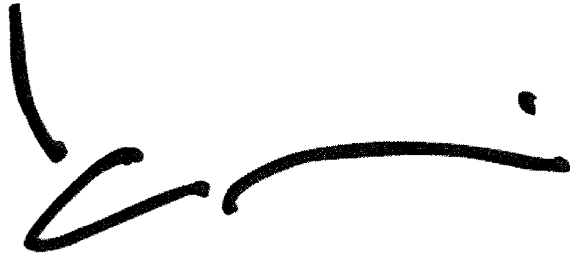


How did you hear about out office? *(please circle):* **Google Search** **Website**

Facebook **Review Site** **TV** **Word of Mouth** **Friend** **Doctor**

Who may we thank for your referral? ____________________

Would you be interested in financing any of your cosmetic procedure(s)? ________

Reason for visit ____________________

____

Patient Name: ____________________
(First) (Middle) (Last)

Address: ____________________

City: ______________ State: ________ Zip Code: ____________

Telephone: Home # ______________ Work # ______________

Mobile # ______________ May we contact you by text message? YES or NO

Email: ______________ May we contact you by Email? YES or NO

Birth Date: ___________ Age: _____ Social Security: ______________

Emergency Contact: ______________ Relationship: ___________

Mobile # ______________ Home or Work # ______________

The above information provided is true to the best of my knowledge.
I understand that I am responsible for the payment of all services rendered.

Signature ____________________ Date ___________

FINANCIAL POLICY

Welcome to the Center of Plastic Surgery. We are committed to providing you with the highest quality of physician and professional service. A clear understanding of our financial policy is important to our professional relationship. Should you have any questions regarding this financial policy, please ask our patient care coordinator for any clarification that you may need.

- **Full payment is due at time of service.** We accept cash, checks, Visa, MasterCard, Discover, American Express, and Care Credit.
- When surgical procedures are scheduled, surgical fees will be discussed privately between you and our patient care coordinator. Surgical fees will be collected on the day of your pre-operative appointment.
- Dr. Bonaldi is not a provider for any health care insurance. Our services are not covered under Medicare and no Medicare payment may be made to any entity for your services, directly or on a capitated basis. You will have an opportunity to speak with our patient care coordinator regarding our insurance policies.
- As with any cosmetic treatment, there are no guaranteed results and no refunds.
- If you are 15 or more minutes late for your appointment you may be rescheduled and incur a $50 rescheduling fee.
- It is the policy of this facility to enforce a $50 fee for no shows or cancellations without 24 hours notice prior to the scheduled appointment time. The fee will be automatically billed to your credit card account. If you do not have a credit card, the fee will be automatically billed to you.
  Credit Card Number: ______________________________
  Credit Card Expiration (MM/YYYY): ______________________
  Credit Card Holder's Signature: ________________________

I have read, understand and agree to the provisions of this financial policy. I understand and agree I am ultimately responsible for charges for my financial account for all professional services rendered.

Signed______________________________ Date____________________

LOUIS A. BONALDI M.D. F.A.C.S.
center for plastic surgery

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name (Print)____

Signature ________________________________ Date_________

6630 South McCarran Blvd., B20 • Reno, Nevada 89509
Phone: 775.828.7400 • Fax: 775.828.7449 • www.bonaldimd.com

LOUIS A. BONALDI M.D. F.A.C.S.

center for plastic surgery

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Nevada law, and not by a lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are voluntarily giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

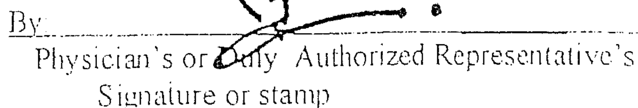
Article 2: **All Claims Must Be Arbitrated**: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A notice or demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator to preside over the matter who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Nevada Revised Statutes (NRS) 38.206 – 38.248, 41A.035, .045, .097, .100, .110, .120, 42.005 and .021 and the Federal Arbitration Act (9 U.S.C. §§ 1-4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the arbitrator's fees and expenses, and hereby waive the provisions of NRS 38.238.

