Mid-Ohio Plastic Surgery Dr. Rafael E. Villalobos 370 Cline Avenue Mansfield, Ohio 44907 Office Phone: (419) 756-1125

Patient Information: Last Name _____M.I. ____First Name _____

Date of birth:_____ Sex: _____ Age:_____ Race_____

Address: _____ City:_____ State:_____ Zip:_____

Social Security #: _____ Home Tel: (_____) _____ Cell Phone: (_____) _____

Email address: _____

Occupation: _____ Employer Name: _____ Phone#_____

Employer address: _____ City: _____ State: _____ Zip: _____

How did you hear about our practice? _____

If patient is a minor: Name of Parents / Legal Guardian: _____

Relationship to patient (if other than parent) :_____ Phone #: (_____) _____

Emergency contact: Name: _____ Phone# _____ Relationship_____

Referring Physician: _____ Phone#_____

Primary Insurance **Name of Insurance Company** _____

Name of person who carries the insurance: First _____ Last _____

Date of Birth of person carrying insurance:_____ Social Security Number:_____

Secondary Insurance **Name of Insurance Company** _____

Name of person who carries the insurance: First _____ Last _____

Date of Birth of person carrying insurance:_____ Social Security Number:_____

Are you receiving benefits for Black Lung? Yes No Have you been diagnosed with End Stage Renal Disease (ESRD)? Yes No
Are you currently receiving disability benefits? Yes No
If you are over age 65; are you employed? Yes No Name of Employer _____ Number of Employees_____
If you are over age 65; is your spouse employed? Yes No Name of Employer _____ Number of Employees_____

WORKER'S COMPENSATION
Is this a worker's compensation claim: Yes/No (please circle one) Claim #: _____

Date of Injury: _____ *Employer:* _____ *MCO:* _____

Do you have an Advanced Directive? (Living will/ do not resituate order) Yes_____ No____
Name of person who has power of attorney over your healthcare_____
Relationship to patient_____

By signing below:
1. I consent to evaluation, testing, and treatment as directed by Dr. Villalobos or his designee.
2. I consent to pre-operative, intra-operative, and post-operative photos being taken for professional medical purposes; such as medical education, insurance predetermination and patient education. Neither your identity nor your personal information will be disclosed during medical or patient education lectures.
   I decline use of my photos for professional medical education_____
3. I understand that co-payments or Consultation fees are due at the time of my visit.
4. I understand that I am responsible for informing the receptionist of any changes in address or insurance coverage.
5. I understand that I am responsible for providing a referral from my primary care physician (PCP), should my insurance carrier require one. If one is not received my appointment may be cancelled.
6. I authorize release of my medical information to the pertinent insurance company(s) or third party carriers necessary to process claims.
7. I hereby assign payment of any and all benefits from insurance company(s) to be made directly to Mansfield Plastic Surgery.

Signature: _____ Date: _____
Relationship to Patient_____

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Patient Evaluation Form

Patient Name: _____ Date of Birth: _____

Height: _____ *Weight:* _____ *Age:* _____ *Pharmacy:* _____

What is the reason for your visit: _____

When did this problem begin: _____

Primary Care Doctor: _____ Tel: (_____) _____

Address: _____ City / State / Zip: _____

Are you currently receiving treatment for any medical condition or under the care of any other physician other than your primary care physician or the referring physician? Yes/No

Name of physician: _____ *Tel:* (_____) _____

What are you being treated for: _____

Please list previous surgeries or hospitalizations along with the date below:

Year	Surgery or hospitalization

Please list any medications you are taking, including ***non-prescription drugs, vitamins and herbals*** *below:*

Medication	Dose	Times/ day

Please list ***any*** *allergies below (this includes any drug allergies):*

Allergies

Social History *(Please Circle):*

Do you smoke/chew tobacco	No	Yes	How much:	Are you employed	No	Yes
Do you drink alcohol	No	Yes	How much:	Do you live alone	No	Yes
Do you take recreational drugs	No	Yes	What:	If no, who do you live with:		

Family & Past Medical History *(Please check if applicable):*

	Self	Family	Comments		Self	Family	Comments
Heart Disease				Diabetes			
Heart Murmur				Cancer - Type			
High Blood Pressure				Kidney Disease			
Blood Clots				Epilepsy/Convulsion			
Stroke				AIDS or HIV +			
Bleeding Disorder				Thyroid Disease			
Anemia				Tuberculosis			
Hepatitis				Depression			

Do you have now or have you had within the past year *(Please circle):*

Weight change	No	Yes	Swollen feet/ankles	No	Yes	Seizures	No	Yes
Dry eyes	No	Yes	Chest pain	No	Yes	Rapid heart beat	No	Yes
Shortness of breath	No	Yes	High cholesterol	No	Yes			

