Kryger Institute
of Plastic Surgery

PROCEDURES PERFORMED

Dr. Kryger regularly performs each of the surgical procedures listed here. You can be confident that the doctor is experienced and specially trained in each one. Our office staff is also knowledgeable about these procedures and will be able to give you thorough information to help you understand the benefits as well as risks of each one.

Please check off each procedure you are interested in discussing with Dr. Kryger today:

Non-Surgical Services
- o Botox
- o Chemical Peel
- o Fillers (Juvederm, Radiesse, Restylane)

Body Contouring
- o Body Lift
- o Liposuction
- o Thigh-Buttock Lift
- o Tummy Tuck
- o Upper Arm Lift
- o Excess Skin Removal

Breast - Cosmetic
- o Breast Enlargement
- o Breast Lift
- o Male Breast Reduction
- o Removal & Replacement of Breast Implants

Breast - Reconstructive
- o Breast Reconstruction after Mastectomy
- o Breast Reduction
- o Nipple Reconstruction
- o Removal of Breast Implants
- o Removal of Breast Tissue
- o Revision of Breast Enlargement

Ears
- o Ear Pinning
- o Earlobe Repair

Facial
- o Cheek or Chin Implants
- o Eyelid Lift
- o Facelift
- o Forehead Lift
- o Lower Eyelid Lift
- o Neck Lift
- o Brow Lift
- o Fat Grafting

Nasal
- o Nose Reshaping
- o Broken Nose
- o Correction of Deviated Nasal Septum
- o Revision of a Rhinoplasty Procedure

Skin & Scars
- o Laceration Repair
- o Removal of Skin Lesions or Skin Cancer
- o Repair of Umbilical Deformity
- o Scar Revision

Other
- o Complex Hernia Repair
- o Pediatric Surgery
- o Wound Care
- o Lower Extremity Reconstruction
- o _____

Microsurgery

Hand Surgery
- o Carpal Tunnel
- o Cyst Removal
- o Fracture Repair
- o Trigger Finger
- o Dupytrens
- o Tendon, Nerve, Blood Vessel Repair
- o _____

KRYGER INSTITUTE OF PLASTIC SURGERY

Patient Information as of _____/_____/ 2011

(Please Print Legibly & Fill In/Correct **All** Fields)

Patient Name: _____ Birthdate: _____ SS#:_____

Street Address: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Email Address: _____ Restrictions for Contacting You: ☐ No ☐ Yes: _____

_____

Gender: ☐ Male ☐ Female Drivers License #: _____

Marital Status: ☐ Single ☐ Seperated ☐ Married to: _____ ☐ Other: _____

Patient's Employer: _____ Occupation: _____

Work Phone: _____ Ext: _____ May we call you at work: ☐ Yes ☐ No

Address: _____

Emergency Contact (*not* in your household) - Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Address: _____

Refferal Source: ☐ Insurance Company ☐ ER ☐ Dr. _____ ☐ Patient: _____
☐ Newspaper ☐ Magazine Website: ☐ DrKryger.com ☐ LoveYourLook.com ☐ Search Engine Result
☐ Other: _____

*** INSURANCE PATIENTS ***

Health Insurance Info: ☐PPO ☐POS ☐HMO ☐Workers Comp ☐None ☐Other

Primary Insurance: _____ ID#: _____ Group #: _____

Insured Party (if not self) – Name: _____ Birthdate: _____ SS#: _____

Relationship To Insured: ☐ Spouse ☐ Child ☐ Other _____ Copay: ☐ No ☐ Yes (Amount $_____)

Primary Care Physician Name (if HMO): _____ and Phone Number: _____

Secondary Insurance: _____ ID#: _____ Group #: _____

Insured Party (if not self) – Name: _____ Birthdate: _____ SS#: _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Kryger to bill my insurance company, however I understand that not all fees may be covered by my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Kryger and myself.

