WILLIAMS

Plastic & Reconstructive Surgery, P.C.

PATIENT INFORMATION

TODAY'S DATE_____

❒ MR. ❒ MRS. ❒ MS. ❒MISS

PATIENT'S NAME (FIRST,MI, LAST)_____

***IF PATIENT IS A MINOR AN ADDITIONAL GUARANTOR INFORMATION FORM MUST BE COMPLETED IN ADDITION TO THE FOLLOWING**

MAILING ADDRESS_____CITY_____ STATE_____ ZIP_____ COUNTY_____

STREET ADDRESS_____CITY_____STATE_____ ZIP_____ COUNTY_____

SOCIAL SECURITY # _____ BIRTH DATE_____ AGE_____

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ WIDOW ❑ DIVORCED ❑ SEPARATED SEX: ❑ MALE ❑ FEMALE

HOME PHONE # (_____)_____ WORK PHONE # (_____)_____EXT_____

CELL PHONE # (_____)_____ E-MAIL_____

PREFERRED DAYTIME CONTACT: ❑ HOME ❑ WORK ❑ CELL

EMERGENCY CONTACT NAME _____ **RELATIONSHIP**_____

EMERGENCY CONTACT HOME PHONE (_____)_____

EMERGENCY CONTACT ALTERNATE PHONE (_____)_____ **❑ CELL ❑ WORK**

PATIENT EMPLOYMENT INFORMATION: ❑ FULL TIME ❑ PART TIME ❑ F/T STUDENT ❑ P/T STUDENT ❑ RETIRED ❑ OTHER

OCCUPATION_____ COMPANY NAME_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

ETHNICITY: ❑ AFRICAN-AMERICAN ❑ ASIAN ❑ CAUCASIAN ❑ HISPANIC ❑ OTHER _____

IS YOUR VISIT THE RESULT OF AN ACCIDENT? ❑ YES ❑ NO

WAS AN AUTOMOBILE INVOLVED? ❑ YES ❑ NO DATE OF ACCIDENT_____

WERE YOU INJURED ON THE JOB? ❑ YES ❑ NO DATE OF INJURY _____

IF OTHER, GIVE A BRIEF DESCRIPTION OF THE ACCIDENT _____

_____ DATE OF INJURY_____

NAME OF REFERRING DOCTOR_____

NAME OF MEDICAL DOCTOR_____

HOW DID YOU HEAR ABOUT US? _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER_____ SECONDARY INSURANCE CARRIER _____

IF DIFFERENT FROM PATIENT, INSURED PARTY'S INFORMATION MUST BE COMPLETED FOR INSURANCE PURPOSES:

NAME_____ GENDER: ❑ MALE ❑ FEMALE

ADDRESS_____ CITY_____ STATE_____ ZIP_____

INSURED'S EMPLOYER_____INSURED'S I.D #_____

INSURED'S BIRTH DATE_____ INSURED'S SOCIAL SECURITY # _____

INSURED'S PHONE # (_____)_____ RELATION TO PATIENT_____

WILLIAMS

Plastic & Reconstructive Surgery, P.C.

