Lowe Plastic Surgery

JAMES LOWE, M.D.
PLASTIC SURGERY

Dear New Patient:

We would like to take this opportunity to welcome you and to thank you for choosing Lowe Plastic Surgery (LPS). We will do our best to provide you and your family with excellent care. We ask that you take a few minutes to fill out or review the enclosed forms in your packet and to bring them to your appointment. Bringing a copy of your medication list and a referral letter from your physician, if applicable, is greatly appreciated.

Our office schedules your appointment based on your complaint and the complexity of your problem. If you have further concerns or you would like to request a more detailed evaluation, a second appointment may be required. We will do our best to accommodate all of your clinical concerns and we want to ensure that adequate time is allotted to address each problem. In addition, if you are coming for a skin screening or for a specific facial skin concern or laser evaluation, we ask that you not wear makeup to your appointment.

If you are coming in to discuss a possible surgery or surgical procedure, please note that the procedure in most cases cannot be performed at the time of your consultation. Surgical procedures require evaluation, time allotment, medication modifications, and preparation that cannot be predicted in advance. The physician will also determine if he or she has the appropriate expertise to perform the procedure and if further medical evaluation is required.

Please bring your insurance card and driver's license to your appointment. All services must be paid for at the time care is rendered, including co-payments, deductibles, and co-insurance amounts. Failure to provide 48 hours' notice when cancelling an appointment will result in a minimum of a \$30 cancellation fee. While payment with credit cards and checks is welcome, we do not accept checks for same day cosmetic procedures. We encourage patient to provide credit card information and to allow us to securely retain this information to cover outstanding balances and to expedite care.

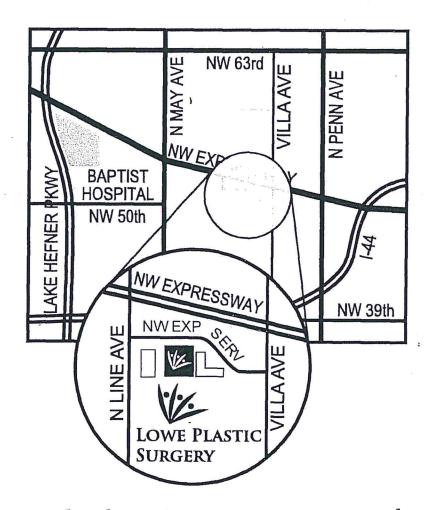
We always welcome your comments and suggestions. If you have any questions about your upcoming visit, please call us at 405-942-4300.

Warmest regards,

Dr. James Lowe Lowe Plastic Surgery



2520 NW EXPRESSWAY OKLAHOMA CITY, OK 73112



Our office is located in between May & Penn on the SW corner of NW Expressway and Villa (stoplight).

Go south on Villa, take the first right (52nd street) and continue past Law office (Olson).

We are the next building. Building colors are tan and black.



HEALTH QUESTIONNAIRE

Other:

Name:

Date of Birth: _____ Age: _____

Please answer all of the questions on the following pages. If you need extra space, please use the comments section at the end.

Best Phone# for Us to Call You?

Referring/Primary Care M.D.:

Date of Birtin			What is the main reason you are here to see us today?				
Occupation:			_				
Email Address:				Have you recently travelled out of country?			
			I	f so where?			
Height: Weight:				Pharmacy Nama & Phana?			
			Pharmacy Name & Phone?				
Please list current medications (prescrib	ed & O	TC)	_	Please list any ALLERGIES	S:		
See Attached List - □ Yes			□ No Known Drug Allergies				
			L	Prug Allergies:			
			1				
			S	easonal Allergies:			
DO YOU HAVE A HISTORY OF	YES	NO		DO YOU HAVE A HISTORY OF	YES	NO	
Heart or Circulation Problems	TES	110	┨	Digestive, Stomach or Liver Problems	TES	110	
Heart murmur			1	Difficulty swallowing			
Heart attack: Month/Year			1	Ulcers			
Irregular heart beat				Acid Reflux / Frequent Heartburn			
High Blood Pressure			1	Hiatal hernia			
Low Blood Pressure			1	Liver disease / hepatitis			
Stroke or blood clots			1	Jaundice (yellow skin)			
Anemia/sickle cell anemia				Frequent diarrhea			
Angina/chest pain			1	Frequent constipation			
Bleeding problems		Crohns Disease					
Swollen ankles or legs		Ulcerative Colitis					
Cardiac Cath, EKG, Stress Test		1	Other:				
DVT / PE							
DO YOU HAVE A PACEMAKER?				Urinary, Kidney or Bladder Problems			
•				Kidney stones			
Lung or Breathing Problems				Frequent urinary infections			
Asthma – Last attack				Difficult urination			
Bronchitis				Unable to hold urine			
Pneumonia		Ų					
Chronic lung disease / COPD				Head or Neurologic Problems			
Sleep apnea				Seizure or black outs			
Shortness of breath				Frequent headaches			
If Yes, circle when:				Weakness in an arm or leg	ŀ		
At rest / Climbing stairs / Walking Briskly				Memory Problems			
Frequent cough							
If Yes, do you cough anything up?]]	Endocrine or Metabolic Problems			
Abnormal chest x-ray]	Diabetes – Diet Controlled			
TB / Positive PPD test				I take Pills I take Insulin			

PLEASE CONTINUE TO PAGE 2

Hypoglycemia/Low blood sugar

Thyroid problems

DO YOU HAVE A HISTORY OF	YES	NO	SOCIAL HISTORY	YES	NO
Do you have or did you ever have:			Tobacco Use?		
Physical disability/Arthritis			Cigarettes pk/day for yrs		
Difficulty walking		•	Date quit Other		
Joint replacement			Cigars or pipe? for yrs		
Back problems			Date quit Other		
Other:			Chewing tobacco foryrs		
			Date quit Other		
Immune System Problems			Alcohol use?		
Rheumatoid Arthritis / Lupus			Do you usually drink alcohol?		
Other immune / autoimmune disease?			Daily Weekly Monthly		
AIDS/ HIV			Never Amount:		
Blood Cancers – Lymphoma, Leukemia			History of alcohol / substance abuse?		
Organ Transplant (What Year?)			·		
			Do you Exercise?		
Skin Problems			How do you exercise?		
Psoriasis			min. / day for days / wk.		
Cold Sores or Fever Blisters					
Eczema			Hobbies that might affect your ability to have surgery / be treated? Describe:		
Scarring or Keloids?			to have surgery / be treated: Describe.		
Ever had UV medical treatment?					
Ever been treated with radiation?			Can you take time off for surgery and		
			recovery if needed?		
Other:					
Do you use tanning beds?			PREVIOUS SURGERIES: (list year)		
Tanningdays/week for years			☐ See attached list		
Have you had Skin Cancer?					
Please list kind of cancer, location, year:					
	-				
Other Cancers (not skin cancer)?					
Please list kind of cancer & year:			Blood products or transfusion?		
			List Years:		
			If yes, any reactions?		
Other Major Illnesses? - Please list and give year:			Have you had a cough or cold in the last 2 weeks?		
			Date		
			Any problems with anesthesia?		
			Describe:		
			Anyone in family have anesthesia		
Do you have chronic pain?			problems?		
Do you have a pain management doctor?			Do you have:		
Name:			Dentures?		
			Chipped or Loose Teeth?		
Other Problems:			Bridgework or Partial Plate?		
Would you describe yourself as being			Glasses / Contact Lenses?		
Extremely anxious?			Cataracts / Glaucoma?		
Depression?			Difficulty hearing?		
Any psychiatric diseases?			Difficulty speaking?		

