

Welcome, and thank you for choosing...



Date _____

Patient Name: _____
First MI Last

Address: _____
City State Zip

SSN: _____ Birth Date: _____ Age: _____

Marital Status ?Single ?Married to: _____ ?Other: _____

Home Phone#: _____ Work Phone #: _____

Cell #: _____ E-mail: _____

Parent or Guardian (if patient is a minor): _____

Emergency Contact _____
(Not in your household) Name relationship

Home Phone _____ Other Phone _____

Patient's Employer _____ Occupation _____

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

Referral Source: _____
Friend, MD, Yellow Pages, Ad, etc.

Primary Physician: _____

Primary Insurance Information

Insurance Company: _____ ID#: _____ Group#: _____ CO PAY \$ _____

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

Home phone: _____ Work Phone: _____ SS#: _____

Patients Relationship to insured: ? Self ? Spouse ? Child ? Other _____

Secondary Insurance Information:

Insurance Company: _____ ID#: _____ Group#: _____ CO PAY \$ _____

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

Home phone: _____ Work Phone: _____ SS#: _____

Name: _____ Reason for this visit: _____

Are you interested in a FREE skin care consult: Y N

Date of Birth _____

Are you interested in information on our medical skin care products Y N

MEDICAL HISTORY: In the last six months have you had:

Abnormal bleeding	Y <input type="checkbox"/> N <input type="checkbox"/>	Cancer	Y <input type="checkbox"/> N <input type="checkbox"/>	Fainting spells	Y <input type="checkbox"/> N <input type="checkbox"/>
Coronary Surgery	Y <input type="checkbox"/> N <input type="checkbox"/>	Hypertension	Y <input type="checkbox"/> N <input type="checkbox"/>	Sleep Apnea	Y <input type="checkbox"/> N <input type="checkbox"/>
Kidney Disease	Y <input type="checkbox"/> N <input type="checkbox"/>	Keloid scars	Y <input type="checkbox"/> N <input type="checkbox"/>	Anemia	Y <input type="checkbox"/> N <input type="checkbox"/>
Abnormal Clotting	Y <input type="checkbox"/> N <input type="checkbox"/>	Asthma	Y <input type="checkbox"/> N <input type="checkbox"/>	Angina	Y <input type="checkbox"/> N <input type="checkbox"/>
Diabetes	Y <input type="checkbox"/> N <input type="checkbox"/>	Acid regurgitation	Y <input type="checkbox"/> N <input type="checkbox"/>	Hepatitis	Y <input type="checkbox"/> N <input type="checkbox"/>
Thyroid	Y <input type="checkbox"/> N <input type="checkbox"/>	Tuberculosis	Y <input type="checkbox"/> N <input type="checkbox"/>		
Heart Attack	Y <input type="checkbox"/> N <input type="checkbox"/>	Other	_____		

Previous Surgery, year and type of procedure:

Indicate the types of anesthesia received in the past, list any complications/reactions you experienced:

- Local anesthesia: complications/reactions _____
- General anesthesia: complications/reactions _____
- Spinal/Epidural: complications/reactions _____

SOCIAL

Married Single Widowed Occupation: _____

Responsible adult available to assist after surgery Y N Relationship: _____

Number of pregnancies: _____ Number of children: _____ Did you breast feed Y N

Date of Deliveries _____

Last Mammogram Date: _____ Results: _____

HABITS

Tobacco/Nicotine Y N Amount: _____ Coffee/Tea/Cola Y N Amount: _____

Alcohol Y N Amount: _____ Daily Exercise Y N Amount: _____

FAMILY HISTORY: Have any blood relatives ever had the following problems:

Abnormal bleeding	Y <input type="checkbox"/> N <input type="checkbox"/>	Diabetes	Y <input type="checkbox"/> N <input type="checkbox"/>	Cancer	Y <input type="checkbox"/> N <input type="checkbox"/>
Coronary Disease	Y <input type="checkbox"/> N <input type="checkbox"/>	Tuberculosis	Y <input type="checkbox"/> N <input type="checkbox"/>	Hypertension	Y <input type="checkbox"/> N <input type="checkbox"/>
Kidney Disease	Y <input type="checkbox"/> N <input type="checkbox"/>	Anesthetic problems	Y <input type="checkbox"/> N <input type="checkbox"/>	Keloid scars	Y <input type="checkbox"/> N <input type="checkbox"/>
Abnormal Clotting	Y <input type="checkbox"/> N <input type="checkbox"/>	Heart Attack	Y <input type="checkbox"/> N <input type="checkbox"/>	Breast Cancer	Y <input type="checkbox"/> N <input type="checkbox"/>

MEDICATIONS: List dose or number of pills per day

Prescription Drugs

Non prescription Drugs (Vitamins/ Herbs)

Regular Aspirin Use: Y N

Dosage & Frequency: _____

Drug Allergy Y N

Latex Allergy Y N

Tape Allergy Y N

List Drugs and type of reaction:

Height: _____ Weight: _____ Weight change past 12 months? Y N How much? _____



Vincent A. Naman
1921 Whittlesey Road • Suite 200
Columbus, GA 31904

I the undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of the physician and medical staff of **Chattahoochee Plastic Surgery**. Health services may include, but is not limited to: examination, preventative and/or curative treatment, x-ray, laboratory examination, anesthetic, medical or surgical diagnosis, and any consultation deemed necessary at the physician's discretion. Services shall not include research or experimentation.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required and is given to encourage the physician to exercise his or her best judgment as to the requirements of such diagnosis or medical treatment.

This consent shall remain in effect until revoked, in writing

_____	_____
PATIENT PRINTED NAME	DATE OF BIRTH
_____	_____
SIGNATURE OF PATIENT	DATE
_____	_____
WITNESS	DATE

If above mentioned patient is not of legal age, consent from a Parent(s) / Legal Guardian(s) must be obtained prior to treatment of the minor child.

_____	_____
MINOR CHILD'S NAME	DATE OF BIRTH
_____	_____
SIGNATURE OF PARENT OR LEGAL GUARDIAN	DATE
_____	_____
WITNESS	DATE

FINANCIAL AGREEMENT

This agreement made and entered into is to be effective as of the date recorded below between Chattahoochee Plastic Surgery, P.C., herein referred to as CPS, and Patient, or Responsible Party if not the Patient, herein referred to as Patient, and named below. By executing this agreement, Patient agrees to pay for all services provided by CPS.

Cosmetic Surgery Deposit & Cancellation Policy: Patients are required to pay a \$400 deposit fee to be placed on the surgery schedule; the remaining balance is due **2 weeks** prior to the surgery date or at the **Pre-op**. If the patient cancels within **fourteen (14)** business days of surgery, a full refund including deposit will be given. If surgery is rescheduled, the deposit will be forwarded towards future surgery date. If the Patient cancels less than **fourteen (14)** business days of surgery, the deposit will be non-refundable. Any other amounts paid will be refunded.

Insurance Covered Surgeries: Patients will be required to pay their Co-pays and Co-insurance **2 weeks** prior to surgery. If insurance terminates prior to surgery and services are rendered, patient is responsible for full payment to CPS.

Physician Assistant Charges: Our facility employs a Physician Assistant, Shana Helms. She assists Dr. Naman in surgeries at the hospitals and The Surgery Center. Therefore, you may also incur additional charges for her services.

Other Charges: If you have surgery performed outside our office; expect charges from other entities such as The Surgery Center, Doctor's Hospital, St. Francis Hospital, Pathology, and Anesthesiology.

Statement: If Patient has a balance on his/her account, he/she will receive a monthly statement. The statement will show any previous balance due, any new charges to account, and any payments or credits applied during the month.

Payments: Unless CPS approves other arrangements in writing, the Patient's balance is due when the statement is issued and will be considered Past Due if not paid within 30 days of the statement date.

