The Georgia Institute For Plastic Surgery/The Plastic Surgery Center Land, LLC

Patient Record Of Disclosures

In general, HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner:

- ❑ ***Home Phone*** - It is ok to leave a message with detailed information.
- ❑ ***Cell Phone*** - It is ok to leave a message with detailed information.
- ❑ ***Work Phone*** - It is ok to leave a message with detailed information.
- ❑ ***Written Communication*** - It is ok to mail to my home address
- ❑ ***Fax Communication*** - It is ok to fax to this telephone number: _____
- ❑ ***Emai***l -It is ok to email this address with detailed information: _____

You may leave a message with, discuss my treatment, appointments, financial obligations, or other scheduling that may occur or give other information as necessary with the following family, friends or personal representatives. I understand that The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC. will refuse to discuss my information with anyone not listed below, except in an emergency. I also understand this consent does not apply to medical providers.

Please Print:

_____

_____

_____

_____

_____

Patient Signature **Date**

_____

Please Print Name:

Acknowledgement of Receipt of Notice of Privacy Practices:

I have received a copy of the Notice of Privacy Practices for The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC, detailing how information may be used and disclosed as permitted under federal and state law. I understand this is an acknowledgement of receipt only. I may refuse to sign this acknowledgement if I wish.

_____

Patient Signature **Date**

_____

Signature of Patient Representative **(Required if patient is a Minor or an Adult who is unable to sign this form)**

Relationship: ❑Self ❑Mother ❑ Father ❑Power Of Attorney ❑Guardian ❑Spouse

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(For Internal Use Only)

If Patient or Patient's Representative Refuses to sign Acknowledgement of Receipt of Notice, please document the date and time the notice was presented to the patient and sign here:

Presented by:_____Date:_____Time:_____

Advance Directive/Living Will

Do you have an Advance Directive (Living Will, DNR-Do Not Resuscitate)? ❑ Yes ❑ No

For a copy of the Georgia Advanced Directives for Healthcare, please visit www.aging.dhr.georgia.gov and click on "Publications" on the left, or call DAS at (404)-657-5319

THE GEORGIA INSTITUTE FOR PLASTIC SURGERY & PLASTIC SURGERY CENTER LAND, L.L.C.

5361 Reynolds Street • Savannah, GA 31405 Phone (912) 355-8000 • Fax (912) 356-0229

Patient Registration Form

Patient Information

Legal Name (Last, First, MI)		Suffix:	Preferred Name:
Date of Birth:	Age:	Marital Status: ❑ Single ❑Married ❑Divorced ❑Widowed ❑Separated ❑Partner ❑Other	
Street Address:	City:	State:	Zip Code:
Home Phone: ( ) Preferred ❑	Work Phone: ( ) Preferred ❑	Cell Phone: ( ) Preferred ❑	
Email Address:	May we contact you through Email? ❑ **YES** ❑ **NO**	Would you like to receive our Quarterly Newsletter through Email? ❑ **YES** ❑ **NO**	
Gender: ❑ Male ❑Female	SSN:	Referring Physician:	Primary Care Physician:
Preferred Language:	Race:	Ethnicity: ❑ Hispanic ❑ Non Hispanic ❑ Unknown	
Does Patient Live in a Nursing Home or Assisted Living Facility? ❑ YES ❑ NO If YES, what is the Name of the Facility?			

Financially Responsible

Name of Responsible Party, if other than patient:			
Relationship to Patient:	Address:	City/State/Zip	Date of Birth:
Home Phone: ( ) Preferred ❑	Work Phone: ( ) Preferred ❑	Cell Phone: ( ) Preferred ❑	

Emergency Contact

Name:	Relationship to Patient:	
Home Phone: ( ) Preferred ❑	Work Phone: ( ) Preferred ❑	Cell Phone: ( ) Preferred ❑

