PRIMA CENTER FOR PLASTIC SURGERY

PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Name: _____ Date of Birth: _____ Age: _____
Legal First Middle Last

Address: _____ Cell Phone: _____

City: _____ State_____ Zip_____ Home Phone: _____

Email Address: _____ Work Phone: _____

Family Doctor: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Name of person(s) we have permission to discuss your care with:_____

Phone #:_____ **Relationship to Patient**: _____

BILLING INFORMATION (if patient is a minor, please include both parents' names)

Billing Name: _____ Spouse's Name: _____

Insurance: _____ Address: (if different) _____

ID#: _____ _____

Group#: _____ Phone #: _____ Employer: _____

Name of person or relative (not living with you) we can Employer Address: _____

contact in an emergency: _____ Employer Phone #: _____

Phone #: _____ Alternate #: _____

PRIVACY POLICY

Our Privacy Notice is located in the reception area. Your signature below indicates you have had the opportunity to review the privacy notice.

_____ _____

Patient/Responsible Party Signature Date

NON-ELECTIVE MEDICAL SERVICES

Primary Insurance Company: _____ Secondary Insurance Company: _____

Please provide your Insurance Card(s) for photocopy services

I hereby authorize Prima Center for Plastic Surgery to furnish information to my insurance company or companies. I hereby assign Prima Center for Plastic Surgery all payments for medical services rendered to my dependents, or myself and I understand that I am responsible for any amount not covered by insurance.

_____ _____

Patient/Responsible Party Signature Date

PRIMA CENTER FOR PLASTIC SURGERY

Legal Name: _____ Age: _____ Today's Date:_____

Date of Birth: _____ Sex: _____ Height: _____ Weight: _____

DRUG ALLERGIES: _____ Occupation: _____
_____(prescriptions, latex, dyes, etc.)

PURPOSE OF VISIT

What is the reason for your visit today? _____
_____
_____

HEALTH REVIEW

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING (CHECK ALL THAT APPLY)

___ Anemia
___ Arthritis
___ Asthma
___ Bleeding Tendency
___ Blood Clots/DVT (Deep Vein Thrombosis)
___ Bronchitis
___ Cancer
___ Colitis
___ Congenital Heart Defect
___ Diabetes
___ Epilepsy
___ Fainting
___ Heart Attack
___ Heart Disease
___ Hernia
___ Hepatitis __ A __ B __ C
___ High/Low Blood Pressure
___ HIV/AIDS
___ Kidney Disease
___ Migraine
___ Nerve Damage
___ Pneumonia
___ Sleep Apnea (CPAP/BiPAP)
___ Stomach Ulcer
___ Stroke
___ Tonsillitis
___ Tuberculosis

ANY OTHER SERIOUS ILLNESSES / INJURIES / MEDICAL INFORMATION:

_____
_____

HAVE YOU HAD ANY PREVIOUS OPERATIONS?

_____ Year_____
_____ Year _____
_____ Year_____
_____ Year_____
_____ Year_____
_____ Year _____
_____ Year_____
_____ Year _____
_____ Year _____
_____ Year _____

PLEASE LIST MEDICATION(S) YOU ARE CURRENTLY TAKING (if any)

___ Antibiotics
___ Aspirin
___ Barbiturates
___ Birth Control Pills
___ Blood Pressure Meds
___ Blood Thinners
___ Coumadin
___ Digitalis
___ Dilantin
___ Herbal Medicine
___ Hormones
___ Insulin
___ Iron
___ Laxatives
___ Psychological Meds
___ Sleeping Pills
___ Thyroid Medication
___ Tranquilizers
___ Water Pills
___ Weight Reduction Pills
___ Other Please List
___ _____
___ _____
___ _____
___ _____

PERSONAL HEALTH

PLEASE CHECK YES OR NO FOR THE FOLLOWING

YES	NO		YES	NO	
___	___	Do you smoke/vape regularly?	___	___	Do you have frequent nosebleeds?
		If yes, how many packs per day? ___ # of years? ___	___	___	Do you bleed excessively from a cut?
___	___	Do you drink over 6 cups of coffee a day	___	___	Do you regularly take aspirin?
___	___	Do you regularly drink alcoholic beverages?			

WOMEN ONLY

YES	NO	
___	___	Do you have regular monthly menstrual cycles?
___	___	Do you have bleeding between periods?
___	___	Do you have heavy bleeding with your periods?
___	___	Have you ever had discharge from your nipples?
___	___	Do you have any children? If yes, how many? ___
___	___	Have you ever had a cesarean operation?

