Christiana Cosmetic Surgery Consultants
Jonathan Saunders, MD – Katheryn Warren, MD – Julia MacRae, MD

E-62 Omega Dr
Newark, DE 19713
(302) 368-9611

Rev 04/25/25

STRICTLY CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT CLEARLY DATE: _____

NAME: _____ AGE: _____ BIRTH DATE: _____ SS#: _____

ADDRESS: _____ E-MAIL: _____

CITY: _____ STATE: _____ ZIP CODE: _____ **PREFERRED NAME:** _____

PRIMARY PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

MARITAL STATUS: ◯S ◯M ◯W ◯D ◯SEP ◯MALE ◯FEMALE ◯TRANS/NON-BINARY PRONOUNS: _____

EMPLOYMENT STATUS: ◯FULL TIME ◯PART TIME ◯RETIRED ◯UNEMPLOYED
ARE YOU A STUDENT? ◯FULL TIME ◯PART TIME ◯NOT A STUDENT

YOUR EMPLOYER: _____ WORK PHONE NUMBER: _____

SPOUSE OR PARENT'S NAME: _____ SS#: _____ BIRTH DATE: _____

SPOUSE OR PARENT'S EMPLOYER: _____ WORK PHONE: _____

PRIMARY CARE PHYSICIAN (PCP): _____ PHONE: _____

PHARMACY NAME, ADDRESS & PHONE: _____

_____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____ PHONE: _____

PERSON RESPONSIBLE FOR PAYMENT **(if not above):** _____

ADDRESS: _____ PHONE: _____

YOU MUST COMPLETE THE FOLLOWING STATEMENT

I authorize release of my protected healthcare information to: _____
Relationship: _____ **Telephone number:** _____
Can appointment reminders be left on your home answering machine/voice mail? ◯**Yes** ◯**No**
Can messages asking you to call the office concerning healthcare information be left on answering machine/voice mail? ◯**Yes** ◯**No**

INSURANCE INFORMATION

PRIMARY (1ST) INSURANCE

NAME OF INSURANCE COMPANY: _____ PHONE: _____
SUBSCRIBER'S NAME: _____ BIRTH DATE: _____
ID or POLICY #: _____ GROUP #: _____ PLAN #: _____
RELATIONSHIP TO INSURED: ◯SELF ◯SPOUSE ◯CHILD ◯OTHER: _____

SECONDARY (2ND) INSURANCE

NAME OF INSURANCE COMPANY: _____ PHONE: _____
SUBSCRIBER'S NAME: _____ BIRTH DATE: _____
ID or POLICY #: _____ GROUP #: _____ PLAN #: _____
RELATIONSHIP TO INSURED: ◯SELF ◯SPOUSE ◯CHILD ◯OTHER: _____

**YOU ARE FINANCIALLY RESPONSIBLE FOR ALL CO-PAYS AND FEES REGARDLESS OF INSURANCE COVERAGE. **

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that any authorized Medicare or other insurance company payments be made for me on my behalf to Jonathan Saunders MD, Katheryn Warren MD and Julia MacRae MD for any services rendered to me by that party that accepts assignment. Regulations pertaining to Medicare assignment of benefits does apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare or other insurance company claim.

I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the CMS-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare or other insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare or other insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare or other insurance company.

Signature: _____ Date: _____

☐ **I have received a copy of this office's Privacy Statement under HIPPA guidelines**

PATIENT HISTORY/ALL INFORMATION IS STRICTLY CONFIDENTIAL

Name: _____ Birth date: _____ Age:_____

Referred by: ◯ Physician: _____ ◯ Magazine ◯ Friend ◯ Other _____

Height: _____ Weight: _____ Religion: _____

PAST MEDICAL HISTORY

FAMILY HISTORY

Relation	Age	State of Health	Age of Death	Cause of Death or Health Issues	Check if your blood relations have/had any of the following:
Father					Arthritis, Gout
Mother					Asthma, Hay fever
Brothers					Breast Cancer
					Diabetes
					Heart Disease
Sister					Hypertension
					Kidney disease
					Tuberculosis
					Other