Insurance Information

PRIMARY Insurance Carrier:		Policy Number:	Group Number:	
Patient's Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other _____		Name of Subscriber (if other than Patient):		
Subscriber's Social Security #:	Gender: ❑ Male ❑Female	Date of Birth:	Subscriber's Employer:	Work Phone: ( )
SECONDARY Insurance Carrier:		Policy Number:	Group Number:	
Patient's Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other _____		Name of Subscriber (if other than Patient):		
Subscriber's Social Security #:	Gender: ❑ Male ❑Female	Date of Birth:	Subscriber's Employer:	Work Phone: ( )

Medicare

IF YOU HAVE MEDICARE COVERAGE OR ARE ELIGIBLE FOR MEDICARE COVERAGE, PLEASE COMPLETE THE QUESTIONS BELOW:

Are you still working? ❑ YES ❑ NO Retirement Date: _____

Do you have an Employer Group Health Coverage Plan? ❑ YES ❑ NO

Is your Spouse still working? ❑ YES ❑ NO Retirement Date: _____

Are you covered through your Spouse's Insurance? ❑ YES ❑ NO

By Signing Below, I acknowledge that the information I have provided is correct to the best of my ability.

Patient Signature: _____ **Date:** _____/_____/_____

Guarantor Signature (if other than patient): _____ **Date:** _____/_____/_____

The Georgia Institute For Plastic Surgery and The Plastic Surgery Center Land, LLC

Payment Policy / Assignment of Benefits /General Disclosures

I hereby authorize and assign payment of my insurance benefits to be paid directly to The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC., any medical or surgical benefits that the professional corporation may be entitled to under my medical-surgical plan. I understand I am financially responsible for non-covered services and for any balance due for services in excess of the benefits provided by my policy. I authorize the release of any medical or other information necessary to process insurance claims on my behalf. I further permit a copy of this authorization to be used in place of the original. This authorization is to apply to all private insurance claims and Medicare benefits I may use.

Financial Liability: All services rendered by the physicians in this office are on a fee for service basis. Deductibles and co-insurance obligations associated with your chosen plan are your responsibility. These will be collected at the time of service for office visits. For cosmetic surgery or other scheduled procedures, these will be collected at least two weeks prior to the procedure/surgery. I understand that I will be responsible for any charges if any of the following apply:

- My health plan requires prior referral by a Primary Care Physician (PCP) before receiving services at The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC. and I have not obtained such a referral or I receive services in excess of the referral, and/or
- My health plan determines that the services I receive at The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC. are not medically necessary and/or not covered by my Insurance plan, and/or
- My health plan coverage has lapsed or expired at the time I receive services at The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC., and/or
- I have chosen not to use my health plan coverage, and/or
- They physician I see does not participate with my health care plan.
- If for any reason the account my account should become delinquent, I or my responsible party agrees to pay for all rebilling charges, collection costs, and reasonable legal fees.

Ancillary Services

- I understand I may need certain ancillary medical services while I am a patient at The Georgia Institute For Plastic Surgery / The Plastic Surgery Center Land, LLC; such as pathology specimen examination, cytology, imaging services, lab work, and cardiac tests. I understand that these services are not provided by any physician of this practice and that I may incur additional charges as a result of the ancillary services. I understand that these services will be billed to me directly, or may required payment from me at the time of service. In addition, I may receive in-patient or out-patient hospital care at an area hospital. If so, I will receive a hospital bill for those services. Hospital bills are separate from our doctor services. I am responsible for providing the name of the preferred hospital, laboratory or any other preferred facility/physician in network with my insurance plan.

Release and Authorization of Information:

- I authorize release of information to my primary care physician.
- I authorize release of information to my referring physician.
- I authorize release of information to my employer if this is a work related condition.
- I understand photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery.
- I authorize the taking of photographs at the direction of my surgeon and under such conditions as may be approved by him/her. I understand these photographs will be used solely for documentation purposes and will be kept confidential.
- I have read the Patient Financial Policy and I agree to abide by all terms. A copy of this policy is available on our website, in our lobby, or you may request a hard copy from the front desk.
- **Medicare Signature On File (*Medicare Patients Only*):** I request that payment of authorized Medicare benefits be made either to me or on my behalf to all providers who treat me for any services furnished to me by these providers. I authorize the holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Patient Signature **Date:**

