

## SUPPLEMENTAL QUESTIONNAIRE FOR RHINOPLASTY



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OMIC requires special underwriting review of physicians requesting coverage for the performance of rhinoplasty. Please answer all questions and attach a copy of your protocol, if available.

### TRAINING AND EXPERIENCE

- 1** What training did you receive specific to the performance of rhinoplasty, including any fellowship programs?  
**Attach a copy of your certificate of completion and course outline.**

Course/Program Title	_____	_____	_____
Dates	_____	_____	_____
Location	_____	_____	_____
Sponsor	_____	_____	_____
Instructor	_____	_____	_____

- 2** During your training, how many cases did you:

**A.** Observe? \_\_\_\_\_

**B.** Assist? \_\_\_\_\_

**C.** Perform? \_\_\_\_\_

- 3** How many rhinoplasty procedures have you performed as primary surgeon (rough estimates are acceptable):

**A.** Since completion of your training? \_\_\_\_\_

**B.** In the past 12 months? \_\_\_\_\_

**C.** Anticipated for the next 12 months? \_\_\_\_\_

- 4** If you do not yet have experience as primary surgeon for rhinoplasty, do you intend to be proctored for your first several cases?  Yes  No

### INFORMED CONSENT

- 5** You, the surgeon, must have an informed consent discussion with each patient. Although other health care professionals may be involved in the informed consent process, this duty may not be delegated exclusively to non-physician staff.

- 6** Consent must be obtained in writing. The consent form must be signed and dated by the patient prior to surgery.

- 7 Submit a copy of your patient education literature and your consent form for this procedure.
- 8 You must write a note in the patient's medical record that the risks, benefits, complications, and alternatives were discussed with each patient.
- 9 Each patient must receive a copy of the consent form prior to the day of surgery.

**OPERATIVE PROCEDURES**

- 10 Where do you perform these procedures?  Hospital  Surgery center  In-office surgical suite

**NOTE:** If performed in an office surgical suite, **describe on a separate page** the setting, sterility of conditions, emergency/resuscitative equipment available, location in miles and minutes of the nearest hospital, and arrangements for transporting patients to the hospital in the event of an emergency.

- 11 Do your hospital staff privileges extend to the performance of this procedure?  Yes  No

**If yes,** at which hospitals? \_\_\_\_\_

- 12 Which technique(s) do you follow?  Open  Closed

**POSTOPERATIVE CARE**

- 13 Who renders the postoperative care? \_\_\_\_\_

- 14 At what frequency do postoperative visits occur? \_\_\_\_\_

**ADVERTISING**

- 15 Do you advertise your availability to perform this procedure?  Yes  No

Advertisements must comply with state law and FDA- and FTC-mandated guidelines. Ads and other patient information materials must not be misleading and must not make statements that guarantee results or cause unrealistic expectations. Similarly, satisfaction guarantees, warranties, and similar contracts are not permitted. Please refer to the attached **Review of Advertisement for Medical Services** form so that you may evaluate and monitor your compliance with OMIC's underwriting requirements with respect to advertising.

**"I have read and hereby agree to comply with OMIC's underwriting requirements specific to rhinoplasty. I also agree to notify OMIC prior to implementing any intended changes to my responses above. I understand that failure to comply with OMIC's underwriting requirements or to notify OMIC promptly of changes in my protocol may result in uninsured risk or termination of coverage."**

\_\_\_\_\_  
Applicant's Signature (Please do not use signature stamp.)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Name (Please type or print.)