Front Range Plastic Surgery
Warren Schutte, MD

Legal Last Name__________________ First Name________________________ MI______

What name do you prefer to be called:______________________ Email:______________________________

Date of Birth_____________________ Male/Female SSN___________________________________

Address____

City_____________ State______ Zip____________ Phone____________________________

Cell (____)______________________ May we send you text message reminders: yes____ no ____

Emergency Contact_______________________________________Phone Number (_____)________________

Spouse Name____Phone Number (_____)________________

Referral Information
Who referred you to our office____

The following is information collected from all our patients and used it to track quality of care. This information goes into your medical record and it is confidential. It is a government requirement to monitor health care processes and outcomes for different population groups, target quality initiatives more efficiently and effectively, and provide patient-centered care.

Please circle or fill in one of the following:

Race: African-American Asian Caucasian Hispanic Other________________________________

Ethnicity: Non-Hispanic Hispanic Other____

Primary Language: English Spanish Other:____

IF Patient is a Minor
Guarantor Name____DOB______________________

Address____

City_____________________________State_________Zip_________SSN___________________________

Communication Authorization

I certify this information is true and correct to the best of my knowledge. I will notify the office of any changes in my status or the above information. I also acknowledge that I reviewed and received the practice privacy notice.

Signature:____ Date:_________________________

Front Range Plastic Surgery
Policies

Thank you for choosing Front Range Plastic Surgery. We are dedicated to providing you the most efficient care and service possible. Your understanding of our policies is an essential element of your care and service. If you have any questions regarding any aspect of our policy, please feel free to present your question to any of our staff.

Front Range Plastic Surgery and Dr. Schutte are affiliated with healthcare teaching institutions. We may participate in programs to teach resident doctors, medical students, nursing students, and other healthcare students. These healthcare workers in training may participate in your care and treatment including office evaluation and surgical procedure, under the guidance of Dr. Schutte.

Payments are due when services are rendered. If you are unable to make payment in full at the time of service, your appointment will be rescheduled to a more convenient time. We accept Visa, MasterCard, Discover, personal checks and cash. Please be aware that we will add a $30.00 charge to your account for returned checks. We reserve the right to send all accounts with balances over 60 days old to an outside collection agency. All accounts sent to collections will be charged a $50.00 processing fee and any additional fees associated. You may be responsible for all collections and attorney costs incurred.

Cosmetic procedures deposit
There is a non-refundable deposit required before the date selected can be reserved exclusively for you. The deposit is $500.00 or 10% of surgery cost whichever is greater. This is a non-refundable deposit. This fee is used to cover the booking and scheduling expenses involved with your surgery. This amount will be deducted from your total cost.

Surgery Final Payment
You will be expected to pay the remaining balance due on your account at your pre-op visit, generally two weeks prior to your surgery. We accept: Visa, MasterCard, Novus (Discover), Money Orders, Cashiers Checks and Cash. Personal checks are accepted only if paid two (2) weeks prior to surgery. No post-dated checks will be accepted. Please note if you plan to use a Bank DEBIT card for your final payment, they usually will not process over $500.00, please contact your bank in advance to make arrangements. We also accept Care Credit and United Medical Credit.

Surgery Cancellation
If for any reason, medical or personal, you cancel surgery two weeks or less than your scheduled surgery date you will be charged a cancellation fee: 14 days = 25% of total surgical fee, 7-13 days = 50% of total surgical fee; 2-6 days = 75% of total surgical fee, 1 day = 100% of total surgical fee

I acknowledge that I have received a copy of this policy. I agree to read this document and comply with the terms set forth for services rendered by Front Range Plastic Surgery.

Patient Signature (Guarantor) Date

______________________________ ______________________________

Print Name ______________________________

Front Range Plastic Surgery

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I,
have been informed that a copy of our offices Notice of Privacy Practices 2022 version is available in the waiting room(s) and online at www.frontrangeplasticsurgery.com. A copy of this Notice will be furnished to me upon my request.

____ ____________________
Signature of Patient Date

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

It is our policy to not release confidential and/or unauthorized information except as defined in the Notice of Privacy Practices. If you would like to have information released to someone other than yourself please complete the following:

Please list names of people we can discuss your medical or skin care with:
Spouse Name ____ yes____ no____
Parent Name ____ yes____ no____
Other Name ____ yes____ no____
Please give name and relationship such as boyfriend, sister, etc.

I authorize the doctor's office to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them, in writing, whenever this information changes.

