PEACHTREE
PLASTIC SURGERY, P.C.

New Patient Registration

Name: _____ Date: _____

Social Security: ____-____-____ Age: _____ Sex _____

Date of Birth: _____ Marital Status (circle one) S M D W

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____
Can we contact you or leave a message at these numbers? (circle one) Yes No

Email Address: _____
Can we send confidential information to you? (circle one) Yes No

Patient Employer: _____ Occupation: _____

Address: _____ State: _____ Zip: _____

Emergency Contact: _____ Relation: _____ Phone: _____

First & Last name of Regular Physician: _____ Phone: _____

Who referred you to this office?
Physician: _____ Friend/Family: _____ Other: _____

Preferred pharmacy: _____ Tel #: _____

Aesthetic Questionnaire

Please check all the procedures/topics that you may interested in receiving information about

Filler (Juvéderm, Restylane, etc.)	Cellulite Treatment	Skincare Products
Neurotoxin (Botox, Dysport, etc.)	Spider Veins	Chemical Peels
Skin Tightening	HydraFacial / Facial	Lymphatic Drainage Massage
Ear Lobe Repair	Microneedling	Scar Treatments
PRP	Hand Rejuvenation	Skin Tag / Mole Removal

I hereby authorize payment directly to Peachtree Plastic Surgery, PC for any surgical and/or medical benefits due. I further authorize release of any information, photographs, and or slides acquired in the course of my examination and/or treatment to recover such payments. I understand that payment is due at the time of service. I further understand and agree that my insurance is filed as a courtesy and that I am ultimately responsible for any balance due after the insurance company has made payment.

Patient Signature _____ Date _____

Thank You!

Peachtree Plastic Surgery Medical History

Please help us assure you the highest quality of care and safety by answering carefully.

Name_____ **Age**_____ **Height**____ **Weight**____ **Last Physical Exam** ____

What is your SPECIFIC reason for consultation today?_____

Past Medical History: Please circle if do you have, or if you had any of the following:

Anemia
Anesthesia reaction
Arthritis
Asthma
Back pain
Bleeding tendency
Blood clots/DVT
Breast cancer
Cancer
Chest pain
Excessive scarring/keloids
Dry eyes
Epilepsy
Fainting/blackouts
Fibromyalgia
Peptic ulcer
Heart disease
Heart murmur
Hepatitis
Herpes simplex/fever blisters
High blood pressure
HIV/AIDS
Kidney disease
Liver disease
Lung disease
Migraines
Diabetes
Pneumonia
Shortness of breath
Stroke
Thyroid disease
Vision defects
Wheezing

If yes or other, please describe:

Past Surgical History: Please list ALL previous operations:

_____Year: _____ _____Year: _____

_____Year: _____ _____Year: _____

Medications: Please circle medications you are taking; certain products can cause excessive bleeding during surgery.

Aspirin or ibuprofen, NSAIDS
Arthritis medications
Vitamins and herbal supplements
Retin A
Insulin
Coumadin (warfarin)
Birth control pills
Steroids in the past year
Accutane
Other (please list) _____

Allergies: Please circle or list any allergies

Latex Medications yes no (please list allergies)_____

Family History: Is there a history of the following in your immediate family? If so, please list the family member:

Heart Disease _____
Stroke _____
Anesthesia Reaction _____
Diabetes _____
Cancer _____
Bleeding Disorder _____

Personal History:

Do you smoke? Yes or No _____packs per day Do you drink alcohol? Yes or No _____per week

For Women Only:

Have you ever been pregnant? Yes or No If yes, # of pregnancies _____ # of children _____
Did you breast feed? Yes or No. Breast Problems:_____
Last mammogram? Date:_____ Where was is it done? _____ Normal_____
Abnormal_____
Breast Cancer? Yes or No Right or Left date _____ Mastectomy?_____ Date_____
Radiation therapy Yes or No date completed _____ Chemotherapy Yes or No date completed _____
Surgeon_____ Oncologist_____

Sternal notch to nipple:	Left _____cm	Right _____cm
Nipple to IMF:	Left _____cm	Right _____cm
Breast width:	Left _____cm	Right _____cm
	Bra size: _____	Nipple sensation: _____

I CERTIFY THAT ALL INFORMATION PROVIDED IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE_____**DATE**_____

Patient Consent of Medical Photography

Patient Name:_____ Date:_____

☐ Check here if minor and/or unable to provide consent

I consent for medical photographs to be made of me or my child or person for whom I am legal guardian. I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals as I have designated below. By Consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may do so by completing a new photo consent form.

