SPIRO
PLASTIC SURGERY

Name:_____

Date of Birth:_____

Today's Date:_____

Please provide a thorough and DETAILED explanation in your own words about what brings you to our office to see Dr. Spiro:

_____

_____

_____

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_____

Has Dr. Spiro ever operated on you in the past? If yes, please explain:

Yes_____ No_____ Reason:_____

_____

Have you ever previously been seen in our office? If yes, please explain:

Yes_____ No_____ Reason:_____

_____

How Did You Hear About Us?

Please take a moment to tell us where you heard about our office. Check all that apply.

Please remember all information is confidential.

☐ Online Review Sites- Google
☐ Online Review Sites- RealSelf
☐ Online Review Sites- American Society of Plastic Surgeons
☐ Online Review Sites- Yelp
☐ Online Review Sites- Other- Please Specify:_____

☐ www.drspiro.com
☐ Instagram @spiroplasticsurgery
☐ X @DrScottSpiro
☐ Facebook Spiro Plastic Surgery, LLC
☐ TikTok @spiroplasticsurgery

☐ Private Facebook Group- Please Specify:_____
☐ Reddit Forum- Please Specify:_____
☐ AI- Please Specify:_____

☐ Suburban Essex
☐ Vicinity Magazine
☐ NJ Top Docs
☐ NJ Monthly
☐ Chatham & Short Hills Lifestyle
☐ Morris & Essex Magazine
☐ Other Print Media- Please Specify: _____
☐ Podcast- Please Specify: _____

☐ Physician Referral: _____
☐ Patient Referral: _____
☐ Friend of a Friend: _____
☐ Other Source (Please Specify): _____

Which referral / advertisement helped most in making your decision to visit our office?

_____

Has the office ever treated any member of your family?
Yes,_____ No_____ Unsure_____ Names/Relations:_____

Did they have surgery with Dr. Spiro?
Yes_____ No_____ Unsure_____ Names/Relations:_____

Did they receive skin care treatments here?
Yes_____ No_____ Unsure_____ Names/Relations:_____

Did they have injectables or laser treatments here?
Yes_____ No_____ Unsure_____ Names/Relations:_____

Patient Name:_____ Date of Birth:_____

Patient Name:_____ **Today's Date:**_____

Home Address:_____**City, State, Zip Code:**_____

Date of Birth:_____ **Age:**_____ **Social Security #:**_____

E-mail:_____ **Marital Status: Married**_____ **Single**_____ **Other**_____

Cell Phone:_____ **Home Phone:**_____

Patient's Occupation:_____ **Employer:**_____

Business Address:_____ **Business Phone:**_____

Significant Other's Name:_____ **Significant Other's Occupation:**_____

Internist/Primary Care Provider Name and Phone Number:_____

Internist/Primary Care Provider Address:_____

Emergency Contact Name/Phone #:_____**Relationship:**_____

<u>Insurance Information:</u>

Primary Insurance Company:_____

Primary Claims Address:_____

Primary Insurance Telephone Number:_____

Identification Number:_____**GroupName/Number:**_____

Subscriber/Insured:_____

Subscriber Social Security

Number:_____

Subscriber Date of Birth:_____

Subscriber Employer:_____

Relationship of Patient to Subscriber:_____

Secondary Insurance Company:_____

Secondary Claims Address:_____

Secondary Insurance Telephone Number:_____

Identification Number:_____**GroupName/Number:**_____

Subscriber/Insured:_____

Subscriber Social Security Number:_____

Subscriber Date of Birth:_____

Subscriber Employer:_____

Relationship of Patient to Subscriber:_____

Purpose of Initial Consultation (please check the procedure(s) that you are interested in):

- ☐ **Brow Lift**
- ☐ **Face Lift**
- ☐ **Neck Lift**
- ☐ **Lip Lift**
- ☐ **Eyelid Surgery**
- ☐ **Otoplasty/Ear Surgery**
- ☐ **Fat Grafting (please specify area(s)):**_____
- ☐ **Liposuction (Please specify area(s)):**_____
- ☐ **Tummy Tuck**
- ☐ **Total Body Lift**
- ☐ **Brachioplasty/Arm Lift**
- ☐ **Completion Body Lift**
- ☐ **Back Lift**
- ☐ **Gynecomastia**
- ☐ **Breast Lift**
- ☐ **Capsulectomy**
- ☐ **Explant/"En Bloc"**
- ☐ **Removal of Implants**
- ☐ **Removal and Replacement of Implants**
- ☐ **Breast Reconstruction (related to breast cancer)**
- ☐ **Revision Breast Reconstruction (related to breast cancer)**
- ☐ **Revision Breast Reconstruction (NOT related to breast cancer)**
- ☐ **Breast Reduction**
- ☐ **Breast Augmentation**
- ☐ **Breast Autoaugmentation**
- ☐ **Gender Affirmation**
- ☐ **Labiaplasty/Vaginoplasty**
- ☐ **Other Body Contouring:**_____
- ☐ **Correction of Facial Wrinkles**
- ☐ **Correction of Brown Spots**
- ☐ **Resolution of Acne**
- ☐ **Botox/Xeomin**
- ☐ **Facial Fillers (Juvéderm)**
- ☐ **CoolSculpting**
- ☐ **Diamond Glow**
- ☐ **Laser Skin Resurfacing**
- ☐ **PRP/PRF**
- ☐ **Chemical Peels**
- ☐ **Microneedling**

