

Breast Reduction Pre-consult Requirements:

Most of the insurance companies would like to see the following documented in order to consider a breast reduction as medically necessary. We have compiled the following list in an effort to help you understand what may be required of you by your insurance company. The following list is a minimum requirement that is requested for predeterminations. Please be aware that each insurance company has its own guidelines and requirements, so additional documentation may be required on a case by case basis as determined by your insurance company.

1. See your Primary Care Physician or a specialist (someone other than Dr. Turkle) and have the following information documented.
 - a. Your complaints and symptoms related to the size of your breasts
 - b. The fact that they have been able to rule out any other diagnosis that would have the same symptoms - meaning that your symptoms are related to the size of your breast.
 - c. The physician's/provider's opinion that a breast reduction will reduce or eliminate your symptoms
 - d. Conservative Care for 3-6 months (depending on your insurance company's requirements).
 1. You are wearing supportive bras with wide straps
 2. You have been taking pain medications; either over the counter or prescriptive
 3. You have completed an exercise program to strengthen your posture
 4. You have completed PT or Chiropractic care

If you have additional questions please feel free to call Pam at 317-848-8123.



PATIENT INFORMATION SHEET

NAME _____ DATE _____
First Middle Last

ADDRESS _____
Street City State Zip

SOCIAL SECURITY NUMBER _____ BIRTH DATE _____

MARRIED SINGLE DIVORCED WIDOWED SEPARATED SEX M F

SPOUSE'S NAME _____

YOUR HOME PHONE _____ YOUR WORK PHONE _____

YOUR CELL PHONE _____ YOUR EMAIL ADDRESS _____

PREFERRED METHOD OF CONTACT (PLEASE RATE 1-4) ___ HOME ___ WORK ___ CELL ___ EMAIL

IN CASE OF AN EMERGENCY, PLEASE LIST NAME, PHONE NUMBER AND RELATIONSHIP OF PERSON TO YOU:

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

PATIENT'S OCCUPATION _____ EMPLOYER'S NAME _____

HOW WERE YOU REFERRED TO US: (CHECK ALL THAT APPLY)

PHYSICIAN (FULL NAME) _____ FRIEND'S NAME _____

Indianapolis Woman Magazine Website Yellow Pages Television/Radio Indianapolis Monthly

Other _____

FAMILY PHYSICIAN (PC) _____
PHONE _____

REASON FOR YOUR VISIT TODAY _____

INSURANCE INFORMATION: Please complete all blanks and have your insurance card available for the receptionist to make a copy. Thank you.

PRIMARY INSURANCE COMPANY _____ MEMBER'S NAME _____

MEMBER'S SOCIAL SECURITY NUMBER _____ MEMBER'S DATE OF BIRTH _____

MEMBER'S EMPLOYER _____

SECONDARY INSURANCE COMPANY _____ MEMBER'S NAME _____

MEMBER'S SOCIAL SECURITY NUMBER _____ MEMBER'S DATE OF BIRTH _____

MEMBER'S EMPLOYER _____

PLEASE SIGN BELOW:

MEDICAL INSURANCE RELEASE:

I authorize the release of all necessary medical information, including photographs, to process any claim for services provided by Associated Plastic Surgeons of Indiana, PC. I further authorize my insurance company to release all medical benefits to Associated Plastic Surgeons of Indiana, PC, dba Turkle & Associates Cosmetic and Reconstructive Surgeons. A copy of this authorization may be used in place of the original.

Signature (if child, responsible party)

Date

MEDICARE REQUIRES A ONE-TIME AUTHORIZATION, PLEASE READ AND SIGN BELOW

I request Medicare and/or Medicaid benefits to be paid to me, or on my behalf to Associated Plastic Surgeons of Indiana, PC, dba Turkle and Associates Cosmetic and Reconstructive Surgeons. I authorize any party possessing my personal medical information, to release to the health care financing administration and its agents all information needed to determine benefits, or to determine the benefit payment for related services.

Signature

Date

PHOTOGRAPH RELEASE

I authorize Associated Plastic Surgeons of Indiana, PC, dba Turkle & Associates to use my pre- and post-operative photographs, in connection with my medical or cosmetic services, for educational and medical purposes. I understand Turkle & Associates will not identify me by name when using my photographs.

Signature (if child, responsible party)

Date

PATIENT FINANCIAL RESPONSIBILITY

I accept financial responsibility for any products or services rendered by any member of Associated Plastic Surgeons of Indiana, PC, dba Turkle & Associates. If a claim is submitted to my insurance company, I accept financial responsibility for any portion not covered by my insurance. If it becomes necessary for Turkle & Associates to pursue collection, I agree to be responsible for any costs associated with collection, including but not limited to court costs and reasonable attorney's fees. I understand that there is a cancellation fee for any missed appointment that the office is not given 24 hour notice and I accept responsibility for that fee. I further understand that there is a fee of \$27.50 for any returned check and I accept responsibility for this fee.

