ATLANTA PLASTIC & RECONSTRUCTIVE SPECIALISTS, LLC

5673 PEACHTREE DUNWOODY RD. NE
SUITE 870
ATLANTA, GA 30342
p 404·255·2975 f 404·255·2276

1800 HOWELL MILL RD.
SUITE 140
ATLANTA, GA 30318
p 404·343·0897 f 404·343·0496

PATIENT REFERRAL FORM

Please provide the COMPLETE name, address and phone number of the **physician who referred you to our practice**. Check N/A if you were not referred by a physician.

Physician Name____ N/A _____________

Address____

____ Phone ____) ____________________

* If you were not referred by another physician, how did you hear about our office?

____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Atlanta Plastic & Reconstructive Specialists, LLC. to bill my insurance carrier if applicable for any services rendered by them or any agents of their practice. With this authorization, I assign any and all benefits payable for services rendered by the doctors at A.P.RS. I understand that I am responsible for any amount not covered by my insurance plan.
I hereby authorize the release of any and all medical information necessary to the treatment I will receive while under the care of the doctors at A.P.R.S. I authorize the release of medical information including x-rays, pathology, laboratory and operative reports. A copy of this authorization shall be valid as the original.

____ ___________________________________
Patient/Legal Guardian Signature Date

____ ___________________________________
Guarantor Name Date of Birth

____
Address

AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS/SLIDES AND/OR VIDEOTAPES

This is a consent document that has been prepared to help inform you concerning permission to take photographs, slides, and/or videotapes and to use these images for a purpose as defined with this consent document. After carefully reviewing, please sign the consent as proposed by your medical provider.

___

Medical photographs, slides, and/or videotapes may be taken before, during or after surgical procedure or treatment. Consent is required to take such images. Additionally, patients may consent to release these medical photographs, slides, and/or videotapes for a stated purpose.

CONSENT TO TAKE PHOTOGRAPHS/SLIDES/VIDEOTAPES

____ I hereby authorize ATLANTA PLASTIC & RECONSTRUCTIVE SPECIALISTS, LLC. & their associates or licensees to take pre-operative, intra-operative and post-operative photographs, slides, and/or videotapes. I additionally consent to photographs, slides and/or videotapes of my interview as deemed appropriate for medical record keeping. I understand these will be considered part of the medical record and may be subject to release under lawful purposes of disclosure as permitted by HIPAA privacy laws and malpractice law.

CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES
****PLEASE NOTE: CHOOSE ONE OF THE FOLLOWING OPTIONS****

____ I hereby authorize ATLANTA PLASTIC & RECONSTRUCTIVE SPECIALISTS, LLC. & their associates or licensees to use pre-operative, intra-operative and post-operative photographs, slides and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on electronic digital networks for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups.

____ I hereby authorize ATLANTA PLASTIC & RECONSTRUCTIVE SPECIALISTS, LLC. & their associates or licensees to post de-identified* photos, on the world wide web and social media to educate other prospective patients. I understand that if I revoke this consent in the future, the practice will initiate steps to remove the original documents from its online accounts but that duplicates that may exist online in other locations and/or under the control of other parties may not be subject to the practice's ability to remove in all cases. *Not applicable to facial images.

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I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

Patient/Legal Guardian Signature____

Witness____________________________________ Date_________________

OUR FINANCIAL POLICY

Our physicians and staff are very concerned about the cost of your healthcare and want to address some current issues related to the cost of medical services in this office.

Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity of the care rendered and the skill and expertise for your care. Our fees are comparable with fees of other surgeons in the metro area.

PAYMENT POLICY

INDEMNITY (not HMO OR PPO): If an insurance company indicates that the physician's fees are above the "usual and customary", please understand that most physician's fees are above the rate at which insurance companies choose to pay. The rate is most often lower than the fees normally charged by a physician. We use many sources to determine the appropriateness of our fees. We cannot and do not allow the payment or allowance of insurance companies to set the amount that we charge for our services. Our policy requires payment at the time of service for office visits and procedures. To assist you in filing your own insurance claim, we will provide you with an itemized statement. You can simply send the itemized statement to your insurance company to expedite your reimbursement.

HMO, POS AND PPO MEMBERS: If you are a member of an HMO, POS or PPO in which we participate, your deductible and/or co-pay is required at the time of service. ***You** are also responsible to see that we have a current referral on file, if your insurance company requires one*. If you don't have a current referral at the time of service, your insurance company will hold you responsible for all charges. You may be sent to your primary care physician to obtain a referral prior to being treated.

