OREGON
PLASTIC
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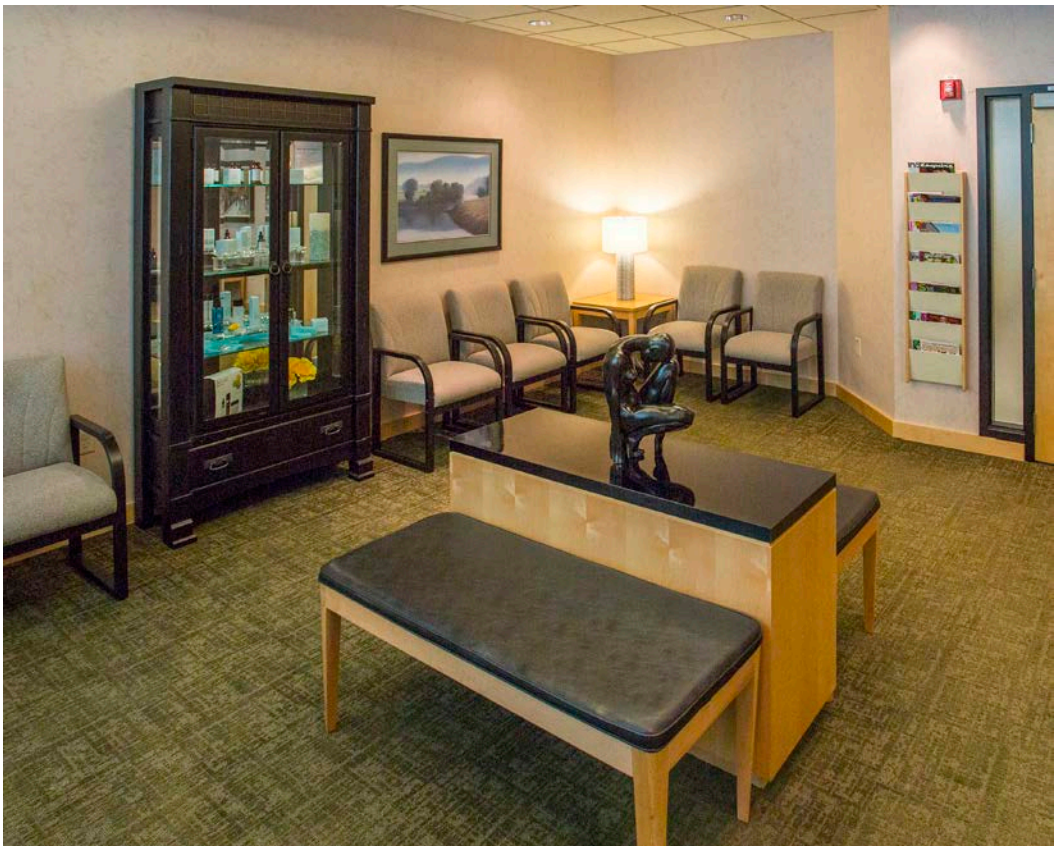
WELCOME



Welcome to Oregon Plastic Surgeons, the offices of Edwin Austin MD, Katie Yonker MD, and R. Jessie Edwards RN, MN, FNP-BC. We are pleased you have chosen our office as you consider your reconstructive and plastic surgery options.

You will find that we are dedicated to the highest possible standards of personalized care and to the continuing advancement of our professional skills and knowledge. We make every attempt to treat you with the utmost respect and compassion, while ensuring your care is private and customized to your particular needs.

Edwin N. Austin, MD
Katie E. Yonker, MD

875 Oak Street SE
Suite 4060
Salem, OR 97301

O | 503.561.7000
F | 503.375.2646

oregonplasticsurgeons.com

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Our Address:

Salem Hospital Campus
Building "C", 4th Floor
875 Oak Street SE, Suite 4060
Salem, Oregon 97301

Phone # 503.561.7000

Our office is conveniently located on the Salem Hospital campus on the fourth floor of Building "C" across from the Salem Hospital Critical Care Tower Building "A". See directions and campus map on following pages.

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SALEM HOSPITAL CAMPUS
BUILDING "C" PARKING

While Salem Hospital is making improvements to the campus, please take note of the following changes to parking and navigation at Salem Health. Vehicle access to the Oak Street turnaround is extremely limited. Please review the directions below.

If you have an appointment in Building C

- Enter the Building C parking garage on Winter Street. The valet service will direct you forward.
- Your valet ticket stub will have the number for a text message system to retrieve your car. If you don't wish to text, you can simply present your ticket to the valet.
- If you would rather self-park, the parking structure on Capitol Street is open for patient parking on the first and second floors.

If you are visiting a patient in Building C

- Park in the parking garage on Capitol Street on the first or second floor.
- Take the stairs or elevator to the ground level.
- Follow the signs and enter the building.