Home telephone	yes____	no ____	Voice mail	yes____	no____
Answering machine	yes____	no____	Cell phone/voice mail	yes____	no____
Work phone	yes____	no____	Text	yes____	no____

Preferred Contact (circle one) Home / Work / Cell / Email

May we fax medical records for referrals? yes____ no____

____ __________________________
Signature of Patient/Guardian Date

CONSENT TO PHOTOGRAPH

I understand that photographs will be taken periodically throughout my treatments. These photographs will be used to monitor progress and other factors. I understand that failure to consent to these photos will give Front Range Plastic Surgery the right to decline my treatment.

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 the use in examination, testing, credentialing and/or certification purposes by The American Board of Plastic Surgery, Inc., AAAASF, and Dr. Warren Schutte.

________________________________ ________________________________

(Patient Full Name – Please Print) (Patient Signature)

____

(Date)

CONSENT TO USE PHOTOGRAPHS

I hereby give Dr. Warren Schutte and staff the absolute right and permission to copyright and/or publish, or use photographic portraits of me, or in which I may be included in whole or in part, or reproductions thereof in color or otherwise, for presentations, photo albums, social media, display on the company's web site, art trade, news or any other lawful purpose whatsoever. I hereby waive any right that I may have to inspect and/or approve the finished product or the advertising copy that may be used in connection therewith, or the use to which it may be applied. Please check one below:

- ☐ Accept
- ☐ Decline

I understand that by signing below Front Range Plastic Surgery need not approach me again for authorization on these photos.

________________________________ ________________________________

(Patient Full Name – Please Print) (Patient Signature)

____

(Date)

Front Range Plastic Surgery
ELECTRONIC COMMUNICATION

Email, text, or other electronic communication provides a fast and easy way to communicate with Front Range Plastic Surgery for those issues that are non-emergent, non-urgent or non-critical. It is not a replacement for the interpersonal contact that is the very basis of the client practice relationship; rather it can support and strengthen an already established relationship.

The following summarizes the information you need to determine whether you wish to supplement your experience at our practice by electronically communicating with FRPS staff.

General Considerations

- Electronic communication will be considered and treated with the same degree of privacy and confidentiality as written medical records. Standard electronic communication services, such as text or gmail, AOL, and hotmail email services are not secure. This means that the electronic messages are not encrypted and can be potentially intercepted and read by unauthorized individuals. Your electronic addresses will not be used for external marketing purposes without your permission. You may receive a group emailing from the practice; however, the recipients email addresses will be hidden.

Provider Responsibilities

- Staff will attempt to electronically confirm your email address by requesting a return response to all email messages.
- Your provider may route your electronic messages to other members of the staff for information purposes or for expediting a response.
- Designated staff may receive and read your electronic messages
- Every attempt will be made to respond to your electronic message within 2 business days (Monday – Friday, non-holidays). If you do not receive a response from the practice within 2 business days, please contact the practice by phone.
- Copies of electronic messages sent and received from and to you could be incorporated into your medical record. You are advised to retain all electronic correspondence for your own files.

Client Responsibilities

- Electronic messages should not be used for emergencies or time-sensitive situations. In the event of an emergency, you should call 911. For emergent or time-sensitive situations, you should contact the practice by phone.
- Electronic messages should be concise. Please arrange for an office appointment if the issue is too complex of sensitive to discuss via electronic messaging.
- Please include your full name and the topic or question, in the email. This will serve to identify you as the sender of the email.
- Please acknowledge that you received and read the message by return electronic message to the sender.

I have read and understood the above description of the risks and responsibilities associated with electronic communication with Front Range Plastic Surgery. I acknowledge that commonly used text services and email services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information. I have been given the opportunity to discuss electronic communication with a representative of FRPS and have had all my questions answered.In consideration for my desire to use electronic communication as an adjunct to in-person office visits with FRPS, I hereby consent to electronic communication via non-secure text and email services.
I understand that I may revoke my consent to communicate electronically at any time by notifying the practice in writing at the following address: Front Range Plastic Surgery, 1992 Rocky Mountain Ave, Loveland, CO 05388. However, if I revoke my consent, the revocation will not have an effect on actions my doctor has already taken in reliance on my consent. I agree and release my provider and Front Range Plastic Surgery from any and all liability that may occur due to electronic communication over a non-secure network. I further agree to be held accountable and to comply with the client responsibilities as outlines in this consent.
CLIENT (over 18 only)

Client Authorized Email Address (Please Print)

Client Name (Print)

Client Signature Date

Please check <u>all</u> procedures that you are interested in discussing with the doctor.