Patient Name:_____ **Date of Birth:**_____

MEDICAL HISTORY:

Height: _____ Weight:_____ BMI:_____ Weight change in the past year:_____Loss/Gain

Date of last physical ___/___/_____ Location of last physical:_____

Did your last physical include any of the following (circle): EKG/ Blood work/ Chest X-Ray/ Stress Test/ Other

Pharmacy Information: (for prescriptions): _____

MEDICATIONS: List all medications, vitamins, supplements, and herbals that you take daily and as needed**:

Medication Name	Dosage	How Often Taken	Reason for Taking	Prescriber (physician)

**Please attach a separate sheet of paper with additional medications, supplements, vitamins, and herbals as needed.

ALLERGIES: Please list all allergies to any drugs, foods, environmental factors, or others with reactions below:

_____

_____

☐ No Known Allergies

MEDICAL CONDITIONS/ILLNESSES: Have you ever been diagnosed with or had the following (If yes, please explain):

- ☐ Acid Reflux_____
- ☐ Adhesive Allergy_____
- ☐ Anemia_____
- ☐ Anxiety_____
- ☐ Arthritis_____
- ☐ Asthma_____
- ☐ Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)_____
- ☐ Autoimmune Disease_____
- ☐ Back Problems_____
- ☐ Bipolar Disorder_____
- ☐ Bleeding Disorder_____
- ☐ Blood Clots_____
- ☐ Body Dysmorphic Disorder_____
- ☐ Bone/Joint Disease_____
- ☐ Bowel/Intestinal Disorder_____
- ☐ Bowel Obstruction_____
- ☐ Brain/Neurologic Disorder_____
- ☐ Breast Biopsies_____
- ☐ Breast Cancer_____

- ☐ Cancer_____
- ☐ Chemotherapy_____
- ☐ Chest Pain/Tightness_____
- ☐ COVID-19_____
- ☐ Dental Problems_____
- ☐ Depression_____
- ☐ Diabetes_____
- ☐ Dry Eye_____
- ☐ Ectopic Pregnancy_____
- ☐ Eczema_____
- ☐ Facial Surgery_____
- ☐ Frequent Infections_____
- ☐ Heart Arrhythmia_____
- ☐ Heart Attack_____
- ☐ Heart Disease_____
- ☐ Hernia_____
- ☐ High Blood Pressure_____
- ☐ High Cholesterol_____
- ☐ Human Immunodeficiency Virus (HIV)_____
- ☐ Hives_____
- ☐ Hormonal Imbalance_____
- ☐ Hyperthyroid_____
- ☐ Hypothyroid_____
- ☐ Kidney Problems_____
- ☐ Kidney Stones_____
- ☐ Large Scars/Keloids_____
- ☐ Latex Allergy_____
- ☐ Learning Disorder_____
- ☐ Liver Disease_____
- ☐ Lung Problems_____
- ☐ Mental Illness_____
- ☐ Metabolic Issues_____
- ☐ Motion Sickness_____
- ☐ Multiple Sclerosis_____
- ☐ MRSA or VRE_____
- ☐ Other_____
- ☐ Other Heart Condition_____
- ☐ Other Skin Disorders_____
- ☐ Pneumonia_____
- ☐ Psoriasis_____
- ☐ Radiation_____
- ☐ Reactions to Anesthetics_____
- ☐ Reproductive Problems_____
- ☐ Seizures_____
- ☐ Sinus Problems_____
- ☐ Skin Cancer_____
- ☐ Skin Disease_____
- ☐ Stroke_____
- ☐ Thyroid Disorder_____

Patient Name:_____ **Date of Birth:**_____

- ☐ Tuberculosis_____
- ☐ Ulcers_____
- ☐ Urinary Problems_____
- ☐ Urinary Tract Infections_____
- ☐ Vascular Disease_____
- ☐ Xray Therapy_____
- ☐ No Pertinent Medical History_____

PRIOR SURGERIES AND HOSPITALIZATIONS (please list all, including cosmetic procedures) If none, write N/A:

DATE	SURGERY OR ILLNESS	HOSPITAL AND PHYSICIAN

PRIOR BREAST SURGERIES (please list all, including cosmetic procedures) If none, write, N/A:

DATE	SURGERY OR ILLNESS	HOSPITAL AND PHYSICIAN

Have you ever had a reaction or adverse event related to anesthesia? Yes_____ No_____

Do you have a history of malignant hyperthermia? Yes_____ No_____

Do you have a family history of malignant hyperthermia? Yes_____ No_____

If yes to any of the above questions, please explain:_____

_____

Patient Name:_____ **Date of Birth:**_____

SOCIAL HISTORY AND OTHER PERTINENT CLINICAL INFORMATION:

Do you smoke cigarettes? Yes_____No_____Quit (date)_____

Do you use a vape? Yes_____No_____Quit (date)_____

Do you use nicotine patches, nicotine chewing gum, nicotine lozenges, or ANY nicotine products? Yes_____No_____

When was your last cigarette or use of ANY nicotine products? _____

Does anyone in your household smoke? Yes_____No_____

Do you smoke marijuana or use edibles or vape? Yes_____No_____If yes, how often_____

Do you vape anything? Yes_____ No_____If yes, please explain_____

Do you use any other recreational drugs? Yes___ No___ If yes, what kind and how often? _____

Caffeine consumption (number of drinks per day): Coffee____Tea____Soda____Energy drinks____

Alcohol consumption (number of drinks per week and what kind): _____

Do you take any stimulant medication(s) for ADD/ADHD, weight control, and/or any other reason? Yes_____No_____

If yes, please explain:_____

Do you or have you ever taken steroid medications, cortisone, or ACTH? Yes_____No_____

Do you use any workout supplements? Yes_____No_____ If yes, what kind and how often? _____

Do you use any other herbal or nutritional or herbal supplements? Yes_____No_____If yes, what kind and how often?_____

Have you ever had any psychiatric or psychological care (including therapy)? Yes_____No_____

If yes, please explain: _____

_____

Do you have any significant emotional problems? _____

Have you ever been diagnosed with Body Dysmorphic Disorder (BDD)? If yes, please explain:_____

_____

Do you have any vision problems?_____

Do you have any neurological deficits (weakness, numbness, difficulty with speech)?_____

Do you have any lifestyle factors that would prevent you from consenting to a blood transfusion? Yes_____No_____

If yes, please explain: _____

WOMEN ONLY:

How many times have you been pregnant? _____How many children do you have? _____

How many miscarriages have you had? _____ Have you ever had an ectopic pregnancy? _____

Are you planning more children? _____ Are you currently pregnant? _____

Have you breastfed in the past? Yes_____No_____When was your last latch? _____

Did you have any complications during your pregnancy? Yes_____No_____

If yes, please explain: _____

When was your last menstrual cycle? _____Date of last mammogram? _____ Facility: _____

Are you currently using contraception? Yes_____No_____If so, what kind? IUD _____Birth Control Pills ___Other _____

If using an IUD, please specify which:_____

For breast procedures: What size bra are you currently wearing and how do you feel it fits? _____

FAMILY HISTORY:

If family has been diagnosed with the following, please detail which family member(s) and explain:

- ☐ Abnormal bleeding_____
- ☐ Abnormal clotting_____
- ☐ Autoimmune disorders_____
- ☐ Breast Cancer_____
- ☐ Other Cancer_____
- ☐ High Blood Pressure_____
- ☐ Hemophilia_____
- ☐ Prostate Cancer_____
- ☐ Skin Cancer_____
- ☐ von Willebrand_____
- ☐ Malignant Hyperthermia_____
- ☐ Reaction to anesthsia_____
- ☐ Other_____

INJURY AND MOTOR VEHICLE QUESTIONS:

Is this consultation related to an injury? Yes_____No_____ Date of Injury_____

Did the injury happen at work? Yes_____No_____ Please explain:_____

Is the injury related to a motor vehicle accident? Yes_____No_____

Patient Name:_____ Date of Birth:_____

For a minimum of ***THREE (3) WEEKS*** prior to any surgical procedure, please avoid the following medications, dietary supplements and herbal teas/remedies. Please disclose EVERY prescription/non-prescription medication, supplement, suspension, oil, etc. that you consume.

PLEASE NOTE: If you take aspirin, Lovaza, an antidepressant, or any other medication under the direction of a physician, check with your doctor *prior* to stopping any medication. Do not resume taking these substances after your surgery until approved by the doctor.

