

Plastic Surgery 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 3.**

SECTION I

PROCEDURES

1. 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:

2. Do you perform bovine or porcine collagen injections? Yes No

If yes, 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:

3. Do you perform fat injections? Yes No

If yes, do you inject the fat into the breast or penis? Yes No

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

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

Liposuction

1. Do you perform liposuction? Yes No

If yes, please answer the remaining questions.

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:

1. 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:

2. 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)