AUTHORIZATIONS & PAYMENT AGREEMENT

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

- **Consultation Charge Policy**: 24 hour notice of cancellation is required to avoid being charged a consultation fee. If failure to give the required notice or without canceling, you do not keep your reserved appointment, your credit card on file will be charged the appropriate consultation fee ($40 for non surgical consults, $75 for surgical consults). If in the future you decide to schedule surgery with our office the consultation fee charged will be deducted from your surgical fees. There is no charge for rescheduling a consultation, however, we kindly ask that you provide 24 hours notice if rescheduling is necessary.
- Unless other arrangements have been made in advance by you or your health coverage carrier, payment in full is expected at the time of service. ANY COSMETIC SURGERY REQUIRES PAYMENT IN FULL A MINIMUM OF TWO WEEKS PRIOR TO SURGERY. For your convenience, we will accept VISA and MasterCard.
- Your insurance policy is a contract between you and your insurance company and is only meant to help you with your medical costs; it is not a pay-all. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer we will refund any overpayment to you.
- We have made prior arrangements with many insurers and other health plans to accept assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-payment and your deductible at the time of service. A $5 billing fee will be added to any co payment not paid at the time of service.
- When assignment is accepted, I hereby authorize payment directly to Williams Plastic & Reconstructive Surgery, P.C. for benefits (including Medicare benefits or major medical) payable under the terms of my insurance or governmental coverage for any services furnished me by Williams Plastic & Reconstructive Surgery, P.C.
- If you have insurance coverage with a plan with which we do not have a prior agreement, in most cases, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, our charges for your care and treatment are due at the time of the service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and signing this Authorizations and Payment form for payment.
- If this account is turned over to collections for non-payment, the patient or responsible party agrees to pay all costs of collection including, but not limited to, 30% collection agency fees, reasonable attorney fees and/or court costs.
- I hereby authorize any physician, hospital, or medical care facility to provide information on my medical history and treatment to Williams Plastic & Reconstructive Surgery, P.C. I also authorize Dr. Joel Williams to release my medical records, if needed, to any physician, hospital, medical care facility or my insurance company for processing of claims.
- PHOTOGRAPH CONSENT: I hereby grant permission to Williams Plastic & Reconstructive Surgery P.C. and staff to take photographs of me to use for documentation in the doctor’s records and/or submit to my insurance carrier for prior authorization for surgery or for proof of disability. These photographs may be used for educational purposes, i.e., publications and/or lectures, both on a National, State and Local level.
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DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM.

BY SIGNING BELOW I AGREE THAT I HAVE READ AND UNDERSTAND THE AUTHORIZATIONS AND PAYMENT AGREEMENT OF WILLIAMS PLASTIC AND RECONSTRUCTIVE SURGERY, PC AND AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND AND AGREE THAT SUCH TERMS MAY BE AMENDED FROM TIME-TO-TIME BY THE PRACTICE.

_____ _____

Date **Signature of Patient or Responsible Party**

WILLIAMS

Plastic & Reconstructive Surgery, P.C.

Patient Consent for Use & Disclosure of Protected Health Information

I hereby give my consent for Williams Plastic and Reconstructive Surgery, PC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Williams Plastic and Reconstructive Surgery, PC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Williams Plastic and Reconstructive Surgery, PC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Williams Plastic and Reconstructive Surgery, PC, Privacy Officer at 1506 Professional Court, Dalton, GA 30720.

With this consent, Williams Plastic and Reconstructive Surgery, PC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Williams Plastic and Reconstructive Surgery, PC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Williams Plastic and Reconstructive Surgery, PC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Williams Plastic and Reconstructive Surgery, PC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Williams Plastic and Reconstructive Surgery, PC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Williams Plastic and Reconstructive Surgery, PC may decline to provide treatment to me.

_____ _____

Print Patient Name **Print Legal Guardian Name**

_____ _____

Signature of Patient or Legal Guardian **Date**

WILLIAMS

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History & Physical

PATIENT NAME: _____ **DATE:**_____

AGE: _____

REFERRING DOCTOR: _____

REASON FOR VISIT TODAY: _____

_____

_____

PLACE A CHECK IN THE BOX INDICATING ANY OF THE FOLLOWING CONDITIONS YOU NOW HAVE, HAVE HAD IN THE PAST, OR HAVE NOT HAD:

