Pedro M. Soler, M.D.
Cosmetic Plastic Surgery
Face | Breast | Body

PATIENT INFORMATION (INFORMACION DEL PACIENTE)

PLEASE PRINT ALL INFORMATION CLEARLY (FAVOR DE ESCRIBIR TODA INFORMACION CLARAMENTE)

LEGAL Last Name_____ LEGAL First Name _____ MI_____
(*Apellido legal*) (*Nombre legal*) (*Inicial*)

Date of Birth _____ Age_____ Sex_____ Race_____
(*Fecha de Nacimiento*) (*Edad*) (*Sexo*) (*Raza*)

Social Security # _____ Email_____
(*seguro social del paciente*) *Would you like to receive email notifications?* *Yes* ☐ *No* ☐

Profession_____
(*Profeción*)

Please indicate if there is a Nickname you prefer:
_____

Marital Status (Estado Marital):

☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed

How did you hear about us? _____
(*Como supiste de nosotros*) (*please check applicable*)

Web Ad ☐ *Magazine Ad* ☐ *Real Self* ☐ *Newspaper* ☐
Event ☐ *Friend* ☐ *Physician Refer* ☐ *Website* ☐
Social Media ☐ _____

Address _____ City_____ State _____ Zip _____
(*Direccion*) (*Ciudad*) (*Estado*) (*Codigo*)

Home # _____ Cell Phone #_____ Work # _____
(*# de la casa*) (*# de cellular*) (*# del trabajo*)

IF PATIENT IS A CHILD (SI EL PACIENT ES UN NIÑO):

Mother's Name_____ SS# _____ DOB# _____
(*Nombre de la Madre*) (*# de seguro social*) (*Fecha de Nacimiento*)
Father's Name_____ SS# _____ DOB# _____
_ (*Nombre de la Madre*) (*# de seguro social*) (*Fecha de Nacimiento*)

MUST BE FILLED OUT!! PERSON TO NOTIFY IN CASE OF EMERGENCY *(EN CASO DE EMERGENCIA PERSONA A NOTIFICAR)*

Emergency Contact Name _____ Relationship to patient _____
(*Nombre en caso de emergencia*) (*Relación al paciente*)

Phone #_____
(*Teléfono*)

REFERRING PHYSICIAN (MEDICO QUE REFIERE EL CASO)

Name_____ Address _____
(*Nombre*) (*Dirección*)
Phone _____ Fax _____
(*Teléfono*)

By my signature below, I acknowledge the above information provided is true and correct, and understand it is my responsibility to notify the office of any change in my information provided.

Patient's Signature or Legal Guardian: _____
(*Firma*)

ALL ITEMS ON THIS PAGE MUST BE COMPLETED

TODOS LOS ARTÍCULOS DE ESTA PÁGINA DEBEN COMPLETARSE

Pedro M. Soler, M.D.
Cosmetic Plastic Surgery
Face | Breast | Body

Primary Care Physician (Doctor Primario)

Name *(Nombre)* _____

Address *(Dirección)* _____

Phone *(Teléfono)* _____ Fax _____

May we provide the above physicians with a copy of Dr. Soler's office note(s): Yes ☐ No ☐ *If yes, please sign below.*

Podemos enviarles a sus médicos copia de las notas de la oficina de Dr. Soler: ☐ *Si* ☐ *No* *Si podemos, porfavor firme abajo.*

Signature *(Firma)* _____

THIS INFORMATION IS NECESSARY, PLEASE COMPLETE
(ESTA INFORMACIÓN ES NECESARIA, POR FAVOR LLENE)

Insurance Information (Información del Seguro Médico)

Primary Insurance Company _____ Subscriber _____
(Compañia de Seguro Primario) *(Subcripción a Nombre de)*

Subscriber's SS# _____ Subscriber's DOB _____ Relationship to patient _____
(Seguro Social del Asegurado) *(fecha de nacimiento)* *(Relación al Paciente)*

