Patient Information

Name:_____

Address;_____

City:_____ State:_____ Zip:_____

Home Phone:_____

Work Phone:_____

Cell Phone:_____

E-mail:_____

Preferred Method of Contact:_____

Date of Birth:_____Sex:___Marital Status:_____

Social Security Number:_____-_____-_____

Student: Y N Occupation:_____

Employer:_____

Patient's Spouse/Guardian

Spouse/Guardian:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____

Work Phone:_____

Reason for Consultation

_____

_____

Whom May We Thank for Referring You?

Name:_____

Other: Newspaper____ Radio ____ TV ____ Seminar _____

Staff ___ Yellow Pages ____ Other _____

Primary Care Physician

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____

Insured/Responsible Party

Insured's Name:_____

Relationship to Patient:_____

Address;_____

City:_____ State:_____ Zip:_____

Home Phone:_____

Work Phone :_____

Date of Birth:_____Sex:___Marital Status:_____

Social Security Number : _____-_____-_____

Employer:_____

Insurance Carrier:_____

Insurance Phone Number:_____

Policy #:_____ Group #:_____

Is this Plan a: PPO_____ POS_____ HMO_____

Are Referrals Required? _____ Are we in network?_____

I certify the above information is correct to the best of my knowledge. I understand that I am financially responsible for all charges whether or not covered by insurance. I also have received a Notice of Privacy Practices and Disclosure of Investment from the Center for Breast and Body Contouring, P.A.

Signature:_____ Date:_____

Update Signature:_____ Date:_____

Update Signature:_____ Date:_____

The Center For Breast & Body Contouring

Patient Name: _____

Patient Medical History

Allergies:
Please list any medical allergies as well as reactions**:**

_____
_____

Major Illnesses/Medical History:

If you answer yes to any of the following, please include date of diagnosis or onset.

			Date				Date
Heart disease	❑Yes	❑No	_____	Seizure Disorder	❑Yes	❑No	_____
				Anxiety Disorder	❑Yes	❑No	_____
High Blood Pressure	❑Yes	❑No	_____	Depression	❑Yes	❑No	_____
Chest pain	❑Yes	❑No	_____	Scarlet or Rheumatic			
Diabetes	❑Yes	❑No	_____	Fever	❑Yes	❑No	_____
Cancer	❑Yes	❑No	_____	Glaucoma	❑Yes	❑No	_____
Kidney Disease	❑Yes	❑No	_____	Cataract	❑Yes	❑No	_____
Asthma	❑Yes	❑No	_____	Arthritis	❑Yes	❑No	_____
Thyroid Disorder	❑Yes	❑No	_____	Tuberculosis	❑Yes	❑No	_____
Hypoactive	❑Yes	❑No	_____	Blood Clots	❑Yes	❑No	_____
Hyperactive	❑Yes	❑No	_____	Bleeding Disorder	❑Yes	❑No	_____
Hepatitis	❑Yes	❑No	_____	**Other:**			
Anemia	❑Yes	❑No	_____	_____			
				_____			

Medication History:

Please include **all prescription and non-prescription medications** you take as well as the dosage and instruction for use. Include separate sheet if necessary.

Medication/Strength	**How often is it taken?**	**Why do you take this medication?**

Do you routinely use aspirin or aspirin products (including Advil, Aleve or the generic equivalent)? ❑Yes ❑No

Surgical/Procedure History:

Have you ever had a surgical procedure (operation)? ❑Yes ❑No If yes, please provide details including dates:

Date	**Type/name of procedure**	**Anesthesia or wound complications:**

Patient Medical History continued

Pregnancy Overview:

Have you ever been pregnant? ❑Yes ❑No If yes, please provide details.

Date(year)	Single/Multiple Birth	Delivery method	Breast Fed
_____		❑ Vaginal ❑C-section ❑Miscarriage	❑Yes ❑No
_____		❑ Vaginal ❑C-section ❑Miscarriage	❑Yes ❑No
_____		❑ Vaginal ❑C-section ❑Miscarriage	❑Yes ❑No
_____		❑ Vaginal ❑C-section ❑Miscarriage	❑Yes ❑No
_____		❑ Vaginal ❑C-section ❑Miscarriage	❑Yes ❑No

Health Maintenance History:

Have you ever had a mammogram?❑Yes ❑No If yes, when was the most recent exam? _____
Have you ever had an abnormal mammogram? ❑ Yes ❑No
If yes, please explain: _____
When was your most recent complete physical? _____
Have you had a Chest X-ray or EKG within the past year? ❑Yes ❑No If yes, when was this performed?_____