Article 4: **Severability Provision**: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with Nevada and federal law.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: 
Physician's or Duly Authorized Representative's Signature or stamp

By: ______________________
Patient's Signature - print name - Date
If not signed by patient, person who signs on Patient's behalf to indicate his/her relationship thereto

LOUIS A. BONALDI M.D. F.A.C.S.
center for plastic surgery

NAME: ______________________ DATE __________

HEIGHT __________

DATE OF LAST PHYSICAL __________

WEIGHT __________

LIST ALL DRUG AND FOOD ALLERGIES ______________________

ARE YOU ALLERGIC OR SENSITIVE TO LATEX? __________

LIST ALL MEDICATIONS (*INCLUDE OVER THE COUNTER AND HOMEOPATHIC MEDICINES*)

	MEDICINE	DOSE	HOW OFTEN
1.			
2.			
3.			
4.			
5.			

WHAT IS YOUR AVERAGE DAILY CONSUMPTION OF

TOBACCO __________ packs per day ALCOHOL __________

DO YOU SUSPECT THAT YOU MAY BE PREGNANT? __________

DATE OF LAST MAMMOGRAM __________

LIST ALL OPERATIONS YOU HAVE HAD

	SURGERY	YEAR	SURGEON
1.			
2.			
3.			
4.			

HAVE YOU BEEN HOSPITALIZED? ______________________

HAVE YOU OR ANY OF YOUR RELATIVES HAD A PROBLEM WITH ANESTHESIA? ______________________

LIST ANY FAMILY HISTORY OF SIGNIFICANT ILLNESS (*blood clots, diabetes, heart disease, melanoma, malignant hyperthermia, cancer*)

____

PLEASE ELABORATE ON ANY MEDICAL INFORMATION THAT MIGHT BE HELPFUL TO US

____

____

____

____

DO YOU OR HAVE YOU EVER HAD:

YES	NO	
☐	☐	High Blood pressure
☐	☐	Stroke
☐	☐	Heart Attack
☐	☐	Irregular Heart Beats
☐	☐	Blood Clots
☐	☐	Rheumatic Fever
☐	☐	Chest Pain
☐	☐	Heart Murmur
☐	☐	Shortness of Breath
☐	☐	Asthma/Emphesema/wheezing
☐	☐	Cough
☐	☐	Back or Neck Injuries
☐	☐	Injuries or Fracutures:
☐	☐	Swollen Glands
☐	☐	Frequent Ear Problems
☐	☐	Frequent Nasal Problems
☐	☐	Skin Problems requiring Meds
☐	☐	Breast Lumps
☐	☐	Recent Weight Gain/Loss Amount__________

YES	NO	
☐	☐	Bleeding Tendencies
☐	☐	Anemia
☐	☐	AIDS/HIV
☐	☐	Transfusions
☐	☐	Diabetes
☐	☐	Thyroid Problems
☐	☐	Hepatitis/Jaundice
☐	☐	Kidney Disease
☐	☐	Stomach Ulcers
☐	☐	Abdominal Pain
☐	☐	Pancreatitis
☐	☐	Seizures
☐	☐	Dizziness/Fainting
☐	☐	Glasses/Contacts
☐	☐	Visual Impairments/Dry Eye
☐	☐	Cataracts
☐	☐	Mental Illness
☐	☐	Hysterectomy
☐	☐	Other

If you have answered "YES" to any of the following questions please explain in detail below:

____

____

____

____

____

____

____

LABORATORY TESTS
(Date & Location)

Yes	No	
☐	☐	Blood Tests ______________________________
☐	☐	EKG (cardiogram) ______________________________
☐	☐	Chest X-Ray/MRI/CT ______________________________
☐	☐	Other Lab ______________________________

I CERTIFY THAT I HAVE DISCLOSED MY MEDICAL HISTORY TO THE BEST OF MY KNOWLEDGE

______________________________ ______________________

Signature Date