PLEASE CIRCLE ANY YOU ARE TAKING

	Common Over-The-Counter/	*	Chinese Herbs	*	Kava Tea	
	Prescription Pain Relievers	*	Chinese Herbal Teas	*	Lavender/Valerian Root	
*	Advil	*	Chinese root extract	*	Licorice Root	
*	Motrin	*	Coenzyme Q10 (CoQ-10)	*	Licorice Tea	
*	Aleve	*	Colon Cleanse	*	Lovaza	
*	Aspirin	*	Damiana Tea	*	Ma Huang (Ephedra)	
*	Bufferin	*	Dandelion Tea	*	Melatonin	
*	Excedrin	*	Dong Quai Root	*	Natural Medications	
*	Ibuprofen	*	Energy Drinks	*	Papaya	
*	Naprosyn	*	Fennel Tea	*	Protein Supplements	
*	Ketaprofin capsules	*	Feverfew	*	Selenium	
*	Alka-Seltzer	*	Fish Oil (Alpha Omega)	*	Seroquel	
		*	Flax Seed Supplement	*	Skull Cap Tea	
	Common Vitamins	*	Garlic (Allium sativum)	*	St. John's Wart Tea	
*	Multi-Vitamins	*	Ginger	*	System Detox	
*	Vitamin E	*	Gingko	*	Willow Bark	
		*	Gingkobilboa	*	Yellow Root	
	Herbals and Other	*	Glucosamine	*	Yarrow Tea	
*	Alfalfa	*	Goldenseal	*	Yohimbe ("The Natural Viagra")	
*	Appetite Suppressants	*	Green Tea	*	Sumatra Coffee (Starbucks)	
	-i.e. Phentermine	*	Guarana	*	Any Additional_____	
*	Berdock Tea	*	Hawthorne Tea			
*	Bilderberry	*	Herbal Supplements			
*	Biotin	*	Herbal Teas			
*	Chamomile Tea	*	Holistic Medications			
*	Cayenne	*	Horse Chestnut			
*	CBD Oil	*	Hydroxycut			

Aspirin and aspirin-containing products, some dietary supplements, "nutraceuticals", and even teas have all been linked to prolonged bleeding which complicates surgery, delays healing, produces more bruising, and may lead to *emergent re- operation* for continued bleeding after surgical procedures. If you need to take an aspirin-free fever reducer/pain reliever prior to your procedure, we recommend Tylenol, or the generic equivalent Acetaminophen.

Alcohol Patients should not consume any alcoholic beverages for a minimum of ten (10) days prior to any surgical procedure.

Hormones- Hormones such as estrogen and progesterone from birth control, intrauterine devices, and bioidentical hormones, hormone replacement therapy, selective estrogen replacement modulators, and aromatase inhibitors can increase your risk of blood clots during surgery and contribute to complications like Deep Venous Thrombosis and Pulmonary Embolism. We recommend hormones be discontinued for 4 weeks prior to surgery with the consent of your prescribing physician.

Patient Name:_____ **Date of Birth:**_____

Coagulation Questionnaire

Part of the normal healing process after surgery involves an interaction with your coagulation system. It is important that we understand how your coagulation system will respond to surgery. Please complete the following checklist:

1) Do you have a history of varicose veins?	Yes	/	No
2) Do you have a history of inflammatory bowel disease? *(Not Irritable Bowel)*	Yes	/	No
3) Do you currently have swollen legs?	Yes	/	No
4) Have you ever been diagnosed with congestive heart failure?	Yes	/	No / NA
If YES, explain			
5) Have you been diagnosed with sepsis within the last 6 months?	Yes	/	No
If YES, explain			
6) Have you been diagnosed with pneumonia within the last 6 months?	Yes	/	No
If YES, explain			
7) Have you ever been diagnosed with abnormal pulmonary function including COPD or emphysema?	Yes	/	No
If YES, explain			
8) Do you have a central venous access port?	Yes	/	No
9) Do you have a history of deep venous thrombosis (DVT) or pulmonary embolism (PE), or blood clots anywhere else in your body?	Yes	/	No / NA
If YES, explain			
10) Do you have a family history of DVT, PE, or any other clotting issues including excessive bleeding?	Yes	/	No
11) Have you ever been diagnosed with any of the following:			
Factor V Leiden?	Yes	/	No
Prothrombin 20210A?	Yes	/	No
Elevated serum homocysteine levels?	Yes	/	No
Positive lupus anticoagulant?	Yes	/	No
Elevated anticardiolipin antibodies?	Yes	/	No
Congenital or Acquired thrombophilia?	Yes	/	No
Heparin-induced Thrombocytopenia (HIT)?	Yes	/	No
Any other type of abnormal clotting?	Yes	/	No
12) Have you had a hip, pelvis, or leg fracture within the last month?	Yes	/	No
13) Have you had a stroke or transient ischemic attack within the last month?	Yes	/	No
14) Are you currently taking oral contraceptives or hormone replacement therapy?	Yes	/	No / NA
15) Have you ever had any miscarriages?	Yes	/	No / NA
How many?			
16) Do you have a history of unexplained stillborn infant, recurrent spontaneous abortion/miscarriage (>3),			
premature birth with toxemia or growth-restricted infant?	Yes	/	No / NA
17) Are you currently taking any medications that are blood thinners, such as aspirin,			
anti-inflammatory medications, anti-platelet medications, Warfarin, Pradaxa, Aggrenox, Plavix,	Yes	/	No
Pletal, Vitamin E, Herbals, or Homeopathic substances?	Yes	/	No
18) Are you currently taking an SSRI or MAOI (anti-depression medication)?	Yes	/	No
19) Have you ever required a blood transfusion because of excessive bleeding?	Yes	/	No
20) Do you commonly have heavy menses?	Yes	/	No / NA
21) Do you experience nosebleeds more often than several times a year?	Yes	/	No
22) History of COVID-19? Last known positive test:_____	Yes	/	No

