WESTBANK PLASTIC SURGERY, L.L.C.

JONATHAN C. BORASKI, M.D., D.M.D.
1111 Medical Center Boulevard
Suite South 640
Marrero, Louisiana 70072
Phone (504) 349-6460
Fax (504) 349-6463

Welcome to Westbank Plastic Surgery!!

Please present your insurance card and driver's license when you check in for your appointment. If any information has changed since your last visit please notify our receptionist.

All insurance patients are required to pay their co-payments, co-insurance or deductibles at the time of service. Please do not ask us to bill this to your account. All accounts with an existing balance will be collected prior to seeing the doctor.

Insurances requiring referrals for office visits must be obtained by the patient prior to the office visit. If a referral is not available the appointment will be rescheduled to a later date. We are not responsible for calling your doctor's office to get this for you.

Authorization from your insurance company is not a guarantee of payment and if your insurance company does not pay your claim you will be responsible for the balance in full.

Our office accepts cash, debit cards, and most major credit cards.

Before any surgery can be performed a full determination of your benefits will be made by this office, either by telephone, Internet or a letter will be mailed to your insurance company requesting authorization for your procedure. You are responsible for any deductible or coinsurance prior to surgery.

The charge for a cosmetic consultation is due at the time of the consultation. The consultation fee will be deducted from the price of your surgery, provided that your surgery is scheduled within six months of your consultation. Payment for cosmetic surgery is due in full two weeks prior to your surgery date. Personal checks are not accepted for payment for cosmetic procedures. We accept cash, credit card, debit card or cashier's check. For cosmetic procedures a $500 deposit is required to hold your date for surgery.

Dr. Boraski is a professor of plastic surgery at Louisiana State University Medical School. As part of the approved residency training programs, LSU residents in Plastic Surgery may participate in your care or surgical procedures under their supervision. Involvement in the teaching process allows us to maintain state-of-the-art care.

Thank you for allowing us to participate in your care.

____________________________________ _________________________

Patient Signature/Parent Date

WESTBANK PLASTIC SURGERY, L.L.C.

JONATHAN C. BORASKI, M.D., D.M.D.

Patient Information as of ________________ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Advanced Directive: ❒ No ❒ Yes

Patient's Name ______________________________
First Middle Last

Address ______________________________
Street & Apt # City State Zip

Home Phone ____________ Cell Phone ____________ Other Phone ____________

Email: ______________________ Preferred Method of Contact ____________

Any restrictions for contacting you? ❒ No ❒ Yes Contact Restrictions: ____________

Age ______ Birthdate ____________ SS# ____________ Gender ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: ____________ ❒ Other: ____________

Race ____________ Ethnicity ____________ Language ____________

Pharmacy ____________ Pharmacy Phone ____________

Patient's Employer ____________ Occupation ____________

Work Phone ____________ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address ______________________________
Street & Suite # City State Zip

How did you hear about us? (Mark all that apply)

❒ Ins.Company ❒ Magazine ❒ Phone Book ❒ Pamphlets ❒ Self ❒ Web/Website

❒Friend/Relative ____________ ❒ Doctor: ____________ ❒ Other: ____________

If you were referred by a specific patient, who: ____________ May we thank them? ❒ Yes ❒ No

Emergency Contact
(Not in your household) ____________ Relationship to Patient ____________

Home Phone ____________ Work Phone ____________ Other Phone ____________

Primary Health Insurance Company ______________________________

Policy # ____________ Group # ____________ Ins. Phone ____________

Referral Required? Copay? ❒ No ❒ Yes, ____________

Insured: Name ____________ DOB ____________ Employer ____________

Secondary Health Insurance Company ______________________________

Policy # ____________ Group # ____________ Ins. Phone ____________

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, ____________

Insured: Name ____________ DOB ____________ Employer ____________

I understand that office visit charges are payable on the day service is rendered. I authorize Jonathan C. Boraski, M.D. to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Jonathan C. Boraski, M.D. and myself.

Signature ______________________________ **Date** ____________

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

(Please check one)

□ I, _________________________, have received a copy of the Notice of Privacy Policies
Patient Name
for Westbank Plastic Surgery, L.L.C.

□ I, _________________________, refuse to accept a copy of the Notice of Privacy Policies
Patient Name
for Westbank Plastic Surgery, L.L.C.

