

Directions to:

170 West 106th Street

Indianapolis, IN 46290

For more information: (317) 575-0330 or
800-345-1962

FROM THE NORTH

Traveling South on Meridian Street (US 31) stay in the right lane, exit right (west) at the 106th Street exit. Our office is on the right on the North side of the street.

FROM THE SOUTH

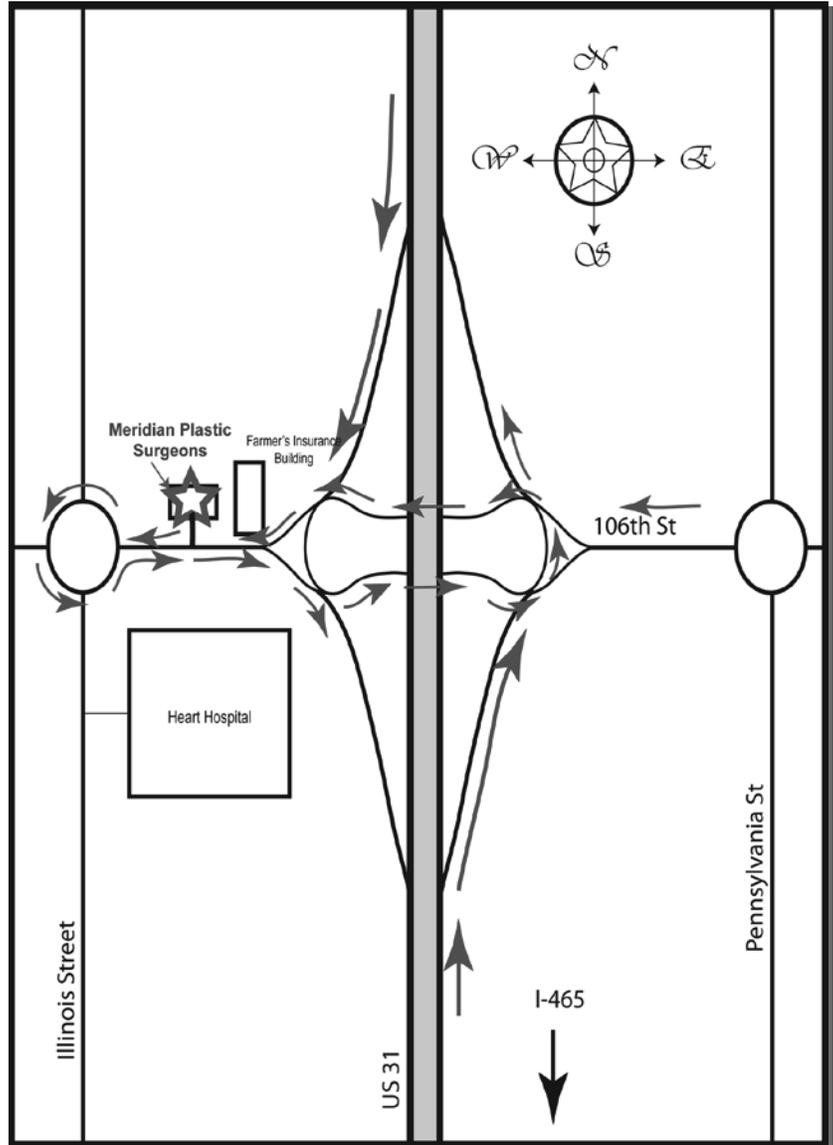
Traveling north on Meridian Street (US 31), stay in the furthest right lane and exit on the 106th Street exit. From the exit ramp, turn left (west) onto 106th street. Stay in the right lane on the roundabout and Meridian Plastic Surgery Center is on the right (north) side of the street.

FROM THE EAST

Traveling from the East on I-465 North, take the Meridian Street exit (US 31) and exit right (north). Stay in the furthest right lane and exit on the 106th Street exit. From the exit ramp, turn left (west) onto 106th street. Stay in the right lane on the roundabout and Meridian Plastic Surgery Center is on the right (north) side of the street.

FROM THE WEST

Traveling from the West on I-465 North, take the Meridian Street exit (US 31) and exit right (north). Stay in the furthest right lane and exit on the 106th Street exit. From the exit ramp, turn left (west) onto 106th street. Stay in the right lane on the roundabout and Meridian Plastic Surgery Center is on the right (north) side of the street.



*Please note that upon exiting Meridian Plastic Surgery Center, you cannot make a left (East) onto 106th Street. You must exit right (West), go around the roundabout at Illinois and exit onto 106th Street east toward US 31 from there.



MERIDIAN PLASTIC SURGEONS

Historical Data Sheet (Ages 0-16)

Patient Name: Last First MI

Date of birth: Age Height: Weight:

Reason(s) for seeing physician:

Parent / Legal Guardian Name:

In what surgical procedure are you interested?

