



Statesboro
Plastic Surgery

Dear Patient,

We would like to take this opportunity to welcome you to Statesboro Plastic Surgery and to familiarize you with some of our policies. Enclosed you will find your new patient paperwork. Please complete it before you arrive for your appointment.

Our office is open from 8:30AM to 5:00PM, Monday through Thursday and 8:30AM to 1:00PM on Friday. Some of the services we offer include. Breast Augmentation, reduction and lift; liposuction; tummy tuck; Juvederm and Botox injections; laser hair reduction; mole evaluation; various hand treatments and surgeries, including carpal tunnel syndrome.

SPECIAL ASSISTANCE: If you require special assistance (wheelchair, transfer to exam table, language, etc.) please let our office know prior to your arrival for the appointment so that we may make arrangements to get you the assistance you need, if possible.

WAIT TIME/APPOINTMENT RESCHUDULES: Everyone here at Statesboro Plastic Surgery understands that your time is just as valuable as ours. We make every effort to keep your wait to see the doctor to an absolute minimum and to not have to reschedule your appointment. However, from time to time, it may be necessary for us to reschedule your appointment date and/or time or the wait to see the doctor may be extended as our physician is on-call for emergencies with the local hospital. In these rare instances we kindly ask for your understanding and cooperation. These situations are unexpected and unpredictable but if one does occur please be assured that we will make every effort to minimize your inconvenience.

NOT KEEPING APPOINTMENTS: *If you are unable to keep you scheduled appointment, please give our office at least 24 hour notice. A \$30.00 fee will be charged for no-shows.*

PAYMENTS AND INSURANCE: *Full payment is required at the time of service for all cosmetic consultations as well as for patients whom we are not providers with their insurance. For your convenience, we accept cash, MasterCard, Visa, American Express, and Discover credit cards. Cosmetic consultations and new patient fees are between \$100-\$250.*

As a courtesy to our patients, we file all insurance claims, even if we are not providers for the insurance. It is your responsibility to furnish our office with a current copy of your insurance card(s). For patients whose insurance has a co-pay, the co-pay must be paid on the day of service. For patients with no insurance or insurance that we are not providers for, payment in full is due at the time of service unless PRIOR arrangements are made with management.

ACCIDENTS (someone else may be responsible for payments): In accidents, legal cases, etc. ,where you the patient believes someone else is responsible for the medical expense, **YOU AS THE PATIENT ARE RESPONSIBLE FOR PAYMENT**

AT THE TIME OF SERVICE. This office cannot be expected to wait for court conclusions or disputed insurance settlements. We will, however, help with any paperwork, etc. needed for reimbursement from the third party believed to be liable for the medical expenses. *****PLEASE NOTE***** any accidents, such as cuts, burns, falls, etc., filed with health insurance may result in a follow-up form from your insurance. This **MUST** be filled out and returned immediately! All outstanding balances will become your responsibility until these forms are filled out and returned. We **DO NOT** file AUTO or THIRD PARTY liability insurance but we will provide you with a claim form to send to your insurance. If you are unsure if this policy applies to you please contact our office.

WORKERS' COMP: In case of **Workers Compensation**, we must have an authorization from your employer or their insurance carrier to provider medical services. If your claim is denied **you** are responsible for payment of the services provided.

Thank you for selecting our office and we look forward to serving you in the future. If we may be of any further assistance, please contact our office at (912)681-3330.

Signature: _____ Date: _____

STATESBORO PLASTIC SURGERY - NEW PATIENT FORM

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Can we contact you and/or leave a message at these numbers? No Yes E-mail _____

Can we send you confidential information to you? No Yes

Race: _____ Ethnicity: _____ Language: _____

Age _____ Birthdate ____ / ____ / ____ SS# ____ - ____ - ____ Sex Female Male

Marital Status Single Married to: _____ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes No

Address _____
Street & Suite # City State Zip

How did you hear about ? (Mark all that apply)

TV News TV Ad Phone Book Magazine Newsletter Seminar Salon

Friend/Relative: _____ Doctor: _____ Website: _____

If you were referred by a specific person, may we thank them? Yes No

Emergency Contact

(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Bisseck to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Bisseck and myself. I further understand that any portion of the bill that the insurance company or responsible party does not cover is my responsibility.

I hereby agree that if my bill has to be turned over to a third party collection agency for non payment, there will be a collection fee added to my bill. This is pursuant to Georgia Statutory Law "O.C.G.A.-13-1-11".

Signature _____ **Date** _____

STATESBORO PLASTIC SURGERY- HISTORY & PHYSICAL

Today's Visit

What are you being seen for today?(Please be specific)	
If this is a result of an accident, give the date of injury.	
--Please describe how the accident occurred.	
If the injury is due to a car accident, has the auto insurance claim been filed?	

