



**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: \_\_\_\_\_

**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**

\_\_\_\_\_

\_\_\_\_\_



## 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
_____		<input type="checkbox"/> Vaginal <input type="checkbox"/> C-section <input type="checkbox"/> Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____		<input type="checkbox"/> Vaginal <input type="checkbox"/> C-section <input type="checkbox"/> Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____		<input type="checkbox"/> Vaginal <input type="checkbox"/> C-section <input type="checkbox"/> Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____		<input type="checkbox"/> Vaginal <input type="checkbox"/> C-section <input type="checkbox"/> Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____		<input type="checkbox"/> Vaginal <input type="checkbox"/> C-section <input type="checkbox"/> Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Breast Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Problems with Anesthesia	<input type="checkbox"/> Yes <input type="checkbox"/> 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 (HIPAA), 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 cotinine, 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