Group#/Name _____ Policy / ID # _____
(Grupo #/Nombre) *(# de polisa o de Identificación)*

IS THIS INFORMATION TRUE AND CORRECT REGARDING YOUR PRIMARY INSURANCE? Yes _____ *(please initial)*
(ESTA INFORMACIÓN ES VERDADERA Y CORRECTA EN LO QUE SE REFIERE NUESTRO PRINCIPAL SEGURO?) *(Iniciales)*

Secondary Insurance Information (Información del Seguro Médico Secundario)

Primary Insurance Company _____ Subscriber _____
(Compañia de Seguro Primario) *(Subcripción a Nombre de)*

Subscriber's SS# _____ Subscriber's DOB _____ Relationship to patient _____
(Seguro Social del Asegurado) *(fecha de nacimiento)* *(Relación al Paciente)*

Group#/Name _____ Policy / ID # _____
(Grupo #/Nombre) *(# de polisa o de Identificación)*

IS THIS INFORMATION TRUE AND CORRECT REGARDING YOUR SECONDARY INSURANCE? Yes _____ *(please initial)*
(ESTA INFORMACIÓN ES RERDADERA Y CORRECTA EN LO QUE SE REFIERE NUESTRO SEGURO SECUNDARIO? *(Iniciales)*

Pedro M. Soler, M.D.
Cosmetic Plastic Surgery
Face | Breast | Body

Agreement to guarantee payment/assign benefits/release information

The undersigned agrees, whether as agent or patient, to accept full responsibility undersigned agrees to pay all charges at time of service or upon receipt of statement. I understand that I am responsible for any costs incurred and the reasonable attorney fees and/or court costs associated with collections. This agreement is valid for the services provided on this date and for all future visits and services until revoked by me.

I authorize third parties to pay directly to the physician's insurance benefits due for services rendered on behalf of the patient.

I authorize the physician to furnish my insurance company and/or other responsible third party payer or their representatives any medical information necessary to process my payment or this claim.

....

PATIENT and/or GUARDIAN DATE

Agreement to guarantee payment for in or out of network/ unauthorized coverage

I understand that the services I am requesting by Dr. Pedro M. Soler on (Date) _____ may be out of network or unauthorized by my health insurance (HMO/PPO/Indemnity/Auto Insurance/Worker's Compensation, etc., coverage). Dr. Soler's office staff does not verify coverage prior to my appointment. Therefore, in the case that my insurance is out of network; or my insurance coverage has lapsed for any reason whatsoever, any/all services rendered by Dr. Soler are not covered, I understand that I will be held solely responsible for all charges.

I also understand that since this possibility exists, any payment(s) made on the part of the insurance company may and/or will be made directly to me. I, in turn, agree to sign over the payment(s) to Dr. Pedro M. Soler. I also understand that I have given the proper insurance information with regard to coordination of benefits. If an overpayment recovery should occur due to incorrect information, I will be held solely responsible for charges.

....

PATIENT and/or GUARDIAN DATE

Pedro M. Soler, M.D.
Cosmetic Plastic Surgery
Face | Breast | Body

Patient's Name:..... Date of Birth: .....

CONSENT FOR IRREVOCABLE NON-ASSIGNMENT (COSMETIC PATIENTS)

I, ... hereby authorize Dr. Pedro M. Soler to provide care for me, as it will be explained to me in the additional consent documents. I understand the procedure(s) I seek are cosmetic in nature, not medically necessary, and therefore would be fraudulent and unethical for Dr. Soler to submit to any insurance company for coverage. I will be fully informed of the financial costs of having Dr. Soler provide surgical care for me and accept those terms. I further understand that Dr. Pedro M. Soler will not accept insurance for this cosmetic procedures(s). My consent to have Dr. Pedro M. Soler provide care and not accept assignment from any insurance company, managed care provider or other coverage source is irrevocable and final. I understand I will be fully responsible for the surgical fees for the surgery I seek.