This section for women only:	Answer
Birth Control	
Number of pregnancies/births	/
Last PAP smear	
Last breast exam	

This section for men only:	Answer	
Prostate screening	Yes	No
Testicular exam	Yes	No

Have you been vaccinated for Covid 19? Yes or No Type of Vaccine: _____ Dates: _____

When did you receive your last tetanus shot? _____

Patient's signature: _____ **Date:** _____

Physician's signature: _____ **Date:** _____

Mid-Ohio Plastic Surgery

Financial Policy for Insurance and Self Pay Patients

Insurance Patients

On your initial visit you will be asked to provide your insurance information. Our office will collect any co-pay at time of service. If you do not have insurance that covers the cost of your visit, we will collect a fee of $100.00. As a courtesy, we will submit claims on your behalf to your medical insurance carrier. The release of your medical record information to your insurance carrier is pertinent for processing medical claims. If your insurance carrier requires a referral from your primary care physician, it is your responsibility to obtain this prior to your visit. At time of scheduling procedure/surgery, if you have an unmet deductible or co-insurance we will collect a portion up to the full amount. You may receive a bill for any remaining balance after we receive your explanation of benefits. **All statement balances are due upon receipt of your statement.** The hospital/surgery center and anesthesia group may contact you to pre-collect a portion as well.

Cosmetic or Self Pay patients

Our consultation fee is $100.00. This fee will be credited against physician's surgical fee. The quote for physician's fee will expire 6 months from the date your quote was given. The hospital and anesthesia fees are subject to change. Self pay patients will be charged $200.00 deposit to secure their surgery date, which will be applied to the cost of the surgery. The full remaining balance is expected 2 weeks prior to surgery. Our goal is to provide you an accurate quote for hospital and anesthesia fees. These fees are based on the time it takes our surgeons to perform your surgery. In the event that more time is needed than expected there will be an additional charge from the hospital and anesthesia group and you will be billed.

Revisions of any procedures are covered under the physician's fee for one year from the date of surgery. However, anesthesia and facility are a separate cost and will require additional fees. Refer to Revision Policy for further explanation.

All Patients

We accept Cash, Cashier's Check, Visa, MasterCard, Discover, American Express and finance companies. No personal checks or credit card checks within 30 days of procedure/surgery. **All statement balances are due upon receipt of your statement.**

Dr. Rafael Villalobos allocates time during the workday for each patient for surgeries/procedures to be performed. Please feel free to call us to let us know when you need to cancel and reschedule a surgery/procedure. To best fulfill all of our patients needs, we require a ***1 week*** notice for surgery/procedure cancellation. As your time is important, so is the time of our medical professionals. Without a ***1 week*** notification, there will be a charge of $200.00. If you reschedule your surgery/procedure within 2 months of cancelling, we will apply the cancellation fee toward your surgery/procedure. After 6 months, the credit will be forfeited to the practice.

To best fulfill all of our patients needs, we require a notice for appointment cancellations. Failure to notify us of the cancellation could result in a cancellation fee of $25.00.

Payments made by check will be refunded by a company check and payable to the patient. Payments made by credit card, the refund will be processed on that same card. You will be responsible for transaction fees assessed by finance company (i.e. care credit) and credit card companies These fees are determined by the company.

Checks returned for insufficient funds will be charged a service fee of $25.00, in addition to the original amount of the check.

Obagi products may be returned if unopened and unused for store credit. Manufacturers will give a refund if a reaction has occurred. You will need to see the physician or medical assistant during the reaction. There is a 10% return fee on Obagi Skin care products. GloMineral makeup is non-refundable.

There will be a fee of $25.00 for all paperwork completed by our physicians and office staff. The fee is due prior to paperwork being completed for you. Allow 7 business days for completion of all paperwork.

Patients may request their medical records by completing an authorization to release medical information form. Contact our office for current fees associated with release.

HIPPA

I am aware that as a patient of Mid-Ohio Plastic Surgery, I am entitled to a copy of the privacy practices at any time.
Initials: _____

_____ _____

Patient Signature Date

Mansfield Plastic Surgery
370 Cline Avenue, Mansfield OH 44907

Social Media Informed Consent

I hereby give Mansfield Plastic Surgery, and any and all employees and/or agents of Mansfield Plastic Surgery, the right and permission to use and/or publish photographs of me for **educational purposes.** I also authorize my photos or videos to be posted on social media, such as Facebook, Instagram, and the office's website page.

Initial the Following:

_____ Yes, you may use my photos and/or videos

_____ No, you may not use my photos and/or videos

_____
Name of Patient or Parent/Guardian (Please Print)

_____
Patient or Parent/Guardian (Signature)

_____
Date