<u>Face</u>

- ☐ Facelift
- ☐ Facial fat transfer/grafting
- ☐ Browlift
- ☐ Upper Eyelid Surgery
- ☐ Lower Eyelid Surgery
- ☐ Neck lift
- ☐ Nose Surgery
- ☐ Ear surgery
- ☐ Cheek implants
- ☐ Chin implants
- ☐ CO2 Fractionated laser
    - ☐ Face
    - ☐ Neck
    - ☐ Chest

<u>Injectables</u>

- ☐ Botox
- ☐ Juvederm
- ☐ Volbella
- ☐ Voluma

<u>Skin Care</u>

- ☐ Genius Microneedling
- ☐ LaseMD laser
- ☐ Skincare products
- ☐ Diamond Glow

<u>Skin</u>

- ☐ Mole removal
- ☐ Scar revision

<u>Breast</u>

- ☐ Augmentation
- ☐ Lift
- ☐ Reduction

<u>Abdomen</u>

- ☐ Tummy Tuck
- ☐ Backlift

<u>Arms</u>

- ☐ Arm Lift

<u>Hands</u>

- ☐ Fat Grafting rejuvenation
- ☐ CO2 laser for hands

<u>Thighs</u>

- ☐ Thigh Lift

<u>Labia</u>

- ☐ Labiaplasty

<u>Liposuction</u>

- ☐ Upper abdomen
- ☐ Lower abdomen
- ☐ Flanks (love handles)
- ☐ Back
- ☐ Axillary (arm pit area)
- ☐ Inner thighs
- ☐ Outer thighs
- ☐ Neck
- ☐ Arm

<u>Non-Invasive Treatments</u>

- ☐ Coolsculpting
- ☐ CoolTone

THROMBOSIS RISK FACTOR
ASSESSMENT

CHOOSE ALL THAT APPLY

EACH RISK FACTOR REPRESENTS 1 POINT	EACH RISK FACTOR REPRESENTS 2 POINTS	EACH RISK FACTOR REPRESENTS 3 POINTS
☐ Age 41-60 years	☐ Age 60-74	☐ Age over 75 years
☐ Minor surgery planned	☐ Arthroscopic surgery	☐ History of DVT/PE
☐ History of prior major surgery (<1 month)	☐ Malignancy (present or previous)	☐ Family history of thrombosis*
☐ Varicose veins	☐ Major surgery (> 45 min)	☐ Positive Factor V Leiden
☐ History of inflammatory bowel disease	☐ Laparoscopic surgery (> 45 min)	☐ Positive Prothrombin 20210A
☐ Swollen legs (current)	☐ Patient confined to bed (> 72 hrs)	☐ Elevated serum homocysteine
☐ (BMI > 25)	☐ Immobilizing plaster cast (<1 month)	☐ Positive lupus anticoagulant
☐ Acute myocardial infarction	☐ Central venous access	☐ Elevated anticardiolipin antibodies
☐ Congestive Heart Failure (< 1 month)		☐ Heparin-induced thrombocytopenia (HIT)
☐ Sepsis (< 1 month)		☐ Other congenital or acquired thrombophilia If yes:
☐ Serious lung disease including pneumonia (< 1 month)		Type: ___________________________
☐ Abnormal pulmonary function (COPD)		* Most frequently missed risk factor
☐ Medical patient currently at bed rest		
☐ Other risk factors ___________________________		

EACH RISK FACTOR REPRESENTS 5 POINTS	FOR WOMEN ONLY (EACH REPRESENTS 1 POINT)
☐ Elective major lower extremity arthroplasty	☐ Oral contraceptives or hormone replacement therapy
☐ Hip, pelvis or leg fracture (< 1 month)	☐ Pregnancy or postpartum (< 1 month)
☐ Stroke (1 < month)	☐ History of unexplained stillborn infant, recurrent spontaneous abortion (>=3), premature birth with toxemia or growth-restricted infant
☐ Multiple trauma (< 1 month)	
☐ Acute spinal cord injury (paralysis) (< 1 month)	

Total Risk Factor Score = _____

Age: Sex:

Weight:

Front Range Plastic Surgery
Malignant Hyperthermia
Risk Factor Assessment

Check All That Apply

- ☐ Have you ever had general anesthesia?
- ☐ Do you have a history of Malignant Hyperthermia?
- ☐ Do you have a family history of Malignant Hyperthermia?
- ☐ Do you have a family history of unexpected death(s) following general anesthesia or exercise?
- ☐ Do you have a muscle or neuromuscular disorder?
- ☐ Do you have a history of a high temperature following exercise?
- ☐ Do you have a history of muscle spasms?
- ☐ Do you have a history of dark or chocolate colored urine?
- ☐ Have you ever and unanticipated fever immediately following anesthesia or serious exercise?