....
PATIENT/GUARDIAN DATE

CONSENT FOR PHOTOGRAPHY

I further authorize Dr. Soler to use my photographs for professional medical purposes deemed necessary to your insurance carrier for medical necessity or pre-determination letters.

Patient's Name: ..... Date of Birth: .....

.....
SIGNATURE

I further consent my photos to be used for the following purposes: (*please initial your selected consent*)

Medical publications and/or Lay publications. _____

Medical and/or Patient education. _____

During lectures to medical or lay groups for training and learning purposes. _____

Marketing /Education on website and/or Media as appropriate. _____

....
PATIENT SIGNATURE DATE

Pedro M. Soler, M.D.
Cosmetic Plastic Surgery
Face | Breast | Body

HIPPA Compliance Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care,
- A source of information for applying my diagnosis and treatment information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff

I have been provided the opportunity to review the "Notice of Patient Privacy Information Practices" that provides a more complete description of information uses and disclosures. I understand that I have the following rights:

- The right to review the "Notice" prior to acknowledging this consent,
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment, or healthcare operations

Restrictions:

I request the following restrictions to the use or disclosure of my health information:

May discuss treatment, payment or healthcare operation with the following persons:

(Please check all that apply) ☐ Spouse ☐ Your Children ☐ Relatives ☐ Other ☐ Parents

Please list the names and relationships, if you checked "Relatives" or "Others" above:

1. _____ 3. _____

2. _____ 4. _____

Messages or Appointment Reminders: (Please check all that apply)

May we leave a message on your answering machine : at home ☐ or at work ☐ Do not leave a message ☐

May we leave a message with someone at your home using the doctor's name or the practice name: ☐ Yes ☐ No

May we leave a message with someone at your work using the doctor's name or the practice name: ☐ Yes ☐ No

** Messages will be of a non-sensitive nature, such as, Doctors name, appointment time & date.

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers, labs, and/or other individuals or agencies as permitted or required by state or federal law. I further understand that it may become necessary to release my protected health information to financial parties such as banks, credit card and debit card entities or third party financing entities when requested to facilitate payment. I fully understand and accept the information provided and my signature acknowledges my consent to this policy.

_____ _____ _____

Signature | Print name of person signing | Date

*If other than patient is signing, are you the parent, legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations. ☐ Yes ☐ No

For Office Use Only

☐ Patient refused to sign the consent form. (Date)_____ Witnessed by: _____

☐ Restrictions were added by the patient (see restrictions listed above)

☐ "Consent form" received and reviewed by_____ on (date)_____ placed in MR (date)_____

Pedro M. Soler, M.D.
Cosmetic Plastic Surgery
Face | Breast | Body

Name:_____
DOB: _____
Height:_____
Weight: _____
BMI: _____

Please answer ALL questions.

What is your reason for today's visit? _____

When did this problem start? _____

Where is this problem located? _____

What makes this problem worse? _____

Are there any other symptoms associated with this problem? Yes ☐ No ☐ If yes, describe: _____

Please check all that apply

Constitutional
- ☐ Unwanted weight changes
- ☐ Recent fevers
- ☐ Weakness
- ☐ Fatigue
- ☐ Unable to exercise

Eye
- ☐ Wear glasses/contacts
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Recent changes in vision
- ☐ Double vision

Ears, Nose, Mouth, Throat
- ☐ Changes in hearing
- ☐ Ear discharge
- ☐ Ringing of the ears
- ☐ Dizziness
- ☐ Nose bleeds
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Sore gums
- ☐ Bleeding gums

Cardiovascular
- ☐ Chest pain Fast
- ☐ heart rate
- ☐ Palpitations
- ☐ High blood pressure
- ☐ Blood clots in the veins of the legs
- ☐ Pain in the legs when walking

Respiratory
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Blood in sputum
- ☐ Cough
- ☐ Tuberculosis

Gastrointestinal
- ☐ Decreased appetite
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting
- ☐ Blood in stools
- ☐ Rectal bleeding

Genitourinary
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in the urine
- ☐ Testicular pain Wake up during the night to urinate