FAMILY HISTORY	YES	NO	FOR WOMEN ONLY:	YES	NO
PLEASE INDICATE RELATIONSHIP			Is there a possibility you are pregnant?		
Cancer (Type)			Are you trying to become pregnant or	5 (5)	
			are you planning a pregnancy in the near		
			future?		
Cardiac:			Number of pregnancies:		.5
Diabetes:			Number of live births:		_
Seizure Disorder:			Date of last period:		
Skin Diseases:			Are you in Menopause?		
Other Diseases in the Family:			Do you have regular monthly cycles?	1	
			Have you been diagnosed with PCOS?		
			Do you have other female problems?		
			Please, provide current bra size?		
Completed by: □Patient □Spouse	□Parent	1	□Staff □Other:	ř	
Patient (Or Guardian) Signature:					
Reviewed by: (Staff / Physician)			Date:/	_/	

Lowe Plastic Surgery Patient Information Name: ___ - (First) (Middle) (Last) (Mother's Maiden Name) _____Email: _____ Address: City, State, Zip: Cell/Primary Phone: Home Phone: () Race: _____ Date of Birth: ____ Sex: _____ Age: ____ Marital Status: Social Security Number: Employer Name & Address: _____ Employer Phone: (____) __ Occupation: Employment Status (Full/Part Time/Retired): Spouse Name: Spouse Employer & Address: _____ Employer Phone: (_____) ____ Spouse Occupation: _____ Employment Status (Full/Part Time/Retired): In Case of Emergency Contact: Phone: (_____) Relationship: Address: Person Responsible for Payment if Other than Above _____ Home Phone: (_____) ____ Name: _____ (First) (Middle) (Last) ___ City, State, Zip:_____ Address: Relationship to Patient: Social Security No: Employer Name & Address: Occupation: Employer Phone: (____)___ ONLY If Workers Compensation Employer: _____ Employer Phone: (____) ____ Address: _____ Workers Comp Insurance Carrier: Address: _____ _____ Phone: (____) ____ Claim #: ______ WC Verification: ______ Date of Injury: _____ Primary Insurance Insurance Carrier _____Employer:____ Address: _____ _____ID #: _____ City, State Zip: _____ Group # / Name: ____ Medicaid / Medicare # ______ State: _____ Secondary Insurance Insurance Carrier Address: _____ ID #: _____ City, State Zip: _____ Group # / Name: _____ Name of Policyholder: _____ DOB: ____ Relationship to Patient: Social Security #: Primary Care Physician: Referring Physician (If different than Primary):______Self or Not Referred (Circle) Phone: (_____) ____ Address: ______ City, State: _____ HOW DID YOU HEAR ABOUT US (Circle)? Friend • Insurance • Internet • Magazine • Newspaper • Patient • Physician • TV-Radio • Unknown • YellowPages Other ____ Today's Date / /

Lowe Plastic Surgery
AUTHORIZATION FOR MEDICAL TREATMENT AND
FINANCIAL RESPONSIBILITY

1.CONSENT

I authorize my physician and other physicians who may attend me, their assistants, including those employed by Lowe Plastic Surgery (LPS) or Associates Surgery Center (ASCO), to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my physician. These services may include emergency services and other special services ordered by my physician(s). In consenting to treatment, I have not relied on any statements as to results. I further authorize my physician or associated staff to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any bones, organs, tissue, fluids or parts removed from my body. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis B & C, and HIV. I also agree to update this office of any related information and health history that may change over the course of my care.

2.STORAGE AND RELEASE OF INFORMATION

I consent to the electronic storage and transmission of patient health information. I hereby authorize my treating physician, or LPS or ASCO, to release by electronic means or otherwise any medical and/or billing information that concerns my care, including copies of my medical records, to the following:

- Any governmental or other entity as required by law for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs.
- The supplier of any blood or blood products which may be administered to me for the purposes of
 quality control and recipient monitoring.
- Any continuing care, residential or long-term care facility, or home health agency for the purposes of providing services for my care.

3.MEDICARE / OTHER INSURANCE BENEFITS

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Medicare Program or its Intermediaries or carriers concerning this or a related claim filed by LPS. I request payment of authorized benefits be made on my behalf. I understand that I am responsible for the Part B deductible for each year and/or visit, the remaining co-insurance and any other non-covered personal charges. I (or my representative) certify that I (or he/she) have read (or if the patient/representative is unable to read has had the form read to him/her) and understand, accepts the above and further certify that I am the patient, or am duly authorized on behalf of the patient to execute such an agreement.