Patient Name:_____ **Date of Birth:**_____

Nicotine and Marijuana Policy

Nicotine, marijuana, and marijuana related products (cannabinoids) negatively impact healing and can cause unwanted and avoidable surgical complications. Because of this, we have a NO NICOTINE and NO MARIJUANA USE POLICY for your safety (see handout of adverse effects).

Patients must be nicotine and marijuana free for AT LEAST SIX WEEKS PRIOR TO SURGERY.

You must avoid all smoking, vaping, and use of edibles or oils. You may not use any nicotine replacement therapy such as nicotine patches, nicotine chewing gum, nicotine lozenges, vapes, or hookahs. You must refrain from using e- cigarettes and herbal cigarettes or vape cartridges of any kind, even if they do not have nicotine in them. You must also avoid second and third hand smoke. If you are able to smell it, you must avoid it.

There are medications that can help you quit smoking that we may approve you to use, but these would need to be prescribed from your primary care provider and approved by us. Please contact us or your primary care provider for more information.

We understand that some patients may have prescriptions for medical marijuana, however it will still have the potential to negatively impact your surgical outcome. Patients with prescriptions for medical marijuana must let our staff know and will also need to contact their prescribing physician for an alternative.

Please be aware that our office requires random nicotine and THC testing as frequently as once a week. These visits take about 10 minutes to complete. We typically will grant our patients 48 hours to comply with a request for an in-office screening, but we do require that you have a scheduled appointment.

- As part of our policy, you may be required to undergo three (3) or more random THC and/or nicotine tests administered and interpreted by our office prior to your scheduled surgery. Fees will be collected by our office at the time we designate it necessary for your upcoming procedure and are separate from your surgical fees. The following are the fees:
    - Up to three (3) nicotine tests: 25.00
    - Up to three (3) THC tests $15.00
    - Up to three (3) nicotine and THC tests: $40.00

If testing is positive, your surgery will need to be postponed to help reduce your risk of complications.

By lack of disclosing nicotine or marijuana use, you are putting yourself at risk for adverse events including the risk of hospitalization, re-operation, stroke, cardiovascular injury, or death.

By signing below, you are acknowledging our policy.

Print Name	Signature of Patient or Legal Guardian	Date

Authorization to Disclose Protected Health Information (PHI)

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is also called "protected health information" (PHI) under HIPAA's Privacy Rule. I understand that if the person or entity receiving this information is not a health plan or health care provider covered by the federal privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

Name of Individual or Company to Whom Disclosures May Be Made To:

1) Name: _____Relationship: _____

   Financial Information (circle): Yes No PHI (circle): Yes No

2) Name: _____Relationship: _____

   Financial Information (circle): Yes No PHI (circle): Yes No

3) Name: _____Relationship: _____

   Financial Information (circle): Yes No PHI (circle): Yes No

Limitations of Disclosure: Please describe any limitations that you would like on the disclosure of your PHI and/or Financial Information:

_____

I understand that I may revoke this permission, in writing, at any time. Revoking permission, however, does not affect previous disclosures that were made with my consent.

Print Name: Signature: Date:

Authorization to be Contacted Through Alternate Means

I hereby request to be contacted through alternate means. I understand that in the course of doing so, my PHI may be viewed by individuals I did not intend. I understand that I may revoke this request in writing, at any time. *Please list any alternate addresses, phone numbers, e-mail addresses, etc. that you would prefer to be contacted at:*

_____

Print Name: Signature: Date:

Authorization to be Contacted by Text Messaging (data rates may apply) and E-Mail

- ☐ I consent to be contacted by e-mail regarding notifications that documents have been uploaded to my patient portal and for promotions/special events within the office.
- ☐ I consent to be contacted by text messaging regarding upcoming appointments and rating services.

Print Name: Signature: Date:

Medical Record and Photographic Consent

I understand that photographs and/or videos will be taken at the time of my consultation, as well as during and after my procedure as part of my medical record. Photographs may be submitted to insurance carriers for the purpose of coverage determinations. I understand that photos sent to Spiro Plastic Surgery, LLC will be at my own will and discretion.