Musculoskeletal
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Arthritis
- ☐ Gout
- ☐ Backpain

Integumentary
- ☐ Rashes
- ☐ Dry skin
- ☐ Jaundice
- ☐ Bruising
- ☐ Breast tenderness
- ☐ Breast swelling
- ☐ Breast lumps
- ☐ Breast pain Nipple
- ☐ discharge Nipple
- ☐ retraction

Neurological
- ☐ Faintness
- ☐ Blackouts
- ☐
- ☐ Seizures Paralysis
- ☐ Memory loss
- ☐ Tremors

Psychiatric
- ☐ Insomnia
- ☐ Nervousness
- ☐ Depression
- ☐ Mood swings
- ☐ Anxiety
- ☐ Lack of energy

Endocrine
- ☐ Thyroid trouble
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Increased appetite
- ☐ Increased urination
- ☐ Excessive sweating

Other
Cold Sores

Shingles

Mammogram
Last Date Done:

_____

What Facility?

_____

Ever had general anesthesia? ☐ Yes ☐ No *If yes did you have any side effects or reactions?* _____

List previous medical problems:

Medical Problems:	Year Diagnosed:

List past Surgeries

Surgical Procedures:	Year:

Pedro M. Soler, M.D.
Cosmetic Plastic Surgery
Face | Breast | Body

List all medications you are currently taking

Please make sure to include any over the counter medications such as Aspirin or Aspirin products, any Diet pills, St. John's Wart, Ginseng, Ibuprofen, Advil, Motrin, etc.:

Drug	Dose	Frequency

Birth Control Pills ☐ Yes ☐ No Method of Birth Control: _____

How many Pregnancies:_____Live _____

ALLERGIES

Penicillin: ☐ Yes ☐ No Effect/s: _____

Novocain/ Xylocaine: ☐ Yes ☐ No Effect/s:_____

Latex: ☐ Yes ☐ No Effect/s:_____

Other Medications:_____Effect/s: _____

_____ Effect/s: _____

_____ Effect/s: _____

_____ Effect/s: _____

_____ Effect/s: _____

Social History (check all that apply):

☐ Tobacco

If checked, how many packs per day_____, for_____years. If stopped, year stopped _____

☐ Alcohol

If checked, ☐ *socially,* ☐ *binge on weekends*

☐ Coffee, tea ,soda

If checked, How many cups per day_____

☐ Recreational drugs

If checked, Type_____How much_____How often_____How long_____yrs. If stopped, year stopped _____

Pedro M. Soler, M.D.
Cosmetic Plastic Surgery
Face | Breast | Body

Family History (check all that apply):

Paternal: Grandparents

- ☐ Diabetes
- ☐ Cancer (Describe the type of cancer and the year diagnosed)
- ☐ Heart disease
- ☐ Lung disease
- ☐ Arthritis
- ☐ Liver disease
- ☐ High blood pressure
- ☐ High cholesterol or triglycerides
- ☐ Genetic disorder

Father ___Alive (Age ___) __Deceased (Age___)___Unknown

- ☐ Diabetes
- ☐ Cancer (Describe the type of cancer and the year diagnosed)
- ☐ Heart disease
- ☐ Lung disease
- ☐ Arthritis
- ☐ Liver disease
- ☐ High blood pressure
- ☐ High cholesterol or triglycerides
- ☐ Genetic disorder

Maternal: Grandparents

- ☐ Diabetes
- ☐ Cancer (Describe the type of cancer and the year diagnosed)
- ☐ Heart disease
- ☐ Lung disease
- ☐ Arthritis
- ☐ Liver disease
- ☐ High blood pressure
- ☐ High cholesterol or triglycerides
- ☐ Genetic disorder

Mother ___Alive (Age ___) __Deceased (Age___)_____Unknown

- ☐ Diabetes
- ☐ Cancer (Describe the type of cancer and the year diagnosed)
- ☐ Heart disease
- ☐ Lung disease
- ☐ Arthritis
- ☐ Liver disease
- ☐ High blood pressure
- ☐ High cholesterol or triglycerides
- ☐ Genetic disorder