MEN ONLY

YES	NO	
___	___	Have you ever been treated for genital problems?
___	___	Have you ever had prostate issues?
		If yes, please describe: _____
		_____

PRIMA CENTER FOR PLASTIC SURGERY

H. Mike Song, M.D.
Dr Aniket Sakharpe, M.D.
3096 Peachtree Industrial Blvd. • Duluth, Georgia 30097

OUR FINANCIAL POLICY

Our doctors and staff are very concerned about the cost of health care and want to address some current issues related to the cost of medical services in our office. It is a statement of our financial policy.

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

Our Policy

Our policy requires payment at the time of service for copays, co-insurance and deductibles. Our agreement is with YOU and NOT with your insurance company. Although we will assist you by submitting your claim to your carrier, you are ultimately responsible for the service you receive. It is your responsibility to be aware of your insurance benefits. Payment is the responsibility of the patient or the patient's guarantor regardless of insurance benefits.

You are responsible to see that we have a current referral on hand if your insurance carrier requires one. If we do not have this referral at the time of your visit, your insurance company may hold you responsible for all charges. You may also be sent back to see your Primary Care Physician prior to being treated to obtain a current referral.

We are pleased to accept MasterCard, Visa, American Express, Discover, and CareCredit® for your services. We also accept certified checks, money orders and cash. Services that are performed that are paid with a credit card, debit card or with financing are not eligible for post-care payment challenges. The practice encourages a complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Secondary Surgery (Revisions) Policy. I agree that this credit card, debit card or financing challenge is irrevocable.

Insurance allowable amount

If an insurance company indicated a physician's fees are above the "usual and customary", please understand that most physician's fees are above the rate which insurance companies choose to pay. That rate is most often lower than the current fees normally charged by any 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 services. We are contracted with most insurance companies to adjust off the difference between the amount we charge and the amount they allow for payment for services. In these cases you are responsible for the deductible and co-insurance based on the allowable amount.

Thank you for taking the time to read this policy statement. We hope it answers some questions for you. If you need additional information please let us know.

I have read and understand the financial policy of this office.

_____ _____

Patient/Responsible Party Signature Date

PRIMA CENTER FOR PLASTIC SURGERY

POLICY REGARDING SECONDARY SURGERY (TOUCH-UPS)

All surgery deals with living tissue. Your ability to heal as an individual is unique. Each of us must accept that the healing process and the body's response to surgery is not always predictable. Therefore, the results of any surgery can never be completely guaranteed.

1. Each patient must understand that their own particular healing characteristics will affect the results.
2. Each patient must understand and accept that Dr. Song/Dr Sakharpe has absolutely no control over how your body heals and cannot predict healing (by tests or examinations prior to surgery) or control your own individual healing characteristics.
3. Each patient must understand and accept that if cosmetic deformities or areas of asymmetry should occur, even though the deformity may be visible, that Dr. Song/Dr Sakharpe is in the best position to determine whether or not additional surgery is needed. Dr. Song/Dr Sakharpe will base this decision on whether he feels the potential benefits outweigh the potential risks of additional surgery. This will be based upon whether or not he feels that you will get predictable improvement from additional surgery.
4. Each patient must understand and accept that Dr. Song/Dr Sakharpe must work on what you bring him to work with, and that he cannot change the qualities of your tissues, skin or muscle. At the time of your consultation Dr. Song/Dr Sakharpe will, to the best of his ability, discuss any particular anatomic factors that may affect your result. Together, as a team, we will plan an approach that would be thought to yield an optimal and satisfactory result.

Cosmetic Surgery – Surgical Touch up

If, after your cosmetic surgery, there are areas, which both you and Dr. Song/Dr Sakharpe warrant a touch up to achieve an optimal result. You will, however, be responsible for the facility fee, equipment, supplies, and anesthesia fees. Some Surgical Touch up procedures can be performed under local anesthesia and others will require conscious sedation or general anesthesia. Dr. Song/Dr Sakharpe is in the best position to determine what type of anesthesia is indicated for your touch up procedure if needed. If desired, we will make available average charges for surgical touch ups. Examples include revising a suboptimal face-lift scar, treatment of significant asymmetry following cosmetic breast surgery or correction of implant malposition, revision of breast lift scars, refining a rhinoplasty, excision of skin at the margins of an abdominoplasty scar or refining an area of liposuction. All surgical touch ups must be performed within one year following the original procedure**. The cost of a touch up under local anesthesia scheduled for less than one hour is a minimum of $250.00. If it exceeds one hour or more, the minimum cost is $375.00.**

Cosmetic Surgery – Patient request for revision or repeat surgery

If after your cosmetic procedure there are areas for which you personally desire a revision, touch-up or repeated surgery and Dr. Song/Dr Sakharpe feels that you have had a satisfactory outcome from your surgery, then this will be considered a new surgical procedure and you will be responsible for expenses. Expenses include the surgeon's fee, the facility fee, equipment, and anesthesia costs. Examples may include a secondary facelift for recurrent skin laxity, changing the size or shape of breast implants, recurrent breast sagging following a breast lift, redoing an area of liposuction after weight gain or pregnancy.

