***** FACE COVERINGS ARE CURRENTLY OPTIONAL *****

MOREA
PLASTIC SURGICAL CENTER
(919) 845-7880 of North Raleigh

PATIENT INFORMATION: Reason for today's visit_____

HOW DID YOU HEAR ABOUT OUR OFFICE? ☐ **RealSelf** ☐ **Google** **Referred By: _____**

NAME:_____
FIRST MIDDLE LAST

ADDRESS:_____
NUMBER STREET CITY STATE ZIP

SSN: _____ DOB: _____ AGE: _____

MOBILE #: _____ EMAIL ADDRESS: _____

I give permission for Dr. Morea and staff of Morea Plastic Surgical Center to leave and/or send messages to voice mail, mobile text or email (without encryption) regarding my upcoming appointments and/or medical status. ☐ Yes ☐ No

SEX: ☐ F ☐ M MARITAL STATUS: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

EMPLOYER:_____ OCCUPATION:_____

SPOUSE NAME:_____ SPOUSE EMPLOYER:_____

I assume full responsibility for any treatment or procedure(s) rendered to me or to my dependent.

_____ _____
DATE SIGNATURE of patient, parent, or guardian

PHARMACY NAME & ADDRESS _____ PHONE _____

_____

EMERGENCY CONTACT:

Name: _____ Relationship to Patient: _____

MOBILE #: _____ ALTERNATE #: _____

Family Medical History: (Diabetes, Heart disease, Hearing Loss, etc.) Please indicate conditions below:

_____

_____

MEDICAL HISTORY

Height _____Weight _____ # of Children _____ Have you ever breastfed? _____

Do you consume alcohol?	YES	NO	How many drinks per week? _____
Do you consume caffeine?	YES	NO	Daily intake? _____
Do you use tobacco and/or vape?	YES	NO	Times per day _____ other ____#of years___
Allergies to any medications?	YES	NO	Please list: _____
Are you currently taking any medication?	YES	NO	Please list: _____
Do you take Aspirin, Ibuprofen, Anacin, Motrin?	YES	NO	Please list: _____
Are you allergic to any local anesthetics?	YES	NO	Please list: _____
Are you allergic to tape, soaps, solutions, etc.?	YES	NO	
Are you allergic to latex?	YES	NO	
Have you had previous allergy treatment?	YES	NO	
Have you ever had a problem w/anesthesia or surgery?	YES	NO	

Have you been vaccinated for COVID-19? YES NO If so, which vaccine? _____

Please list all previous surgeries/operations:

_____

_____

Do you or have you ever had a history of the following:

	YES	IN THE PAST	NO
Hearing Loss	☐	☐	☐
Psychiatric problems	☐	☐	☐
Heart attack, angina, chest pain	☐	☐	☐
Blood Pressure Problems	☐	☐	☐
Cardiac pacemaker	☐	☐	☐
Back problems, (numbness, or weakness in arms or legs)	☐	☐	☐
Hepatitis or yellow jaundice	☐	☐	☐
Cancer	☐	☐	☐
Kidney disease, stones cystitis	☐	☐	☐
Diabetes	☐	☐	☐
Thyroid disease or goiter	☐	☐	☐
Anemia or low blood	☐	☐	☐
Asthma, bronchitis, pneumonia	☐	☐	☐
Abnormal chest x-ray or difficulty breathing	☐	☐	☐
HIV/AIDS	☐	☐	☐
Frequent headaches	☐	☐	☐
Arthritis	☐	☐	☐
Ulcers	☐	☐	☐
Skin problems	☐	☐	☐
Excessive bleeding when cut	☐	☐	☐
Bruises easily	☐	☐	☐
Slow wound healing	☐	☐	☐
Keloids or excessive scarring	☐	☐	☐
Skin cancer	☐	☐	☐
Hives or allergic skin reaction	☐	☐	☐
VARICOSE VEINS	☐	☐	☐

I certify that the above information is accurate and correct to the best of my knowledge and I have not withheld information concerning my medical history.

_____ _____

SIGNATURE of patient, parent, or guardian Date

MOREA PLASTIC SURGICAL CENTER of North Raleigh
(919) 845-7880

Cosmetic Surgery Policy Information for Patients

The Plastic Surgical Center of North Raleigh is accredited by the American Association of Ambulatory Surgical Centers. Most cosmetic surgeries can be performed here.

There is a **$200.00** fee (unless you are an established patient) for cosmetic surgery consultations. This fee is due at the time of your consultation. We will apply that amount to your surgery fee if you elect to have surgery. Should you wish to schedule a procedure, we require a deposit in the amount of **$500.00** in order to post your procedure on the OR schedule. This deposit is **not refundable** if you cancel your surgery.