_________________________________ _____________________________
Signature of Patient

Date

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PAYMENT POLICY

- All payments are due at the time of service. Any service denied by the insurance company will be billed to the patient.
- Patients are solely responsible for all balances not covered by their insurance company which could include co-pays, deductibles, and co-insurances.
- All patient due accounts must be paid within 30 days of statement date.
- All checks returned for insufficient funds must be paid within ten (10) working days from the time we notify you, or the account will be placed with our outside collection agency. An NSF fee will be charged to your account as well.
- Missed appointments will be assessed a $15.00 fee if not canceled within 24 hours.

ANY ACCOUNT THAT MUST BE PLACED WITH AN OUTSTANDING COLLECTION AGENCY WILL BE CHARGED A COLLECTION FEE.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL STATEMENT.

_______________________________ _______________________________

PATIENT/GUARDIAN SIGNATURE DATE

WESTBANK PLASTIC SURGERY, L.L.C.

AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS

AUTHORIZATION FOR RELEASE OF PATIENT IMAGE

Name: ____

Address: ____

(Street address, city, state and zip code)

I consent to the taking of photographs by Dr. ____________________________ or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed.

I understand that such photographs shall become the property of Westbank Plastic Surgery, L.L.C. and may be retained by Westbank Plastic Surgery, L.L.C. or released by Westbank Plastic Surgery, L.L.C. for the limited purpose of including them in any print or reproduction of print.

I understand that in some circumstances the images may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive from Dr. _____________________________.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1006 (HIPAA).

I release and discharge Westbank Plastic Surgery, L.L.C. and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

___________________________________ _________________________

Signature Date

WESTBANK PLASTIC SURGERY, L.L.C.

COSMETIC, RECONSTRUCTIVE & MICROSURGERY

Jonathan C. Boraski, M.D., D.M.D., F.A.C.S.
Diplomate, American Board of Surgery
Diplomate American Board of Plastic Surgery
Fellow American College of Surgeons

Patient Name: ____

If you like, you may specify an individual who would have complete access to your health status. Please list person's name and specify their relationship to you.

______________________________ ______________________________
Name Relationship

______________________________ ______________________________
Name Relationship

______________________________ ______________________________
Name Relationship

______________________________ ______________________________
Name Relationship

______________________________ ______________________________
Name Relationship

____
Signature of patient

____
Date

Westbank Plastic Surgery, LLC

Jonathan C. Boraski, M.D., D.M.D

History & Physical

NAME: «Person_First_Name» «Person_Middle_Initial» «Person_Last_Name» **DATE:** ____________________________

REASON FOR VISIT: ____ **Height:** ______ ____**Weight**__________

MEDICAL HISTORY

LUNGS	YES	NO
Born with lung disease	◻	◻
Bronchitis	◻	◻
Asthma	◻	◻
Emphysema	◻	◻
COPD	◻	◻
TB	◻	◻
Do you smoke?	◻	◻
If yes, how many per day? _______________		
Have you ever smoked?	◻	◻
How long? _____________________________	◻	◻
If yes, when did you quit? _________________________		
Last chest x-ray:___________________________________		
Other lung issues	◻	◻

If yes, please explain: _______________________________

____

HEART	YES	NO
Pain/swelling in arms or legs	◻	◻
Born with any heart disease	◻	◻
Pacemaker/defibrillator	◻	◻
Heart Murmur	◻	◻
Rheumatic Fever	◻	◻
High Blood Pressure	◻	◻
Irregular Heart Beat	◻	◻
Chest Pain	◻	◻
Heart Attack	◻	◻
Heart Failure	◻	◻
Hardening of Arteries/PVD	◻	◻
High Cholesterol	◻	◻
Last EKG: ______________________________		
Other heart issues	◻	◻

If yes, please explain: _______________________________

____

BLOOD	YES	NO
Bruises easily	◻	◻
Blood clots	◻	◻
Pulmonary Embolism	◻	◻
Sickle Cell trait or disease	◻	◻
HIV / AIDS	◻	◻
Other blood issues	◻	◻

If yes, please explain: _______________________________

____

ENDOCRINE	YES	NO
Diabetes [Blood Sugar]	◻	◻
Thyroid Disorder	◻	◻
Metabolic Disorder	◻	◻
Other endocrine issues	◻	◻

If yes, please explain: __________________________________

____

NERVOUS SYSTEM	YES	NO
Numbness/paralysis	◻	◻
Epilepsy	◻	◻
Stroke	◻	◻
Seizures	◻	◻
Neuropsychiatric Disorder	◻	◻
Migraines	◻	◻
Mental illness	◻	◻
Other nervous system issues	◻	◻

If yes, please explain: __________________________________

____

EYE	YES	NO
Obstructed field of vision	◻	◻
Glaucoma	◻	◻
Contact lenses/glasses	◻	◻
Dryness and/or burning	◻	◻
Other eye issues	◻	◻

If yes, please explain: __________________________________

____

INTESTINAL	YES	NO
Colon Disease	◻	◻
Ulcers	◻	◻
Gall Bladder disease	◻	◻
Liver problems	◻	◻
Other intestinal issues	◻	◻

If yes, please explain: __________________________________

____

Westbank Plastic Surgery, LLC

Jonathan C. Boraski, M.D., D.M.D.