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand. **PLEASE CHOOSE ONE:**

- I consent for these ***photographs to be used in medical publications, including medical journals, textbooks and electronic publications including the company website and social media.*** Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. ***I also agree for my image to be shown for teaching purposes and to be used for my medical record.***

Signature:_____ Witness:_____

- I agree for my photos to be shown for ***teaching purposes AND for my medical record*** but ***NOT FOR medical publication.***

Signature:_____ Witness:_____

- I agree for use of my photos for ***medical records/chart ONLY***.

Signature:_____ Witness:_____

CHOOSE ONE!

***For patients **under 18 years old** or for whom a legal guardian is required, a signature below indicates that the information in this consent form has been explained to me, and I assent to use of my images as outlined above**

Signature:_____ Witness:_____

Financial Policy

Thank you for choosing Peachtree Plastic Surgery! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. Any balance older than 30 days is the patient's responsibility.

For your convenience, we have answered a variety of commonly asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Administrator.

How May I Pay?
We accept payment by cash, check, VISA, MasterCard, AMEX and Discover.

Do I Need A Referral or Pre-certification?
If your insurance plan requires a referral authorization from your primary care physician or a pre-certification from your insurance, you need to contact your primary care physician or insurance company to be sure it has been obtained. If we have not received an authorization prior to your arrival at the office your appointment will be rescheduled.

Which Plans Do You Contract With?
Peachtree Plastic Surgery accepts most major insurance plans. It is always best for you to contact your insurance company prior to your appointment to see if we are participating providers. As well as verifying that the physicians and/or facility in which you are seeking treatment are an authorized provider under your insurance plan and whether they are in/out-network. A current provider listing should be made available to you by your employer, insurance company or insurance company's website.

What Is My Financial Responsibility for Services?
Unless in a global period, all appointments are billable. **Each visit will be billed to your in-network insurance payer, or you will be charged a cosmetic fee.** Copays are due at the time of service. Coinsurance, deductibles and all other procedure or treatments not covered by the insurance plan will be the patient's responsibility.

Any account greater than 90 days will be considered delinquent and will be sent to a collection agency, a fee may be added to the total balance. All collection costs must be paid in full before returning to the practice. Also, any outstanding balance on account must be paid in full before next surgery is scheduled, no exceptions.

What If I Have Billing or Insurance Questions?
Peachtree Plastic Surgery is supported by a staff of dedicated professionals. Our office staff has the expertise to assist in all financial matters, relieving the patient of burdensome paperwork.

Signature: _____

Print: _____

Surgery

If your physician recommends surgery, your surgery will be scheduled by your physicians' nurse or assistant. They will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it.

The Billing Department will require a pre-surgical deposit in the amount of $500.00 for all cosmetic procedures to hold a surgery date for you, as well as the physician's fee to be paid in full at the pre-operative visit.

What if I missed my appointment to see the Physician?

We understand that on rare occasions, issues may arise causing you to miss your appointment without the ability to notify our office prior to your appointment. Should you experience any unforeseen circumstance that causes you to miss your appointment, please call our office to have it rescheduled.

Our highly skilled Physicians are committed to your wellbeing and have reserved time just for you. Patients that miss more than one appointment, without notifying our office prior to the scheduled appointment, are subject to a $20.00 missed appointment fee.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles and any charges older than 30 days from the date of service, are my responsibility.

I authorize Peachtree Plastic Surgery to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim. I authorize my insurance benefits be paid directly to Peachtree Plastic Surgery.

Date **Signature** **Printed Name**

Peachtree Plastic Surgery
3286 Northside Parkway NW
Suite 1000
(404)841-8450

Patient Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party providers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this acknowledgment. I understand that Peachtree Plastic Surgery has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the organization at any time at the address above to obtain a current copy of the copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you agree then you are bound to abide by such restrictions.

_____ _____

Signature Date

PEACHTREE PLASTIC SURGERY FORM COMPLETION AND MEDICAL RECORDS POLICY

(effective January 1, 2022)

We are happy to complete disability forms for you, and make copies of your medical records for you, however, due to the growing number of forms that need to be completed and the time involved, our office has instituted the following policy. There will be no exceptions to this policy.

1. Forms and copies are completed in the order they are received. All patient information must be completed before we can process these request.

2. Please allow 2 weeks for completion and plan accordingly.

3. Forms cannot be completed until your most recent office notes has been dictated and transcribed. This may increase the time it takes to complete the form.

4. There is a $25 fee per form which must be paid prior to completion of the forms.

5. There is a $25 fee for copies of your medical records which must be paid prior to release of your medical records.

6. There will be no charge for completion of FMLA forms.

7. If you are covered by Worker's Compensation, please be aware that you are responsible for the payment of diability forms, Worker's Compensation does not cover this cost.

8. When forms are completed they will be mailed to the patient's home address or be available for pick-up. Please indicate which you would prefer. A copy may be faxed to the insurance company if the patient requests.

Thank you for your cooperation.

_____ (print name)

_____ (signature) _____ (date)