Patient Name:_________________________________ Date:_____________

Front Range Plastic Surgery - Medical History Form

Name:____ Date: ________

Birth date: _____________ Age:_____ Height:_______ Weight:_________ Occupation________________

How did you hear about us?: ____

Reason for your visit today: ____

Physicians that care for you: (PCP/Specialists)____

Pharmacy Name ____Location:_____________________________

Do you have a responsible adult available to assist you during a recovery period? ☐ Yes ☐ No

CURRENT MEDICAL CONDITIONS for which you are presently being treated: ______________________________

____

____

PAST MAJOR ILLNESSES: ____

____

ALLERGIES: ☐ NONE

Allergy: (Drug, Food, Tape, Latex)	Reaction

MEDICATIONS: List All Prescription, Over-the-counter, Supplements, and topical creams

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQENCY

Have you taken any steroids within a year? ☐ Yes ☐ No When? _______ How long?______ Why? ______________

PAST SURGERIES (including cosmetic surgery) with dates:

Have you had an EKG? ☐ Yes ☐ No When? ________ Where? _____________Why?____________________________

ANESTHESIA HISTORY:

Local anesthesia? ☐ Never had ☐ No complications ☐ Severe Reaction:_________________________________

General anesthesia? ☐ Never had ☐ No complications ☐ Severe Reaction:______________________________

FEMALES ONLY: Have you had a mammogram? ☐ Yes ☐ No When last:_________________

Where? __________________________Results: ☐ Normal ☐ Abnormal______________________________________

Number of Past Pregnancies:____ Future pregnancies planned: ☐ Yes ☐ No Are you lactating? ☐ Yes ☐ No

Office Use: Ht________ Wt_______ BMI_________ BP________ P _______ BSA _______ Schnur _________

SN-N	N-IMF	Width
L-	L-	L-
R-	R-	R-

FAMILY HISTORY: ***Have any blood relatives ever had any of the following problems***:
☐ Abnormal bleeding or clotting ☐ Cancer ☐ Problems with Anesthesia ☐ Heart disease ☐ Other serious illness:
Describe relation and condition:____

SOCIAL HISTORY: Exercise Frequency: ☐ None ☐ 1x/week ☐ 2-3 x/week ☐ 4-6x week
Do you ever use nicotine-containing products? (Smoke/Chew/ E Cig) ☐ No ☐ Quit ☐ Yes Amount______________
If Quit: When? _____________ Have you ever quit?________________ For how long?___________________________
Do you drink alcohol? (circle one) No Yes How much? ___________________

REVIEW of SYSTEMS: **Please check <u>all</u> past and present medical conditions**

CONSTITUTIONAL:
☐ Good general health lately
☐ Recent weight gain
☐ Recent weight loss
☐ Night sweats
☐ Headache
☐ Fever
☐ Fatigue
☐ Other: ______________________

CARDIOVASCULAR:
☐ High blood pressure
☐ Heart attack(s) history
☐ Pacemaker
☐ Coronary artery disease
☐ Heart murmur/Mitral valve prolapse
☐ Irregular heartbeat/palpations
☐ Stroke/TIA history
☐ Chest pain/pressure/burning
☐ Swelling of feet, ankles, or hands
☐ Atrial fibrillation
☐ High cholesterol
☐ Tachycardia
☐ SVT
☐ CHF
☐ Fainting episodes
☐ Other ________________

RESPIRATORY:
☐ Asthma
☐ Chronic cough
☐ Shortness of breath
☐ Wheezing
☐ Spitting up blood
☐ COPD
☐ Sleep Apnea
☐ Bronchitis
☐ Other: ______________________

HEMATOLOGY/LYMPHATIC:
☐ Blood transfusion history
☐ Bleeding disorder
☐ Slow healing
☐ Easily bruise/bleeding
☐ Anemia
☐ Clotting disorder
☐ Taking anticoagulants
☐ DVT/PE history
☐ Enlarged glands
☐ Other: ______________________

NEUROLOGICAL:
☐ Frequent or recurring headaches
☐ Migraines
☐ Dizziness
☐ Numbness/Tingling sensation
☐ Tremors
☐ Seizure disorder/convulsions
☐ Paralysis
☐ Parkinsons Disease
☐ Other: ______________________