***Our agreement is with YOU and NOT your insurance company. You (or perhaps your employer) have chosen your insurance coverage. Although we will assist you in submitting your claim to your carrier, you are ultimately responsible for the services you receive. Payment to our office is not contingent or dependent upon your insurance company.

In your interest, we are pleased to accept cash, check, MasterCard or Visa for your charges. Returned checks will receive a $20.00 overdraft charge. A monthly billing fee will be added to all account balances beyond 30 days of service.

A collection agency may take over a delinquent account. If any account is placed with a collection agency, the patient will be responsible for all costs of collection. Timely payment will prevent consequences to your credit rating.

If you have any questions about our financial policy or your insurance reimbursement, please feel free to discuss this with our office staff.

I have read and *understand my financial* responsibilities under this policy.

____ ________________________

Patient/Legal Guardian Signature Date

INSURANCE CLAIM FILING POLICY

Our office, as a courtesy, will file your claim to your insurance company. ***We must make it clear that insurance contracts are between you, the patient, and your insurance company. You are responsible for any amount not paid by your insurance company. (______initials.)***

Please be aware that ***it is ultimately the patient's responsibility to be aware of their coverage and benefits, and whether the provider you choose is in your network, and if a referral is needed, if applicable. (_____initials.)***

By accepting your insurance on assignment, we are extending you credit. This courtesy may be withdrawn if circumstances below warrant. All of the following are applicable to your agreement except any unfilled lines.

It is imperative that you understand these conditions and agree to them:

1. You are required to sign informed consent and medical records release forms as well as any other assignment documents required by this office and your insurance company.
2. **Co-pay/Co-Insurance, deductible payments and fees for non-covered services are due at time of service.**
3. Your insurance company should provide an Explanation of Benefits to our office and the patient within 30 days of your office visit. **If your insurance has not paid within 75 days, then you will be responsible to pay the balance due, and if not paid within 90 days the account is considered within default. You are responsible for all fees resulting in and associated with the collection of any outstanding balance.**
4. **Our office does not guarantee that your insurance company will pay for services provided.**
5. **If your insurance claim is denied, you are responsible for the full amount of your balance.**
6. Our office will not enter into a legal dispute with your insurance company over any claim. **This is ultimately your responsibility and obligation.**

____
Patient Name (Printed)

____ ____________________
Patient/Legal Guardian Signature Date

____ ____________________
Witness Date

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Race: (One or more categories may be selected)

☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other

☐ Declined To Provide

Ethnicity: (One or more categories may be selected)

☐ Hispanic or Latino ☐ Puerto Rican ☐ Not Hispanic or Latino ☐ Other ☐ Declined To Provide

Language: (One or more categories may be selected)

☐ English ☐ Spanish ☐ Korean ☐ Portuguese ☐ Russian ☐ Other

☐ Declined To Provide

PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices (“Notice”) provides information about how we, Atlanta Plastic & Reconstructive Specialists, LLC, may use and disclose protected health information (“PHI”) about you. You have the right to receive and review our Notice prior to signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents or our Notice have been answered.

_________________________ ____

Date Name/Legal Guardian

HIPPA EMAIL, TEXT AND VOICE COMMUNICATION CONSENT

___________________________________ __________________________

Patient Name Date of Birth

I permit Atlanta Plastic & Reconstructive Specialist (APRS) and their staff (“Health Care Providers”) to discuss my health information through the following technology.

Can leave a voice mail message about my care at this number: **NO** or **YES**: # _______________

Can send an appointment reminder text to this number: **NO** or **YES**: #_____________________

Can email me at: ____

This authorization is limited to the following time frame _____________ (date) to __________ (date). **If no dates are indicated,** this form will remain in effect for an unlimited amount of time.

If at any time, I do not want to receive my health information this way, I must notify my Heath Care Provider by contacting the office at (404) 255-2975.

____ ____________________________

Patient/Legal Guardian Signature Date

____________________________ _______________________ _______________________

Emergency Contact Relationship Phone Number

PERMISSION FOR VERBAL COMMUNICATIONS

______________________________ ______________________________
Patient Name Date of Birth

______________________________ ______________________________
Street Address City, State, Zip Code

I permit ATLANTA PLASTIC & RECONSTRUCTIVE SPECIALISTS, LLC. & their staff ("Health Care Providers") to discuss health information, in person, or by telephone with the following family members or friends involved in my medical care.