Indoor route

- Walk toward the main lobby and turn left to continue through the lobby to the escalators on the west side of the building.
- Take the escalators or elevator up one floor and cross the sky bridge to enter Building C.
- You will be in the surgery lobby. There are elevators, stairs, and a directory that will lead you to your destination.

Outdoor route

- Walk toward the main lobby and exit through the front door.
- Turn left and walk down the sidewalk toward the Building C entrance.
- Enter Building C and check in at the registration desk or find your destination on the directory next to the elevators.

To Learn More

Salemhealth.org/campus-improvements

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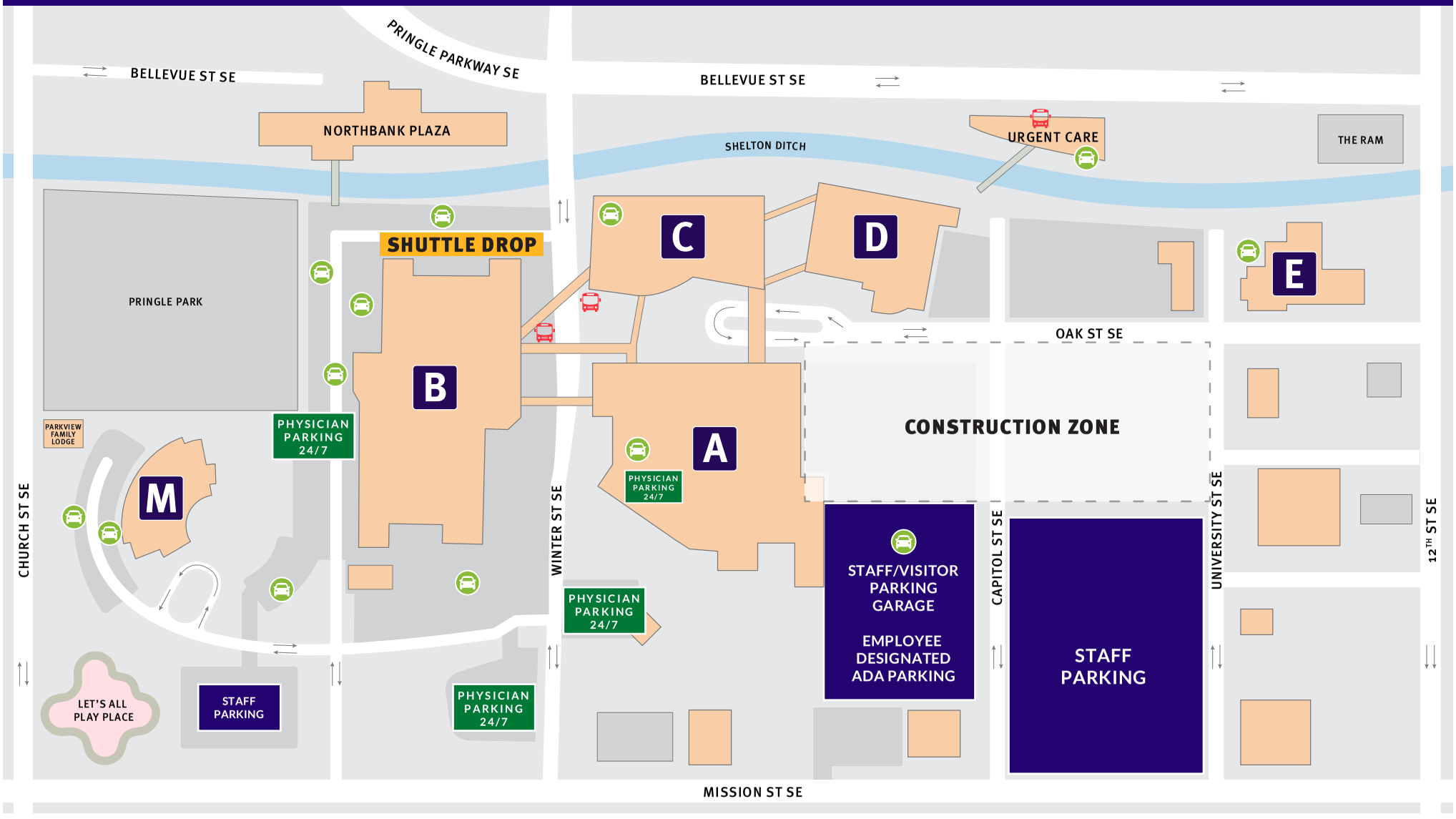
CAMPUS MAP



A Building A **B** Building B **C** Building C **D** Building D **E** Building E **M** Building M

N

Staff parking
(Three locations – follow your group assignment)

Physician parking

Patient/visitor parking

City bus stop

Questions?
Parking and Transportation department
503-814-7275

Salem Health® Hospitals & Clinics

426350

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FINANCIAL POLICY

Insurance Coverage:

- The benefits paid by insurance companies for reconstructive surgery vary greatly. Your insurance benefits and co-payments are set by your insurance company and your specific plan. Providing a copy of your current insurance coverage, and advising of any changes in your plan will allow our office to obtain prior authorization for procedures performed.

