attack
□ Heart Disease
□ Heart Murmur
□ High Blood Pressure
□ Hypertension
□ Kidney Disease
□ Multiple Sclerosis
□ Stroke
□ Tuberculosis
□ Other: _____

Please describe checked with an explanation:

_____

Personal Medical History

Hearing aid? **Y** ☐ **N** ☐ Dentures? **Y** ☐ **N** ☐

Have you ever received a blood transfusion? **Y** ☐ **N** ☐ If yes, what year? _____

Have you been tested for HIV? **Y** ☐ **N** ☐ If yes, what year? _____ Test results: ☐ Positive ☐ Negative

Are you having ongoing Dental Work? **Y** ☐ **N** ☐ Are you experiencing an ongoing infection? **Y** ☐ **N** ☐

If yes, explain: _____

Contact lenses? **Y** ☐ **N** ☐ Eyeglasses? **Y** ☐ **N** ☐ Cataracts? **Y** ☐ **N** ☐ Glaucoma? **Y** ☐ **N** ☐ Lasik? **Y** ☐ **N** ☐

Number of pregnancies: ____ Number of Children: ____ Did you breastfeed? **Y** ☐ **N** ☐ Last menstrual period: _____

Patient's Name: _____ Date of Birth: _____

Surgical History List all previous surgeries:

Surgery:	Date:

Medical History (Please check all that apply)

- □ Acid Regurgitation
- □ Anemia
- □ Anesthetic Problems
- □ Angina
- □ Arthritis
- □ Artificial Joints
- □ Asthma
- □ Autoimmune
- □ Bleeding Disorder
- □ Blood Clots
- □ Bronchitis
- □ Burns
- □ Cancer
- □ Chemotherapy
- □ Chronic Cough
- □ Cold Sores
- □ Colitis
- □ Connective Tissue Disorder
- □ Coronary Surgery
- □ Defibrillator
- □ Diabetes
- □ Dialysis
- □ Depression
- □ Fibromyalgia
- □ Fainting Spells
- □ Heart Attack
- □ Heart Disease
- □ Heart Murmur
- □ Hepatitis A, B or C
- □ High Blood Pressure
- □ Herpes Simplex
- □ HIV/AIDS
- □ Hypertension
- □ Irregular Heartbeat
- □ Irritable Bowel Syndrome
- □ Kidney Disease
- □ Migraines
- □ Multiple Sclerosis
- □ Pacemaker
- □ Radiation
- □ Raynaud's Disease
- □ Seizures
- □ Sleep Apnea
- □ Snoring
- □ Stroke
- □ Thyroid Disorder
- □ Tuberculosis
- □ Ulcers
- □ Ulcerative Colitis
- □ Weight Change past 12mos
- □ Other: _____

Please describe checked with an explanation. If none, **please write N/A**:

_____

_____

_____

Topical Medications (Please check all that apply)

- ☐ Differen
- ☐ Hydroquinone
- ☐ Retin A
- ☐ Renova
- ☐ Refissa
- ☐ Tazorac

Are you currently being treated for skin issues by a doctor or dermatologist? If yes, please explain:

_____

_____

_____

Dr. Christine Rodgers
DENVER PLASTIC SURGERY

Medical Aesthetics Information

Patient Name: _____ Date of Birth: _____

What are your main aesthetic concerns?

- ☐ Wrinkles
- ☐ Sun damage
- ☐ Acne/ acne Scars
- ☐ Enlarged pores
- ☐ Sagging skin
- ☐ Rosacea
- ☐ Unwanted skin pigmentation
- ☐ Intimate feminine issues

What procedures are you interested in? Check all that apply

- ☐ Neurotoxin: Botox / Dysport
- ☐ Facial Fillers (Juvéderm / Restylane)
- ☐ Sculptra
- ☐ BBL Corrective Laser and/or Fotofacial
- ☐ Halo / Moxi Laser
- ☐ Laser Resurfacing
- ☐ PRF / PRP (Platelet Rich Fibrin/Plasma)
- ☐ Morpheus8 Radio Frequency
- ☐ Microneedling
- ☐ Chemical Peels
- ☐ Acne treatments
- ☐ diVa Vaginal Laser
- ☐ O-Shot
- ☐ Skincare Products
- ☐ Other: _____

