

Otolaryngology Supplemental Questionnaire



INTRODUCTION

Your Full Name:

Policy Number:

Directions: Please answer all questions fully and completely. If a question does not apply to your practice, state "N/A." Use the Remarks section if you need additional space or attach additional pages as necessary. **Please ensure that you sign and date the questionnaire on page 4.**

SECTION I

PROCEDURES

Cosmetic Procedures and Cosmetic Surgery

1. Do you perform cosmetic procedures and/or cosmetic surgery of the head and neck? Yes No

NOTE: NORCAL uses the American Medical Association's (AMA) definition of cosmetic surgery. According to the AMA, cosmetic surgery is "surgery performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem."

If no, please go to Section II.

If yes, please complete the following:

Procedure	Estimated Number Performed Per Year	Procedure	Estimated Number Performed Per Year
<input type="checkbox"/> Ambulatory Phlebectomy	<input type="text"/>	<input type="checkbox"/> Facial Implants	<input type="text"/>
<input type="checkbox"/> Blepharoplasty	<input type="text"/>	<input type="checkbox"/> Forehead Lift	<input type="text"/>
<input type="checkbox"/> Botox Injection	<input type="text"/>	Hair Restoration Surgery specify type(s) (e.g., Minigrfts): <input type="text"/>	<input type="text"/>
<input type="checkbox"/> Chemical Peel	<input type="text"/>	<input type="checkbox"/> Laser Hair Removal	<input type="text"/>
<input type="checkbox"/> AHA Peel	<input type="text"/>	<input type="checkbox"/> Laser Resurfacing	<input type="text"/>
<input type="checkbox"/> TCA Peel	<input type="text"/>	Liposuction specify type(s) (e.g., Tumescent): <input type="text"/>	<input type="text"/>
<input type="checkbox"/> Phenol Peel	<input type="text"/>	<input type="checkbox"/> Microdermabrasion	<input type="text"/>
<input type="checkbox"/> Collagen Injection	<input type="text"/>	<input type="checkbox"/> Microlipoinjection (i.e., Autologous Fat Injection)	<input type="text"/>
<input type="checkbox"/> Dermabrasion	<input type="text"/>	<input type="checkbox"/> Otoplasty	<input type="text"/>
<input type="checkbox"/> Dermaplaning	<input type="text"/>	<input type="checkbox"/> Rhinoplasty	<input type="text"/>
<input type="checkbox"/> Facelift	<input type="text"/>	<input type="checkbox"/> Sclerotherapy	<input type="text"/>

2. Do you perform any cosmetic procedures and/or cosmetic surgery of the head and neck not already specified in question 1?

Yes No

If yes, please identify the procedure(s) and the estimated number of each you perform per year:

3. Please identify which, if any, of the following apply to you:

- I am certified by the American Board of Otolaryngology with a general certificate in otolaryngology and a subspecialty certificate in plastic surgery within the head and neck
- I am certified by the American Osteopathic Boards of Ophthalmology and Otolaryngology—Head and Neck Surgery in otolaryngology and facial plastic surgery
- I am certified by the American Board of Facial Plastic and Reconstructive Surgery
- I completed a 12-month or longer fellowship in facial cosmetic surgery (provide details):

If none of the above applies to you, please provide the following for each procedure/surgery identified in question 1 and 2:

- Proof of the training that you received
- If cosmetic surgery, a copy of your consent form(s)
- If cosmetic surgery, proof of hospital privileges for the procedure(s) and a description of the proctoring procedure used at the hospital:

4. Do you perform any cosmetic procedures or cosmetic surgery below the head and neck area? Yes No

If yes, please identify the procedure(s) and/or surgery(ies) and explain for what purposes you perform it:

5. Do you perform cosmetic surgery on patients younger than 21 years of age? Yes No

If yes, please provide a list of procedures performed and your patient selection criteria:

6. If you indicated that you perform bovine or porcine collagen injections, is an allergy test performed at least one month before the procedure to determine whether the patient is allergic to the applicable material? Yes No

If no, please explain:

7. If you indicated that you perform fat injections, do you inject the fat into the breast or penis? Yes No

If yes, please explain:

Liposuction

NOTE: Please complete this section only if you indicated in the preceding table that you perform liposuction.

1. Please indicate where on the body you perform liposuction:

- Abdomen Buttocks Thighs
 Arms Neck Other (please specify):

2. Do you perform liposuction in an office-based surgical suite? Yes No

If yes, please complete the following:

- a. Are 5000ml or more of total aspirate extracted? Yes No
- b. Is IV access available for procedures of less than 2000ml total aspirate? Yes No
- c. Is an IV placed for procedures of 2000ml or more total aspirate? Yes No
- d. Please indicate which of the following monitoring systems are available for volumes greater than 150ml and less than 2000ml of total aspirate (please mark all that apply):
- Pulse oximeter Blood pressure monitoring
 EKG monitoring Fluid loss and replacement monitoring and recording
- e. Are the monitoring systems listed under 2d always used for volumes of 2000ml or more? Yes No

If you answered no to 2b, 2c or 2e, or did not mark every one of the items in 2d, please explain:

SECTION II

MISCELLANEOUS

1. Do you have hospital privileges for all surgical procedures you perform? Yes No

If no, please identify the procedure(s) and explain:

2. Do you use computer imaging to show patients an estimate of postoperative appearance? Yes No

If yes, is a copy of the image given to the patient? Yes No

If a copy of the image is given to the patient, does the image contain a disclaimer which advises that the image is no guarantee of outcome and actual results may vary? Yes No

If no, please explain:

3. Do you use photographs for any purpose other than medical documentation of the patient's chart? Yes No

If yes, do you obtain specific written permission in all cases? Yes No

If you do not obtain specific written permission, please explain for what reasons you use the pictures and why you do not obtain written permission:

SECTION III**REMARKS**

Please provide any additional information to further describe your practice that has not otherwise been addressed in this questionnaire:

REPRESENTATIONS AND WARRANTIES

NOTE: "Warrant" in the following statement is not applicable to Alaska or Arizona health care providers. By statute, Alaska or Arizona health care providers are only required to represent the truth of their statements and information.

I represent and warrant the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to my coverage. I agree to notify NORCAL Mutual Insurance Company immediately if my practice changes in any way and of any change in the information contained on this questionnaire.

Signature

Date

(mm/dd/yyyy)

Name (Print)