Riverside
PLASTIC AND RECONSTRUCTIVE SURGERY

24 Memorial Medical Dr. Greenville, SC 29605
Ph. 864-478-8748 Fax: 864-708-0897 Riversideprs.com
Brent Moister, MD

Patient Information

Name:_____ Date:_____
Address:_____
City, State, Zip:_____
Birth Date:_____Sex:_____ SSN:_____
Primary Phone:_____Type: Home / Work / Cell / Other
Emergency Contact:Name_____Phone:_____
Relationship to Patient:_____
Email:_____
Race: [ ] White/Caucasian [ ] Black/African American [ ] Native Hawaiian [ ] AM Indian/Alaska Nat [ ] Asian/E Indian [ ] Unavailable/Unknown [ ] Declined to Provide
May choose multiple races
Ethnicity: [ ] Hispanic/Latino [ ] Not Hispanic/Latino [ ] Declined

Would you like access to our patient portal to send/receive secure messages with our staff? Y/N
Preferred method of contact: [ ] Phone [ ] Email via patient portal
How would you like to receive appointment reminders? [ ] Text [ ] Phone [ ] Email

Preferred Pharmacy:_____
Do you give us consent to retrieve your medication history from your pharmacy? Y / N

Reason for visit today:_____
Doctor or person who referred you to see Dr. Moister:_____
Primary care physician: _____Oncologist:_____
Cardiologist:_____Surgeon:_____
Pulmonologist:_____Other:_____

Insurance Information

Primary Insurance Company:_____ Policy Number:_____
Subscriber Name:_____Subscriber DOB:_____
Secondary Insurance Company:_____Policy Number:_____

Social History

Marital Status: (circle one) M S D W
Current employment status: Employed Unemployed Retired Homemaker
Occupation:_____Employer:_____
Are you being seen today for a work related injury? Y / N
Disability: Are you disabled? Y / N Reason:_____

Medical Questionnaire

Please circle additional areas of concern that you would like to discuss with Dr. Moister:

Abdomen	Thighs	Face/Forehead	Lips	Brown Spots/Age Spots/Freckles	
	Buttocks				
Breast/ Chest		Eyelids	Ear lobes	Chin/Check Procedures	
Arms	Back	Eyebrow(s)	Filler	Moles(s) of	Length/Fullness of Eyelashes
Thighs	Hands/Fingers	Neck	Botox	Skin CareProducts	Scars

Medication Allergies

_____

_____

Current Medications

If longer, please attach or use back

Name	Dose	How Often	Date Last taken
1.			
2.			
3.			
4.			
5.			
6.			

Do you take Aspirin on a regular basis? Y / N _____

Have you ever had a blood transfusion? Y / N _____

Do you have any metal in your body? Y / N _____

Any chance that you may be pregnant? Y / N _____

Date of your last period? Y / N _____

Has anyone in your family had an unusual reaction to anesthesia?

Y / N _____

Has anyone in your family/self have a history of malignant hypothermia?

Y / N _____

Has anyone in your family had unexplained fevers following surgery?

Y / N _____

Medical History

Height: _____ft. _____in. Weight: _____lbs.

Do you presently have, or have you ever experienced the following: (check all that apply)

YES	NO		YES	NO	
☐	☐	abnormal bleeding	☐	☐	hernia
☐	☐	blood clots	☐	☐	high blood pressure
☐	☐	breast implants	☐	☐	high cholesterol
☐	☐	cancer	☐	☐	kidney disease
☐	☐	COPD	☐	☐	lung disease
☐	☐	diabetes	☐	☐	psychiatric disease
☐	☐	emphysema	☐	☐	renal disease
☐	☐	epilepsy or seizures	☐	☐	stroke
☐	☐	heart attack	☐	☐	abnormal mammogram
☐	☐	heart disease			

Review of Systems: (Check if you currently have any of the following symptoms)

CONSTITUTIONAL

☐Fatigue/Weakness
☐Fever
☐Weight loss
☐Weight gain
☐Swelling in legs
☐Night Sweats

BREAST

☐Breast discharge
☐Breast lumps
☐Breast pain
☐Breast Cancer

RESPIRATORY CARDIOVASCULAR

☐Cough
☐Shortness of breath
☐Spitting up blood
☐Wheezing
☐Chest Pain
☐Heart murmur
☐Short of breath on exertion
☐Palpitations

PSYCHIATRIC

☐Anxiety
☐Depression
☐Difficulty sleeping

NEUROLOGIC

☐Dizziness
☐Seizures
☐Syncope (Fainting/Passing out)

HEMATOLOGIC

☐Anemia
☐Easy bleeding
☐Easy bruising
☐Swollen lymph nodes

EYES

☐Vision problems
☐Blurred vision
☐Vision loss
☐Dry eyes
☐Glasses/Contacts
☐Glaucoma
☐Cataracts

