



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 _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

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

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

Emergency Contact
(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

Please list your primary care physician _____

How did you hear about us?

TV Ad Phone Book Magazine Newsletter Seminar Salon Doctor _____

Friend/Relative _____ Website _____

Parent Information if the patient is a minor under the age of 18

Parents Name _____ Date of Birth _____ Phone Number _____

Parents Employer _____ Work # _____

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

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				CURRENT MEDICATIONS			
	Yes	No		Yes	No		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/> <input type="checkbox"/> CHECK HERE IF YOU ARE NOT ON ANY MEDS
Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> 1. _____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/CVA/TIA	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/> <input type="checkbox"/> 2. _____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/> <input type="checkbox"/> 3. _____
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/> <input type="checkbox"/> 4. _____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> 5. _____
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<u>Other (please list below)</u>	<input type="checkbox"/> <input type="checkbox"/> 6. _____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/> 7. _____
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/> 8. _____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/> 9. _____
Cancer _____			Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/> 10. _____
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	COPD	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> 11. _____

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

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? If 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"/>	
Hemophilia	<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"/>	

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

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' expressed 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 as long as visitation does not encumber operations, and the rights of other patients are not infringed.
- 17) Patients have the right to develop Advance Directives which will be respected by staff members.
- 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 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 practice manager.
- 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 seeking clarification from their physician on 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 considering 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 Advance Directives.

**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



IMPORTANT PLEASE READ CAREFULLY

We appreciate you 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 out. We ROUTINELY send these to SEPA Lab and East Georgia Regional Medical Center Lab. If the lab or hospital 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 "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: _____