PATIENT INFORMATION SHEET

I, _____________________________________, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and the treatment by my doctor and such assistant or staff as may be assigned by him/her.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of any medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. In the event of any litigation arising from treatment, I agree to submit the case to arbitration. I understand that 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. These photographs will be used solely for documentation purposes and will be kept confidential.

I understand that there may be a consultation fee for the initial visit which is due at the time of my appointment unless other arrangements have been made in advance.

SIGNATURE: _______________________________ DATE: __________________________

RELATIONSHIP: (Circle one) PATIENT SPOUSE PARENT GUARDIAN
MEDICAL AND SURGICAL HISTORY
THE GEORGIA INSTITUTE FOR PLASTIC SURGERY

Patient Name: ________________________________    Sex: _________    Age: __________    Today’s Date: ____________________

Weight: _________   Height: __________

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    Heart Burn/Reflux
High Blood Pressure    Shortness of Breath    Depression
Irregular Heartbeat    Emphysema/COPD
Chest Pain [angina]    Bronchitis    Steroid treatment
Mitral Valve Prolapse    Sleep Apnea    Seizures
Abnormal EKG    Sleep Apnea    Mental Illness
NONE OF THE ABOVE    NONE OF THE ABOVE    NONE OF THE ABOVE

HAVE YOU EXECUTED AN ADVANCED DIRECTIVE (DNR – Do Not Resuscitate)? (Circle One) YES NO

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  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 had 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!    Patient Signature:________________________________________________________
Patient: ___________________________________________  Date: _____________________________

Chief Complaint: _______________________________________________________________________
____________________________________________________________________________________
______________________________________________________________________________________

IMPRESSION: _________________________________________________________________________
______________________________________________________________________________________

PLAN: ________________________________________________________________________________
______________________________________________________________________________________

PHYSICIAN SIGNATURE: _______________________________________________________        Date:  ______________ _________

OTHER COMMENTS: __________________________________________________________________
____________________________________________________________________________________

☐  The History and Physical Exam remain valid from the above date.
If not, list changes: __________________________________________________________________
____________________________________________________________________________________

PHYSICIAN SIGNATURE: _____________________________________________________________    Date:  _______________________

☐  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.
INSURANCE INFORMATION
Please fill out all of the appropriate information

PRIVATE INSURANCE - Primary
Policy Holders Name__________________________________________________________
Policy Holders SSN#_________________________ Sex _______ DOB ________
Policy Holders Employer________________________________________________________
Patient's Relationship to Policy Holder  ❑ Self  ❑ Spouse  ❑ Child  ❑ Other
Effective date of Coverage__________________
ID/Policy #_____________________________ Group No.__________________________
Name of Insurance Company____________________________________________________

PRIVATE INSURANCE - Secondary
Policy Holders Name__________________________________________________________
Policy Holders SSN#_________________________ Sex _______ DOB ________
Policy Holders Employer________________________________________________________
Patient's Relationship to Policy Holder  ❑ Self  ❑ Spouse  ❑ Child  ❑ Other
Effective date of Coverage__________________
ID/Policy #_____________________________ Group No.__________________________
Name of Insurance Company____________________________________________________

PRIVATE INSURANCE - Other
Policy Holders Name__________________________________________________________
Policy Holders SSN#_________________________ Sex _______ DOB ________
Policy Holders Employer________________________________________________________
Patient's Relationship to Policy Holder  ❑ Self  ❑ Spouse  ❑ Child  ❑ Other
Effective date of Coverage__________________
ID/Policy #_____________________________ Group No.__________________________
Name of Insurance Company____________________________________________________

ACCIDENTS-Auto-Other
If your injury is a result of an auto accident, please fill out this section
Policy Holders Name__________________________________________________________
Policy Holders Address________________________________________________________
Auto Insurance Co. Name_____________________________________________________
Policy No._____________________________ Insurance Co. Address_________________
Date Accident Occurred____________ How Did Accident Occur?
___________________________________________________________________________
___________________________________________________________________________
__________ Attorney's Name_________________________________ Address________________

WORKMEN'S COMPENSATION
If your injury is a result of an accident that occurred on the job, please fill out this section
Employer_______________________________________________________________
Employer's Address_______________________________________________________
Date of Injury____________________ Was Injury Reported to Employer? Yes_____ No____
Tell us how injury occurred____________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Signature _________________________________________ Date ______________________________
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*This is an acknowledgement of receipt only.

I have received a copy of the Notice of Privacy Practices for The Georgia Institute For Plastic Surgery.

______________________________
Name of Patient (Print or Type)

______________________________
Signature of Patient

______________________________
Date

______________________________
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

______________________________
Relationship of Patient Representative to Patient

1. Can we call you at home? Yes or No
2. Can we leave a message for you at home? Yes or No
3. Can we leave a message for you at work? Yes or No
4. With whom may we discuss your medical condition:
   1. __________________________________________
   2. __________________________________________
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY

Uses and Disclosures

Treatment - Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment - Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations - Your health information may be used as necessary to support the day-to-day activities and management of The Georgia Institute For Plastic Surgery. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement - Your health information may be disclosed to law enforcement agencies to support government audits and inspectors, to facilitate law enforcement investigations, and to comply with government-mandated reporting.

Public health reporting - Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state’s public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders - Your health information may be used by our staff to send you appointment reminders.

Information about treatments - Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.
**Individual Rights**

You have certain rights under the federal privacy standards. These include:
- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your private health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

**The Georgia Institute For Plastic Surgery duties:**

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

**Right to Revise Privacy Practices**

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

**Requests to Inspect Protected Health Information**

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Medical Records Clerk or the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

**Complaints and Contact Person**

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer  
The Georgia Institute For Plastic Surgery  
5361 Reynolds Street  
Savannah, GA 31405  
(912) 355-8000

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

**Effective Date**

This notice is effective on or after April 14, 2003.