Signature: _____ **Date:** _____

Kryger Institute of Plastic Surgery

New Hand Patient Health History

Name:_____ **DOB:**_____ **Date:** _____

SOCIAL

Age: _____ Sex: □M □F Married: □Y □N Occupation: _____

HABITS

Smoke: □ N □ Y Amount: _____ HEIGHT: _____ WEIGHT: _____

Alcohol: □ N □ Y Amount: _____ □ Right Handed □ Left Handed □ Ambidextrous

MEDICATIONS: *List dose or number of pills per day*

Prescription Drugs:	Dose:	Treatment for:	Non-Prescription (Vitamins, Herbs, etc.):

Allergies: □N □Y -- List all allergies and type of reaction:

_____

_____

PERSONAL PAST HISTORY: Have **you** ever had:

Abnormal Bleeding:	□Y	□N	Asthma:	□Y	□N	Hypertension:	□Y	□N
Abnormal Clotting:	□Y	□N	Diabetes:	□Y	□N	Sleep Apnea:	□Y	□N
Acid Regurgitation:	□Y	□N	Cancer:	□Y	□N	Snoring:	□Y	□N
Anemia:	□Y	□N	Heart Attack:	□Y	□N	Weight Change past 12 Mo.:	□Y	□N
Angina:	□Y	□N	Hepatitis:	□Y	□N	Other Serious Illness:	□Y	□N
Psychiatric Treatment:	□Y	□N	Infections:	□Y	□N	Scarring Problems:	□Y	□N

Please describe questions with a "Yes" answer: _____

_____

_____

Previous Surgeries:	**Surgery Date:**	**Surgeon:**

History of Steroid Injection in Hand/Finger: □N □Y - Where: _____

FAMILY HISTORY: Have any **blood relatives** ever had the following problems:

Abnormal Bleeding:	□Y	□N	Diabetes:	□Y	□N	Heart Disease:	□Y	□N
Abnormal Clotting:	□Y	□N	Anesthetic Problems:	□Y	□N	Cancer:	□Y	□N

Please describe questions with a "Yes" answer: _____

_____

_____

Primary Care Physician: _____

Referred from (please circle): Patient: _____ Physician: _____

Internet site: _____ Insurance Co.: _____

ER: _____ Other source _____

Women Only: Number of pregnancies: _____ Number of children: _____ Planning more pregnancies? □Y □N

_____ **M.D.**

Kryger Institute
of Plastic Surgery

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Reconstructive Surgery
Microsurgery
Post-mastectomy
Abdominal wall
Lower extremity
Facial fractures
Skin cancer
Wounds
Pediatric

Hand Surgery
Fractures
Wrist injuries
Nerve compression

Aesthetic Surgery
Face
Breast
Body contouring
Non-surgical procedures

- I hereby give my consent for The Kryger Institute of Plastic Surgery, AMC to use and disclose protected health information about me to carry out treatment, payment and healthcare operations (TPO). The Kryger Institute's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

- I have the right to review the Notice of Privacy Practices prior to signing this consent. The Kryger Institute reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Kryger Institute of Plastic Surgery.

- With this consent, The Kryger Institute of Plastic Surgery, AMC and staff may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carry out TPO such as appointment reminders, insurance items and any calls pertaining to my clinical care.

- With this consent, The Kryger Institute and Staff may mail to my home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

- With this consent, The Kryger Institute and Staff may e-mail to my home or other alternative location any items that the practice in carrying out TPO, such as appointment reminder cards, patient statements.

- With this consent physician peers may review my office and operating room charts for operative consent and completeness of chart.

- I have the right to request that The Kryger Institute restrict how it uses or discloses my information to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

- By signing this form, I have consented to The Kryger Institute of Plastic Surgery, AMC's use and disclosure of my protected information to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, The Kryger Institute may decline to provide treatment to me.