Social History:

Do you currently smoke? ❑Yes ❑No Have you smoked in the past? ❑Yes ❑No If yes, provide details: _____
_____
❑Cigarettes ____PPD x ____ years ❑Cigars _____Per day x _____years Other**:**
_____
Do you drink alcohol? ❑Yes ❑No If yes, what type? ❑Wine ❑Mixed Drinks ❑Beer ❑Liquor How often? ❑Daily ❑1-2 x week ❑1-2 x month ❑1-2 x year
Do you live alone? ❑Yes ❑No If no, who lives with you? ❑Spouse ❑Children ❑Significant other ❑ Other relative ❑Other: _____
If you were to have a surgical procedure, who would assist you at home during your recovery?
_____

Family History:

Have any blood relatives had:

Condition			If yes, who had this? Please indication maternal or paternal (mother or father) relative.
Diabetes	❑Yes	❑No	_____
Breast Cancer	❑Yes	❑No	_____
Other Cancer	❑Yes	❑No	_____
Bleeding Disorder	❑Yes	❑No	_____
Heart Disease	❑Yes	❑No	_____
Hypertension	❑Yes	❑No	_____
Problems with Anesthesia	❑Yes	❑No	_____

❑ **I am adopted and do not know my family history.**

Additional:

Ethnicity: ❑ Caucasian/White ❑ African American/Black ❑Asian ❑Hispanic/Latino ❑Native American ❑Middle Eastern ❑Other _____
Are you ❑ right or ❑ left handed?
Height: _____
My Normal Weight: _____

Please list any additional medical conditions, illnesses, or handicaps you may have: _____
_____
_____
_____

The information I have provided about my medical history is accurate and complete to the best of my knowledge.

Patient's signature: _____ **Date:** _____

Financial Policy

We are committed to providing you with the best possible health care, and we are pleased to discuss our professional fees with you at any time. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policies. Please ask if you have any questions about our fees, your responsibility, or the financial policy.

All patients must complete our Patient Information Form and inform our office of any changes in address or insurance. In order for us to treat and care for our patients, we must have complete and correct information.

Payment for services rendered is ***due at the time of service***. We accept cash, check, Mastercard, Visa, Discover, and American Express. There will be a $25.00 service charge for any returned checks.

We expect TOTAL PAYMENT two weeks prior to all aesthetic procedures unless you have been pre-approved with one of our financial plans.

The charges on your account with our office will reflect ***our*** doctor's fees only, *unless otherwise noted*. Any hospital, x-ray, laboratory, anesthesia, pathology, etc. will be billed by the provider performing the service.

Insurance policy:
We will gladly answer questions regarding your insurance. If the proposed services are medically necessary, we will attempt authorization from your insurance company. You must realize, however, that:

- Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
- We do not handle third party billing, therefore, you are responsible for payment to the practice and being reimbursed by the third party.
- Not all services are a covered benefit in your contract. Some insurance companies arbitrarily select certain services they will not cover and these are a patient responsibility.
- If your insurance coverage is through a plan that we are ***not*** contracted with, regardless of your carrier's rate of reimbursement, you will be responsible for the **FULL** balance of your account. This includes any amount over the "reasonable and customary".

We must emphasize that as a medical care provider, the relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. It is understood that temporary financial problems may affect timely payment of your account. If such problems arise, you are encouraged to contact us promptly for assistance in the management of your account.

"I hereby assign, transfer, and set over to The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy with my current insurance company."

_____***Initials***

As part of your treatment, we require both before and after treatment photographs for which the fees are included in our charges.

If at any time after your initial surgery you feel that you need a revision surgery, facility and anesthesia fees will be applicable. Surgeons' fees are at the discretion of your surgeon.

"I authorize The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids and personnel of their choosing to photograph me prior to, during, and following any surgery. I understand these photographs will be a part of my medical records and are vital to my quality of care and post surgical result."

Signature:_____ Date;_____

Photography Release

Dated: _____

I, _____(patient's name) hereby give The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids the absolute and irrevocable right and permission, with respect to photographs they have taken of me and/or in which I may be included with others:

a. To copyright the same in their own name or any other name they may choose.
b. To use, re-use, publish and/or re-publish the same in whole or in part, individually, or in conjunction with other photographs, in any medium and for any purpose whatsoever, including (but not limited to) illustration, promotion and/or advertising and/or trade.
c. To use my name in connection therewith if they so choose.