4.ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by LPS, all physicians and services, I authorize direct payment to LPS and/or the associated facilities of all insurance benefits applicable to these medical and other services, which are now or which shall become due and payable. In addition, I hereby authorize payment to LPS of applicable insurance benefits for medical and/or surgical services rendered by physicians or representatives for whom the entity is authorized to bill and collect.

Rev. 1/1/22 $\sqrt{\text{Read}}$

I understand that LPS may utilize facilities or other services in or out of my insurance network. Fees or other concerns associated with such interactions should be addressed with that entity directly. Certain ancillary services (i.e. lab work or pathology) or facilities that are out-sourced by the practice may not be partially or fully covered by my insurance. LPS can never guarantee that other consultants or services will be covered by my insurance plan. I understand that I should contact my insurance for further information. I also understand that if my insurance plan has specific restrictions on such services, I need to make a written request in advance of care for special accommodations. In some cases, based on the restrictions of the insurance plan, accommodations cannot be made and an out of pocket cost may be incurred if care is to be provided. LPS may on occasion utilize facilities or services in which it has direct interest or ownership. In most cases, regardless of the indications or services performed, any and all tissue, implant, or materials surgically removed are sent to pathology resulting in fees that cannot be fully determined in advance.

Patients who request evaluation for a medical condition through insurance will be billed based on a standard fee schedule. It is noteworthy that the actual fee paid is often significantly reduced due to contractual agreements. Those conditions deemed medically indicated, which are generally covered by insurance, will be billed based on a pre-determined fee schedule. Cosmetic consultation fees and other associated discounts are only applicable for visits for cosmetic conditions. LPS reserves the right at any time to cancel, not renew, or re-negotiate any health plan based on contract terms.

5.GUARANTEE FOR PAYMENT

In accordance with the above terms and in consideration of the services provided to the patient by LPS, the undersigned agrees, whether he/she signs as patient or guarantor, to pay LPS and related facilities for all services ordered by the physician, or requested by the patient and/or the patient's family. If the requirements for referral, second opinion, pre-certification of care, hospitalization, or surgery as otherwise outlined by the insurer, benefit plan or other payer, have not been fully followed, the patient /or guarantor agrees to be personally responsible for all charges incurred. LPS intends to provide timely invoices, but due to the complexities of medical billing, delays may occur. Please contact LPS or the billing company if there is concern about the invoice. Patients may request, or may be required, to file their own insurance claims. If the patient /or guarantor fails to pay within a timely manner or payment is invalid or insufficient, then extra charges will be incurred, and a collection agency will be utilized.

As in any office, the physician may not be on time due to paperwork, unexpected issues, or an emergency. The physicians do their best to provide timely care, and to stay on schedule, but medicine can be unpredictable and delays do occur. Patients can help by respecting the physician's time by focusing on the reason for their visit. Physicians may not be able to provide an expected service, or provide the desired service, on an anticipated day. Patients who speak a language other than English must provide their own translator. Patients should be aware that fees are related to the time and complexity of their visit or procedure. Note that failure to provide 48 hours notice when cancelling an appointment will result in a minimum \$50 cancellation fee.

6.ADVANCE BENEFICIARY NOTICE (ABN)

Patients and families must make choices in their care as it relates to clinical services and insurance coverage. Insurance is a means to assist in payment of medical services. Insurance companies are not health care providers. The fact that a patient's medical insurance does not pay for services provided, recommended, or arranged does not mean that the patient should not receive said services or that such are not indicated. Physicians recommend treatments, medications, and services based on their experience, knowledge and training in the practice of medicine.

Rev. 1/1/22 $\sqrt{\text{Read}}$

No matter what the situation or process, your insurance provider may choose not to pay for your medications, treatments, or services. Not all medically indicated services will be covered by your insurance, regardless of the timing, notification, or approvals. This does not mean that the procedure of service was not "coded correctly" by the physician. Many health insurances simply make a blanket statement that they will pay for a service if it is "medically indicated." Only later will the insurance company review the records and decide independently how much they will cover, if at all. This is part of most patient insurance contracts and is not negotiable. For instance, Medicare will not guarantee payment of any service in advance.