Print Name: Signature: Date:

Use of Medical Records

I acknowledge that Spiro Plastic Surgery, LLC can use information from my medical record, plan of care, and surgery outcome in future presentations to residents and regional and national meetings and presentations. Your name, Social Security number, and/or date of birth will never be used for presentations or meetings.

Print Name: Signature: Date:

Use of Medical Records

I consent to the use of pre- and post-operative photos for use in scientific meetings. Your name, Social Security number, and/or date of birth will never be used for presentations or meetings.

Print Name: Signature: Date:

Notice of Privacy Practices Acknowledgement Receipt

I acknowledge receipt of the Notice of Privacy Practices, amended June 24, 2025.

Print Name: Signature: Date:

Financial Policy Agreement for Spiro Plastic Surgery

CONSULTATION FEES: Patients who wish to discuss multiple surgical procedures and/or treatment of multiple body regions may be charged an additional fee. Consultations that are functional in nature may be submitted to insurance and subject to deductible, co-insurance, and co-pay. If consultations are both cosmetic and functional, they may be subject to both a self-pay/out-of-pocket consultation fee as well as a billable charge to your insurance carrier.

ACCEPTED METHODS OF PAYMENTS: For services provided by our office, we accept cash, bank checks, money orders, Visa, MasterCard, Discover, and American Express. Personal checks will not be accepted upon your first encounter. Payment for surgical procedures with personal checks will only be accepted up to three weeks prior to the services being rendered. Please be advised that the business reserves the right to use its own discretion when accepting forms of payment. There is a fee of $30.00 for returned checks.

OUT-OF-NETWORK/NON-PARTICIPATING: Spiro Plastic Surgery, LLC is a non-participating provider with all health insurance plans.

- ***Claims for services rendered in the office:*** Healthcare claims for any services rendered in the office will be processed under the out-of-network provisions of your policy.
- ***Claims for services rendered at facilities:*** Our providers operate at facilities that are in-network with all major insurance carriers which protects you from balancing billing under The No Surprises Act. Any approved surgeries performed at in-network facilities will be processed per your in-network benefits, and you will be responsible for any in-network co-pays, deductibles, and co-insurance per the terms of your plan.

COVERED SERVICES:

- ***Approved Surgeries:*** If you meet the criteria for coverage, we will initiate all pre-certifications/pre-determinations required for medically necessary procedures prior to your surgery and notify you of the outcome. Prior to your approved procedure, we will collect any applicable co-pays, deductibles, and co-insurance per the terms of your plan. We will submit all approved procedures to your insurance carrier on your behalf.

NON-COVERED SERVICES:

- ***Non-Covered Surgeries:*** If your procedure does not meet criteria for coverage under your plan provisions, we will collect 100% of the surgical fee in advance of your procedure, due three (3) weeks prior to surgery. Not all services rendered by Spiro Plastic Surgery, LLC that your provider may consider medically necessary are covered benefits under every insurance carrier. All procedures that are submitted to insurance and denied as a non-covered service will be your financial responsibility.

COSMETIC PROCEDURES: Procedures deemed cosmetic in nature will not be submitted for pre-certifications or pre-determinations to your insurance carrier.

MEDICARE: – Effective April 1, 2011, Dr. Spiro has “opted out” of the Medicare system and may

enter into private contracts with Medicare beneficiaries. As such, patients must accept full responsibility for payment of Dr. Spiro's fees for all services rendered. Medicare limiting charges do not apply to Dr. Spiro's services. Our office cannot submit claims to Medicare for services provided by Dr. Spiro. Similarly, Medigap plans and other supplemental plans will not make payment for services rendered by Dr. Spiro as he is opted out of Medicare.

MEDICAID – Spiro Plastic Surgery, LLC does not participate with Medicaid or any Medicaid plans administered through other carriers. Please advise our office if you have a primary or secondary Medicaid plan.

INSURANCE PAYMENTS: Our office may be notified by your insurance carrier that you have received an insurance check/ACH payment. Should you receive an insurance payment for services rendered by Spiro Plastic Surgery, LLC, you will be responsible for reimbursing our office within seven (7) days of receipt with a copy of the explanation of benefits. If you have not received any insurance correspondence, it is your responsibility to follow-up with the insurance carrier immediately. Non-payment to our practice may result in default of your account and subsequent placement with an attorney or bonded collection agency.

COLLECTIONS: In the event a patient balance exceeds 90 days, the undersigned authorizes Spiro Plastic Surgery, LLC and/or their authorized agent to verify any information provided to the practice, now or in the future, and/or obtain additional information by securing data from a credit reporting agency. In addition, the undersigned agrees to pay a thirty percent collection fee in the event of default on their account, if the account is placed with an attorney or bonded collection agency.

