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)
- ❑ Breast Implant Removal / Exchange
- ❑ 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 pregnant? ❑No ❑Yes ______months **Breastfeeding?** ❑No ❑Yes **Taking Birth Control?** ❑No ❑Yes

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 Cold Sores or Fever Blisters? ❑Yes ❑No

Do you have a history of lighter or darker skin color changes? ❑Yes ❑No

Terms and Conditions of Service

RESPONSIBILITY

As a recipient of our services, you are responsible for the charges associated with the services you receive. You may have other means of payment, for example: insurance, any other third-party reimbursement source, or financing agency, but you remain legally and fully responsible for your entire bill. Payment is due payable in full at the time of service and/or service scheduling.

METHODS OF PAYMENT

Cash, Cashier's Check, Credit Cards: Visa, Mastercard, Discover, American Express, Debit cards and personal checks. We also accept Financing via CareCredit. A $35.00 service fee will be charged to any returned or stopped payment checks.

MEDSPA DEPOSITS

Due to the lengthy time slots required for certain Medspa procedures, we require a pre-paid deposit to secure your appointment. If for any reason you need to cancel one of these appointments, we ask that you provide a **2 business day notice.** We do not accept cancellation notices over the weekend. If you cancel or no-show within the 2 business days, you will forfeit your deposit and a new deposit will be required to re-book your service. Coolsculpting - $100 deposit. Permanent Makeup - $100 deposit.

PRODUCTS

We do not offer refunds on any products purchased. Products may be returned for in-store credit within 7 days from the date of purchase when there is a documented allergic reaction to the product. Defective products (i.e., a broken pump) may be exchanged within 7 days from the date of purchase for the same product only. In accordance with federal law, we do not offer refunds or exchanges on prescription products for any reason.

CANCELLATIONS / REFUNDS

We do not offer refunds on services rendered even if you are disappointed in the result or unhappy with the outcome. We ask that you contact our office directly if there are any concerns. If a refund is due for any reason, we require a minimum of 14 business days to process a refund.
If you paid by credit card, we will refund you the amount you paid to us, minus credit cards/financing processing fees. These fee percentages vary depending on the financing plan or card used.

SURGERY SCHEDULING

To schedule a surgical procedure, a non-refundable $500 deposit is due upon date selection. The balance of the surgical fee is due 14 days prior to surgery at your pre-op appointment.

SURGERY RESCHEDULING

Surgeries rescheduled more than 14 calendar days from the surgery date, will be given a one-time courtesy without penalty. Surgeries rescheduled within 14 calendar days of the surgery date will incur a $1000 rescheduling fee. Surgeries rescheduled within 3 calendar days of the surgery date will incur a $1500 rescheduling fee. Any additional rescheduling will incur a $500 rescheduling fee. The balance still remains due in full 14 days prior to the original surgery date. Your surgery must be rescheduled to a date within 6 months of the original date. All pre-paid deposits are forfeited if not rescheduled within 6 months of the original surgery date. Your surgery must be rescheduled to a date within 6 months of the original date. All pre-paid deposits and surgical fees are forfeited in full if your surgery is cancelled at any time, or if not received within 6 months of the original date. All forfeited fees are non-transferable to another service, surgery date or person.

Koger Cosmetic Clinic & Medspa
4600 Military Trail, Suite 202 Jupiter Florida 33458
Ph (561) 748-1565 Fx (561)748-1568

SURGERY CANCELLATION

If for any reason you cancel surgery, you will forfeit a $500 cancellation fee. If for any reason you cancel surgery within 14 calendar days of your surgery date, you will forfeit fifty percent of the “Surgeons Fees”. If for any reason you cancel surgery within 3 business days of your surgery date, you will forfeit one hundred percent of the “Surgeons Fees”. All forfeited cancellation fees are non-transferable to another person, surgery date or service.

When you book a surgical procedure, you will be provided with a full description of our entire Surgical Financial and Cancellation Policy.

INSURANCE

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. **Self-Pay Non Participating Insurance**: If we are not a participating provider for your health insurance, and you choose to have services performed here, we will require that your services be paid, in their entirety, at the time of service or at your surgical booking if surgery is being performed off-site. You will be considered a self-pay patient; therefore, we are not required to verify insurance or 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. We are not a party to that contract as a non-participating provider and will not file disputes on your behalf.
Cosmetic Surgery and Medspa services are not covered by insurance and will not be billed to your insurance company. By signing below, you are authorizing insurance payments to Koger Plastic Surgery.

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 the 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. I acknowledge that I will receive an in-depth Financial and Cancellation Policy Upon Scheduling.

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 reviewed 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. (If you would like a printed copy, please ask the receptionist.)

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:____