Insurance companies may not be forthright with their rules and regulations and may not notify physicians regarding policy changes. Concerned patients should review their individual health plan and contact their insurance providers regarding fees or coverage. If you do contact your insurance provider, you should document the number you called, the date and time of your call, who you spoke with, and get a reference number for your records. Please remember that we are here to take care of you. Our staff spends an extensive amount of time working with insurance companies to assist in prior authorizations for medications, pre-determinations for surgery, sending records to verify that your services were "medically indicated," etc. We do our best to assist you with this complicated and exhaustive process and our intention is to be honest and transparent. By signing this document, you understand that your medical insurance may not cover part or all the services provided, recommended, or arranged and that you will be responsible for the bill.

Please also note that you have a contract with your insurance company and, if we are in your network, then we have a contract with your insurance policy. We, or any other physician or provider, cannot "waive" your co-pay or deductible. Doing so would be a violation of your contract and our contract with the insurance provider. In the same way, as part of our contract, your insurance sets the fee schedule that determines the amount that we are paid for your services. We cannot lower or adjust that amount, and we cannot see you and not charge you as that also would violate our contractual agreement with the insurance company.

7.FINANCIAL POLICY

You are responsible for payment of all medical treatment and related services provided by LPS. As a service and out of consideration to you, this office will, in most cases, file insurance claims for covered services. As appropriate, based on our contractual provisions with your insurer, this office will accept your insurance's maximum allowable reimbursement. You are responsible for any deductibles or copayments and any non-covered services (i.e. medical supplies, clerical work, etc.) incurred. You agree to pay these fees regardless of your interpretation of information provided from LPS staff or physicians, and you agree to be responsible for interpreting the complexity of your own health plan.

- All accounts are considered due after payment from insurance company is received.
- For your convenience, we have secured arrangements for partial payments
- The following include but are not limited to TWO OPTIONS made available under the financial policy as it pertains to an outstanding balance.

Option 1: Pay the account in full. Enclose payment for the complete balance.

Option 2: In the event that we do not receive payment in full within 30 days from the statement date, the following will automatically occur:

- 1) Collection Agency of our choice, shall be the agent on this account for future billings.
- 2) The patient shall be billed \$15.00 annual fee by group selected for account set up & administrative costs.
- 3) The patient shall be billed 1.375% monthly service fee on the outstanding balance.
- 4) The patient will be required to pay the GREATER of \$25.00 or 3% of the outstanding balance each month until the balance is paid in full.
- 5) The Attorney General of Oklahoma will be notified regarding any false payments, bounced checks, or payment fraud if the problem is not resolved in a timely manner.

8. INDEPENDENT PRACTICES & AGREEMENT TO HOLD PARTIES HARMLESS

I understand Jim Lowe MD, and any other on-site doctor or care giver practice independently of one another. I agree that if I am a patient or under the care of any one of the doctors or their representatives, or their physician assistant or aesthetician, I hold the other doctors and practices harmless for any events while under one doctor's or their representative's care. Independent physicians or caregivers may have financial ties to LPS of Oklahoma or its related companies. I understand all other physicians and/or "practices" function as independent corporations or entities. If I am a patient of Jim Lowe MD, or another independent caregiver, I hold all other caregivers harmless for any events under their care. Likewise, if I am a patient of any other physician or practice on-site, I hold Jim Lowe MD, and Lowe Plastic Surgery, or any related corporations, harmless for any events while under their care. Likewise, if I am a patient of Associates Surgery Center, I hold any other MD, Lowe Plastic Surgery, or any related corporations or uninvolved doctor, staff, or caregiver harmless for any events while under their care.

I agree to communicate with the practice directly in urgent, emergent, and time sensitive situations not relying on voicemail, fax, email, or other forms of communication that may not be reliable. I agree that in such situations I will talk to Dr. Lowe directly, allow him to see me when requested, and will proceed immediately to the emergency room of his choice or call 911 if he is not immediately available. I know that Dr. Lowe may not always be able to see me in a timely manner and he is unable to fully evaluate my clinical situation or condition without direct examination or all clinical information. I know and agree that leaving a message, sending fax, or emailing does not constitute direct communications and is not reliable. If I chose to communicate in such a manner, I agree to hold the practice, Lowe Plastic Surgery, Dr. Lowe and/or any associates harmless for all such communications.