Patient Past Medical History

	---Yes---	Details
-Patient has no relevant past medical history.	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	
Bleeding/Clotting Problems	<input type="checkbox"/>	
Breast Cancer	<input type="checkbox"/>	
Chest Pain/Tightness	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	
Easy Bruising	<input type="checkbox"/>	
Eczema	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	
Heart Murmur	<input type="checkbox"/>	
Heart Problems	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	
HIV or Aids	<input type="checkbox"/>	
Kidney Stones	<input type="checkbox"/>	
Lung/Breathing Problems	<input type="checkbox"/>	
Psychiatric/Depression	<input type="checkbox"/>	
Skin Cancer	<input type="checkbox"/>	
Skin Disease	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	
Thyroid Disorder	<input type="checkbox"/>	
Ulcers	<input type="checkbox"/>	
Unexpected Weight Loss	<input type="checkbox"/>	
Other	<input type="checkbox"/>	

Patient Past Surgeries/Hospitalizations (if none please write none)

	Surgery/Hospitalization	Date	Anesthesia complications	Notes
1				
2				
3				
4				
5				
6				
7				
8				

Allergies

List	Reaction
1.	
2.	
3.	
4.	
5.	
6.	

Medications

List	List
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

Patient Name: _____ Date: ____/____/____

STATESBORO PLASTIC SURGERY- HISTORY & PHYSICAL

Patient Social History

Alcohol	Yes	No	Frequency:
Illegal Drugs	Yes	No	
STD	Yes	No	

Patient Smoking History

Smoker or any tobacco products	Yes	No
Packs Per Day:	Length:	Years if Quit:

Female Questions

	Yes	No	N/A	Details
Do you have children? I yes, please list number of pregnancies & ages of children.				
Do you have regular periods?				
Are you going through menopause?				
Are you pregnant or lactating?				
During pregnancy, did you ever get hyperpigmentation or masking?				
Have you had any mammograms?				Results:
Current Bra Size				

Patient Family History

	YES	Family Member
Pt denies any contributing family hx	<input type="checkbox"/>	
Abnormal Bleeding	<input type="checkbox"/>	
Abnormal Clotting	<input type="checkbox"/>	
Anesthesia Problems	<input type="checkbox"/>	
Autoimmune Disorder	<input type="checkbox"/>	
Brain Tumor	<input type="checkbox"/>	
Breast Cancer	<input type="checkbox"/>	
Cleft Lip	<input type="checkbox"/>	
Cleft Palate	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	
Drug Allergies	<input type="checkbox"/>	
Endocrine Disease	<input type="checkbox"/>	
Hearing Loss	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	
Hemophilla	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	
Liver Disease	<input type="checkbox"/>	
Lung Cancer	<input type="checkbox"/>	
Malignant Hyperthermia	<input type="checkbox"/>	
Other Cancer	<input type="checkbox"/>	
Ovarian Cancer	<input type="checkbox"/>	
Prostate Cancer	<input type="checkbox"/>	
Skin Cancer	<input type="checkbox"/>	
Skin Disease	<input type="checkbox"/>	
Substance Abuse	<input type="checkbox"/>	

Review of Systems

	Please List Problems/ Conditions
Allergic/ Immunologic	
Cardiovascular	
Constitutional	
Ears, Nose, Mouth, Throat	
Eyes	
Endocrine	
Gastrointestinal	
Genitourinary	
Hematologic/ Lymphatic	
Musculoskeletal	
Neurological	
Psychiatric	
Respiratory	
Skin	

Body Size

	Details
Age	
Height (ft)	
Height (in)	
Weight (lbs)	
Recent Weight Changes	

Patient Name: _____ Date: ____/____/____

IMPORTANT PLEASE READ CAREFULLY

We appreciate your choosing Statesboro Plastic Surgery for your care. However, we do not participate with every insurance company. If you are a member of a PPO, POS, HMO, or any managed care program, please check with your insurance manual and/or insurance representative at your place of employment to see if we are on your provider list. If we are not, that does not mean that we will not file your insurance, but you could be penalized by your insurance company on claims. That holds true for any hospital that your company requires you to use for surgery. If we perform any insurance covered procedures in our office, a pathology specimen may be sent. We ROUTINELY send these to Southeastern Pathology Associates and Statesboro Pathology Associates. If the lab or hospital out facility used is out of network you may be penalized either by nonpayment or reduction in benefits. THIS INFORMATION IS TO BE OBTAINED BY THE PATIENT AND PROVIDED TO OUR OFFICE.