Past Due Accounts: CPS will take all of the necessary steps allowed by law to collect on past due accounts. If Patient's account balance becomes past due and Patient does not contact CPS to set up a payment plan, the account will be subject to Collection Procedures. The Patient will receive 2 monthly statements, 1 collection letter, and 3 phone calls before account will be turned to COLLECTIONS. Once in COLLECTIONS, **the amount due will increase by up to 18%.**

Returned Checks: CPS will charge a fee in the amount of \$25 for each check returned by the Patient's bank.

Insurance: Insurance coverage is a contract between Patient and the Insurance Carrier. Any co-payment/coinsurance required by an insurance company must be paid at the time of service. Patient will also be required to pay deductibles if not met at time of service. For any procedure not covered by insurance, such as cosmetic procedures, patient agrees to pay the full consultation fee at the time of service. Every patient is responsible for knowing the specific requirements of their insurance companies. CPS will bill Patient's primary insurance carrier as a courtesy, however, it is the insurance carrier that makes the final determination of eligibility and payment. To assist you in making sure all insurance requirements are met, please let us know if you are required to have of the following:

1. A referral / permission slip from your PCP to see our doctor. This is the responsibility of the Patient to obtain prior to visit.
2. The required use of a particular hospital _____.
3. The required use of a particular laboratory _____.

It is the Patient's responsibility to make sure all insurance requirements are fulfilled. It is also the Patient's responsibility to notify CPS of any changes in their insurance coverage.

Transferring/Receiving of Records: Patient will need to make a written request to have copies of their records sent to another doctor or organization. However, it is preferable for the patient to pick up his/her own records. If Patient requests that records be sent to CPS from another doctor, Patient authorizes CPS to receive all relevant information concerning patient, including payment history.

By signing this agreement, Patient agrees to all of the terms and conditions contained herein and the agreement will be in full force and effect. I authorize the use of my signature on all insurance submissions. CPS may use my health care information and may disclose such information to my insurance carrier and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

Signature (Patient) _____ Date _____

Signature (Responsible Party if not Patient) _____ Date _____

Patient's Name _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Social Security # _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you have acknowledged that you have received a copy of this office's Notice of Privacy Practices and will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing the Consent.

We reserve the right to change our practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practice, including any revisions of our Notice, at any time by contacting our practices Privacy Officers at (706)494-7700.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed below. You can either file a complaint with our practice's Privacy Officer, or with the office of Civil Rights, U.S. Dept of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our practice or the OCR. The address for the OCR is as follow:

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH building
Washington D. C. 20201

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name: _____

Relationship to the patient: _____

Patient Photographic Authorization and Release

In order to provide you with the highest quality results that you desire we have found it necessary to have photographic documentation of your progress while under our care. This includes preoperative and postoperative photographs.

All photographs will be maintained with the highest of confidentiality possible.

I _____ consent to release to **Chattahoochee Plastic Surgery, P.C.**, photographs taken of me, or parts of my body, with respect to my plastic surgery treatment. Insurance companies require photographs to determine medical necessity for many procedures. This release includes the photographs taken by Dr. Naman or his medical staff.

I understand that such photographs shall become the property of CPS and may be retained by CPS or released by CPS for PUBLICATION or REPUBLICATION in any PRINT, VISUAL, ELECTRONIC (INTERNET) or BROADCAST MEDIA for any purpose which CPS deems appropriate to inform the medical profession or the general public about plastic surgery methods. The media may include, but are not limited to, the following: MEDICAL JOURNALS AND TEXTBOOKS, PAMPHLETS, NEWSPAPERS, MAGAZINES, VIDEO TAPES, TELEVISION or MOTION PICTURES.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable.

I release and discharge Dr. Vincent Naman and Chattahoochee Plastic Surgery and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I have relating to such use and publication, including any claim for payment in connection with distribution or publication of the photographs.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above authorization and release and fully understand its terms.

Patient Signature: _____ **Date:** _____

Parent / Guardian Signature: _____ **Relationship:** _____

Witness: _____