Brandywine Surgery Center

Patient Notification and Disclosure of Physician Ownership

This document serves as formal notice to you that your physician, Christopher J. Saunders, M.D., is an investor/owner of the Brandywine Surgery Center. By signing below you acknowledge that you have received this notice and that if you choose to have surgery and it is at the Brandywine Surgery Center, you understand that your physician is an investor/owner. You further acknowledge that you understand it is your right to ask your physician for an alternative service location should you choose not to use the Brandywine Surgery Center.

If you have any questions, comments or concerns regarding this notification and disclosure, please speak to your physician or ask to speak to a member of the Brandywine Surgery Center staff by calling: 610-459-1559.

Thank you for choosing the Brandywine Surgery Center!

By signing this notice, I acknowledge that this has been received prior to my date of surgery.

_____
Printed Name of Patient

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____
Printed Name of Witness

_____ _____
Signature of Witness Date

For Office Use Only

MD Name: Christopher J. Saunders

Witness is: ☐ Spouse ☐ Family ☐ Office Staff ☐ Other _____

CONSENT FOR PHOTOGRAPHS

Christopher J. Saunders, M.D., P.A.

Brandywine Surgery Center
1224 Baltimore Pike Suite 100
Chadds Ford, PA 19317
(610) 459-1559

Lombardy Medical Center
410 Foulk Road Suite 203
Wilmington, DE 19803
(302) 652-3331

Medical Arts Pavilion I Suite 137
4745 Stanton-Ogletown Road
Newark, DE 19713
(302) 652-3331

DATE: _____

PATIENT'S NAME: _____

In connection with the medical services I am receiving from Dr. Christopher J. Saunders, I consent that photographs may be taken of me or parts of my body, under the following conditions:

1. **The photographs may be taken only with the consent of my physician and under such conditions and at such times as may be approved by him.**

2. **The photographs shall be taken by my physician or by a photographer approved by my physician.**

3. **The photographs shall be used for medical records, and if in the judgment of my physician, medical research, education, or science will benefit by their use, such photographs and information relating to my case may be published and republished either separately or in connection with each other, in professional journals or medical books, or used for any other purposes which may deem proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use, I shall not be identified by name.**

4. **The above mentioned photographs may be modified or retouched in any way that my physician, in his direction, may consider desirable.**

PATIENT SIGNATURE: _____
(Or if minor, Parents Signature above)

NAME: _____ DATE: _____

PERSONAL PAST HISTORY - Have you ever had the following: (please check Yes or No)

	Yes	No		Yes	No		Yes	No
Abnormal Bleeding	___	___	Asthma	___	___	Hypertension	___	___
Abnormal Clotting	___	___	Diabetes	___	___	Sleep Apnea	___	___
Acid Regurgitation	___	___	Fainting Spell	___	___	Snoring	___	___
Anemia	___	___	Heart Attack	___	___	Weight Change past 12 mos	___	___
Angina	___	___	Hepatitis	___	___	Other Serious Illness	___	___
Staph Infection	___	___	M.R.S.A.	___	___	Latex Allergies	___	___

Please describe Other Serious Illness and any questions with "Yes" answer: _____

_____

Have you ever received a transfusion? Yes _____ No _____ If yes, what year? _____

Have you ever been tested for HIV? Yes ___ No ___ If yes, what year? _____ Test Results: __Positive __Negative

Do you wear any of the following:

Contact Lenses? ___Yes ___No Eye Glasses? ___Yes ___No Hearing Aid? ___Yes ___No Dentures ___Yes ___No

Previous Surgery (Please provide year & type of procedure): _____

_____

Indicate the type(s) of anesthesia received in the past, list any complications or reactions you experienced:

____ Local Anesthesia - complications / reactions _____

____ General Anesthesia - complications / reactions _____

____ Monitored Anesthesia care - complications / reactions _____

____ Spinal / Epidural - complications / reactions _____

Date last seen by Primary Care Physician: _____ Primary Care Physician Name: _____

Primary Care Physician Address: _____ Phone #: ( ) _____

Have you ever been seen by a cardiologist? ___Yes ___No If yes, Cardiologist Name: _____

Cardiologist Phone # ( ) _____

SOCIAL HISTORY

Age: _____ Sex: ____M ____F Married: ____Y ____N Occupation: _____

Responsible adult available to assist during recovery period: ___Y ___N Relationship: _____

Smoke: ____Y ____N Amount: _____ Coffee/Tea/Cola: ___Y ___N Amount: _____

Alcohol: ____Y ____N Amount: _____ Daily Exercise: ___Y ___N Amount: _____

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

	Yes	No		Yes	No		Yes	No
Abnormal Bleeding	___	___	Coronary Surgery	___	___	Kidney Disease	___	___
Abnormal Clotting	___	___	Diabetes	___	___	Tuberculosis	___	___
Anesthetic Problems	___	___	Heart Attack	___	___	Cancer	___	___
Hypertension	___	___	Stroke	___	___	Other Serious Illness	___	___