The balance of the surgery fee is due **2 weeks prior** to your surgery date. We require **7** business days' notice of cancellation. If less than this time frame is given, a cancellation fee of $1000 will be charged. Any other money you have paid will be returned to you.

If you would like to finance your surgery, please ask an office staff member to provide you with the information at your consultation. We also accept cash, cashier or certified checks, and most major credit cards.

On the day of your surgery, you **must** arrange for someone to drive you home and stay with you for at least the first day.

We do not accept and/or file insurance for any cosmetic surgery procedure. Dr. Morea is completely out of network.

We do not release your medical information, with the exception of post-surgical requirements related to pharmacy needs, unless you complete a signed medical release form.

We cannot be responsible for items left at our office. Please do not bring valuables with you on the day of your surgery.

I have read and understand the above policies:

____ ______________________________

Signature of Patient, Parent or Guardian Date

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Insurance Coverage Policies

Unfortunately, we are **out of network** with all insurance companies. If you choose to have a procedure at this facility, we do not accept insurance and you are responsible for the payment in full two weeks prior to your surgery date. You can always file a claim yourself, if there is a possibility of insurance coverage for any or all of your surgery/procedure. However, because we do not file insurance, we can only provide ICD-10/CPT coding and a receipt for services. Each quote is individual to each patient; therefore, we are unable to give you an itemized statement.

I have read and understand the above policies:

____ ______________________________

Signature of Patient, Parent or Guardian Date
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COVID-19 INFORMED CONSENT AGREEMENT

PLEASE INITIAL ALL BOXES BELOW

☐ I, the undersigned patient, consent to an in-person consultation and/or to have my Doctor and/or his/her staff (hereinafter collectively "my Doctor") perform medical procedures, whether regarded as necessary, elective or aesthetic, during the time of the COVID-19 pandemic and after. I understand in-person consultations and/or having my procedure performed at this time, despite my own efforts and those of my Doctor, may increase the risk of my exposure to COVID-19. I am aware that exposure to COVID-19 can result in severe illness, intensive therapies, extended intubation and/or ventilator support, life-altering changes to my health, and even death. I am also aware of the possibility that the procedure itself, whether performed in my Doctor's office or in a hospital, may result in a more severe case of COVID-19 than I might have had without the procedure.

☐ I also understand in-person consultations and/or having my procedure performed at this time increases the risk of my transmission of COVID-19 to my Doctor. This virus has a long incubation period, there may be as yet unknown aspects of its transmission, and I realize that I may be contagious, whether or not I have been tested or have symptoms. To reduce the possibility of COVID-19 exposure or transmission at my Doctor's office, I accept that my Doctor will implement infection-control procedures with which I must comply, before, during and after my consultation and/or procedure, for my own protection as well as that of my Doctor. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures are necessary.

☐ I have informed my Doctor of any COVID-19 testing I or any person living with me during the past 14 days has received, as well as the results of that testing, and if I am tested between now and the date of my procedure, I will immediately provide the results of that testing to my Doctor. I understand my Doctor may require that I be tested, possibly at my own expense and regardless of any prior testing, and that the results of that testing must be satisfactory to my Doctor, before I may receive my procedure.

☐ I confirm neither I nor any individual living with me has any of the COVID-19 symptoms listed by the Centers for Disease Control https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf, which website I have consulted; neither I nor any individual living with me during the past 14 days has experienced any such symptoms; and that I and all persons living with me for the past 14 days have practiced all personal hygiene, social distancing and other COVID-19 recommendations contained within all governmental orders issued by my city and state. I understand I must honestly disclose this information to avoid putting myself and others at risk.

☐ All topics above have been discussed with me, and all my questions have been answered to my satisfaction. Being fully informed, I accept the risk of COVID-19 exposure and I will bear the cost of any COVID-19 treatments required. I have been given the opportunity to postpone my in-person consultation and/or procedure until the COVID-19 pandemic is less prevalent, but I choose to have my in-person consultation and/or procedure performed now. If I am the parent, guardian or conservator of the patient, I hold his/her health care power of attorney. I have read this COVID-19 Informed Consent Agreement and am authorized to consent on the patient's behalf.

☐ _____ _____

Patient/Authorized Representative Signature and Initials Print Name & Date **[Day of Appointment]**

The Aesthetic Society

Notice and Disclaimer. Medical information changes constantly. This COVID-19 Informed Consent Agreement sets forth the current recommendations of The Aesthetic Society, is provided for informational purposes only, and does not establish a new standard of care. April 28, 2020