Insurance Covered Procedures – Secondary Surgery

If your insurance covered all or part of your expenses for your original surgery, then you are responsible for that part of the expenses your insurance company does not cover. Your insurance company, depending on your particular policy, may cover secondary surgery. We will assist you in obtaining surgical pre-authorization in this situation. If your insurance company determines that the secondary surgery is cosmetic in nature and not covered then you will be responsible for expenses. Expenses include the surgeon's fee, the facility fee, equipment, and anesthesia costs. Examples include revision of a scar following breast reconstruction, revision of a breast reduction or revision of a scar following skin cancer excision.

These notes are provided for your information to clarify our approach to billing secondary surgical procedures. If you have any questions or if this information is unclear to you, please contact our office manager for further explanation.

_____ _____

Patient/Responsible Party Signature Date

PRIMA CENTER FOR PLASTIC SURGERY

Cigarette Smoking/Tobacco/Vape Use Informed Consent

When you smoke cigarettes or use any tobacco/nicotine products, either before or after your plastic surgery procedure you are accepting additional risks greater than those discussed with patients who do not now or never smoked cigarettes. The longer you have smoked cigarettes and the more packs of cigarettes smoked per day also increases your risk of healing complications.

There is a definite yet undetermined increased risk of healing complications that can be directly linked to cigarette smoking. These include scarring, poor healing, skin loss and complications in general. **It is always best to stop smoking at least two (2) weeks prior to surgery and to continue to not smoke for two (2) weeks after surgery.** The exact length of time smoking should be discontinued to ensure good healing is unknown, but it would seem reasonable that more time is better. There is also no guarantee that even if all of the no smoking instructions are followed that healing will be satisfactory and without complications.

If you elect not to stop smoking or discontinue the use of all tobacco products and all medications containing nicotine, you will be unnecessarily accepting an increased risk of healing difficulties including the sloughing (dissolving away) of skin or fat. The result of these potential healing problems may require additional surgery, additional costs and additional time off of work. This is a choice, which you and you alone will be making. The physicians of Prima Center for Plastic Surgery are expressing our considerable concern on this issue in order to decrease, but not eliminate, healing difficulties after surgery. **By signing this form and continuing to smoke, use medications with nicotine or use any tobacco product** during the minimum two week before and two weeks after surgery restricted period you are accepting and acknowledging the increased chance of wound healing difficulties. You are also cautioned against **second hand smoke**, which has the same consequences as smoking.

When you smoke, there are both acute and long-term changes. The chronic changes associated with smoking are well known and include hardening of the arteries, the buildup of plaque in the arteries, a condition known as atherosclerosis, acceleration of the aging process due to the absorption of multiple toxins including carbon monoxide which binds to hemoglobin in the blood and blocks oxygen saturation thus lowering the amount of oxygen available for the tissues. There is also a sensitization of the lining of the arteries causing them to be more likely to go into spasm thus narrowing their diameter and allowing less room for blood flow. The acute changes from smoking also create an increased risk of arterial spasm thus decreasing the diameter of the arteries and decreasing blood flow to healing areas.

I have read, understood and have received a copy of the Prima Center for Plastic Surgery Cigarette Smoking Informed Consent and I realize the serious negative implications of cigarette smoking/nicotine products/tobacco products on my surgical result. I was given the opportunity to stop smoking to help decrease these complications. I will notify my physician prior to surgery if I am unable to stop smoking at least two weeks prior to surgery and for the two weeks following surgery and if necessary, my procedure will be cancelled. **I ALSO UNDERSTAND THAT IN ADDITION TO CIGARETTES, I WILL NOT EXPOSE MYSELF TO SECOND HAND SMOKE, BE IN THE PRESENCE OF SMOKERS, USE ANY TOBACCO PRODUCTS AND WILL NOT USE NICORETTE GUM OR NICOTINE PATCHES.**

_____ _____

Patient/Responsible Party Signature Date

PRIMA CENTER FOR PLASTIC SURGERY

HIPPA EMAIL CONSENT

- HIPPA stands for the *Health Insurance Portability and Accountability Act*
- HIPPA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email
- **When we send you an email, the information that is sent to you is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPPA act, the federal government provided guidance on email and HIPPA.
- The information is available in a pdf (page 5643) on the U.S. Department of Health and Human Services website:
  - http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

Please Sign and Date ONE of the Options Below

ALLOW UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to Prima Center for Plastic Surgery to send me personal health information via unencrypted email.

_____ _____

Signature Date
(parent or guardian if patient is a minor)

_____ _____

Printed Name Please Print Email Address

DO NOT ALLOW UNENCRYPTED EMAIL

I do not wish to receive personal health information via email.

_____ _____

Signature Date
(parent or guardian if patient is a minor)

_____

Printed Name