- We make every effort to determine in advance of your procedure if your insurance plan provides coverage. If your policy does provide coverage, we calculate the estimated insurance payment and your projected balance due prior to the procedure.

Cancellation Policy:

- We understand that a situation may arise that could cause you to postpone an appointment. Please contact our office within 48 hours of your appointment time to reschedule.

- If you have missed an appointment and chose to reschedule, we will ask for a credit card to hold your next appointment time. A fee of $25 will be charged to the credit card for a second no show.

Date:_____ Signature of Patient in Agreement:_____

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DATE ___/___/___

Office: 503.561.7000
875 OAK ST. SE, STE 4060 | SALEM, OR 97301

OREGON PLASTIC SURGEONS

REFERRED BY

PRIMARY CARE PHYSICIAN

PATIENT INFORMATION

GENERAL INFORMATION

PATIENT'S FIRST NAME	MIDDLE INITIAL	LAST NAME	BIRTHDATE ___/___/___
PATIENT'S ADDRESS (IF MAILING ADDRESS IS PO BOX, STREET ADDRESS REQUIRED ALSO)			SEX M F / AGE / ❑S ❑D ❑DP ❑M ❑W
CITY	STATE		ZIP CODE
HOME PHONE	CELL PHONE	WORK PHONE	
PREFERRED DAYTIME NUMBER (CIRCLE ONE) HOME CELL WORK	Oregon Drivers License #	PATIENT'S SOCIAL SECURITY NUMBER	
PATIENT'S EMPLOYER	OCCUPATION	PATIENT'S EMAIL ADDRESS OK TO CONTACT WITH PROMOTIONS? ☐ YES ☐ NO	

SPOUSE, GUARDIAN OR RESPONSIBLE PARTY INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME	BIRTHDATE ___/___/___	RELATIONSHIP TO PATIENT
EMPLOYER			SPOUSE'S SOCIAL SECURITY NUMBER	
HOME PHONE NUMBER	CELL PHONE NUMBER		WORK PHONE NUMBER	

NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU (ALTERNATE CONTACT REQUIRED)

NAME	RELATIONSHIP	PHONE NUMBER

INSURANCE

PRIMARY HEALTH INSURANCE

INSURANCE CO.			SUBSCRIBER
CLAIM BILLING ADDRESS			EMPLOYER
INSURANCE PHONE NUMBER	GROUP #	I.D. #	PRE-AUTH REQUIRED ☐ YES ☐ NO

SECONDARY HEALTH INSURANCE

INSURANCE CO.			SUBSCRIBER
CLAIM BILLING ADDRESS			EMPLOYER
INSURANCE PHONE NUMBER	GROUP #	I.D. #	

ACCIDENT

COMPLETE SECTION BELOW IF THIS IS AN ON-THE-JOB INJURY, AUTOMOBILE, OR HOUSEHOLD ACCIDENT		INS. CARRIER
HOW DID INJURY OCCUR?		CLAIM NUMBER
DATE OF INJURY	IF UNABLE TO WORK, DATE LAST WORKED	ADJUSTER'S NAME
WHERE DID INJURY OCCUR? ❑ AT WORK ❑ AT HOME ❑ OTHER: EXPLAIN		ADJUSTER'S PHONE NUMBER
PREVIOUS DOCTORS SEEN FOR THIS INJURY		CLAIMS ADDRESS

Assignment and release: I hereby assign my insurance benefits to be paid directly to my treating physician. I understand that I am financially responsible for non-covered services. I authorize my treating physician to release any information required to process this claim. I consent to medical photography and authorize release for medically related purposes. If my account is turned over to CSO Financial (OPS' collection agency), I understand that credit reporting will occur on my account.

Signed _____ **Date** _____

Thank you for choosing our office!

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MEDICAL HISTORY

DATE: _____/_____/_____

NAME: _____ Age: _____ GENERAL HEALTH: Poor_____ Fair_____ Good _____

If not good, please explain: _____

Height_____ Weight _____ Weight change past year of _____ lbs. ☐ Loss ☐ Gain Date of last menstrual period _____

PRIMARY CARE PHYSICIAN: Name_____ City _____ Phone _____

When did you last have the following? Physical Exam:_____ EKG:_____ Chest X-ray:_____ Blood work:_____

Frequency and duration of use (circle one):

Coffee/Tea _____ day/week for_____ yr.

Tobacco _____ day/week for_____ yr.