History & Physical

NAME: «Person_First_Name» «Person_Middle_Initial» «Person_Last_Name» **DATE:** ______________________________

LIVER	**YES**	**NO**
Jaundice	□	□
Have you had hepatitis?	□	□
Drink alcoholic beverages	□	□
If yes, how often? ______________________		
Other liver issues	□	□
If yes, please explain: ________________________________		

REPRODUCTIVE	**YES**	**NO**
Are you pregnant?	□	□
Are you attempting to become pregnant?	□	□
Still able to become pregnant?	□	□
Number of pregnancies: C-Section________ Vaginal________		
Birth Control method used: ____________________________		
History of breast disease?	□	□
Do you have breast implants?	□	□
Date of last mammogram: ______________		
Bra Size: ______________________________		

CANCER OR BENIGN TUMOR	**YES**	**NO**
Skin	□	□
Breast	□	□
Lung	□	□
Uterus	□	□
Ovary	□	□
Colon	□	□
Thyroid	□	□
Radiation	□	□
Chemotherapy	□	□
Other cancer/tumor issues	□	□
If yes, please explain:		

KIDNEY	**YES**	**NO**
Kidney stones	□	□
Kidney infection	□	□
Kidney failure / dialysis	□	□
Other kidney issues	□	□
If yes, please explain: _______________________________		

IF YOU HAVE ANY MEDICAL ISSUES NOT INCLUDED ON THIS CHECKLIST, PLEASE EXPLAIN:

____

____

____

____

SKIN	**YES**	**NO**
Do you have a history of fever blisters?	□	□
Do you have a history of scarring or poor wound healing?	□	□
Have you had a chemical peel previously?	□	□
If yes, which type? □ TCA □ GLYCOLIC □ OTHER		
Do you have a history of any skin disorders?	□	□

If yes, please explain: ____

____

SURGICAL HISTORY (hospitalizations, surgeries and illnesses/injuries) LIST OPERATIONS AND APPROXIMATE DATES

Reason	Date

Westbank Plastic Surgery, LLC

Jonathan C. Boraski, M.D., D.M.D.

History & Physical

Did you have complications after surgery?	☐	☐
Bleeding or blood clots?	☐	☐
Infection (staff/MSRA)?	☐	☐
Keloids or thick scars?	☐	☐

ANESTHETIC HISTORY

Allergy to any drug used in dental work, anesthesia, or surgery?	☐	☐
Any blood relative has any allergy to any drug used in surgery?	☐	☐
Any problems resulting from any local or general anesthetic ever given to you?	☐	☐

If you checked YES for any of the above, please explain: ____

____

____

LIST ALL PRESENT MEDICATIONS [Please include the medication name, dosages and reason for taking it.] Especially important to note are the following: Cortisone, hormones or birth control pills, aspirin or aspirin---containing medications, heart medication, water pills [diuretics], tranquilizers, sedatives or anti-depressants, steroids, aspirin, blood thinners [or anticoagulants], vitamins, herbal products, including over-the-counter medications. Attach list if needed:

____

____

____

____

____

DO YOU USE ILLICIT DRUGS/STREET DRUGS? ☐ **YES** ☐ **NO** If yes, please list:

____

HAVE YOU EVER USED ILLICIT DRUGS/STREET DRUGS? ☐ **YES** ☐ **NO** If yes, please list:

____

DO YOU HAVE ANY DRUG ALLERGIES? ☐ **YES** ☐ **NO** If yes, please list:

____

____

WHO IS YOUR PRIMARY CARE/REFERRING DOCTOR ANY OTHER TREATING PHYSICIANS? (include cardiologist, pulmonologist and other specialist) First and last name, address and phone number:

____

____

____

____

PATIENT'S SIGNATURE: ______________________________________ **DATE:** ________________

[If patient is a minor, parent/legal guardian's signature]