Please describe questions with a "Yes" answer: _____

_____

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REVIEW OF SYSTEMS ----- BELOW TO BE COMPLETED BY PHYSICIAN ONLY

	Yes	No		Yes	No		Yes	No
Loose Dental Devices	___	___	Recent Up Resp Infection	___	___	Vomiting	___	___
Neck Mobility Prob.	___	___	Normal Menstrual Cycle	___	___	Difficulty Voiding	___	___
Short Neck	___	___	Stroke	___	___	Seizure	___	___
Cough	___	___	Chest Pain	___	___	Current Pregnancy	___	___
Shortness of Breath	___	___	Irregular Heart Beat	___	___	Black Out	___	___
Obesity	___	___	Height _____	Weight _____		Hosp _____	ASF ____	

Comments: _____

_____

NOTICE OF PRIVACY PRACTICES

QUESTIONS AND COMPLAINTS:

If you have any questions about this notice, please contact:

Christopher J. Saunders, M.D., P.A.
Attention: Practice Manager
Medical Arts Pavilion 1, Suite 137
4745 Stanton Ogletown Road
Newark, DE 19713
(302) 652-3331

If you think we have violated your privacy rights, contact the person named above. You may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

ACKNOWLEDGEMENT FORM

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

NAME: _____

SIGNATURE: _____

DATE: _____

MONETARY AND CANCELLATION POLICIES

OFFICE VISITS AND CONSULTATIONS

Dr. Saunders strives to give all of his patients the highest quality care in the office and in the operating room. Missed appointments and cancelled appointments cost time and money. Please be courteous and notify the office of your change of plans. You will be billed for missed appointments and cancellations within 48 hours of the appointment. If you have cosmetic surgery, however, these charges can be deducted from the cost of surgery.

1. Cancelled office visits within 48 hours of the appointment and missed appointments ("no-shows") have a $100 expense billed to you as this does not allow the office the opportunity to offer this appointment time to another patient.
2. Initial cosmetic consultations are complimentary but policy #1 above still applies.
3. Payment for cosmetic office procedures such as: Botox, Juvéderm, Restylane, Radiesse, Sclero therapy, Collagen, laser treatments, etc. are due upon scheduling. Cancellations within one week of the procedure will lead to a $200 charge, because of lost time and materials which have been purchased in anticipation of your procedure.

SCHEDULING SURGERY

Many patients are trying to schedule surgery and the office is trying to help you and all others interested in surgery dates, which best accommodate all parties' schedules. Schedules are done far in advance and rescheduling/cancellations can cause lost time. Please carefully choose your surgery date.

1. A non-refundable deposit of $500.00 is required to schedule surgery. This is applied towards the cost of the procedure.
2. Full payment of the remaining balance is due one month prior to your surgery date.
3. Cancellation of surgery:
    - 30 day or more notice – Full refund except deposit.
    - 15-29 days – 50% refund.
    - 14 business days or less – No refunds.

INSURANCE CASES

The office attempts to have insurance cases authorized whenever possible. However, most cosmetic cases are not covered. Sometimes insurance companies will authorize surgery, but later will deny claim for payment. If this happens our office will help you appeal, but you will be responsible for any fees not paid for your surgery.

_____ _____

Patient Signature Date

PATIENT REGISTRATION

PLEASE ANSWER ALL QUESTIONS IN THIS SECTION DATE: _____

Patient's Name: _____ Home Phone: ( ) _____
Parent's Name (minors only): _____ Cell Phone: ( ) _____
Social Security Number: _____-_____-_____ Address: _____
Date of Birth: _____ Sex: (circle) M F _____
Marital Status: (circle) Single Married Divorced Widowed City, State, Zip: _____
Drug Allergies: _____ E-mail Address: _____
Medications Currently Taking: _____ Employer: _____
Family Doctor: _____ Employer's Address: _____
Referring Physician: _____ _____
Referring Physician Address: _____ Employer's Phone #: ( ) _____
Reason for Visit: _____

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HEALTH INSURANCE INFORMATION

Insurance Company: _____ Identification Number: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
Do you have a referral from your primary care physician for today's visit? (circle) YES NO Subscriber's Social Security #: _____-_____-_____

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MEDICARE PATIENTS ONLY

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Christopher J. Saunders, M.D., P.A. / Dr. Benjamin Cooper, M.D. for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

Signature: _____ Date: _____

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IF YOUR INJURIES OCCURRED AT WORK OR IN AN AUTO ACCIDENT YOU MUST COMPLETE THE FOLLOWING OR YOU WILL BE BILLED FOR THESE SERVICES

Insurance Company: _____ Identification Number: _____
Claims Mailing Address: _____ Claim Number: _____
City, State, Zip: _____ Claims Adjuster: _____
Phone Number: (____) _____

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I request that payment of authorized Insurance Benefits be made either to me, or on my behalf to Dr. Christopher J. Saunders, M.D., P.A. / Dr. Benjamin Cooper, M.D.. I authorize any holder of medical information about me to release any said information needed to facilitate payment for related services."

Signature: _____ Date: _____

ATTENTION -- Where did you hear about us?

Circle one: Yellow Pages Physician Referral Friend Delaware Today Former Patient

Seminar, date: _____ Website: _____ Other: _____