Alcohol_____ day/week for_____ yr.

MAJOR INJURIES OR ILLNESSES Year

_____ _____

_____ _____

_____ _____

ALLERGIES:

_____

_____

_____

Supplements	**Dosage**	**Medications**	**Dosage**

PREVIOUS OPERATIONS

	Year	Complications
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No

Personal Medical History

Have you had any problems with any of the following?

	YES	NO		YES	NO
Eyes & Ears	☐	☐	Nervous System	☐	☐
Nose/Sinus & Throat	☐	☐	Blood	☐	☐
Heart/Blood Vessels	☐	☐	Bones/Joints	☐	☐
Breasts	☐	☐	Urinary System	☐	☐
Lungs (Asthma, Bronchitis)	☐	☐	Psychiatric	☐	☐
Gastrointestinal (Reflux)	☐	☐	Reproductive System	☐	☐
Liver (Hepatitis)	☐	☐	Other (Diabetes, etc.)	☐	☐

Family Medical History

	Age	General Health
Mother	____	_____
Father	____	_____
Brother(s)	____	_____
	____	_____
	____	_____
Sister(s)	____	_____
	____	_____
	____	_____
Children	____	_____
	____	_____
	____	_____
	____	_____
	____	_____

Has any blood relative had:

	YES	NO
Tuberculosis	☐	☐
Cancer	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Diabetes	☐	☐
Kidney Disease	☐	☐
Asthma	☐	☐
Lung Disease	☐	☐
Blood Disorder	☐	☐
Epilepsy	☐	☐
Mental Disorder	☐	☐
Blood Clots	☐	☐

	YES	NO
Do you take aspirin products regularly? _____	☐	☐
Have you ever had a bad reaction to a GENERAL anesthetic? a LOCAL anesthetic? _____	☐	☐
Are you subject to motion sickness or nausea with anesthesia? _____	☐	☐
Have you ever had previous leg blood clots or a pulmonary embolus? _____	☐	☐
Do you have high blood pressure? _____	☐	☐
Have you ever had scarlet fever or rheumatic fever? _____	☐	☐
Have you ever been told you have a heart murmur? _____	☐	☐
Have you ever had any chest pain? _____	☐	☐
Do you have shortness of breath with walking or when lying flat? _____	☐	☐
Do you have, or have you ever had, any unusual bleeding from cuts, surgery or tooth extractions? _____	☐	☐
Do you form large scars or keloids? _____	☐	☐
Do you have frequent infections, boils or cold sores? _____	☐	☐
Have you taken steroid medications, cortisone or ACTH? _____	☐	☐
Does your religion prohibit blood transfusions? _____	☐	☐
Do you have or have you ever had psychiatric care or been advised to see a psychiatrist? _____	☐	☐

PRESENT CONCERN:

Specific condition(s) for which you are being seen: _____

Other physicians you have consulted about this condition: _____

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PERMISSION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION TO A FAMILY MEMBER, FRIEND OR LEGAL REPRESENTATIVE

IMPORTANT NOTICE: The law prohibits release of confidential Medical Information to an entity without the written, voluntary consent of the undersigned patient.

Name of Patient: _____ Date of Birth: _____

- Oregon Plastic Surgeons may leave messages on my phone: YES NO
- I authorize Oregon Plastic Surgeons to confirm appointments and/or discuss information regarding my medical condition with: (spouse, relatives, friends and physicians)

_____	_____	_____
Name	Phone	Relationship
_____	_____	_____
Name	Phone	Relationship
_____	_____	_____
Name	Phone	Relationship

- If you do not want any information given to anyone other than yourself please initial here: _____

I understand this Authorization. I also understand that the information used or disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and not longer be protected under federal law

Signature of Patient _____ Date _____

Signature of Legal Representative _____ Date _____

Printed Name of Legal Representative _____

Please be prepared to update this authorization which is required by the HIPAA law regulations. This authorization can be revoked any time by the patient in writing.

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Name:_____

The United States Government has asked physicians to obtain race, ethnicity, and language information from patients with the intent to improve patient care with the following objectives:

Improve Quality, Safety, Efficiency
Engage Patients and Families
Improve Care Coordination
Improve Public and Population Health
Ensure Privacy and Security for Personal Health Information
Better clinical outcomes
Improved population health outcomes
Increased transparency and efficiency
Empowered individuals
More robust research data on health systems

What is your Race?

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Hispanic
- ☐ Other Race
- ☐ Other Pacific Islander
- ☐ Unreported/Refused to Report

What is your Ethnicity?

- ☐ Hispanic
- ☐ Latino
- ☐ Not Hispanic or Latino

What is your primary language?

- ☐ English
- ☐ Other
- ☐ Indian includes Hindi or Tamil
- ☐ Spanish
- ☐ Russian
- ☐ Do you require a translator?

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