

PIEDMONT PLASTIC SURGERY AND DERMATOLOGY

(Please print legibly and fill in all fields)

Patient Information as of _____ (Today's date)

Patient's Name: _____
First Middle Last

Address: _____
Street & Apt. # (City, State, Zip)

SS#: _____ - _____ - _____ **Birth date:** ____/____/____ **Age:** _____

Sex: Female Male **Race:** _____

Marital Status: _____ **Spouse's Name (If Applicable):** _____

Home Phone: _____ **Work Phone:** _____ **Ext:** _____

Employer: _____ **Is it okay to call you at work?** Yes No

Cell Phone: _____ **Email:** _____

***Emergency Contact (Outside Household):** _____
(Name) (Relationship)
Home Phone: _____ **Other Phone:** _____

FILL OUT THIS SECTION IF PATIENT IS A MINOR OR NURSING HOME PATIENT:

Responsible Party Name: _____ **Relationship:** _____
Birth date: _____ **SS#:** _____ **Home Phone:** _____
Work Phone: _____ **Employer:** _____

1) Primary Health Insurance Company: _____

Policy #: _____ **Group#:** _____ **Phone #:** _____

Insured: Name: _____ **DOB:** _____ **Employer:** _____

Patient's Relationship to Insured: Self Spouse Child Other _____

2) Secondary Health Insurance Company: _____

Policy #: _____ **Group#:** _____ **Phone #:** _____

Insured: Name: _____ **DOB:** _____ **Employer:** _____

Patient's Relationship to Insured: Self Spouse Child Other _____

Referral (How did you hear about our office?):

Physician _____ Previous Patient _____ Newspaper _____

Billboard Yellow Pages, City _____ Magazine _____ Other _____

IF YOU WOULD LIKE TO SET UP A FREE CONSULTATION WITH ONE OF OUR PHYSICIANS REGARDING ANY OF THE FOLLOWING PLEASE CIRCLE AND LET US KNOW.

- Facial Aging •Skin Care Products •Spider Veins •Tummy Tuck •Restylane •Eyelifts •Breast Augmentation
- Facelift •Ear Surgery •Nose Surgery •Radiance •Botox •Laser Hair Removal •Laser Vein Removal
- Mole Removal •Liposuction •Spa Services •Chemical Peel •Thread Lift •Breast Reduction

History Intake Form

Health History: Piedmont Plastic Surgery & Dermatology

Patient Name: _____ Birth Date: _____ Height: _____ Weight: _____

Please answer all of the questions as accurately as possible.

Reason for visit: _____

Primary Care Doctor: _____

Drug Allergies: _____

Past Medical History: Have you ever had the following:

| | | | | | | | | |
|----------------|-----|----|------------------------|-----|----|-----------------------|-----|----|
| AIDS/HIV | Yes | No | Easy Bleeding/Bruising | Yes | No | Kidney Disease | Yes | No |
| Anemia | Yes | No | GI/Bowel Disease | Yes | No | Mitral Valve Proplase | Yes | No |
| Arthritis | Yes | No | Glaucoma | Yes | No | Rheumatic Fever | Yes | No |
| Asthma | Yes | No | Heart Disease/Attack | Yes | No | Stomach Ulcer | Yes | No |
| Breast Disease | Yes | No | Hepatitis | Yes | No | Stroke | Yes | No |
| Cancer | Yes | No | High Blood Pressure | Yes | No | Thyroid Disease | Yes | No |
| Diabetes | Yes | No | High Cholesterol | Yes | No | Tuberculosis | Yes | No |

List previous surgeries or major illnesses and dates: _____

List any medications you are taking, including non-prescription drugs, vitamins, and herbals: _____

Circle if you have a Pacemaker/AICD, Prosthesis, Artificial Heart Valve, or Joint Replacement.

