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 RESCHEDULES: Everyone here at Statesboro Plastic Surgery understands that your time is just as valuable as ours. We make every effort to keep your time to an absolute minimum. However, from time to time, it may be necessary for us to reschedule your appointment, 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, be assured that we will make every effort to minimize your inconvenience.

MISSED APPOINTMENTS: *If you are unable to keep your scheduled appointment, please give our office at least a 24 hour notice. A $25.00 fee will be charged for no-shows.*

PAYMENTS AND INSURANCE: ***Full payment is required when a cosmetic consultation is scheduled and for all non-insured patients a payment is due at the time of service. For your convenience, we accept cash, MasterCard, Visa, American Express, and Discover credit cards. Cosmetic consultations and new patient fees are between $50.00 and $150.00.***
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 without 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.**
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.

REQUEST FOR MEDICAL RECORDS: For patients requesting copies of their medical records, there **will be a $25.00 charge**.

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

Thank you for selecting our office, 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.

STATESBORO PLASTIC SURGERY

(912) 681-3330

(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 _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

Race _____ Ethnicity _____ Lanuage _____

Age _____ Birthdate ___/___/___ SS# _____ Gender ❒ 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 ❒ Web

❒ Friend/Relative: _____ ❒ Doctor: _____ ❒ Other: _____

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 _____

Areas of Interest: (mark all that apply)

Facial Procedures

❒ Blepharoplasty (Eyelid Lift)
❒ Botox
❒ Brow or Forehead Lift
❒ Earlobe Repair
❒ Facial Liposuction (Neck, Jowls)
❒ Face or Neck Lift
❒ Lip Enhancement
❒ Otoplasty (Ear Pinning)
❒ Rhinoplasty (Nose Reshaping)
❒ Skin Resurfacing (Laser, Peel, Etc.)
❒ Wrinkle Fillers (Injections)

Breast Procedures

❒ Breast Augmentation
❒ Breast Reconstruction
❒ Breast Reduction
❒ Mastopexy (Breast Lift)
❒ Nipple Reduction or Inversion

Body Procedures

❒ Abdominoplasty (Tummy Tuck)
❒ Brachioplasty (Arm Lift)
❒ Full Body Lift
❒ Liposuction (Thighs, Abdomen, Etc.)
❒ Thigh or Buttock Lift

Other Procedures

❒ Skin Care
❒ Chemical Peels
❒ Telangectasia (spider veins)
❒ Laser Hair Removal
❒ Laser IPL
❒ Leg Veins
❒ CO2 Fraxel

I understand that office visit charges are payable on the day service is rendered.

Signature _____ **Date** _____

Would you like to schedule a complimentary skin evaluation ? ❒ Yes ❒ No

1402 Brampton Ave * Statesboro, GA 30458 * phone 912-681-3330 * fax 912-681-3303

STATESBORO PLASTIC SURGERY – HISTORY & PHYSICAL

Name:	Date:
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.	

Are you allergic to any medications? NO☐ YES☐ Please List:

PAST MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
Diabetes	☐	☐	Osteoporosis	☐	☐	Blood Clots	☐	☐
Chest Pain/Angina	☐	☐	Asthma	☐	☐	Tuberculosis	☐	☐
High Blood Pressure	☐	☐	Stroke/CVA/TIA	☐	☐	Depression	☐	☐
Heart Disease	☐	☐	Seizures	☐	☐	Congestive Heart Failure	☐	☐
Heart Attack	☐	☐	HIV/AIDS	☐	☐	Thyroid Disease	☐	☐
High Cholesterol	☐	☐	Hepatitis	☐	☐			
Pacemaker	☐	☐	Stomach Ulcer	☐	☐	Other (please list below)		
Headaches	☐	☐	Liver Disease	☐	☐	_____		
Kidney Stones	☐	☐	Heart Palpitations	☐	☐	_____		
Kidney Disease	☐	☐	Arthritis	☐	☐	_____		
Cancer _____			Heart Surgery	☐	☐	_____		
Skin Cancer	☐	☐	COPD	☐	☐			

CURRENT MEDICATIONS

☐ **CHECK HERE IF YOU ARE NOT ON ANY MEDS**

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

ROS		Please check all CURRENT positive findings
Constitutional		Weight loss ☐ Fevers ☐ Chills ☐ Poor appetite ☐ Fatigue ☐ Weight gain ☐ Insomnia ☐ Night sweats ☐
Eyes		Blurry vision ☐ Eye pain ☐ Eye discharge ☐ Eye redness ☐ Decrease in vision ☐ Dry eyes ☐ Double vision ☐
ENT		Sore throat ☐ Hoarseness ☐ Ear pain ☐ Hearing loss ☐ Ear discharge ☐ Nose bleeds ☐ Tinnitus ☐ Sinus problems ☐
Cardiovascular		Chest pain ☐ Palpitations ☐ Rapid heart rate ☐ Heart murmur ☐ Poor circulation ☐ Swelling in the legs or feet ☐
Respiratory		Shortness of breath ☐ Chronic cough ☐ Coughing up blood ☐ History of Tuberculosis ☐ Excess sputum production ☐
Gastrointestinal		Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Blood in the stool ☐ Frequent heartburn ☐ Trouble swallowing ☐
Skin		Rash ☐ Hives ☐ Hair loss ☐ Skin sores or ulcers ☐ Itching ☐ Skin thickening ☐ Nail changes ☐ Mole changes ☐
Musculoskeletal		Joint pain ☐ Muscle aches ☐ Frequent leg cramps ☐ Muscle weakness ☐ Bone pain ☐ Joint swelling ☐ Back pain ☐
Endocrine		Goiter ☐ Heat intolerance ☐ Cold intolerance ☐ Increased thirst ☐ Change in skin pigment ☐ Excess sweating ☐
Neurological		Seizures ☐ Tremors ☐ Migraines ☐ Numbness ☐ Dizziness/Vertigo ☐ Loss of balance ☐ Slurred speech ☐ Stroke ☐
Psychiatric		Anxiety ☐Depression ☐ Alcohol or drug dependence ☐ Suicidal thoughts ☐ Panic attacks ☐ Use of anti-depressants ☐
Genitourinary		Increased urinary frequency ☐ Blood in the urine ☐ Incontinence ☐ Painful urination ☐Urinary retention ☐ FrequentUTIs ☐
Hem/Lymphatic		Low blood count ☐ Easy bruising ☐ Swollen lymph nodes ☐ Transfusions ☐ Prolonged bleeding ☐ Blood clots ☐
Allergic/Immun		Allergic reactions ☐Hay fever ☐ Frequent infections ☐ Hepatitis ☐ HIV positive ☐Positive tuberculin skin test (PPD) ☐