Brothers:

- ☐ Diabetes
- ☐ Cancer (Describe the type of cancer and the year diagnosed)
- ☐ Heart disease
- ☐ Lung disease
- ☐ Arthritis
- ☐ Liver disease
- ☐ High blood pressure
- ☐ High cholesterol or triglycerides
- ☐ Genetic disorder

Sisters:

- ☐ Diabetes
- ☐ Cancer (Describe the type of cancer and the year diagnosed)
- ☐ Heart disease
- ☐ Lung disease
- ☐ Arthritis
- ☐ Liver disease
- ☐ High blood pressure
- ☐ High cholesterol or triglycerides
- ☐ Genetic disorder

Children:

- ☐ Diabetes
- ☐ Cancer (Describe the type of cancer and the year diagnosed)
- ☐ Heart disease
- ☐ Lung disease
- ☐ Arthritis
- ☐ Liver disease
- ☐ High blood pressure
- ☐ High cholesterol or triglycerides
- ☐ Genetic disorder

Print Name: ..... Date of Birth : .....

Patient Signature_____ Date_____

Physician's Signature_____ Date_____

Pedro M. Soler, M.D.
Cosmetic Plastic Surgery
Face | Breast | Body

*** PLEASE READ THIS LEGALLY-BINDING DOCUMENT CAREFULLY ***

DOCTOR/PATIENT ARBITRATION AGREEMENT

This Doctor/Patient Arbitration Agreement (the "Agreement") is made between Pedro M. Soler, M.D., on behalf of the company and its officers, directors, principals, agents, and employees, all collectively referred to hereinafter as "Doctor" and _____ referred to hereinafter as "you" or "the Patient." It is the intention of the parties to this Agreement that it binds themselves, and also their heirs, personal representatives, guardians, children, spouses or any person deriving their claims through or on behalf of the Patient.

It is understood by you, the Patient, that you are not required to use the professional services of Pedro M. Soler, M.D., or any of Dr. Soler's staff or those referred to in this Agreement as "Doctor" for the performance of general surgery, plastic surgery, reconstructive surgery and/or related medical procedures and services. It is also acknowledged by you, the Patient, that there are numerous other physicians in the Tampa Bay area who are qualified to perform general surgery, plastic surgery, reconstructive surgery, cosmetic surgery and/or related medical procedures and services.

For and in consideration of the mutual benefits flowing between the parties pursuant to this Agreement, it is understood and agreed that in the event of any controversy, dispute or claim which might arise between Doctor and you the Patient, in connection with medical procedures or services performed by Doctor for you the Patient, regardless of whether the dispute concerns the medical care rendered, or payment of surgical or other fees, or any other matter whatsoever, the dispute shall be resolved by arbitration as provided in the Florida Arbitration Code, Chapter 682, Laws of Florida. **IT IS UNDERSTOOD THAT THIS ARBITRATION SHALL BE IN LIEU OF ANY INSTEAD OF ANY TRIAL BY JUDGE OR JURY.** Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. All the arbitrators shall be licensed physicians who are members in good standing of the American Society of Plastic Surgeons, certified by the American Board of Plastic Surgery, and actively engaged in the practice of plastic and reconstructive surgery in the State of Florida. The panel of arbitrators shall hear and decide all aspects of any controversy, dispute or claim between the parties to this Agreement, and their decision shall be binding on all parties.

It is further understood and agreed by Doctor and you the Patient that the arbitration of any controversy, dispute or claim pursuant to this Agreement shall be commenced within the time prescribed by the applicable Florida Statute of Limitations. An action pursuant to this Agreement shall be deemed to commence upon the receipt of a written claim notifying the Doctor or Patient, whichever the case may be, of the nature of the controversy, dispute or claim, and demanding that the parties proceed with arbitration in accordance with the terms of this Agreement.