CREDIT CARD DISPUTES: If you engage your credit card company by disputing a charge, you are hereby authorizing Spiro Plastic Surgery, LLC to share details regarding appointments, treatments, and purchases with your credit card company, thereby relinquishing your HIPAA rights as it pertains to the financial dispute.

APPOINTMENT SCHEDULING FEES, LATE FEES, AND CANCELLATION FEES:

Spiro Plastic Surgery LLC collects fees for scheduling appointments**.** Scheduling fees are collected prior to scheduling the appointment and will be applied towards your consultation fee or service fee. Please read the following carefully.

- **CONSULTATION/SCHEDULING FEE FOR DR. SPIRO:**
    - The cosmetic consultation fee for Dr. Spiro is $500. This is prepaid and collected at the time of scheduling an appointment. This amount is retained as a cancellation fee for appointments that are cancelled or rescheduled within two business days of an appointment and "no shows."
    - Specialist co-pays are prepaid and collected at the time of scheduling an appointment for patients seeking treatment for medically necessary or potentially medically necessary procedures for patients with Blue Cross Blue Shield commercial insurance plans. This amount is retained as a cancellation fee for appointments that are cancelled or rescheduled within two business days of an appointment and "no shows."
    - Spiro Plastic Surgery is out-of-network with all other carriers, opted out of Medicare, and we do not accept Medicaid. The consultation fee for patients seeking treatment for medically necessary or potentially medically necessary procedures with out-of-network plans, Medicare, or Medicaid is $200 and is prepaid and collected at the time of scheduling an appointment. This amount

is retained as a cancellation fee for appointments that are cancelled or rescheduled within two business days of an appointment and "no shows."

- If you have out-of-network benefits, your consultation fee will be submitted to your carrier on your behalf.

- **SCHEDULING FEE FOR COOLSCULPTING CONSULTATIONS, SKIN CARE SERVICES, AND INJECTABLES:**
    - The scheduling fee for CoolSculpting consultations, injectables, lasers, and all other skin care services is $100 which is prepaid and collected at the time of scheduling an appointment. This amount is retained as a cancellation fee for appointments that are cancelled or rescheduled within two business days of an appointment and "no shows." The fee may be allocated towards services rendered for treatments performed within thirty days of the consultation.
- **SCHEDULING FEE FOR COOLSCULPTING:**
    - The scheduling fee for CoolSculpting treatments is $250 per treatment cycle. The balance for treatment cycles is due prior to treatment on the day of the appointment. The scheduling fee for CoolSculpting treatments will be assessed and retained as a cancellation fee for appointments that are cancelled or rescheduled within two business days of an appointment and "no shows."
- **LATE FEES AND CANCELLATION FEES**:
    - A late fee will be assessed for all appointments for patients who do not arrive on time. If you are late and we cannot accommodate you, your appointment will be subject to cancellation. The scheduling fee will be assessed and retained as your late fee charge.
    - If you are late and our office is able to accommodate you, the scheduling fee will be assessed and retained as a late fee charge and will not be applied towards the balance of your consultation or treatment. The full amount of the service will be due at the time of the appointment.

PRODUCT REFUND POLICY: If a patient has a documented skin reaction within three weeks of the purchase date of the product, a credit for the product may be issued. Credits may be used towards future products and/or services within Spiro Plastic Surgery, LLC. No credits will be issued after three weeks from the purchase date. All credits expire one year from the date issued.

By signing below, you are agreeing that you have read and understand our financial policy. If you have any questions about our financial policies, please feel free to ask for additional clarification from our Billing Manager. We are here to assist you in any way possible. Thank you for choosing Spiro Plastic Surgery, LLC.

Print Name: Signature: Date:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Any questions or concerns regarding information contained in this document should be directed to:

Privacy Officer, Spiro Plastic Surgery, LLC
101 Old Short Hills Road Suite 510
West Orange, NJ 07052
Telephone (973) 736-5907

We Have a Legal Duty to Safeguard Your Protected Health Information (PHI).

This includes information that can be used to identify you that we have created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We must provide you with this notice regarding our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use and disclosure. We are legally required to follow the privacy practices that are described in this notice. However, we reserve the right to change the terms of this notice at any time. Any changes will apply to the PHI we already have. We will promptly post the revised policy in our office waiting room. You may also request a copy of this notice from the individual named above at any time.

How We May Use and Disclose Your Protected Health Information:
We use and disclose health information for many reasons. Below we describe the different uses and disclosures. Uses and disclosures which do not require your authorization:

- Treatment - We will use your health information for treatment. We may provide your information to hospitals, anesthesiologists, and other physicians involved in your care, nurses and technicians.
- Payment – We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. A bill may be sent to you, a third-party payer, or collection agency. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis and procedures.
- Health Care Operations – We may disclose your PHI in order to operate this practice. We may use your information in order to evaluate the quality of health care services our office provides. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make certain we are complying with laws that apply to our practice.

