Name:_____ **Reason for this visit:**_____ **Date of Birth:** _____

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

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 ☐ N ☐	Cancer	Y ☐ N ☐	Fainting Spells	Y ☐ N ☐
Coronary Surgery	Y ☐ N ☐	Hypertension	Y ☐ N ☐	Sleep Apnea	Y ☐ N ☐
Kidney Disease	Y ☐ N ☐	Keloid Scars	Y ☐ N ☐	Anemia	Y ☐ N ☐
Abnormal Clotting	Y ☐ N ☐	Asthma	Y ☐ N ☐	Angina	Y ☐ N ☐
Diabetes	Y ☐ N ☐	Acid Regurgitation	Y ☐ N ☐	Hepatitis	Y ☐ N ☐
Thyroid	Y ☐ N ☐	Tuberculosis	Y ☐ N ☐		
Heart Attack	Y ☐ N ☐	Other _____			

Previous surgery, year, and type of procedure:

_____

_____

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

☐ Local anesthesia: complications/reactions_____

☐ General anesthesia: complications/reactions_____

☐ Spinal/epidural: complicastion/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/soda	Y ☐ N ☐ Amount:_____	
Alcohol	Y ☐ N ☐ Amount:_____		Daily exercise	Y ☐ N ☐ Amount:_____	

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

Abnormal Bleeding	Y ☐ N ☐	Diabetes	Y ☐ N ☐	Cancer	Y ☐ N ☐
Coronary Disease	Y ☐ N ☐	Tuberculosis	Y ☐ N ☐	Hypertension	Y ☐ N ☐
Kidney Disease	Y ☐ N ☐	Anesthetic Problems	Y ☐ N ☐	Keloid Scars	Y ☐ N ☐
Abnormal Clotting	Y ☐ N ☐	Heart Attack	Y ☐ N ☐	Breast Cancer	Y ☐ N ☐

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 ☐

List drugs and type of reaction: _____

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

Welcome, and thank you for choosing . . .

cps **Chattahoochee** PLASTIC SURGERY P.C.

(706)494-7700 fax (706)494-8800

Patient Information as of _____ (enter today's date)

(Please Print Legibly & **Fill In All Fields**)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

Contact Restrictions: _____ Drivers License # (include State) _____

Age _____ Birthdate __/__/____ SS# ___-___-____ Sex ❒ Female ❒ Male

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

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

Emergency Contact
(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

Referral Source _____ **Primary Physician** _____
Physician – Patent – Friend – Yellow Page – Ad Physician Name

Primary Health Insurance Company _____
Effective Date

Member # _____ Group # _____ Ins. Phone «Primary_Ins_Co_Phone»

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $_____ Ins. Type _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company _____
Effective Date

ID # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $_____ Ins. Type _____

Insured: Name _____ DOB _____ Employer _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Naman to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Naman and myself.

Signature _____ **Date** _____

Chattahoochee
PLASTIC SURGERY P.C.

Vincent A. Naman, MD
Shana B. Helms, PA-C
2430 Brookstone Centre Parkway
Columbus, Ga 31904

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

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ 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 healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures 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 this Consent.

We reserve the right to change our privacy 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 Practices, including any revisions of our Notice, at any time by contacting our practice's Privacy Officers at (706)494-7700

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

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 Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart

Chattahoochee
PLASTIC SURGERY P.C.

Vincent A. Naman, MD
Shana B. Helms, PA-C
2430 Brookstone Centre Parkway
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, PC.** 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 medic al 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 _____

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 pre-operative and post-operative photographs.

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

I _____ consent to release to **Chattahoochee Plastic Surgery, PC (CPS)** 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 the 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 CPS 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.

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN RELATIONSHIP

_____ _____

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 CPA, 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.

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, is it 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 the following:

1. A referral, particular hospital or laboratory. This is the responsibility of the Patient to obtain prior to visit.

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.

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. 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. If you have a 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. CPS will charge a fee in the amount of $25 for each check returned by the Patient's bank.

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. Once in COLLECTIONS, **the amount due may increase up to 20%.**

Insurance: Insurance coverage is a contract between the patient and the Insurance Carrier. Any co-payment/coinsurance required by an insurance company must be paid at the time of service. Patients will also be required to pay deductibles not met at time of service. All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within 60 days, the balance may be due in full from you. For any payment made directly to you for services billed by Chattahoochee Plastic Surgery, PC, you recognize an obligation to promptly remit payment to CPS.

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 determining benefits payable for related services.

Signature (Patient) _____ Date _____

Signature (Responsible Party if not Patient) _____ Date _____

Patient's Name _____

Authorization for Release of Medical Information
Vincent Naman M.D.
Shenita White M.D.

Chattahoochee Plastic Surgery P.C.
2430 Brookstone Centre Parkway
Columbus, GA 31904
Phone 706-494-7700
Fax 706-494-8800

Name of Patient_____ Date_____

Date of Birth_____ Social Security Number_____

INFORMATION TO BE RELEASED OR ACCESSED:

____History & Physical	____Consultation Report	_____Emergency Room Record
____Operative reports	____X-Ray/Reports/images	_____Face Sheet
____Other		

I,_____ authorize and request the disclosure of protected medical information from:

Name_____

Address_____

Phone/Fax_____

Please release medical records to:

Vincent Naman M.D.
Shenita White M.D.
2430 Brookstone Centre Parkway
Columbus, GA 31904
Fax: 706-494-8800

_____ _____

Signed Date