- Rhinoplasty (nose) Scar revision
Skin Resurfacing Chin
Laceration repair Removal of cysts, moles, etc.
Protruding ears Removal of birthmark, hemangioma

Other:

Have you consulted another doctor in regards to this type of surgical procedure? If so, whom?

Please list all medications, vitamins, or supplements you are currently taking (including birth control, aspirin, hormones and natural dietary supplements):

Previous surgeries (including cosmetic):

Describe any complications you may have experienced:

Any known allergies? yes no. Please list:

Family doctor / Internist: Address:
OB/Gyn? Address:
Date of last physical exam: May we notify him/her of your upcoming surgery?
If you are currently being treated by a psychiatrist or psychologist:
Name: Phone number

Have you ever been treated for or diagnosed with any of the following? Mark all that apply.

- Rheumatic heart Reflux Anemia Diabetes
Heart murmur Ulcers Hypoglycemia Kidney disease
Angina / Chest pain Lupus / Scleroderma Excessive scarring Clotting disorder
Heart attack HIV / (AIDS) Staph infections History of immuno-suppressive drugs or chemotherapy past or present
High blood pressure Cancer: DVT, pulmonary embolas
Stroke Sleep Apnea Any eye problems / Glaucoma
Cold sores / Fever blisters Migraines / TMJ Skin condition, infection, irritation
Hepatitis / Jaundice Depression / Anxiety or shingles
Type: A B C Psychiatric problems Latex allergy Please note if you have:
Hay fever / Nasal allergies Seizures / Convulsions Alcohol / Drug dependency Body Jewelry
Lung / Chest problems Bleeding disorder Recreational drugs: Contact Lenses
Asthma MRSA Dentures - upper / lower

Yes No Are you allergic to any medications? _____
 Yes No Have you ever received local anesthesia (Novacaine or Xylocaine)?
 Yes No Have you ever had any reaction to the above mentioned? Explain _____

 Yes No Have you ever been treated with Accutane?
 Yes No Are your immunizations up to date?
 Yes No Do you consume more than 3 cups of a caffeinated drink a day?
 Yes No Are you a smoker?

Females:

Yes No Are your periods regular?
 Yes No Are you pregnant? Date of last period.: _____

Do you have *any* other medical problems that have **not** been covered? _____
 If so, please explain: _____

Do you realize every operation is followed by a period of healing before the tissues return to normal and a final result is apparent? Yes: _____ No: _____

Do you understand that the objective of any cosmetic surgery is improvement in appearance, **not perfection**?
 Yes: _____ No: _____

Please list any other information you think is or would be important for us to know about your medical or social history.
 Do you have any questions you want answered? _____

Confidential Record: Information contained here **will not be released** unless you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your doctor in making decisions regarding your care.

I authorize my physician and/or administrative and clinical staff to telephone or otherwise contact me (or responsible party) regarding appointments, treatment information, or any other details related to patient therapy and treatment.

➔ Signature: _____ Date: _____

Do you realize every operation is followed by a period of healing before the tissues return to normal and a final result is apparent?

Yes No

*Do you understand that the objective of any cosmetic surgery is improvement in appearance, **not perfection**?*

Yes No

DOS:		<input type="checkbox"/> No Changes	<input type="checkbox"/> Updated
Date:	M.D. Signature:		



Patient Information

Name: _____ Sex: M F
 Last First MI

Home Address: _____
 Street Apt. City State Zip Code

Phone: _____
 Home Work Cell

E-Mail: _____ Social Security: _____

Birth Date: _____ Age: _____ Marital Status: S M D W Name of Spouse: _____

Referral Information

How were you referred? (Check all that apply)

- Patient: Name: _____ Friend: Name: _____
- Physician/Dentist: Name: _____ Nurse: Name: _____
- Newspaper Radio Yellow Pages Magazine: Name: _____
- Other Source: _____

Patient Employment Information

Employers Name: _____ Occupation: _____

Employer's Address: _____

Employer's Phone: _____

In case of emergency

Please list name, phone number, and relationship of person to contact:

Name: _____ Phone numbers: _____

Relationship to Patient: _____

Family Physician: _____ Address: _____ Phone #: _____

I recognize and accept full financial responsibility for all professional services rendered, regardless of the amounts covered by any applicable insurance coverage. In the event Meridian Plastic Surgeons or the Meridian Plastic Surgery Center is required to collect my account after default, I will be responsible for all attorney fees and cost of collection. If insurance is to be filed, I authorize release of medical information including photographs necessary to process any claim for services provided by Meridian Plastic Surgeons and the Meridian Plastic Surgery Center. I further authorize an insurance company to pay benefits directly to Meridian Plastic Surgeons and/or the Meridian Plastic Surgery Center.

Date: _____

 Signature of Patient/Responsible Party

 Relationship to Patient



Patient Insurance Information

As a courtesy to our patients, we will file your charges with your insurance company. However, the following information must be filled out completely for your procedures to be filed with your insurance carrier. Insurance deductibles which have not been met may require payment prior to your surgery. If this form is incomplete, you will be billed directly.