SOCIAL HISTORY:

Marital Status _____ Occupation _____ **Non-Smoker ☐Ex-Smoker ☐(how long ago quit?)** _____

Current Smoker ☐ Light Smoker ☐ Heavy Smoker ☐ (How many packs/day and how long?)_____

Alcohol consumption: Never ☐ Occasional ☐ Frequent ☐ Illegal drugs use: Yes ☐ No ☐

STATESBORO PLASTIC SURGERY – HISTORY & PHYSICAL

Patient Past Surgeries/Hospitalizations (IF NONE PLEASE WRITE NONE ON THE FIRST LINE)

Surgery/Hospitalization	Date	Anesthesia complications	Notes

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	☐	
Abnormal Bleeding	☐	
Abnormal Clotting	☐	
Anesthesia Problems	☐	
Autoimmune Disorder	☐	
Brain Tumor	☐	
Breast Cancer	☐	
Cleft Lip	☐	
Cleft Palate	☐	
Diabetes	☐	
Drug Allergies	☐	
Endocrine Disease	☐	
Hearing Loss	☐	
Heart Disease	☐	
Hemophilla	☐	
High Blood Pressure	☐	
Kidney Disease	☐	
Liver Disease	☐	
Lung Cancer	☐	
Malignant Hyperthermia	☐	
Other Cancer	☐	
Ovarian Cancer	☐	
Prostate Cancer	☐	
Skin Cancer	☐	
Skin Disease	☐	
Substance Abuse	☐	

Body Size	Details
Height (ft)	
Height (in)	
Weight (lbs)	
Recent weight changes	

Statesboro
Plastic Surgery

PAYMENT POLICIES FOR COSMETIC PATIENTS & PROCEDURES

Before we can schedule you for surgery, a 30% deposit must be paid. This deposit is *NON-REFUNDABLE*.

The total cost of the procedure must be paid ***NO LATER THAN 1 WEEK PRIOR TO YOUR SURGERY***. If we have not received your payment by that time, your procedure will be cancelled and your deposit will not be refunded. Payment cannot be made on the day of surgery.

If you are not able to mail us your payment or come to the office, we can take your credit card over the phone. There will be a 3% fee added to the charge for all credit card payments over a $1,000.00.

No Show/Late Cancellation Policy

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case-by-case basis.

A prepayment of $50.00 will be required for all initial Cosmetic Consultation appointments and is Non-refundable if less than 24 hours' notice is given.

A charge of $25.00 will be assessed for each no show or late cancellation for all cosmetic appointments if less than 24 hour notice is given.

By signing below I am agreeing that I have read and understand the above information. I completely understand the payment policies and procedures described to me by the office staff as well as in the document. I have no remaining questions about when payment is due and what types of payments are accepted.

_____ _____

Signature Date

1402 Brampton Ave * Statesboro, Georgia 30458 * phone 912-681-3330 * fax 912-681-3303

Statesboro
Plastic Surgery

Financial Policy Regarding Revision and Complications

Every plastic and reconstructive surgeon has a few patients who will require revision or have some complications requiring additional surgery. As you have been or will be told, one cannot guarantee a result. In cosmetic procedures there are certain problems that will happen statistically no matter how good the care or how careful the doctor and team. Examples of problems that may be encountered are bleeding or an unfavorable scar after a surgical procedure. In both of these cases, it may be necessary to return the patient to surgery, either on an emergency basis (as in the case with bleeding) or an elective basis (as in the case of scarring). It is our policy as a predetermined courtesy to our patients not to charge a surgeon's fee for complications or revisional surgery within 6 months from the original surgery date. We do, however, expect the patient to pay whatever other expenses arise as a result of treatment in hospital or outpatient settings. If the revisional surgery occurs, the patient is responsible for the expense of the facility and anesthesia. Sometimes the patient will have insurance that will cover these revisions or complications. It depends upon the individual policy and how it is written. When a person does have insurance, the insurance company is billed for the surgeon's fee as well as the facility fees.

We hope that no complication arises and no revisional surgery is necessary in your case. However, no plastic surgeon can guarantee this to their patients. It is important for the patient undergoing an elective surgical procedure to understand this financial policy. If you have any questions regarding this policy, the office staff would be happy to discuss it with you.

My signature below indicates that I understand and agree to the above policy.

Signature _____ Date _____

Witness _____

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Statesboro
Plastic Surgery

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.

_____ _____

Date Signature

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Statesboro
Plastic Surgery

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 "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: _____

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