PSYCHOLOGICAL:
☐ Depression
☐ Anxiety
☐ Memory loss or confusion
☐ Receive(d) psychiatric treatment
☐ Sleeping problems
☐ Bipolar disorder
☐ ADHD
☐ OCD
☐ PTSD
☐ Panic attack history
☐ Other: ______________________

EARS/NOSE/THROAT:
☐ Nasal allergies
☐ Difficulty breathing by nose
☐ Previous nasal injury
☐ History of sinus infections
☐ Hearing loss
☐ Hoarseness
☐ Nose bleeds
☐ Sinus problems
☐ Sore throat
☐ Ringing in ears
☐ Nasal deformity
☐ Difficulty swallowing
☐ Other: ______________________

EYES:
☐ Dry eye
☐ Blurred/double vision
☐ Cornea problems
☐ Glaucoma
☐ Thyroid eye disease
☐ Wear glasses/contacts
☐ Eye pain
☐ Eye disease/injury
☐ Visual field obstruction
☐ Macular degeneration
☐ Decreased vision
☐ Other: ______________________

ENDOCRINE:
☐ Diabetes/Prediabetes
☐ Thyroid disease
☐ Excess thirst/urination
☐ Other: ______________________

GENITOURINARY:
☐ Dialysis
☐ Burning/painful urination
☐ Frequent urination
☐ Incontinence/Dribbling
☐ Blood in urine
☐ Kidney stones
☐ Indwelling catheter
☐ BPH
☐ Kidney disease
☐ Other: ______________________

GASTROINTESTINAL:
☐ Colitis
☐ GERD
☐ Stomach ulcers
☐ Loss of appetite
☐ Change in bowel movement/habits
☐ Nausea/Vomiting
☐ Frequent diarrhea
☐ Blood in stool
☐ Stomach pain
☐ IBS
☐ Crohns
☐ Gastric bypass history
☐ Other: ______________________

MUSCULOSKELETAL:
☐ Scoliosis
☐ Osteoporosis
☐ Joint pain
☐ Joint stiffness or swelling
☐ Muscle or joint weakness
☐ Muscle pain or cramps
☐ Back pain
☐ Difficulty walking
☐ Paraplegic
☐ Fibromyalgia
☐ Gout
☐ Arthritis
☐ Other: ______________________

ALLERGIC/IMMUNOLOGIC/INFECTIOUS DISEASES:
☐ Environmental allergy
☐ HIV/AIDS
☐ Hepatitis
☐ TB
☐ RA
☐ Lupus
☐ History of MRSA
☐Psoriatic arthritis
☐ Autoimmune disorder
☐ Other: ______________________

DERMATOLOGICAL:
☐ Excessive sweating
☐ Cold sores/herpes
☐ Acne
☐ Rosacea
☐ Eczema
☐ Psoriasis
☐ Radiation to face/neck
☐ Scarring/keloid formation
☐ Skin lesion
☐ Mass
☐ Hidradentitis
☐ Rash or itching
☐ History of skin cancer
☐ Skin excess
☐ Wound/abscess

FRONT RANGE PLASTIC SURGERY

(970) 372-2310

FOR OFFICE USE ONLY:

Operative Plan Discussed on «Procedure_Consult_Date»

Patient's Name ______________________________ Age ____________

Procedures Discussed:

Overnight Stay? ❐ None ❐ 1 night ❐ 2 nights ❐ 3 nights

Surgery	Location	Time	Supplies	Anesth.	Reason
	❐ ASC ❐ Office ❐ Hosp			❐ General ❐ Local	❐ Cosmetic ❐ Dx
	❐ ASC ❐ Office ❐ Hosp			❐ General ❐ Local	❐ Cosmetic ❐ Dx
	❐ ASC ❐ Office ❐ Hosp			❐ General ❐ Local	❐ Cosmetic ❐ Dx
	❐ ASC ❐ Office ❐ Hosp			❐ General ❐ Local	❐ Cosmetic ❐ Dx
	❐ ASC ❐ Office ❐ Hosp			❐ General ❐ Local	❐ Cosmetic ❐ Dx

❐ Lovenox 1 week 4 weeks

❐ Nicotine Check

❐ CBC, PT/INR, PTT

❐ BMP, Iron, Prealbumin, Albumin

❐ EKG

❐ In Office Pregnancy Test Needed

❐ BMI Reduction

❐ Vitamin A (steroid use)

❐ DMSO (former smoker)

❐ Need Medical Clearance

❐ Imaging: ______________________________

❐ Records Needed: ______________________________

❐ Other: ______________________________