If your insurance requires that you have a referral from your Primary Care Physician, you must handle this by calling your Primary Care Physician. Please check to be sure that our Physicians and the Meridian Plastic Surgery Center are contracted with your insurance company. This is especially important if you have an HMO policy. Some Primary Care Physicians may refer you to Physicians not contracted with your insurance company, which poses a problem for you. If we are not a network provider for you, then check to see if you have out-of-network benefits. If so, out-of-network coverage is provided at a reduced rate. Refer to the phone number on your insurance card.

In order for our facility to give you the most information regarding your insurance benefits, you must supply us with a CURRENT insurance card including the billing address and phone number. Our medical assistants can help you with any question you may have if you call during our regular business hours, Monday through Friday, 9:00 a.m. to 5:00 p.m.

Primary Insurance Information

Primary Insurance _____

Address to Mail Claims _____

Phone _____ ID _____ Group _____

Member's Name _____

Member's SSN _____ Member's Birth Date _____

Member's Employer _____

Relationship to Member: Self Spouse Child Other _____

Secondary Insurance Information

Secondary Insurance _____

Address to Mail Claims _____

Phone _____ ID _____ Group _____

Member's Name _____

Member's SSN _____ Member's Birth Date _____

Member's Employer _____

Relationship to Member: Self Spouse Child Other _____



Patient Insurance Checklist

As patients approach surgery, they frequently need information regarding insurance benefits. As a courtesy to our patients, we would like to inform you of several things that are important to you when having any procedure that involves your insurance company. It is the patient's responsibility to check on the following:

- 1.** If your insurance requires that you have a referral from your Primary Care Physician (PCP), you must obtain the referral by calling your PCP. Please verify that both physician(s) and Meridian Plastic Surgery Center are contracted with your insurance company. This is especially important if you have an HMO policy. If we are not a network provider for you, please verify if you have out-of-network benefits.
- 2.** Meridian Plastic Surgery Center utilizes North Side Anesthesiologist Service, LLC. Billing for North Side Anesthesia is handled by Susan J. Taylor Billing Service. You should ask to speak to Melissa Shank at 317-614-9812. Hours for the billing service are 8 am - 5 pm Monday through Friday.
- 3.** The Meridian Plastic Surgery Center uses Ameripath of Indiana Laboratory for any pathology testing. If you are having procedures that will require pathology testing, you will need to verify that your insurance company will accept this lab. The telephone number for the Ameripath is (317) 275-8112 or 1-866-635-1917.

In order for our facility to give you the most information regarding your insurance benefits, you must supply us with your most current insurance card(s) with the billing address(es) and phone number(s).

It is our goal to help you get the maximum benefits from your insurance company, but your failure to follow through with the above information could result in denial of coverage and cause your benefits to be waived. If you have a deductible that has not been met, you may be responsible for payment at the time of service. Please keep in mind that your insurance contract is between you and your insurance company, making it your responsibility to know your benefits.

The average waiting period for predetermination for approval for procedures is 6-8 weeks. The process can vary with different insurance companies. Please contact Brenda Hatcher (317) 663-7217 with any questions or concerns you may have regarding precertification, predetermination, or insurance benefits.

I have been informed that Dr. Perkins and Dr. Van Natta are not in network health providers. Dr. Sadove, Dr. Kelley, and the fellow participate in Anthem insurance only.

Please initial to confirm receipt of this information. _____

Date: _____



Patient Contact Authorization Form

Patient Name: _____

How may we contact you and/or leave a message? (Please circle)

Home: yes no

Fax Home: yes no

Fax Work: yes no

Work: yes no

Email Home: yes no

Email Work: yes no

Cell: yes no

Can we send mail to you at: (Please circle)

Home: yes no

Work: yes no

To WHOM may we speak about your appointments, treatments, insurance, or billing?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

(This form is valid for one year unless revoked or changed by the patient.)



HIPPA Acknowledgment

I hereby acknowledge that I have been made aware of the above-identified provider's Notice of Privacy Practices and that I may read a copy of it by my request.

Date: _____

Signature of Patient

Printed Name

Please return this page to the provider.



Mission Statement

Through our collaborative effort, the mission of Meridian Plastic Surgeons is to:

Provide superior patient care, utilizing the clinical and surgical experiences of our staff. Bring energy, enthusiasm, care, and commitment to our patients every day.

We strive for distinction through continuing education in cosmetic and reconstructive surgery, ensuring quality care by balancing technical expertise with warmth and dedication. We believe in a well-informed patient. By practicing the highest ethical standards, we will better serve our patients and gain their trust.

We continuously advance to provide safe, high quality care to our patients in a confidential, convenient setting: which is devoted solely to plastic surgery. Patient satisfaction is our final reward. We are committed to excellence.

Dr. Stephen Perkins

Dr. Bruce Van Natta

Dr. A. Michael Sadove

Dr. Christine Kelley

The Staff at Meridian Plastic Surgeons and the Meridian Plastic Surgery Center