I hereby release and discharge The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids from any and all claims and demands arising out of or in connection with the use of the photographs, including any and all claims for libel.

This authorization and release shall also ensure to the benefit of the legal representatives, licensees, and assignees of The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids as well as the person(s) for whom they took the photographs.

_____ Please **DO NOT use my photos** on the website or for marketing purposes.
(initial)

I have read the foregoing and fully understand the contents thereof.

_____
(patient signature or legal guardian if minor)

_____
(witness signature)

_____
(legal guardian relationship to patient if minor)

_____
(patient address)

_____

Pharmacy Authorization

Dated: _____

In order to maintain accurate medication records and history, we are requesting authorization to access your medication history. Please notate your pharmacy information below:

_____ _____
Pharmacy Name and Location Phone

_____ _____
Pharmacy Name and Location Phone

_____ _____
Pharmacy Name and Location Phone

I, _____(patient's name) hereby give The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids authorization to access my medication history for the purpose of maintaining accurate medication records and history.

This authorization will remain in effect as long as I am an active patient under the care of Dr. Christine Stiles.

I may terminate the authorization at any time with a written request.

_____
(patient signature or legal guardian if minor)

_____ _____
(witness signature) (legal guardian relationship to patient if minor)

_____
(patient name printed)

HIPPA Privacy Rule

In effort to comply with the Privacy Rule to implement the requirement of the Health Insurance Portability & Accountability Act of 1996 (HIPPA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

Please circle your response to the following:

May we leave messages concerning your appointments with a co-worker, receptionist or secretary that regularly answers your calls? YES NO N/A

May we leave messages on a voice mail at work/home regarding an appointment, referral or test results? YES NO N/A

May we discuss your appointments/treatments with your spouse? YES NO N/A

May we discuss your appointments/treatments with your children or other family members? Please list names: _____

_____

YES NO N/A

May we share your pertinent medical information with specialists you may be seeing? YES NO N/A

Request for Electronic Communication:

I request that the following communications from the practice be delivered to me by the provided electronic means. I understand that this form of communication may not be secure, creating a risk of improper disclosure to unauthorized individuals. I am willing to accept that risk, and will not hold the practice responsible should such incident occur.

Communications: ____ Appointment Reminders ____ Prescription Refill Reminders

____ Other (list specifically) _____

Method: ____ Email: _____

____ Text - Phone Number: _____

Acknowledgment and Agreements:
I understand and agree that the requested communication method is not secure, making PHI (Private Health Information) at risk for receipt by unauthorized individuals. I accept the risk and will not retaliate against the practice in any way should this occur.

You must inform us, in writing, of any changes in your directives. This record takes effect immediately and will be kept in your file along with acknowledgement of Receipt of Your Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Witness Date

Print name: _____ Phone No.: _____

Address: _____

Personal Representative: _____ Request Received By Date: _____

Smoking Risk Acknowledgement

In an effort to fully inform our patients on the risks of smoking associated with healing & surgery, we require all prospective patients to read the following statements and initial each line confirming that they received this information and understand it.

I have advised my physician that (please initial one):

_____ I do not smoke and have never smoked in the past.

_____ I currently smoke or have smoked in the recent past.

_____ I am not currently smoking, but have smoked in the past.

All patients must read the following statements and initial each line.

_____ I understand that I may not smoke six (6) weeks before my procedure.

_____ I understand that exposure to second-hand smoke is just as harmful to me as if I smoked myself.

_____ I understand that smoking six (6) weeks prior to surgery and ANY smoking following surgery greatly increases the risk of postoperative complications.

Possible complications include:

- Blood clots
- Death of skin or tissue requiring additional surgery
- Delayed wound healing
- Unfavorable scars
- Increased risk of infection

_____ If I currently smoke, I understand that I will be tested for continine, a byproduct of nicotine, at my pre-operative visit approximately two (2) weeks before my surgery. I understand my surgery will be rescheduled for a positive test.

_____ I understand that a positive test will cause the cancellation of my surgery and may lead to forfeiture of 50% of my surgeon's fees.

_____ I understand that the use of nicotine post operatively will impact the longevity of my results. I will be responsible for all fees associated with all revisions that may be necessary.

_____ _____

Patient Signature Date

_____ _____ _____

Witness Date