MEDICAL AND SURGICAL HISTORY

THE GEORGIA INSTITUTE FOR PLASTIC SURGERY
THE PLASTIC SURGERY CENTER LAND, LLC

Please Fill Out COMPLETELY – Do Not Leave Anything Blank

Today's Date: _____ **Patient Name:** _____ **Date of Birth:**_____

Sex: Male / Female **Height:** _____ **Weight:** _____ **Age:** _____

Occupation: _____ Referred by: _____

All of Your Medical Doctors: _____

Chief Complaint: _____

SIGNIFICANT MEDICAL HISTORY:

Medical Allergies/Sensitivities: _____ Pregnant? N Y

List ALL Medications {including Aspirin, Diet Pills, Herbal Supplements, Prescriptions, Over-The Counter Meds}: _____

_____

_____

Are you a smoker? NO YES How many packs per day? _____ For how many years? _____

Have you ever used {circle}: LSD/speed/cocaine/marijuana None How much alcohol do you drink? _____

PAST MEDICAL HISTORY	**{ Please check all that apply.}**		
Cardiovascular	**Pulmonary**	**Medical**	**Other**
☐ Heart Attack	☐ Asthma	☐ Diabetes	☐ Bleeding Tendencies
☐ High Blood Pressure	☐ Shortness of Breath	☐ Heart Burn/Reflux	☐ Blood clots in legs/lungs
☐ Irregular Heartbeat	☐ Emphysema/COPD	☐ Depression	☐ AIDS/HIV positive
☐ Chest Pain {angina}	☐ Bronchitis	☐ Steroid treatment	☐ Hepatitis
☐ Mitral Valve Prolapse	☐ Sleep Apnea	☐ Seizures	☐ Dry Eyes
☐ Abnormal EKG		☐ Mental Illness	☐ Kidney Disease
☐ **NONE OF THE ABOVE**	☐ **NONE OF THE ABOVE**	☐ **NONE OF THE ABOVE**	☐ **NONE OF THE ABOVE**

FAMILY HISTORY

Have you or anyone in your family ever had problems with anesthesia? YES / NO

If yes, who and what happened? _____

Any Family History of: Heart Disease Lung Disease Malignant Hyperthermia Other

Describe: _____

REVIEW OF SYSTEMS: Do you have any? (circle): fever chills nausea vomiting diarrhea **NONE**

PAST SURGICAL HISTORY: List all Operations you have had, including plastic surgery.	
OPERATION	**DATE**
☐ **I have NOT had any Operations**.	

Do you have any other health issues that we may need to be aware of? NONE / YES Explain: _____

_____

PATIENTS, PLEASE STOP HERE. THANK YOU!

Physician Signature: _____ _____/_____

Date **Time**

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HISTORY AND PHYSICAL

THE GEORGIA INSTITUTE FOR PLASTIC SURGERY
THE PLASTIC SURGERY CENTER LAND, LLC

Chief Complaint: _____

_____

PHYSICAL EXAM	
HEENT:	☐ PERRLA ☐ EOMs intact
HEART:	☐ RRR without murmur
PULM:	☐ Lungs clear
ABD:	☐ Soft, non-distended
EXTREM:	
BREAST:	☐ No palpable masses ☐ Deferred
OTHER:	

IMPRESSION:_____

_____

PLAN: _____

_____

_____

☐ **PREVIOUS PAGE HISTORY REVIEWED AND UPDATED. The patient is cleared for surgery in an ambulatory surgical setting.**

PHYSICIAN SIGNATURE: _____ Date/Time: _____/ _____

OTHER COMMENTS:

_____

☐ **The History and Physical Exam remain valid from the above date.**

If not, list changes:

_____

_____

PHYSICIAN SIGNATURE: _____ Date/Time: _____/_____

☐ **SKIN LESION, SKIN CANCER, SOFT-TISSUE TUMOR REMOVAL DISCUSSION:**

Risks/Benefits/Alternatives discussed with patient: infection, bleeding, delayed healing in smokers, widened or hypertrophic scars, keloid scarring, additional surgery for positive margin or recurrence, scars at recipient site, scars and grafts that take over 2 years to mature, recurrence, option of no treatment.