Patient Signature (or person authorized):_____

Printed Name of Patient: _____ Date: _____

425 Haaland Drive
Suite 102
Thousand Oaks, CA. 91361

Tel: (805) 777-3877
Fax: (805) 777-4822
www.drkryger.com

7325 Medical Center Dr
Suite 2
West Hills, CA. 913

Kryger Institute of Plastic Surgery

Our Financial Policy

We are dedicated to providing you with the best possible care and service, and we regard your understanding of our financial policy as an essential element of your care and treatment. If you have questions about this policy, contact our Insurance Biller at (805)777-3877.

Please have available, at every visit, the following documents:

- Your Insurance Identification Card
- Your Driver's License

Reconstructive Surgery
Microsurgery
Post-mastectomy
Abdominal wall
Lower extremity
Facial fractures
Skin cancer
Wounds
Pediatric

Hand Surgery
Fractures
Wrist injuries
Nerve compression

Aesthetic Surgery
Face
Breast
Body contouring
Non-surgical procedures

Payment Policy:

- Payment in full is expected at the time service is rendered. For your convenience, we accept cash, checks and credit/debit cards. Any refunds made to a credit/debit card will result in a 3% deduction from the total refund amount. Bounced checks will be subject to a $35 fee.

- In the event of non-payment, we will submit the charge to an outside collections agency and the expenses will be added to your account balance. By signing here, you understand that this will adversely affect your credit rating.

- **Self-Pay Patients:** If you do not have a valid insurance plan to cover the cost of our services, you will be required to make a full payment at the time of your visit.

- Insurance Plans:
  1. We bill those insurance companies with which we contract (a full list of insurance plans may be obtained from the office), however, the patient or guarantor is responsible for the co-payment, co-insurance, or deductible at the time of the visit.
  2. In many cases, you will be responsible for a portion of your bill. This amount will be determined by your agreement with your insurance plan. In some cases, you will be responsible for the entire fee (e.g. if you have not met your deductible).
  3. In the event that your health plan determines a service to be "non-covered", we will bill you, and your payment is due upon receipt of that statement. Any amount not covered by your insurance company within 30 days will be billed to you.
  4. If your insurance plan is with a company with which we do not have an agreement, payment is expected in full at the time of service. As a courtesy, we will submit a claim on your behalf to your insurance company.

I have read the above policy and I understand and agree to it.

Patient Signature (or person authorized): _____

Printed Name of Patient: _____ **Date:** _____

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Kryger Institute
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PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I _____, consent to the taking of photographs or videotapes of me or parts of my body, by Dr. Gil and/or Zol Kryger, or his designee, of procedures to be performed by Dr. Gil and/or Zol Kryger. I further consent to the release by Dr. Gil and/or Zol Kryger to the American Society for Aesthetic Plastic Surgery, Inc. ("ASAPS"), the American Society of Plastic Surgery ("ASPS"), and the American Board of Plastic Surgeons ("ABPS") of such photographs, videotapes or case histories.

I understand that such photographs, videotapes or case histories may be published by Dr. Gil and/or Zol Kryger and/or ASAPS, ASPS, ABPS, and/or any part acting under their license and authority in any print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and the doctor's web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation, if I do not revoke this authorization, it will expire twenty (20) years from the date written below.

I understand that I may refuse to sign this authorization and such refusal *will* have no effect on the medical treatment I receive from Dr. Gil and/or Zol Kryger.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because ASAPS, ASPS, and ABPS are not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA and may be re-disclosed by ASAPS ASPS, and/or ABPS.

I release and discharge Dr. Gil and/or Zol Kryger, ASAPS, ASPS, ABPS, and all parties acting under their license and authority from all rights that I may have in the photographs, videotapes or case histories and from any claim that I may have relating to such use in publication, including any claim for payment in connection with the distribution or publication of these materials in any medium.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____

Patient Date

_____ _____

Patient/Guardian (If Applicable) Date

_____ _____

Witness/Physician Date