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 Provider _____

How did you hear about us?

☐ Google ☐ Facebook ☐ Instagram ☐ Driving by ☐ Seminar ☐ Doctor _____

☐ Friend/Relative _____ ☐ Website _____ ☐ Other _____

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

Guardians Name _____ Date of Birth _____ Phone Number _____

Guardians 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 futher understand that any portion of the bill that the insurance company or responsible party does not cover is my responsibility. For any disputes of financial policy, the patient waives his/her right to privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) guidelines. 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

	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

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

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.

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

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

Statesboro
Plastic Surgery

IMPORTANT PLEASE READ CAREFULLY

We appreciate you choosing Statesboro Plastic Surgery for you 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 sent 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: _____

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

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 for one or more of the following purposes: (i) my medical record, (ii) promotional brochures, (iii) patient education materials, (iv) instructional videos, (v) medical journals, (vi) websites, (vii) social media (the practice and individual staff members), and (viii) other formats.

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.

By making this authorization, I understand that:

- I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- I will not be paid in any way for the use of pictures/digital images or videos of me.
- The information released in response to this authorization may be re-disclosed to other parties.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
- This authorization shall be in force and effect until revoked by me in writing.

Signature: _____ Date: _____

Statesboro
Plastic Surgery

Online Communication

Online communication is a form of communication using “secure” Web sites or e-mail applications that apply appropriate encryption technology designed to protect the transmission of confidential information
The details of online communication have been explained to me in terms I understand.
Alternative methods of communication (telephone, in-person, mail) are still available to me.
I understand that all medical communications carry some level of risk. While the likelihood of risks associated with the use of online communication in a secure environment is substantially reduced, the risks are nonetheless real and very important to understand. These risks include but are not limited to:

- *It is easier for online communication to be forwarded, intercepted, or even changed without my knowledge.*
- *Online communication is easier to falsify than handwritten or signed hard copies. Backup copies may exist on a computer or in cyberspace, even after both of us have deleted our copies.*
- *It is my responsibility to use a secure network.*
- *Online communications become part of my medical record.*

I agree to take precautions to keep online communication confidential, including but not limited to the following:

- *I will keep my password confidential.*
- *I will store messages on a secure computer.*
- *I will not leave messages on my screen for others to read.*
- *I will update my contact information as soon as it changes.*

I understand that I am responsible for taking steps to protect myself from unauthorized use of online communication. Statesboro Plastic Surgery is not responsible for breaches of confidentiality caused by an independent third party or me.
I agree to follow the procedure Statesboro Plastic Surgery implements to allow SPS to verify my identity in connection with online communication. I acknowledge that failure to comply with these procedures may terminate our online communication. I understand that online communication cannot be used for emergencies or time sensitive matters
I understand that online communication cannot be used to communicate highly sensitive medical information, such as treatment or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).
I have informed Statesboro Plastic Surgery of any information I do not want transmitted via online communications.
I understand that it is my responsibility to determine if an unanswered online communication was received.
I acknowledge that I have read and fully understand this consent form, including the risks associated with the online communication. Statesboro Plastic Surgery has answered all of my questions.

Signature: _____ Date: _____

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