In the event of a final arbitration decision based on you the Patient's failure to pay for medical services rendered by Doctor, you the Patient expressly agree that any arbitration award in favor of Doctor shall include pre-award interest calculated at the rate of one and one-half percent (1.5%) per month of the total principal amount awarded for each month unpaid from the date of initial invoice until the date of the arbitration award, regardless of any differential between the invoice and award amounts. The parties further agree that any final judgment may be submitted for enforcement to a state or federal court of competent jurisdiction located in Tampa, Florida, and to that end both Doctor and you the Patient expressly consent to the personal jurisdiction of said court for such purposes.

In witness whereof, we have signed in agreement below on this _____ day of _____, 202__.

"Doctor" **"Patient"**

By:_____ By:_____
Authorized Agent Patient

Witness:_____

Witness:_____

Pedro M. Soler, M.D.
Cosmetic Plastic Surgery
Face | Breast | Body

Financial Policy

We believe that transparency in our financial policies is essential to a good doctor patient relationship, so we have created this financial policy.

Cosmetic Consultation: Cosmetic surgery is elective and not covered by your health insurance. If during the course of this consultation it is determined that your desired procedure could be classified as medically necessary by your insurance carrier you have the option to seek medical preapproval for this service.

Fees for cosmetic surgery

Surgery Scheduling Policy: After your consultation (either in person or a virtual consultation) you may decide on a procedure(s) and a surgery day and time. This requires a nonrefundable deposit of $500-$1500 determined by your total procedure fees and is due at the time of scheduling. The remainder of your balance is due in full no less than THREE (3) Weeks prior to your surgery date.

Surgery Quotes: You will be provided with a detailed surgery quote on the day of your consultation. The quoted fee is non-negotiable,and the quoted amount is effective for a period of thirty (30) days.

The quoted fee includes the surgeon's fee,garment fee, implant fee(if applicable), operating room facility fees and anesthesia fees.

Your quote does not include medical clearance charges, medications or labs needed for surgery.

Late Fee: At your preoperative visit you will be given an expected time of arrival for your surgery. A 15 minute grace period will be granted. If you arrive past the grace period, you may be charged a non-refundable $500 late fee. If you elect not to pay the late fee your surgery will be canceled and NO REFUND will be issued. The operating room can choose to cancel your case if you are more than 30 minutes late and your total surgery fee including the scheduling deposit is nonrefundable.

If the patient's surgery is financed by a third-party financial provider, the terms and conditions of the financing agreement, including interest rates, are at the sole discretion of the third party financial provider. In such cases, the financing agreement is binding exclusively between the patient and the third-party financial provider.

Rescheduling Fee: In the event that you need to reschedule your surgery, you must give a minimum of 14 days/2 weeks' notice prior to your scheduled surgery date. If you reschedule your surgery date without giving a minimum 14 days' notice, a nonrefundable $500 fee will be collected upon rescheduling your surgery.

Cancellation of Surgery: A nonrefundable deposit (as outlined above) will be collected at the time you schedule your surgery. This scheduling deposit is a reservation fee and will be applied towards your surgery balance. Final payment is required (14) days prior to your scheduled surgery date. Failure to make this payment on time will cause for cancellation of your surgery. Failure to have your medical clearance completed and in our office 14 days prior to your surgery date will cause for cancellation of your surgery. No refunds will be issued.

If you choose to cancel your surgery for any reason with less than a 14 business day notice from your scheduled surgery date, (unless you are not cleared for surgery by a Physician and cannot reschedule), you will be eligible to receive a refund of any of the money you have put toward your surgery, minus the non-refundable deposit as follows:

Financial Policy

Cancellation Of Surgery Cont'd:

*Cancellation 8-14 days prior to the scheduled surgery date will result in 25% loss of fees paid

*Cancellation 2 - 7 days prior to the scheduled surgery date will result in 50% loss of fees paid

*Cancellation 0 -1 days prior to the scheduled surgery date will result in 100% loss of fees paid

While this may appear to be a charge for services which were not provided, this fee is necessary to reserve time in the OR and in the practice, which are done when you schedule.