MEDICATIONS: List medications you are currently taking	**ALLERGIES**: To any medications or substance

Do you currently take any opioids (pain medication)? ◯ No ◯ Yes ☐ Oxycodone ☐ Fentanyl ☐ Hydrocodone ☐ Dilaudid ☐ Codeine ☐ Demerol ☐ Methadone ☐ Other: _____

PAST MEDICAL CONDITIONS

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Asthma
- ☐ Anorexia
- ☐ Arthritis
- ☐ Gallbladder disease
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chicken Pox
- ☐ HIV
- ☐ Colitis/Ulcers
- ☐ Constipation/Rectal bleeding
- ☐ DES
- ☐ Diabetes
- ☐ Mumps
- ☐ Heart disease
- ☐ Headaches/migraines
- ☐ Hepatitis/Liver disease
- ☐ Hirsutism (excessive hair growth)
- ☐ Hypertension
- ☐ Hyperlipid
- ☐ Kidney disease/Stones
- ☐ Measles
- ☐ Pacemaker
- ☐ Painful urination/incontinence
- ☐ Phlebitis/blood clots
- ☐ Pneumonia
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Rubella
- ☐ Thyroid Disorder
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Syphilis
- ☐ Seizure disorder/epilepsy
- ☐ COVID-19 ***
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Do you have an Advance healthcare directive? ◯ **Yes** ◯ **No**

An advance healthcare directive, also known as living will, personal directive, advance directive, medical directive or advance decision, is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity.

PLEASE COMPLETE OTHER SIDE

SURGICAL HISTORY

Date	*Surgery*	*Physician*	*Hospital*	*Complications*

HEALTH HABITS: Please check which substance you use and describe how much/often you use them.			**OCCUPATIONAL CONCERNS:** Please check if your employment exposes you to any of the following.	
☐	Alcohol		☐	Stress
☐	Caffeine		☐	Hazardous Substances
☐	Drugs		☐	Heavy Lifting
☐	Tobacco		☐	Other
☐	Vaping			
☐	OTHER			

Completed by: ◯ Patient ◯ Office Nurse ◯ Physician ◯ Other: _____

Signature of Patient: _____ Date: _____

Date reviewed by physician with patient: _____

Physician's signature: _____

Annual Review of History:

Date reviewed: _____ Date reviewed: _____

Date reviewed: _____ Date reviewed: _____

Date reviewed: _____ Date reviewed: _____

Date reviewed: _____ Date reviewed: _____

CHRISTIANA
cosmetic surgery consultants
Jonathan N. Saunders, M.D., F.A.C.S.
Katheryn M. Warren, M.D., F.A.C.S.
Julia MacRae, M.D.
E-62 Omega Dr Newark, DE 19713
Phone: (302) 368-9611
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CHRISTIANA
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OUR FINANCIAL POLICY

Thank you for choosing Jonathan Saunders MD, Katheryn Warren MD, or Julia MacRae MD as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy. We request that you review it, then sign it before any treatment that we render to you. Full payment is due and expected at the time of service. You may make your payment by check, cash, money order or most major credit cards. All unpaid balances will be subject to a 1.75% monthly finance charge.

INSURANCE PLANS

You must understand that your insurance coverage is a contract between you and your insurance carrier. Please be aware that some and perhaps all of the services provided may be considered a non-covered service. This non-covered service may be considered medically unnecessary under the Medicare program and/or other medical insurance carriers. If this is the case, you will be financially responsible for the services rendered to you at the time of your visit. Furthermore, all co-pays will be collected from you before you see the physician. You must also present a current insurance card at the time of your visit. If you do not have a current insurance card, you may be asked to reschedule your appointment.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what are the usual and customary fees for our area. You are responsible for payment regardless of any insurance companies' arbitrary determination of usual and customary rates.

REFERRAL RESPONSIBILITY

I understand that if I DO NOT obtain a referral from my primary care physician, I will be responsible for any payment of services rendered to me.

