

## 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**

- Botox
- Chemical Peel
- Fillers (Juvederm, Radiesse, Restylane)

### **Body Contouring**

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

### **Breast - Cosmetic**

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

### **Breast - Reconstructive**

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

### **Ears**

- Ear Pinning
- Earlobe Repair

### **Facial**

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

### **Nasal**

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

### **Skin & Scars**

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

### **Other**

- Complex Hernia Repair
- Pediatric Surgery
- Wound Care
- Lower Extremity Reconstruction
- \_\_\_\_\_

### **Microsurgery**

### **Hand Surgery**

- Carpal Tunnel
- Cyst Removal
- Fracture Repair
- Trigger Finger
- Dupuytren's
- Tendon, Nerve, Blood Vessel Repair
- \_\_\_\_\_

# 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  Separated  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: \_\_\_\_\_

**Referral 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 Patient Health History

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**SOCIAL**

Age: \_\_\_\_\_ Sex: M  F  Married: Y  N  Occupation: \_\_\_\_\_

**HABITS**

Smoke: Y  N  Amount: \_\_\_\_\_ HEIGHT: \_\_\_\_\_  
Alcohol: Y  N  Amount: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

**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 <input type="radio"/> N <input type="radio"/>	Asthma: Y <input type="radio"/> N <input type="radio"/>	Hypertension: Y <input type="radio"/> N <input type="radio"/>
Abnormal Clotting: Y <input type="radio"/> N <input type="radio"/>	Diabetes: Y <input type="radio"/> N <input type="radio"/>	Sleep Apnea: Y <input type="radio"/> N <input type="radio"/>
Acid Regurgitation: Y <input type="radio"/> N <input type="radio"/>	Cancer: Y <input type="radio"/> N <input type="radio"/>	Snoring: Y <input type="radio"/> N <input type="radio"/>
Anemia: Y <input type="radio"/> N <input type="radio"/>	Heart Attack: Y <input type="radio"/> N <input type="radio"/>	Weight Change past 12 Mo.: Y <input type="radio"/> N <input type="radio"/>
Angina: Y <input type="radio"/> N <input type="radio"/>	Hepatitis: Y <input type="radio"/> N <input type="radio"/>	Other Serious Illness: Y <input type="radio"/> N <input type="radio"/>
Psychiatric Treatment: Y <input type="radio"/> N <input type="radio"/>	Infections: Y <input type="radio"/> N <input type="radio"/>	Scarring Problems: Y <input type="radio"/> N <input type="radio"/>

Please describe questions with a "Yes" answer: \_\_\_\_\_

\_\_\_\_\_

**Previous Surgeries:**

**Surgery Date:**

**Surgeon:**

_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Abnormal Bleeding: Y <input type="radio"/> N <input type="radio"/>	Diabetes: Y <input type="radio"/> N <input type="radio"/>	Heart Disease: Y <input type="radio"/> N <input type="radio"/>
Abnormal Clotting: Y <input type="radio"/> N <input type="radio"/>	Anesthetic Problems: Y <input type="radio"/> N <input type="radio"/>	Cancer: Y <input type="radio"/> N <input type="radio"/>

Please describe questions with a "Yes" answer: \_\_\_\_\_

\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

**Referred from (please circle):**

Patient: \_\_\_\_\_  
Internet site: \_\_\_\_\_  
ER: \_\_\_\_\_

Physician: \_\_\_\_\_  
Insurance Co.: \_\_\_\_\_  
Other source \_\_\_\_\_

**Women Only:**

Number of pregnancies: \_\_\_\_\_ Number of children: \_\_\_\_\_

Are you planning more pregnancies? Y  N

\_\_\_\_\_ M.D.



**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: \_\_\_\_\_



### **Our Financial Policy- Cosmetic Surgery**

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 Patient Care Coordinator (PCC) at (805) 777-3877.

The total cost to you for any procedure is comprised of the following: Surgeon's fee; operating room/facility fees; anesthesia fees; any required implants or garments.

**Payment Policy:**

- **Payment in full is expected at the time service is rendered.** 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.
- If you fail to pay us, in full, prior to surgery - we will CANCEL SURGERY. In the event of non-payment for fees charged, we will submit the charge to an outside collections agency and the expenses will be added to your account balance. By signing this agreement, you understand that this will adversely affect your credit rating.
- Financing for cosmetic surgery procedures may be done in select cases. Any payment plan must be approved by our PCC *before* your surgery or procedure.
- **Surgery payment policy:**  
A \$1,000 deposit is due to hold a surgical date (unless otherwise discussed), and the rest of the balance is due is due **1-2 weeks** prior to the surgical date.
- **Rescheduling policy:**  
If you are forced to reschedule your surgery to another date due to an emergency (i.e. illness), then you will not be charged any additional amount.
- **Cancellation policy:**  
If you cancel your procedure more than 14 days prior to your scheduled surgery, there will be no cancellation fees charged. However, if you cancel 8-14 days prior to your surgery, you will be charged 10% of the total bill because it is too late for us to reschedule a different patient. If you cancel your procedure 3-7 days before surgery, you will be charged 50% of the total bill. If you cancel your surgery within 1-2 days prior to the date of surgery, then you will forfeit the entire surgeon's fee (you will be refunded fees paid for the surgery center, the anesthesiologist and any implants).

**Complications and Revisions:**

- Although the need for further unplanned surgery due to complication or revision is extremely uncommon, it is always a possibility. In the event of a complication requiring surgery, there will be no surgeon's fee. However, any supply, operating room, anesthesia or hospital fees will be the responsibility of the patient.
- Be aware that your health insurance may not cover the costs of complications related to cosmetic surgery.
- The costs for any revisions will be your responsibility, unless your surgeon indicates otherwise; in these cases the surgeon's fee will be dropped. However, you must wait 6 months before your surgeon will perform the revision free of charge.

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

Patient Signature (or person authorized): \_\_\_\_\_

Printed Name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**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*



# Kryger Institute of Plastic Surgery

## 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