If your surgery is canceled or rescheduled because of an approved medically acceptable reason, submitted in writing by a consulting physician and acceptable to the practice, ***before 14 days of the scheduled surgery, you may be entitled a refund***. If your medical clearance arrives to our office late, requiring cancellation or rescheduling, **within 14 days** of your surgery, you will not be entitled to any refund.

We reserve the right to refuse plastic surgery services for any reason including but not limited to if we deem the patient not physically or mentally healthy enough for such services.

Insurance: The expenses connected with cosmetic surgery are not covered by medical insurance. Occasionally cosmetic surgery is done in conjunction with a procedure designed to improve function or is reconstructive in nature. In these cases, your health insurance *may* cover part or all of the incurred expenses.

Although we are happy to assist you with your application for any reasonable insurance coverage, we cannot ethically, and will not, fill out any forms in such a way as to disguise the true purpose of any cosmetic procedures you wish to have done. Furthermore, even in cases that are clearly functional or reconstructive in my opinion, I cannot guarantee that your particular insurance company will agree with my findings and cover your procedure.

If your insurance company declines any of the fees associated with our services to you, even those billed as medically necessary but which were declined by your insurer as being cosmetic, medically unnecessary or an uncovered preexisting condition, you, the patient, are ultimately responsible for all charges incurred. You should consult the terms of your own benefit plan to determine if there is any exclusion or other benefit limitations applicable to the procedure of interest. In this manner, you can ensure all necessary requirements for coverage are known and met.

Treatment and Complications: The practice of medicine and surgery is not an exact science. Although good results are anticipated, there can be no guarantee or warranty, expressed or implied, by anyone as to your results. Surgical revisions and/or other medical treatment or management of problems and/or complications may be required. These will result in additional charges for which you are responsible.

Patient Agreement: I have read and understand the above Financial Policy. I have had the opportunity to address questions about this Policy, and all my questions have been answered to my satisfaction. I agree to be bound by the terms of this Policy. I further agree that, if I default on any obligations under this Policy, I will be responsible for attorney fees, court costs, prejudgment interest allowed by law, and expenses of collection.
No matter the payment method, this agreement is binding

Patient Name: _____ Date: _____

Patient Signature: _____

Pedro M. Soler, M.D.
Cosmetic Plastic Surgery
Face | Breast | Body

At Soler Cosmetic Plastic Surgery our patients are the center of all that we do. Our physician, Dr. Soler and his team are committed to providing the highest quality care during all stages of your treatment. With this in mind, we want to share our process for completing Disability and FMLA Forms.

Our policy regarding completion of all forms is as follows:

Forms and signed authorization to release medical information may be delivered directly to the office. Please turn in your paperwork directly to the front desk. Do not give the paperwork to your doctor, as this can cause a delay in completion.

Please provide the office with your preferred method of distribution once the forms are completed. ie. Pick up in office, mail or fax to you or the company requesting the information.

The cost for completion of the below forms are as follows and payment is due when forms are left for completion. This is payable by check, cash or credit card.

Disability Form $25.00
Family Medical Leave Act (FMLA) $25.00
Special letters done by Physician $25.00

The patient information portion of the form must be completed prior to processing. Any re-submission of the forms will be an addition $25.00.

Once we receive your forms(s) and your signed authorization to release your medical information, please allow 5 to 7 business days for processing of the form.

All completed forms will be mailed or faxed to the disability carrier/employer as indicated by the patient or may be picked up at our office.

By law, we are required to have a signed authorization from all patients prior to disclosure of their medical information to any outside source. Most disability or FMLA forms include an authorization to disclose information page or paragraph to be signed by the patient. If your paperwork contains this, please be sure to carefully read and complete that section by signing and dating where indicated.

If your forms do not include and authorization page or section you will be required to sign our office authorization form prior to completion or release of these forms to anyone, including you. Please note this includes FMLA for your spouse or relatives as well. We must have an authorization from the patient before any medical information will be given.

_____ _____

Patient Signature Date