This authorization is limited to discussions regarding the following medical condition(s):

____

Name	Relationship
1. ______________________________	______________________________
2. ______________________________	______________________________
3. ______________________________	______________________________
4. ______________________________	______________________________

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document **does not** permit release of any written health information to the individuals named above.

This authorization is limited to the following time frame from _____________ (date) to ___________ (date). **If no dates are indicated**, this form will remain in effect for an unlimited amount of time.

If at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting the office at (404) 255-2975.

____ ______________________
Patient/Legal Guardian Signature Date

Atlanta Plastic & Reconstructive Specialists

Date: _______________ Name: ____________________________________ DOB: ____________________

Reason for today's visit: ____

Patient Medical History – Have you had or are you experiencing any of the following:

____ Patient denies any past medical history *Please review entire form & sign where indicated.

DETAILS

___ Abdominal Bleeding ____

___ Asthma ____

___ Blood Clots/Bleeding Disorder ____

___ Chest Pain ____

___ Diabetes ____

___ Eye Problems ____

___ Gastrointestinal Disorder ____

___ Heart Disease ____

___ Heart Murmur ____

___ Hepatitis ____

___ High Blood Pressure ____

___ High Cholesterol ____

___ HIV ____

___ Kidney Problems ____

___ Malignant Hyperthermia ____

___ MRSA ____

___ Musculoskeletal Disorder ____

___ Neurologic Disease ____

___ Psychiatric Condition ____

___ Sleep Apnea ____

___ Stroke ____

___ Thyroid Disorder ____

___ Tuberculosis ____

Cancer History

____ Patient denies any past Cancer history

	LOCATION	TREATMENT
___ Basal Cell Carcinoma ____		
___ Breast Cancer ____		
___ Malignant Melanoma ____		
___ Ovarian Cancer ____		
___ Skin Cancer ____		
___ Squamous Cell Carcinoma ____		
___ Chemical/Radiation Therapy ____		
___ Other ____		

Allergic/Immunologic/Infectious – Past Medical History

____ No known drug allergies

DETAILS

___ Medication Allergies ____________________

___ Allergic/Immunologic/Infectious Problems ____________________

___ HIV/AIDS ____________________

___ Tuberculosis (TB) ____________________

___ Autoimmune Disorder ____________________

___ Other ____________________

Patient Implant/Device History

____ None

DETAILS

___ Breast Implants ____________________

___ Tissue Expander ____________________

___ Joint or other replacement implant ____________________

___ Other ____________________

*** **Please bring a COMPLETE list of all prescription and over-the-counter (supplements & vitamins) to your appointment. Include the dosage for EACH medication.**

Patient Past Surgeries/Hospitalizations

Surgery/Hospitalization	Date	Reason	Anesthesia Complication	Notes

Patient Family History

____ Patient denies any family history ____ Unknown – Adopted

	Family Member	Notes
___	Breast Cancer	
___	BRCA Positive	
___	Other Cancer	
___	Diabetes	
___	Heart Disease	
___	High Blood Pressure	
___	Hemophilia	
___	Clotting Issues	
___	Obesity	
___	Other	

Smoking Status

____ Patient denies any history of smoking

____ Current/Previous Smoker Age started _________ Packs/Day _________ Age Quit ____________

Height/Weight/BMI

_________ Height ___________ Weight ____________ Highest Weight ___________ BMI

Patient Social History

____ Patient denies use of alcohol

Use of Alcohol - How much/How often ____

____ Patient denies use of recreational drugs

Use of Recreational Drugs - How much/How often ______________________________________

Preferred Pharmacy

Pharmacy Name ________________________________ Phone No. ______________________________

Address ____

Patient Social History Details

Marital Status _______________ Occupation ____

No. of Children __________ Exercise ____________________ Frequency _____________________

Additional Details ____

Previous Breast Surgery Details

Procedure ____

Reason for Procedure ____

Surgeon _________________________________ Date/Year _________________________________

Implant Manufacturer _______________________ Implant Type _______________________________

Implant Placement ________________________ Implant Size ________________________________

Additional Details ____

Breast Desired/Current Size Details

Band Size Cup Size Comments

Current Size ____

Desired Size ____

Size during pregnancy ____

Size at highest weight ____

Size at lowest weight ____

Mammogram/Testing

Type of Diagnostic Testing ____

Date of last test ____

Results ____

Comments ____

____

Patient/Responsible Party Signature ____

Date __________________________