- Federal, State, or Local Law, Judicial or Administrative Proceedings, or Law Enforcement – We may disclose your information when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, domestic violence, or when ordered in a judicial or administrative proceeding.
- Business Associates - There are some services provided in our practice through contacts with business associates. Examples include radiology, anesthesiology, laboratory diagnostics, hospital and surgical facilities, etc. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer when necessary. So that your health information is protected, however, we require the business associate to appropriately safeguard your information.
- Public Health Activities – We may report information to government officials in charge of collecting information about various diseases, infections, and medical products. We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls. We may provide coroners, medical examiners, and funeral directors any necessary information.
- Health Oversight Activities – We will provide information to assist the government when it conducts an audit or investigation of a physician or medical practice.
- Tissue/Organ Donation – We may contact tissue procurement organizations to assist them in donations and transplants.
- Research - We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. We will always ask for your specific written permission if the researcher will have access to any information that reveals who you are, such as your name, address or other patient identifying information.
- To Avoid Harm - In order to avoid a serious threat to the health and safety or a person or the public, we may provide your information to law enforcement personnel or persons able to prevent or lessen such harm.
- Specific Government Functions – We may disclose information on military personnel or veterans in certain situations. We may disclose information for national security purposes or conducting intelligence operations.
- Workers' Compensation – We may provide information to comply with applicable workers' compensation laws.

- Appointment Reminders and Health Related Benefits or Services – We may use information to advise you of future appointments, treatment alternatives, or other health care services or benefits we offer.
- Incidental Uses and Disclosures – An incidental use and disclosure is a secondary use that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. Such uses are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your information than is necessary to accomplish the permitted disclosure.

Uses and disclosures where you have the opportunity to object:
Disclosures to Family, Friends, and Others – Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. You may object in whole or in part to these disclosures.

Other uses and disclosures of medical information not covered by this policy or applicable laws will only be made with your prior written approval. You may revoke that permission, in writing, at any time. Revoking your permission does not require us to take back any disclosures we have previously made with your permission.

Your Rights Regarding Your Protected Health Information
Although your health record is the physical property of the healthcare practitioner, the information belongs to you. You have the right to:

- Obtain a copy of the Notice of Privacy Practices upon request.
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522. This request must be made in writing to the attention of the Privacy Officer and must include what information that patient wants to limit and to whom the limits apply. We will consider your request but are not legally required to accept it.
- Inspect and copy your health record as provided for in 45 CFR 164.524. This request must be made in writing to the attention of the Privacy Officer. We will respond to you within 30 days of receiving your written notice. We may charge a fee for the costs of copying, mailing, faxing, reproducing photographs, or other expenses associated with a patient's request.
- Choose how we send health information to you. You may request that we send information to you at an alternative address or by alternate means.
- Request an amendment of your health record if you feel the information, we have is incomplete or incorrect as provided in 45 CFR 164.528. Requests must be made in writing to the attention of the Privacy Officer and must include a valid reason to support the request. We will respond within 60 days of receiving your written request.

- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528. This list will not include disclosures you have already consented to such as those made for treatment, payment, or health care operations, or disclosures made prior to the effective date of this policy. This request must be made in writing and must state a period of no longer than six years. We will respond within 60 days of receiving your written request.

For More Information or to Report a Problem

If you have any questions or would like additional information, you may contact the Privacy Officer at (973) 736-5907. If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint. All complaints must be made in writing.

Revisions of Privacy Policy

We reserve the right to change our Privacy Practices at any time and to make the new provisions effective for all protected health information we maintain. You may request a copy of any revisions made to our Notice of Privacy Practices either by mail, telephone, or in person.

Policy Effective Date: June 24, 2025.

ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/LIMITED SPECIAL POWER OF ATTORNEY

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to Spiro Plastic Surgery, LLC and Scott A. Spiro, MD (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of one or more of the Providers, or their attorney (or other representative) to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against any person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account.

In the event the insurance carrier responsible for making medical payments to Spiro Plastic Surgery, LLC and Scott A. Spiro, MD for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/ special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider including attorney fees and costs. To this end, Provider has exclusive settlement authority.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers or any other person or business that provides healthcare activity services as a "business associate' (including Gottlieb and Greenspan, LLC) under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.

1.The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.

2.The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.

3.The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.

4.The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third- party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name:_____ Date:_____

Patient Signature: _____

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In the event the insurance carrier responsible for making medical payments to Spiro Plastic Surgery, LLC and Scott A. Spiro, MD for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/ special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider including attorney fees and costs. To this end, Provider has exclusive settlement authority.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers or any other person or business that provides healthcare activity services as a "business associate' (including CH Revenue Management Solutions, LLC) under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.

1.The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.

2.The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.

3.The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.

4.The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

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I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third- party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

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Patient Name:_____ Date:_____

Patient Signature: _____