What to expect for your Video chat with our doctors.

Prior to your video chat with our doctors, you will need the following:

- complete the video chat forms
- Submit photographs of the areas you would like to discuss with the doctors. Photographs should be taken in a well-lit room with a neutral background for better visibility.
- Send your photographs and forms with your name and the date of video chat on the subject line to Coordinator@CRSplasticsurgery.com
- We take your confidentiality very seriously. If you do not feel comfortable sending photos over email, contact our office to make other arrangements (954) 533-8029
- For your video chat you must have an iPhone for FaceTime or download Skype if you have an Android phone. You may also join via Google Meets (we will text you Meet code the day of your consult). Please advise the scheduling staff which option best suits your needs.

The date of your Video Chat:

- Our office will contact you 5-15 minutes prior to your scheduled chat to confirm your availability
- You will want to proceed to a space in your home or office that is quiet and where you are able to discuss your personal medical information with your doctor
- The Medical Assistant or Surgical Coordinator will contact you via Video Chat and may remain present throughout your chat with the doctor
- We will confirm your email address with you so the surgical coordinator may email you a quote of the procedures you discussed at during your video chat

To book your procedure with us:

- Contact our surgical coordinator directly at Coordinator@CRSplasticsurgery.com or (954) 530-6265 directly to book your surgery date.
- A $500.00 deposit will be collected to secure your surgical date. Unless there are extenuating circumstances, this is an otherwise non-refundable deposit.
- The coordinator will email the pre-operative testing and clearances required to undergo your procedure

Patient Information Form

Thank you for Choosing CRS Plastic Surgery. To better assist you, please fill out the forms prior to your virtual visit.

Name: Last:___________________________________First:_________________________________M.I.: ________

DOB:_______________________Age:________ Gender: □ M □ F □ Other: _________________

Address: ____ Apt/Unit#____________________________

City: ______________________________ State:____________ Zip Code:_________________________________

Home Phone:___________________________________ Cell Phone:___________________________

Email: ____

Occupation:____________________________Employer:________________________Work Phone: _____________

How Did you hear of CRS Plastic Surgery: _□ Google □ RealSelf □Yelp □ Instagram □Other:_______________

Reason for today's consult: □ Tummy Tuck □ Breast Augmentation □Breast Reduction □Mommy Makeover □Lipo of:____________________________ □Facelift □Eyes Other:____

Appointment with □ **Dr. Low** □ Dr. **Cheung**

Preferred Method of appointment reminders: □ Call □ Text □ Email

Primary Care Doctor Name: _______________________________ Phone: ____________________________________

Please list any insurance we may keep on file:

☐ Self-Pay □ Health Insurance

Health Insurance company:________________________________Policy Number:______________

Patient's Relationship to subscriber: _______________Subscriber's Name: __________________________________

Secondary Insurance Company: ____________________________ Policy Number: ____________________________

AUTHORIZATION OF RELEASE OF MEDICAL PHOTOGRAPHS

Medical photographs may be taken before, during or after surgical procedure or treatment. Consent is required to take such images. These images are used only for the education of other patients and physicians. Occasionally photos may be posted on social media outlets for the same purposes concealing any obvious identifying markers. Your signature below constitutes acknowledgement and consent. You may also choose decline signature and this will not affect your care in any way.

□ I consent with signature below □ I choose to decline at this time

Patient/Guardian Signature:____ Date:_________________

Confidential Patient History Form

Last:______________________________ First: ______________________Age: __________

Race: _________________________ Ethnicity: ________________________ ☐ I Decline to answer

Height:_______ Weight: ________

Preferred Pharmacy: ___________________________
Pharmacy Phone: ( ) ________-______________

Please list All Your Medical Conditions (i.e.: Diabetes, Thyroid, Asthma, Hypertension…):

_________________________ ______________________________
_________________________ ______________________________
_________________________ ______________________________

Have you had any surgeries? ☐ **Yes** ☐ **No** If YES Please List Below:

SURGERY:	YEAR:	SURGERY:	YEAR:

PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING VITAMINS:

____
____
____

PLEASE LIST ALL ALLERGIES: ____________________ ☐ **NO KNOWN ALLERGIES**

____
____

Social History

Tobacco:

☐ **Never smoked** ☐ **Quit smoking (Quit Date)**:____________

☐ **Current smoker**: Packs per day: _________________ Since Year: _____

Alcohol:

Never drank ☐ Social drinking ☐ Daily Beer/Wine: How many per week? ________

Recreational Drugs:

☐ Yes ☐ No If yes, please list: ____

Family History

Do you have family history of:

Diabetes: ☐ Yes ☐ No Breast Cancer: ☐ Yes ☐ No

Skin Cancer: ☐ Yes ☐ No Heart Disease: ☐ Yes ☐ No

The above information is accurate and complete to the best of my knowledge.

Patient/Guardian Signature:_________________________________ **Date:**_______________

Reviewed By Signature (Office): ______________________________ **Date Reviewed:** __________

Cosmetic and Reconstructive Specialists of Florida Office Policy

Thank you for choosing us as your health care provider. Our staff and physicians are committed to providing you the best service we can. The following is a statement of our office policy which we request you read and sign.

- All patients are required to complete our registration form, provide us with a valid medical Insurance card and photo ID, as well as new Insurance cards as they become available.

- **We accept assignment of insurance benefits as a courtesy to our patients; however, the balance is your responsibility. Deductibles applied by your insurance, not covered by any another insurance, will also be your responsibility. Please be aware that some services may not be covered and may not be considered medically necessary, under Medicare and other insurances. Patients will be responsible for payment in full at the time of visit, unless valid insurance is presented. All copayments are to be paid at the time services rendered. Initials ______**

- Some visits are performed by the nursing staff, without seeing a doctor, are still considered an office visit and fees will be charged accordingly where applicable. **Initials ______**

- **We ask 24-48 hours to process prescription requests and prescription refills**. **Initials ______**

- If you are calling to make an appointment from a referring physician and your insurance requires a referral to be seen, please allow at least 3 business days prior to appointment to assure we receive the authorization. If you choose to be seen without proper authorization, you will be given a waiver to sign stating you aware authorization has not been received and would like to be seen. You will be responsible for any charges your insurance denies because of un-authorized visit. **Initials ______**

- **There is a fee for copied medical records. We will notify you of the records fee and will require payment in full prior to the release of records. We require at least 5 business days to receive records and make copies. Initials:_______**

- If you need any forms filled out, the patient's portion is to be filled out prior to giving to a staff member. We ask 5-10 business days for forms to be completed. **Initials ______**

- **Should you arrive late to your appointment, you may be asked to reschedule, or you may have to wait to be seen between or after other patients who have arrived on time. Initials ______**

I,____have read, understand and agree to the office policy of Cosmetic and Reconstructive Specialists of Florida, PLLC.

____ ____________________________

Patient Signature Date

____ ____________________________

Responsible Party (if patient is minor or you are legal guardian) Date