To help us serve you better, please fill out the following information: Today's Date: ____________________

Legal Name: ________________________ ______________________ _______ ________________________
Last First MI Knick-Name

Gender: ❑M ❑F **Marital Status:** ❑Married ❑Single ❑Divorced ❑Widowed **Date of Birth:** _____/_____/_____

Social Security # ____________________________ **Employer:** ____

Address: ____ **Apt / Unit:** _____________________

City: ________________________ **State:** _______ **Zip:** ______________ **May we contact you by mail?** ❑Yes ❑No

Email: ____ **May we contact you by email?** ❑Yes ❑No

Cell: (_____) - _______ - ________ **Home:** (_____) - _______ - ________ **May we leave phone messages?** ❑Yes ❑No

Emergency Contact: ____ **Phone:** (_____) - ________ - _________

How did you hear about us? ____

What procedure(s) are you interested in?

- ❑ Breast Augmentation (enlargement)
- ❑ Mastopexy (breast lift)
- ❑ Breast Reduction
- ❑ Breast Reconstruction
- ❑ Liposuction / Coolsculpting™
- ❑ Abdominoplasty (tummy tuck)
- ❑ Rhinoplasty (nose surgery)
- ❑ Blepharoplasty (eyelid surgery)
- ❑ Facelift / Neck Lift / Browlift
- ❑ Otoplasty (ear pinning)
- ❑ Chin / Cheek Enlargement
- ❑ Scar Revision
- ❑ Labiaplasty (vaginal enhancement)
- ❑ Brachioplasty (upper arm lift)
- ❑ Thighplasty (thigh/buttock lift)
- ❑ Belt Lipectomy (body lift)
- ❑ Mohs Skin Cancer Surgery

- ❑ Botox™
- ❑ Fillers (Juvederm, Voluma, Restylane etc.)
- ❑ Kybella™
- ❑ Aquagold™ Microchanneling
- ❑ Microneedling
- ❑ Dermablading
- ❑ Microblading / Permanent Makeup
- ❑ Chemical Peels
- ❑ Facials / Skin Care Treatments
- ❑ Diamondglow / Microdermabrasion
- ❑ Laser Hair Removal
- ❑ Frax Laser Skin Tightening
- ❑ Lash & Brow Services / Eyelash Extensions

Other: ____

____
_____

What time frame for surgery are you considering?

❑ Within the next month ❑ Within the next 3 months ❑ Within the next year ❑ No specific timeframe

Have you had any previous consultations? ❑Yes ❑No

Medical History Questionnaire

Family Physician / Internist Name: ____ **Phone:** (______)-________-____________

Date of last physical: _______/_______/_______ **Height:** ________________________ **Weight:** ___________________________

Pharmacy Name: ____ **Pharmacy Phone:** __________________________________

Are you allergic to any medications or substances? ❑Yes ❑No If yes, please list: ______________________________________

____

Please list all current medications and supplements: ____

____

Please list past surgeries and /or hospitalizations: ____

____

Do you smoke or vape? ☐Yes ☐No **How often per day?** ____

WOMEN ~ Are you currently pregnant? ❑No ❑Yes _______months **Nursing?** ❑Yes ❑No **Taking Birth Control?** ❑Yes ❑No

Indicate which of the following you have had or have at present:

- ❑ High Blood Pressure
- ❑ Heart Disease
- ❑ Heart Attack
- ❑ Stroke
- ❑ Diabetes
- ❑ Blood Clotting Abnormalities
- ❑ Bleeding Disorder
- ❑ DVT
- ❑ Seizure Disorder
- ❑ Asthma / Lung Problems

- ❑ Cancer
- ❑ Thyroid Disorder
- ❑ Liver Disorder
- ❑ Kidney Disorder
- ❑ Hepatitis
- ❑ HIV / AIDS
- ❑ Psychiatric Care
- ❑ Skin Lesions / Cancer
- ❑ Any Active Infection
- ❑ Herpes / Cold Sores

Any other conditions not listed above? ____

Family Medical History: Please list any blood relatives (Mother, Father, Siblings, Children) who have had the following:

Breast Cancer: ____________________________
Other Cancer: ____________________________
Diabetes: ________________________________
Asthma: ________________________________

High Blood Pressure: ____________________________________
Stroke: ____
Heart Disease: ____
Bleeding Disorders: ______________________________________

Are you using / taking any of the following products?

❑ Benzoyl Peroxide ❑ Retin A / Retinol ❑ Glycolic / Lactic / Salicylic Acids ❑ Differin / Tazorac / Metrogel or cream
❑ Body Exfoliants ❑ Hair Depilatories ❑ Topical Cortisone ❑ Accutane (last taken): ______________________________

Do you get any of the following treatments?