YES NO

- ❑ ❑ WEIGHT LOSS OR GAIN _____
- ❑ ❑ EVER TAKEN PHENTERMINE OR OTHER WEIGHT LOSS MEDICATION_____
- ❑ ❑ FEVER OR CHILLS, NIGHT SWEATS_____
- ❑ ❑ SKIN DISORDERS OR ALLERGIES_____
- ❑ ❑ PROBLEMS WITH EYES OR EARS_____
- ❑ ❑ PROBLEMS WITH MOUTH, COLD SORES OR FEVER BLISTERS _____
- ❑ ❑ PROBLEMS WITH THROAT OR NECK_____
- ❑ ❑ BREASTS _____
- ❑ ❑ HEART ATTACK, CHEST PAIN, HIGHBLOOD PRESSURE, RHYTHM DISORDERS _____
- ❑ ❑ LUNG PROBLEMS, ASTHMA, EMPHYSEMA, SHORTNESS OF BREATH_____
- ❑ ❑ SLEEP APNEA, USE OF CPAP _____
- ❑ ❑ STOMACH PROBLEMS, ULCERS, ACID REFLUX_____
- ❑ ❑ INTESTINAL OR COLON PROBLEMS, CONSTIPATION_____
- ❑ ❑ RECTAL BLEEDING OR CHANGES IN BOWEL HABITS_____
- ❑ ❑ URINARY, KIDNEY PROBLEMS_____
- ❑ ❑ DIZZINESS, BLACK-OUTS OR HEADACHES_____
- ❑ ❑ STROKE, MINI-STROKE (TIA) OR SYMPTOMS_____
- ❑ ❑ SEIZURE OR NEUROLOGICAL PROBLEMS_____
- ❑ ❑ MUSCULAR OR BONE PROBLEMS_____
- ❑ ❑ DEPRESSION, ANXIETY OR PSYCHIATRIC PROBLEMS_____
- ❑ ❑ DIABETES OR THYROID PROBLEMS_____
- ❑ ❑ BLOOD CLOTTING OR BLEEDING PROBLEMS_____
- ❑ ❑ SWOLLEN LYMPH NODES_____
- ❑ ❑ IMMUNE DISORDERS OR FREQUENT INFECTIONS_____
- ❑ ❑ HIV OR AIDS _____
- ❑ ❑ LIVER, JAUNDICE OR HEPATITIS PROBLEMS_____

LIST ANY MEDICATIONS THAT YOU ARE TAKING (INCLUDING HERBS, VITAMINS OR OVER THE COUNTER MEDICINE):

_____

_____

LIST ANY MEDICATIONS THAT YOU ARE ALLERGIC TO, OR STATE "NONE":_____

LIST ANY SURGERIES YOU HAVE HAD IN THE PAST: _____

_____

_____

DID YOU HAVE ANY COMPLICATIONS WITH ANESTHESIA?
❑ YES ❑ NO

LIST ANY PRIOR HOSPITAL ADMISSIONS & REASON: _____

_____

TOBACCO USE
❑ NONE ❑ CIGARETTE, PIPE, OR CIGAR ❑ SNUFF ❑ CHEWING

ALCOHOL
❑ NO ❑ YES _____

DRUGS OR SUBSTANCE ABUSE
❑ NONE ❑ PILLS ❑ SMOKE ❑INJECTION

CHECK ANY CONDITION THAT A <u>BLOOD RELATIVE</u> HAS HAD: ❑ NONE

❑ DIABETES ❑ HIGH BLOOD PRESSURE ❑ CANCER ❑ HEART DISEASE ❑ COMPLICATIONS WITH ANESTHESIA

FAMILY HISTORY OF BREAST CANCER (CHECK ALL THAT APPLY) ❑ NONE

❑ GRANDMOTHER ❑ MOTHER ❑ DAUGHTER ❑ SISTER ❑ AUNT

<u>FOR WOMEN ONLY</u>
LAST MAMMOGRAM_____ WHERE_____ RESULTS_____

NUMBER OF PREGNANCIES _____ NUMBER OF CHILDREN_____ AGES_____

LIST ANY GYNECOLOGICAL PROBLEMS, OR STATE "NONE": _____

_____

_____ _____
PATIENT'S SIGNATURE **DATE**

_____ _____
REVIEWED BY **DATE**

_____

FOR OFFICE USE ONLY