I agree to fully release my HIPAA rights and health care records as well as any forms of communication or clinical information, if I or any representative or source choose to publicly attack or disparage Dr. Lowe, the practice, caregivers, and/or any associates regarding my care, directly or indirectly, in press, print, internet, or any other form of public, electronic, and/or written communication. In such cases, I agree to hold harmless Dr. Lowe, the practice, caregivers, and/or any associates, allowing all parties to be unrestricted, to publicly present relevant opinions, impressions, and/or care objectives in defense of the practice and Dr. Lowe's professional standing, legal position, and good name. Such attacks and/or disparagement, described above, may result in termination of care and/or future clinical responsibilities.

9. PREMISSION FOR PHOTOGRAPHY

I hereby voluntarily grant permission to Dr. James Lowe, LPS, and/or his or her designated representatives to take and use clinical photographs with the understanding that such photographs are for confidential, clinical record purposes, and that all photographs remain the property of the doctor. Occasionally, such photographs are used for teaching purposes, research, medical publications, medical, as well as public education and for patient information and education. By not crossing out the statements below your permission is thereby affirmed.

 $\frac{\sqrt{}}{\sqrt{}}$ I will permit the use of my photographs for such ethical professional purposes. (cross out if no) I will permit the use of my photographs for ethical professional purposes to include Dr. Lowe's website or other media publications. (cross out if no)

Neither I, nor any member of my family, will be intentionally identified by name. I understand that in some circumstances the photographs may portray features that will make my identity recognizable. Whenever possible these features will be concealed except in the cases of facial photographs where it would not be possible. I further understand that I have the right to revoke this authorization in writing at any time. I also understand that photographs are required by the practice to obtain approval from insurance, prepare for the case, and assist with quality improvement.

 $\underline{\sqrt{}}$ I fully understand and reviewed the above sections of this authorization (pages 1-4).

Rev. 1/1/22 $\sqrt{\text{Read}}$

10. RELEASE OF INFORMATION TO FAMILY AND FRIENDS

		of persons) to receive my protected health ren/ Other(s):
AUTHORIZATION FOR RE	LEASE OF ME	EDICAL INFORMATION
I hereby authorize my Physician	(s) or facility, to 1	release my medical information:
x Any and all materials as specif		
I am requesting a copy of my r	nedical records re	garding:
For date (s) of service From:		To:
Please forward the requested record Lowe Plastic Surge 2520 NW Expressw Oklahoma City, Ok	ry ay K 73112	
Phone: (405) 942-43		
Fax: (405) 942-4312		
	OF	
I hereby authorize LPS, to releas	e my medical inf	ormation:
Any and all materials as reque	sted by below enti	ty
I am requesting a copy of my r	nedical records re	garding:
For date (s) of service From:		To:
Please forward the requested record	ds to:	
Doctor or entity Name (s)		
Address (street, City, State, Zip)		Phone #/ Fax #
I understand that this authorization m	av he revoked hy t	he person giving authorization by a written and dated
		has been made prior to receipt of the revocation. Thi
		nless I specify otherwise or revoke my authorization.
Practice" that explains when, where, acknowledge LPS, the physicians, nur	opportunity to reco and why my conf ses, and other staff	ment eive a copy for review only of the "Notice of Privacy idential health information may be used or shared, may use and share my confidential health information successures that concern LPS operations and responsibilities.
Signature of patient or person	Date	Patient's relationship to person
Signature of Guarantor	Date	Patient's Relationship to Guarantor
Signature of Witness	Date	_