❑ Microdermabrasion ❑ Chemical Peels ❑ Fillers ❑ Botox / Dysport ❑ Laser / IPL /Waxing ❑ Spray Tan / Suntan

Do you get Cold Sores or Fever Blisters? ❑Yes ❑No **Do you receive regular facials or skin care treatments?** ❑Yes ❑No
Do you wear sun block daily? ❑Yes ❑No **Do you have a history of lighter or darker skin color changes?** ❑Yes ❑No

Terms and Conditions of Service

In consideration of all services provided by Dr. Kim Edward Koger, M.D. and its employees, contractors and/or affiliates, the undersigned hereby acknowledges and agrees (on behalf of himself or herself and his or her children, dependents and other persons for whom he or she serves as guarantor [collectively, "Dependents"]) with the following term and conditions of service.

Cosmetic / Spa Patient Information: Cosmetic and spa services are not covered by insurance and therefore by signing below you are acknowledging our financial policy and assume responsibility for all services rendered. Payment is due payable in full at the time of service.

For cosmetic patients, during your consultation, we will provide you with a surgical fee estimate that is valid for 3 months unless otherwise noted. The quote for the facility and anesthesia fees are quoted on the behalf of those organizations and are an estimate only. If your surgery runs longer than estimated, you will be billed for additional fees. Pre-surgical lab work, medications, additional garments, transportation and any possible pathology charges, or additional facility or anesthesia fees are not included in the quote and are the sole financial responsibility of the patient. To schedule a surgical procedure, 50% of the surgical fee is due upon date selection. The balance of the surgical fee is due at your pre-op appointment. Facility and anesthesia fees are paid directly to the surgery center or hospital.

Our goal is to provide the optimal result with your plastic surgery. However, infrequently operative revisions may be required. If you have problems with wound healing or other factors that do not allow for optimal healing, a surgical revision may be necessary. In this instance, the surgeon's fee may be negotiable; however, you will be responsible for related fees such as operating room, anesthesia, or hospitalization. Notification of cancellation of your surgery is required at least 2 weeks prior to your scheduled surgery date. If you cancel your surgery within 2 weeks of your surgery date, 50% of the surgical fee is non-refundable. If you cancel your surgical procedure the day of surgery, no refund will be made.

Insurance Patient Information: Dr. Koger is a participating provider with **Medicare Only**. We require payment of deductibles and/or co-insurance / co-payments at the time of service. If we are not a participating provider for your health insurance, we will require that your services be paid, in their entirety, at the time of service. We are not required to file claims to insurance carriers that we are not contracted with. Please be advised that as a non-participating provider, your insurance company may deny some or all the charges as non-covered. We are not a party to that contract as a non-participating provider.

Medical Malpractice: The patient understands that Dr. Koger cannot guarantee the final outcome of any medical services, treatment or surgery, and that unfortunately, disputes between the parties can sometimes result in a medical malpractice claim even with the best of medical care. Dr. Koger has decided not to carry medical malpractice insurance which is permitted under Florida law with the below notice to the patient. He has also agreed to resolve any medical malpractice claim by binding arbitration in order to keep things as simple as possible, enhance early resolution and hopefully minimize costs and attorney's fees.

"Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant to Florida law."

I, the undersigned, give consent to furnish medical care and treatment to myself, or to the patient (which includes minors), for whom I am responsible. I authorize all insurance companies, other medical providers and any other entity having information concerning my healthcare to release such information to Kim Koger, M.D. and/or its employees, contractors and affiliates. I further authorize release of information concerning my care to my insurance company, to assist in processing of my health care claims. If further collection efforts are required, I understand I will be responsible for collections fees, attorney's fees and/or court costs.

I, the undersigned, have completely read, fully understand, and agree to the above Terms and Conditions of Service.

Signature: ____ Date: _________________________________

Authorization for and Release of Medical Photographs

Consent to Take Surgical and/or Spa Procedure Photographs:

Photographs are taken before and after and sometimes during a surgical or clinical / spa procedure or treatment. Consent is required to take such images for clinical documentation. I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

I hereby authorize Kim Edward Koger, M.D. and/or his associates or licensees to take clinical photographs.

Signature: ____ Date: ____

Consent for Release of Surgical and/or Spa Procedure Photographs:

I hereby authorize Kim Edward Koger, M.D. and/or his associates or licensees to use pre-operative, intra-operative, and post-operative medical photographs, and/or clinical / spa treatment photographs for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, print media, electronic digital networks, internet platforms, for purpose of medical education, patient education, lay publication, or during lectures to medical or lay groups

Signature: ____ Date: ____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices for Koger Cosmetic Clinic & Medspa. The Notice of Privacy Practices is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996.

Signature: ____ Date: ____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other: Please specify:____

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