Have you ever had Skin Cancer? (If yes, list type, date, and location): _____

Review of Systems: Circle any of the following you have had in the past year:

| | | | |
|----------------------|------------------------|---------------------|---------------------|
| Blood in urine/stool | Chronic pain | Irregular heartbeat | Seizures |
| Blurry vision | Depression | Jaundice | Severe sunburns |
| Chest pain | Dry eyes | Joint pain | Swollen feet/ankles |
| Chronic cough | Easy bruising/bleeding | Migraines | Weight gain/loss |
| Chronic diarrhea | Heartburn | Mouth sores | Yeast infections |

Family History: Has any blood relative ever had the following:

| | | | | | | | | |
|---------------|-----|----|---------------------|-----|----|-------------|-----|----|
| Breast Cancer | Yes | No | Heart Disease | Yes | No | Melanoma | Yes | No |
| Depression | Yes | No | High Blood Pressure | Yes | No | Skin Cancer | Yes | No |
| Diabetes | Yes | No | Kidney Disease | Yes | No | Stroke | Yes | No |

Social History:

Do you use tobacco? (Type & Amount Per Day) _____ Date quit: _____

Do you drink alcohol (Type & Amount Per Week) _____

Do you use a tanning bed? (How often) _____

Women Only:

Age period began _____ Number of pregnancies _____ Date of last pregnancy _____

Date of last mammogram _____ Did you breast feed: Yes No

Do you do regular breast self examinations: Yes No Breast lump or discharge Yes No

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X _____
Signature of patient or parent if minor

Date

Provider Initials _____

Clinical Staff Initials _____

Consent To Use or Disclose Health Information

DATE _____

I authorize Piedmont Plastic Surgery and Dermatology to use and disclose the health and medical information of _____ for the purposes of Treatment, Payment and Health Care Operations.*
Name of Patient

***Treatment** (includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers our practice by telephone as the on-call physician).

***Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

***Health Care Operations** (includes the necessary administrative and business functions of our office).

You may review Piedmont Plastic Surgery and Dermatology’s “Notice Of Privacy Practices” for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent. Please verify that you have received a copy of our Notice by placing your initials here: _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that Piedmont Plastic Surgery and Dermatology has already used or disclosed the information in reliance on this Consent.

Signature of Patient

Signature Of Person Authorized By Law

•Other: _____

**PIEDMONT PLASTIC SURGERY AND DERMATOLOGY
FINANCIAL POLICY**

Piedmont Plastic Surgery & Dermatology believes that part of a good health care practice is to establish and communicate a financial policy to our patients. An informed and responsible patient should never have a credit problem with our practice.

PAYMENT is expected on the same day of each visit prior to the physician encounter. We accept cash, checks, Visa, MasterCard, Discover and American Express.

PAYMENT will include any unmet deductible, co-insurance, co-payment amount, prior balance, cosmetic or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit.

We are participating providers for most insurance carriers. We will file all primary and secondary insurance claims for you. We do NOT file with third parties but will provide you with the information for you to do so. **Please remember that insurance is a contract between the patient and the insurance company and ultimately you are responsible for payment in full to Piedmont Plastic Surgery & Dermatology.**

Occasionally an *established* patient incurs unusually high financial responsibility for charges provided by one of our physicians. We will work with these patients to establish an appropriate payment plan and obtain a signed financial agreement.

RETURNED CHECKS will incur a \$25.00 service charge. You will be asked to bring cash or money order to cover the amount of the check plus the service charge.

ACCOUNTING PRINCIPLES – Payment and credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding charges.

DISABILITY FORMS, INSURANCE FORMS, COPIES OF MEDICAL RECORDS, ETC. require office staff time and time away from patient care for the physicians. Therefore we require 3 business days to complete the forms and requests and a fee may be charged.

Patients whose accounts have been turned over to a collection agency will be responsible for the account balance and all costs associated with collection, including attorney fees.

AUTHORIZATION / FINANCIAL INFORMATION

1. I hereby authorize the release of medical information to my insurance carriers concerning my medical condition and treatment for the purposes of claim payment.
2. I assign Piedmont Plastic Surgery & Dermatology ALL payments from my insurance carrier for medical services rendered to myself and dependents.
3. I agree that if my insurance carrier sends payment to me for the medical services instead of to Piedmont Plastic Surgery & Dermatology, I will immediately pay the amount due to Piedmont Plastic Surgery & Dermatology.
4. I agree it is my responsibility to understand my insurance benefits and to notify Piedmont Plastic Surgery & Dermatology immediately of any changes to my insurance coverage.
5. I fully understand that I am financially responsible for any co-payments, deductibles, co-insurance, cosmetic or non-covered services as determined by my insurance carrier.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____