MUSCULOSKELETAL

☐Amputation
☐Bone fracture
☐Joint pain
☐Muscle pain
☐Joint swelling
☐Musculer weakness
☐Arthritis
☐Gout

GASTROINTESTINAL

☐Abdominal pain
☐Bloody stool
☐Constipation
☐Nausea
☐Diarrhea
☐Heartburn
☐Vomiting
☐Reflux

INTEGUMENTARY/SKIN

☐Acne
☐Changes in existing lesions/moles
☐New skin lesions
☐Shoulder grooving/bruising
☐Itching
☐Rash
☐Non-Healing wound/lesion
☐Skin Cancer
☐Itching
☐New Rashes/moles

Are there any other medical conditions we should know about? Please explain:

_____

_____

_____

List all operations, date and hospital:

YEAR	OPERATION	HOSPITAL

Past Medical History

Exercise: ☐ Sedentary ☐ Mild exercise ☐ Occasional vigorous exercise ☐ Regular vigorous exercise

Caffeine: ☐ NONE ☐ Coffee ☐ Sodas ___ Number per day ☐ Tea

Alcohol: ☐ Yes ☐ No How often? _____

Tobacco: ☐ NONE ☐ Former Smoker ☐ Cigarettes ___ packs per day

_____ Year quit using tobacco products_____ Number of years using tobacco products

☐ Other: _____

Drugs: Do you currently use recreational or street drugs? ☐ Yes ☐ No

Are there any significant medical problems in your family? If so please list all medical issues for family members.

IMMEDIATE FAMILY MEMBER (parents/siblings)	MEDICAL PROBLEM(S)

"I verify that the above information is true and accurate to the best of my knowledge."

Patient or Legal Guardian Signature _____ Date_____

RPS Office Staff Signature _____ Date_____

Riverside
PLASTIC AND RECONSTRUCTIVE SURGERY

24 Memorial Medical Dr. Greenville, SC 29605
Ph. 864-478-8748 Fax: 864-708-0897 Riversideprs.com
Brent Moister, MD

Medical Information Release Form (HIPAA)

Name:_____ **DOB:**_____

Messages

Please call: [ ] my home [ ] my work [ ]my cell Number:_____
If unable to reach me [ ] you may leave a message [ ] you may not leave a message

Release of Information

[ ] I authorize the release of information to include the diagnosis, records; examination rendered to me ınd claims information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ]Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Patient or Legal Guardian Signature _____ **Date**_____
RPS Office Staff Signature _____ **Date**_____

Photographic Consent

All patients who are candidates for plastic surgery treatments must have photographs taken before and .fter. I understand that photograph images will be taken, during and after my procedure/treatment as a ɔutine part of my medical care. I further understand that these photographs will be kept strictly confidential. (print name)_____ authorize Riverside Plastic Surgery to take photographs ıf me for medical purpose to be used for my care, insurance predeterminations and examination strictly for ıedical office files only.

Patient or Legal Guardian Signature _____ **Date**_____
RPS Office Staff Signature _____ **Date**_____

Additionally, I authorize the use of these images to be used for the purpose of communication, ·romotion, education, public relations and marketing by Riverside Plastic Surgery.

- In-office education including, but not limited to, **office photo albums and Powerpoint slideshows**
- In print **advertisements or professional journals**
- On our practice **website**
- On Riverside Plastic Surgery's **social media platforms**, including but not limited to, Facebook, Instagram, Snapchat, RealSelf and Youtube

Yes _____ No_____

Strict confidentiality will be maintained. Identifying features, such as your face, clothing, jewelry, and ıttoos will be covered or blurred. I understand that if surgery or treatment is performed above the shoulders ·acelift, necklift, eyelift, ear pinning, facials, injections, acne treatment, etc.)I may be recognizable to friends nd family.

This consent can be revoked at any time with a written request.

Patient or Legal Guardian Signature _____ **Date**_____

RPS Office Staff Signature _____**Date**_____

Co-pays

Please be prepared to pay your copay amount at each visit and have a copy of your current insurance card. We understand you may feel this is unnecessary, however insurance plans are becoming more complicated and changes to policies are occurring more frequently. In order to file your claims correctly, we must have the most current card on file. Failure to provide complete insurance information may result in patient responsibility for the entire bill. If we have not received your information within 60 days, you will remain responsible for all charges incurred up to the date you provide us with your insurance information and we receive payment from the insurance plan. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network with your insurance company and your insurance pays you directly, you are responsible for full payments and agree to forward the payment to us immediately.