Sun Exposure Check all that apply

How often do you work/spend outdoors?	☐	Daily	☐	Weekly	☐	Monthly	☐ Never
How often do you use sunscreen?	☐	Daily	☐	Weekly	☐	Monthly	☐ Never
How often do you use tanning beds?	☐	Daily	☐	Weekly	☐	Monthly	☐ Never

Skin Evaluation

List how you care for your skin and the names of the products you are currently using:

MORNING:

_____
_____
_____
_____

EVENING:

_____
_____
_____
_____

How would you describe your skin type? Please chose one:

□Very Oily Skin □ Oily Skin □ Combination Skin □ Dry Skin □ Sensitive skin

Are pregnant? Y □ N □ Are you nursing? Y □ N □ Are you planning on becoming pregnant? Y □ N □ Are you currently taking ACCUTANE or have you taken this in the last 12 months? Y □ N □

Skin History Please circle all that apply:

- ☐ Actinic Keratosis
- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Connective Tissue Disorder
- ☐ Itching/Eczema
- ☐ Lupus
- ☐ Melanoma
- ☐ Melasma
- ☐ Non-healing skin
- ☐ Psoriasis
- ☐ Scleroderma
- ☐ Serious Skin Infection
- ☐ Swelling/Hives
- ☐ Undiagnosed Skin Lesions
- ☐ Vitiligo

Dr. Christine Rodgers
DENVER PLASTIC SURGERY

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Payment and Expenses

Dr. Christine Rodgers does not accept health insurance, and DPSA will not assist in establishing medical necessity, pre-authorization, or procedure coding for services provided by Dr. Rodgers. **Dr. Cecelia Nguyen** accepts BCBS/Anthem, Cigna, United Healthcare, and Aetna, but does not accept Medicare or Medicaid.

I understand that most procedures and/or surgeries performed by Denver Plastic Surgery physicians and medical providers are considered cosmetic and not medically necessary, and therefore, insurance will not cover them.

Payment for all aesthetic treatments and services is expected at, or prior to, time of service, unless other arrangements have been made in advance. I understand that if I choose to schedule a surgery, I am personally responsible for all expenses incurred during evaluation and treatment by DPSA. These expenses may include, but are not limited to preoperative testing, surgical clearance, lab work, prescription medications, pathology reports, and any additional procedures added to the surgical plan.

Self-Pay Surgery Terms

If I elect to self-pay for a surgical procedure, I understand and agree to the following terms:

- A non-refundable deposit of 20% of the surgeon's fee, with a minimum charge of $500, is due at the time of scheduling. The remaining balance is due four weeks prior to the scheduled surgery date.
- If I opt to cancel or reschedule my surgery within 6 weeks of the scheduled procedure date, all payments made will be forfeited.
- A rescheduling fee of $350 will apply to any changes to the surgery date or surgical plan.

Insurance Reimbursement Terms

Should I choose to pursue insurance coverage, I understand and agree to the following:

- I am responsible for any amounts not covered by my insurance plan
- I am responsible for all copays and any outstanding balances.
- I should educate myself on the self-pay cost of my surgery to understand what I will be responsible for if my surgery is not covered.
- I understand that meeting out-of-pocket maximums required by my insurance could result in a higher cost than the self-pay discounted rate for the surgery or procedure.

Finance Charge Authorization

If I have an outstanding balance aged 30 days or more, I understand that a finance charge may be applied to my account. The finance charge will be:

- A periodic rate of 2% per month or a minimum charge of $5.00 for a balance under $100.00, which equates to an annual percentage rate of 24% applied to the balance.
- In the event of default in payment, all costs of collection and reasonable attorney's fees will be added to my account.to pursue payment,

Acknowledgement

I have read this agreement and have had the opportunity to ask any questions I may have. All my questions have been answered to my satisfaction. I acknowledge that a photocopy of this agreement holds the same validity as the original

Patient Name: _____ Date of Birth: _____

Patient/Responsible Party Signature: _____ Date: _____

Dr. Christine Rodgers
DENVER PLASTIC SURGERY

OFFICE POLICIES AND PROCEDURES

HOURS OF OPERATION
Denver Plastic Surgery and Medical Aesthetics regular office hours are Monday thru Friday from 9am- 5pm. Hours may vary seasonally.