Lowe Plastic Surgery

COVID-19 PANDEMIC PATIENT CARE AND IMMUNITY STATEMENT

- 1. I hereby authorize the physician, James B. Lowe MD, providing care during medical pandemic and staff at Lowe Plastics Surgery (LPS), Associates Surgery Center (ASCO), all affiliated entities, as well as all providers participating in my care, to render treatment and surgery to me at this time.
- 2. I am aware all designated medical care provided by Lowe Plastic Surgery, during this medical crisis and COVID-19 pandemic, is for non-urgent, medically indicated surgical services. I agree to follow all safety protocols including but not limited to: social distancing when possible, good hygiene, restricting non-essential family or friends, and limiting non-urgent care when sick, febrile, or signs or symptoms of the flu or COVID-19.
- 3. Preservation of resources and protection of staff, family, and friends: I agree to do my best to limit the unnecessary use of medical products or services. I agree to use the phone, texting, email, or other electronic forms of communication when necessary to limit the exposure of myself or others to risk of infection, to include but not limited to COVID-19.
- 4. I am fully aware that contracting the COVID-19 or any other infectious disease before or after treatment or care may increase my risks of complications including: cardiac or pulmonary compromise or death. I am also aware contracting COVID-19 or any other infectious disease increases the risks to myself and others no matter the time, place, or situation. I agree most of the population will get the disease at some time and that my and others exposure is most likely inevitable.
- 5. I have made the decision to proceed with care at this time without coercion, pressure, or manipulation. I was given the opportunity to post-pone, delay, or cancel care but refused.
- 6. I agree not to openly or publicly criticize, complain, or lay blame for any services or care rendered during this time against the physician and employees of Lowe Plastic Surgery (LPS), associated personnel, entities, or staff.
- 7. I am aware that by signing this form, I have granted immunity form legal action or lawsuits against Dr. Lowe or any medical provider and their staff at Lowe Plastic Surgery (LPS) now and in the future. This immunity is also extended to anyone associated with services or care at Lowe Plastic Surgery and covers any and all medical treatment dates.

I have read and fully understand the above and all my questions have been answered.

Name Patient	Signature of Patient	Date
James Lowe, MD		/ /
Name	Signature of Dr./Staff	Date
X		/ /
Name	Signature of Witness	Date

Page | 1 Revised: 1/11/21

Lowe Plastic Surgery DR. JAMES LOWE - SURGICAL CONSULTATIONS

Dear Potential Surgical Patient:

Are you planning to undergo an elective or cosmetic surgical procedure that requires an anesthesiologist? Have you been diagnosed with a skin cancer or other medical condition requiring surgical evaluation or treatment? If so please review the information on this sheet. If you are not planning to have surgery ignore the below information!

In most cases, there are a number of alternatives in the treatment of cosmetic deformities, medical disease, or skin cancer (observation, radiation, chemotherapy cream, or surgery). If you have a medical condition, skin cancer, or any other indicated surgical condition, you may be referred for consultation with **Dr. James Lowe**, a board certified Plastic Surgeon. Please, let our office know if you already have a surgeon or you would like a referral to another board certified, Plastic & Reconstructive Surgeon. At your request, we can forward a copy of your record or other relevant information we may have in our possession.

If you wish to see Dr. James Lowe and do not already have an appointment, please call our office to schedule your consultation. The Plastic Surgery phone number is (405) 942-4300. When you come to our office for surgical consultation, Dr. James Lowe, will review your medical history, pathology, or other laboratory reports, examine the problem area, and develop a possible surgical plan with you.

Your surgical procedure will in most cases not be performed on the same day as your first surgical consultation. A significant amount of time may be needed for your evaluation and surgery can be lengthy. In some instances, the complexity of your medical conditions and the location of the disease may prevent surgery without a referral note from your primary care doctor, a medical work-up, an on-site pathologist, or a medication change. If your surgery cannot be performed in our office, the surgeon is often required to order blood work or other studies prior to scheduling the surgery.

If you have a significant medical condition, or you are over the age of 45, please bring a copy / have your doctor forward any lab work, chest x-rays, or EKGs that have been performed by any other physician in the past two months.

If you are scheduled for consultation for a cosmetic or self-pay surgery our office will provide an estimate for the surgical cost after your consultation. In most cases, medical insurance pays for the treatment and reconstruction of skin cancer or other significant medical disease. Our office may need to submit information to your insurance company in advance of your surgery. You are encouraged to call your insurance provider for exact rules related to your specific plan. If you elect to have surgery without pre-approval and/or if any of the costs associated with the procedure are denied, you will need to pay these costs. If we can provide you with further information please do not hesitate to contact us at (405) 942-4300.

JBL/jbl Rev. 3/2018