



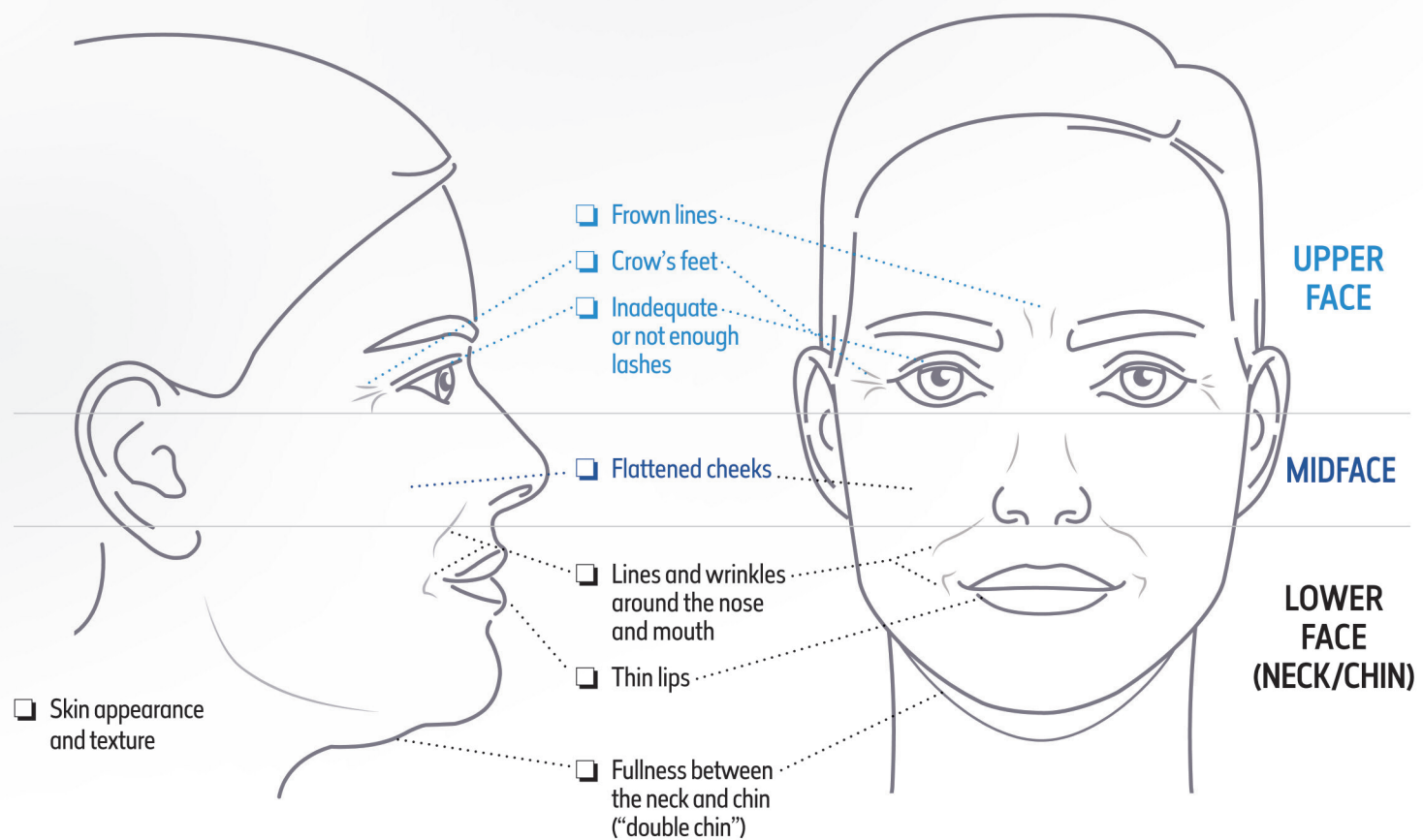
# SELF-ASSESSMENT

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ DATE: \_\_\_\_\_

What brings you in today? \_\_\_\_\_

Select which areas of the face concern you on the diagram below.

By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you.



Office Notes

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Please complete and return this form to the front office before your consultation.