Missed Appointments

Riverside Plastic Surgery requires a 24-hour notice of appointment cancellation. Much time and effort is associated with each patient visit. Dr.Moister and our staff strive to provide efficient and attentive care to each patient. We understand emergencies and/or extenuating circumstances arise that require your schedule to change. **If you are unable to keep your scheduled appointment, please notify our office 24 hours prior to your scheduled appointment. This will allow our staff the opportunity to offer the time to another patient. Failure to do so may result in you being charged a $50 fee for New Patient appointments or a $25 fee for existing patients.**

Returned Checks

The charge for a returned check is $35.00 payable by cash, credit card, or money order. This fee will be added to the account. Following a returned check, all future payments must be made by cash, credit card, or money order as we will no longer be able to accept a check as a method of payment.

Outstanding Balance Policy

It is our policy to collect outstanding account balances at each visit. If payment in full cannot be made, you will need to speak to our billing specialist. We will send 3 statements on outstanding accounts of $10.00 or more. If payment is not made on account, it will be sent to the collection agency for processing. (Extenuating circumstances will be considered.) Once the account is turned over to the collection agency, a 20% collection fee will be added to the account and the person (18 years or older) financially responsible for the account will be responsible for all collections cost. At this point you may be discharged from our practice.

Medical Leave/ Disability Forms

Forms will be completed within 7-10 business days upon receipt of the form. Please be sure to allow enough time for completion of the forms. There will be a **$25.00 form completion fee** for each form which will need to be paid at the time of request.

Medical Records Copying Fees

$.65 per page for the first 30 pages	$.50 per page for all other pages
Clerical Fee not to exceed $25.00	Plus actual postage cost

Patient or Legal Guardian Signature _____ **Date**_____

RPS Office Staff Signature _____**Date**_____

Riverside
PLASTIC AND
RECONSTRUCTIVE
SURGERY

24 Memorial Medical Dr. Greenville, SC 29605
Ph. 864-478-8748 Fax: 864-708-0897 Riversideprs.com
Brent Moister, MD

Patient Financial Policy

Thank you for choosing Riverside Plastic Surgery as your healthcare provider. We are committed to building a successful physician-patient relationship with you and your family. It is important that you have a clear understanding of our Patient Financial Policy. Please understand that payment for services is part of the relationship. **It is your responsibility to notify our office of any patient information changes (ie. address, phone number, insurance, etc).**

Methods of Payment

We gladly accept cash, checks, money order, or credit cards (Visa, Mastercard, Discover, and American Express, Care Credit) as methods of payment.

Cosmetic Services

- Payment for cosmetic surgery is due in full at the time of your preoperative visit.
- We will be happy to assist you with applying for financing with Care Credit should you desire. Please ask a member of the staff for information.
- Personal checks written for cosmetic services will only be accepted (14) days prior to surgery date.
- We understand a situation may arise that could require you to postpone your surgery. Please understand such changes affect Dr.Moister as well as that of the operating room staff. Your courtesy and concern will be appreciated.
- If you need to cancel your surgery after your preoperative visit you will be refunded the prepayment for surgery minus the $500 surgery deposit. This fee will be applied to your rescheduled surgery or used for processing fees if you have not rescheduled in 30 days.
- **Cosmetic Quotes will only be honored 6 months from the date quoted.**

Medically Necessary Cosmetic Surgery

The benefits paid by insurance companies for plastic surgery vary greatly by carrier and plan. Therefore, we make every effort to determine in advance if insurance coverage exists. Our knowledge and experience can be an important factor in assisting you to collect your maximum benefits. **You will be required to pay a $500.00 surgical deposit. If you need to cancel your surgery after your surgery has been booked this deposit will be retained. You will receive reimbursement if applicable ONLY after outstanding claims are paid in full and you have been released by the provider.**

Medicare

Please notify the front office immediately if you have recently changed Medicare plans. Medicare deductibles and coinsurance are expected at the time of service. As a participating provider with Medicare, we will file your claim to Medicare and if applicable, to your secondary insurance carrier.

Riverside Plastic Surgery

Brent Moister, MD

Nicotine Disclosure

Plastic surgeons frequently manipulate the skin during surgery in ways that robs that skin of its natural blood flow. We know through years of experience and research that there are safe ways to perform such surgeries to maintain reasonable blood flow and keep skin healthy. However, we know that certain medical conditions and the habit of using nicotine products can further increase risk to challenged skin. People who are currently smoking, breathing second-hand smoke, or using any type of tobacco or nicotine product are at greater risk for significant surgical complications such as the death of skin and delayed healing. Please indicate your current status:

Check the following that apply:

_____I am a non-smoker and do not use nicotine in any form. I understand the potential risks of nicotine exposure.

_____I successfully quit smoking or using nicotine in the past. My last use of nicotine was _____ days/months/years ago.

_____I am a smoker or use tobacco/nicotine products.

I acknowledge that smoking or using nicotine in any form can be harmful to my overall health and to my healing potential after a surgery. I know that Dr. Moister will make me aware of the procedures deemed too risky to perform on an active smoker. I understand that a urine test may be used to confirm abstinence from nicotine as needed.

_____Patient/Guardian Signature

_____Date