IT IS THE RESPONSIBILITY OF THE PATIENT TO INSURE THAT ALL REFERRAL REQUIREMENTS ARE MET AT EACH VISIT. IF YOUR INSURANCE COMPANY REQUIRES THIS TYPE OF COORDINATION OF CARE, PLEASE MAKE SURE THAT THE REFERRAL IS IN PLACE BEFORE YOUR VISIT. FAILURE TO DO SO, MAY RESULT IN A HIGHER OUT OF EXPENSE FOR YOU.

I have read the above and understand that I am responsible for any nonpayment or reduction in benefits to Statesboro Plastic Surgery, and/or any facility used as a result of not using a participating physician, laboratory, or facility as required by my insurance company.

Signature: _____ Date: _____

PICTURE RELEASE

I am a patient of Statesboro Plastic Surgery. I give my permission to Statesboro Plastic Surgery to utilize my preoperative and postoperative photographs to be shown to future patients, in medical journals, at public presentations, and on the website at www.statesboroplasticsurgery.com for the purpose of education and information.

"I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc."

I understand that the pictures will be cropped to assure discretion and that any distinguishing marks will be eliminated.

Signature: _____ Date: _____

**NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM**

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that the privacy policy has been made available to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

Signature: _____ Date: _____

PATIENT RIGHTS

- 1) The privacy of all patients shall be respected at all times. Patients shall be treated with respect, consideration and dignity.
- 2) Patients shall receive assistance in a prompt, courteous, and responsible manner.
- 3) Patient medical records are considered confidential. Except as otherwise required by law, patient records and/or portions of records will not be released to outside entities or individuals without patients' and/or designated representatives' express written approval.
- 4) Patients have the right to know the identity and status of individuals providing services to them.
- 5) Patients have the right to change providers if they so choose.
- 6) Patients, or a legal authorized representative, have the right to thorough, current and understandable information regarding their diagnosis, treatment options and prognosis, if known, and follow-up care. All patients will sign an informed consent form after all information has been provided and their questions answered.
- 7) Patients have the right to refuse treatment and to be advised of the alternatives and consequences of their decisions. Patients are encouraged to discuss their objectives with their provider.
- 8) Patients have the right to refuse participation in experimental treatment and procedures. Should any experimental treatment or procedure to be considered, it shall be fully explained to the patient prior to commencement.
- 9) Patients have the right to express complaints about the care they have received and to submit their grievance to the Clinical Supervisor who will complete and "Incident Report" and bring the issue to the attention of the Medical Director in a timely manner so the grievance may be addressed.
- 10) Patients have the right to be provided with information regarding emergency and after-hours care.
- 11) Patients have the right to obtain a second opinion regarding the recommended procedure. Responsibility for the expense of the second opinion rests solely with the patient.
- 12) Patients have the right to a safe and pleasant environment during their stay.
- 13) Patients have the right to have procedures performed in the most painless way possible.
- 14) Patients have the right to an interpreter if required.
- 15) Patients have the right to be provided informed consent forms as required by the laws of the State of Georgia.
- 16) Patients have the right to have visitors at the Center as long as visitation does not encumber Center operations and the rights of other patients are not infringed.
- 17) Patients have the right to develop Advance Directives which will be respected by Center staff.
- 18) Patients will be provided, upon request, all information regarding services available at the Clinic, as well as information about estimated fees and options for payment.

PATIENT RESPONSIBILITIES

- 1) Patients are expected to provide complete and accurate medical histories including providing information on all current medications, keep all scheduled pre- and post-procedure appointments and comply with treatment plans to help ensure appropriate care.
- 2) Patients are responsible for reviewing and understanding the information provided by their Physician or nurse. Patients are responsible for understanding their insurance coverage and the procedures required for obtaining coverage.
- 3) Patients are responsible for providing insurance information at the time of their visit and to notify the receptionist of any changes in information regarding their insurance or medical information.
- 4) Patients are responsible for paying all charges for co-payments, co-insurance, and deductibles on non-covered services at the time of the visit unless other arrangements have been made in advance with the Medical Practice.
- 5) Patients are responsible for treating Clinic Physicians and Staff in a courteous and respectful manner.
- 6) Patients are responsible for asking questions about their medical care and to seek clarification from their physician of the services to be provided until they fully understand the care they are to receive.
- 7) Patients are responsible for following the advice of their provider and to consider the alternatives and/or likely consequences if they refuse to comply.
- 8) Patients are responsible for expressing their opinions, concerns or complaints in a constructive manner to the appropriate personnel at the Clinic.
- 9) Patients are responsible for notifying their health care providers of patient's Advance Directives.

I have read and agree with the above. Signature: _____ Date: _____