MISSED APPOINTMENTS

Unless an appointment is canceled at least twenty-four hours in advance there will be a $100.00 charge applied to your account for the missed appointment. Please help us serve you better by keeping your scheduled appointment. However, if you are more than **15** minutes late for your appointment you will be asked to reschedule your appointment.

MISCELLANEOUS FEES AND INFORMATION

It is our office policy to charge a fee of $50.00 for any returned check and remanded to the State Attorney General's office. A credit number will be required when you call to make a consultation appointment, if you no show for your appointment or fail to cancel with in the required 24 hour notice a $75.00 administrative fee will be applied to your credit card. I give Christiana Cosmetic Surgery Consultants, Jonathan Saunders MD, Katheryn Warren MD and Julia MacRae MD and any business associate related to Christiana Cosmetic Surgery Consultants, Jonathan Saunders MD, Katheryn Warren MD and Julia MacRae MD my expressed permission to call this number using an auto-dial contact platform and prerecorded messages.

AUTO ACCIDENT

I understand that I am fully responsible for payment of ALL outstanding medical expenses incurred with regard to my injuries regardless of the outcome of the litigation. In the event that my medical expenses are not paid by the automobile insurance carrier involved, I agree to make arrangements for balance due on my account to Jonathan Saunders MD, Katheryn Warren MD, or Julia MacRae MD.

WORKMAN'S COMPENSATION

I agree that I am fully responsible for any balance that my workman's carrier does not cover.

SURGICAL CANCELLATIONS

Cosmetic surgical procedures MUST be cancelled at least two weeks in advance in order to receive a full refund. Cancellations less than two weeks will be refunded at 80% of the fee.

Once again thank you for choosing Christiana Cosmetic Surgery Consultants. I further understand, that if [am dissatisfied with any service or person related to my treatment, I will notify the office in writing within 5 (five) days of my visit.

I HAVE READ THIS FINANCIAL AGREEMENT AND UNDERSTAND AND AGREE TO THIS POLICY.

Patient/Responsible Party (Print) Guarantor Signature Date

ALL OFFICE VISITS ARE SUBJECT TO COPAY.

Please initial here:

CHRISTIANA
cosmetic surgery consultants

Jonathan N. Saunders, M.D., F.A.C.S.
Katheryn M. Warren, M.D., F.A.C.S.
Julia MacRae, M.D.

STATE REQUIRED OPIOID TREATMENT AGREEMENT

As a patient of Jonathan Saunders MD, Katheryn Warren MD, or Julia MacRae MD, you are being asked to sign this document as receipt and understanding of our narcotic prescribing policy. This agreement will be maintained in your chart throughout the course of your care while in our practice. Any violation of the below information will result in dismissal from our practice and/or referral to a pain management specialist.

The use of and prescribing of narcotics is restricted due to state and federal regulations and the physicians in our practice will not prescribe narcotics for any extended period of time. If you receive a prescription for narcotics from our office, you **may not** receive narcotics from any other office during the same treatment period. During the course of your treatment, we may check the Delaware Prescription Monitoring Programs website to make assure that you are only receiving your prescriptions from our office. If in found in violation you will not receive any subsequent prescriptions from our office.

By signing this agreement, you agree to take the medication at the dose frequency as prescribed. As such, the office will not prescribe early refills. You also agree that you will not abuse alcohol or other medically unauthorized substances or medications while you are a patient of Jonathan Saunders MD, Katheryn Warren MD, or Julia MacRae MD.

Narcotic prescriptions will not be prescribed beyond ninety (90) days, under any circumstances. On the rare occasion where your provider feels that narcotic prescriptions are still the best way to manage your condition beyond the ninety (90) days, we will refer you to a pain management specialist.

I, _____ (please print your name), agree to adhere to the above policy as of _____(today's date).

_____ _____

Your Signature Date

Omega Professional Center – E-62 Omega Dr., Newark, DE 19713
Phone (302) 368-9611 – Fax (302) 368-3424

Clear Form