APPOINTMENTS
Please always plan to arrive at least 15 minutes prior to your scheduled appointment. Earlier arrival times may be required depending on the type of appointment you have scheduled so we are able to properly prepare you for your treatment. A credit card is required to be kept on file for all scheduled appointments.

PAYMENT INFORMATION
Denver Plastic Surgery and Medical Aesthetics accepts all major credit cards, cashier's checks, and CareCredit Financing. Please note that we do not accept personal checks. **Dr. Cecelia Nguyen** can accept the following insurance plans, depending on individual patient coverage: BCBS/Anthem, Cigna, United Healthcare, and Aetna. We do not accept Medicare or Medicaid.
Payment is expected at, or prior to, time of service, unless other arrangements have been made in advance.

LATE POLICY
If you are more than 10 minutes late to your scheduled appointment, we may have to reschedule your appointment and charge you a non-refundable late reschedule fee of $50. Please call our front desk at (303)-320-8618 if you think you may be late to your scheduled appointment.

CANCELLATION POLICY
We understand that things come up and you may have to cancel or reschedule your appointment with us. We ask that you provide us with at least 24 hours' notice of cancellation for any appointment. Appointments cancelled with less than 24 hours' notice will incur a $100 charge. **If your appointment is cancelled same day, full cost of the treatment is due**. Patients who do not show for their appointment and do not call to notify our office, will be charged a $200 no show fee.

In the event of a true, unavoidable emergency, all or part of your cancellation may be applied to future services.

For surgical consultations, we ask that you provide her with at least 2 two business days' notice to cancel or reschedule. This allows us to offer the appointment to other patients on our waitlist. Appointments canceled with less than 2 business days' notice will forfeit their consultation fee.

REFUND POLICY
All payments made to Denver Plastic Surgery and Medical Aesthetics are non-refundable. No refunds will be provided on any services and all treatment packages or treatment series paid for in advance are also non-refundable. If you are displeased with any service, we ask that you contact us regarding the issue within (3) business days of your appointment to ensure that management can address any concerns.

TIPPING POLICY
Tips are never expected, but they are certainly appreciated. Please know that our employees can only accept tips on non-medical services. If you want to thank your provider for a job well done, we would love for you to leave us a review on Google, RealSelf or Yelp. Hearing that you loved your experience with us makes our team so happy and helps us spread the word about Denver Plastic Surgery and Medical Aesthetics.

PATIENT ACKNOWLEDGEMENT
I acknowledge that I have read and understand these policies and procedures.

Patient Name: _____ Date of Birth: _____

Patient/Responsible Party Signature: _____ Date: _____

Dr. Christine Rodgers
DENVER PLASTIC SURGERY

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that by signing below I have been offered the ***Notice of Privacy Policies*** established for Denver Plastic Surgery Associates.

Patient Name: _____ Date of Birth: _____

Patient/Responsible Party Signature: _____ Date: _____

****

IF NECESSARY, THE FOLLOWING IS TO BE FILLED OUT BY PRACTICE STAFF

DOCUMENTATION OF GOOD FAITH EFFORTS TO OBTAIN PATIENT'S ACKNOWLEDGEMENT THAT THEY HAVE RECEIVED PROVIDER'S NOTICE OF PRIVACY PRACTICES

For use when acknowledgement cannot be obtained from the patient.

This patient presented to our office on _____and was provided with a copy of our *Notice of Privacy Policies*. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

☐ Patient refused to sign

☐ Patient was unable to sign or initial because: _____

☐ The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.

☐ Other reason: _____

Employee Signature: _____ Date: _____

Dr. Christine Rodgers
DENVER PLASTIC SURGERY

How did you learn about our office?

Please check all statements that apply

☐ My friend _____ told me about the office
☐ My family member _____ told me about the office
☐ My Doctor _____ told me about the office
☐ Your location is convenient to my home or office
☐ 5280 Magazine
☐ My insurance company
☐ Other: _____
☐ Internet Search

- Google- Keywords: _____
- Yahoo: Keywords: _____
- Another Search Engine- Keywords_____
- Real Self
- Professional Association Website
- Implant Company Website
- Other: _____

.