Signature (if a child, responsible party)

Date

PATIENT'S PERSONAL HISTORY

Date: _____

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

PATIENT INFORMATION:

NAME: _____

LAST FIRST MIDDLE

AGE: _____ HEIGHT: _____ WEIGHT: _____

SURGICAL OPERATIONS AND DATES: _____

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING: (Please circle answers)

Y	N	STROKE	Y	N	MIGRAINE	Y	N	RHEUMATIC HEART
Y	N	CANCER	Y	N	HAY FEVER	Y	N	BLEEDING TENDENCY
Y	N	LEUKEMIA	Y	N	COLITIS	Y	N	HIGH BLOOD PRESSURE
Y	N	TUBERCULOSIS	Y	N	GOITER	Y	N	CONGENITAL HEART
Y	N	BRONCHITIS	Y	N	BLADDER INFECTION	Y	N	DEPRESSION
Y	N	EPILEPSY	Y	N	ASTHMA	Y	N	AIDS/HIV
Y	N	PNEUMONIA	Y	N	HEART ATTACK	Y	N	THYROID CONDITION
Y	N	DIABETES	Y	N	STOMACH ULCERS	Y	N	LUPUS
Y	N	HEPATITIS	Y	N	KIDNEY DISEASE	Y	N	FIBROMYALGIA
Y	N	OSTEO-ARTHRITIS	Y	N	TONSILITIS	Y	N	RHEUMATOID ARTHRITIS
Y	N	FIBROCYSTIC DISEASE	Y	N	COLD SORES	OTHER: _____		

Does any family member have a history of the listed diseases? YES _____ NO _____; IF YES, Please Specify: _____

Do you regularly smoke? Y _____ N _____; If yes, How Much? _____

Do you use nicotine products (such as patches, gums, etc) Y _____ N _____;
If ever, when did you quit? _____

Do you regularly drink alcohol, beer, or wine? Y _____ N _____; If yes, how much? _____

PATIENTS CONSULTING FOR BREAST SURGERY--Please complete this section, all others skip to page 2:

Date of last Mammogram: _____

Where done? _____ Results? _____

Family history of Breast Cancer:	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

Personal history of Breast Cancer? Yes _____ No _____ Date: _____
Side: Left _____ Right _____ Both _____

Other Previous Breast Surgery: _____

Number of pregnancies? _____ Complications during pregnancy? YES _____ NO _____
If YES, Please specify: _____

Number of live births: _____ Did you nurse? YES _____ NO _____ Number of children breastfed: _____

MEDICATION RECORD:

YES _____ NO _____ Do you take aspirin/anti-inflammatory regularly? (IBUPROFEN, ALEVE, ETC)

ALLERGIES TO MEDICATIONS: (Please List)

YES _____ NO _____ Do you take herbs, vitamin supplements or over the counter medication?
If Yes, please list:

Please list any Prescription Medications you are currently taking:

Pharmacy Name: _____ Pharmacy Phone Number: _____

Name of Medications (Brand or Generic Name)	Dosage (mg)	How Often?	Purpose of Medication	Employee Initial & Date

Patient Signature _____ Date: _____

Turkle & Associates

Breast Reduction Patient Questionnaire

- 1) Do you currently experience any symptoms listed below because of large breasts?
Back Pain ___yes___no Shoulder Pain___yes___no Neck Pain___yes___no

- 2) If yes, have you been treated by a doctor, chiropractor or physical therapist for these symptoms within the last year? If yes, who was the doctor(s)?

- 3) If yes, have you provided records today from the doctor(s) or physical therapist listed above? Do you have additional records that need to be provided? Please list the doctor(s) who will be sending records?

- 4) Do you currently have, or have you had in the last year, rashes or skin irritations under or between your breasts?

- 5) If yes, have you been treated by a doctor for this condition?_____If yes, who was the doctor?_____
Have you provided the medical records to support the rashes/irritation?_____
If you've had no physician treatment, have you used over-the-counter creams, lotions or powder?_____

- 6) Do you have difficulty with everyday activities because of large breasts? If yes, please list what activities. (ie: exercise, household chores, job duties)

- 7) Do you currently wear a support bra? ___yes___no
Does your bra have wide straps? ___yes___no
Has it been specially fitted? ___yes___no

- 8) Have you lost weight in the last year?_____ If yes, how much weight?_____ Did the size of your breasts change?_____ What was this change? from_____to_____

Patient Name (printed)_____

Patient Signature:_____date:_____

Physician Signature:_____date:_____

TURKLE

associates

Three Penn Mark
11455 North Meridian
Street
Suite 150
Carmel, IN 46032
317-848-0001
877-848-0001