## FINANCIAL POLICIES

At Weber Facial Plastic Surgery (WFPS), we are committed to providing you with the best possible care. Your clear understanding of our financial policies is important to our professional relationship. WFPS is pleased to discuss the practice's professional fees with you at any time.

- If you are unable to keep a scheduled appointment with our office, please give at least 24-hour notice. Initial \_\_\_\_
- To reserve your surgery date, a scheduling and booking fee is required. Initial \_\_\_\_
- The balance of any surgical, anesthesia or facility fees is due in full at your pre-operative appointment. Initial \_\_\_\_
- Dr. Weber's time, and that of his staff, is scheduled months in advance. If a medical or family emergency arises and your surgery must be postponed, please notify the office as soon as possible. Initial \_\_\_\_
- In case of a medical emergency, WFPS requires documentation for cancellation. Initial \_\_\_\_
- Fees for any additional medical expense (blood work, EKG, imaging, hospital admission etc.) are the responsibility of the patient and are not included in your surgery fee. Initial \_\_\_\_
- Quotes for surgical fees are valid for three (3) months. Initial \_\_\_\_
- There is a \$55.00 charge for all returned checks.
- Should your account become delinquent, you will be responsible for all costs incurred for collection of your balance including any potential court costs and attorney fees. Initial \_\_\_\_
- WFPS does not bill insurance companies for any procedures. Initial \_\_\_\_
- The surgical fee includes twelve (12) months of routine post-operative care at WFPS. Initial \_\_\_\_
- WFPS **DOES NOT** provide refunds for any services performed. Initial \_\_\_\_

## REVISION PROCEDURES

Infrequently, a patient may require a revision procedure. Please review the details outlined below regarding revision surgery.

- If a minor, in-office, revision procedure is necessary within the first twelve (12) months, there will be a \$1000.00 revision fee collected, provided that all post-operative instructions have been followed and all follow-up appointments attended as prescribed by Dr. Weber. Initial \_\_\_\_
- If any major revision procedure requires the use of the surgery center, the patient will be responsible for the \$1000.00 revision fee in addition to any applicable facility and anesthesia costs. These expenses will be discussed with you in detail prior to scheduling revision surgery. Initial \_\_\_\_
- This stated policy applies to the twelve (12) months following your initial surgery. Revision surgery scheduled more than twelve (12) months following the date of your initial surgery will incur the entire surgery cost at the current WFPS surgical rates. Initial \_\_\_\_

Thank you for taking the time to fully understand our financial policies. Please let us know if you have any further questions.

I certify that I have read, understand and agree to the policies and financial obligations outlined above.

Patient Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_



## PHONE/ ELECTRONIC MESSAGE CONSENT

Dr. Weber and our staff may need to contact you. By filling out the information below, Weber Facial Plastic Surgery (WFPS) is better able to serve you and protect your privacy.

- 1) WFPS staff will **NOT** leave messages with anyone except the patient or legal guardian.
- 2) WFPS staff will **NOT** leave detailed messages by voicemail, answering machine, email or text message **unless we have your written consent.**

Please read below and consider carefully who should have access to your medical information.

I, \_\_\_\_\_, give Weber Facial Plastic Surgery permission to contact me regarding medical care, account information or promotional information. I understand that this consent can be revoked at any time in writing.

Communication Source

Leave a message?

Pertinent Information

Cell Phone	Yes / No	
Home Phone	Yes / No	
Text Message	Yes / No	
Email	Yes / No	
Other	Yes / No	

### WFPS MAY SPEAK WITH THE PERSON(S) LISTED BELOW ABOUT MY MEDICAL CARE:

Please Circle One

If yes, please list name below.

Partner	Yes / No	
Son or Daughter	Yes / No	
Friend/ Neighbor	Yes / No	
Other	Yes / No	

Additional Notes: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_



## RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I, \_\_\_\_\_, hereby acknowledge that I have reviewed the Notice of Privacy Practices from Weber Facial Plastic Surgery (WFPS). This document details the manner in which personal health information may be used or disclosed by WFPS and outlines rights with respect to such information.

If necessary to collect a debt related to my medical care, I authorize the release of any information acquired in the course of my examination(s) or treatment(s) provided by Dr. Weber and/ or his staff members.

Patient Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_