Patient Information Form

Date: ______________________

Panacea Plastic Surgery

1366 Wellbrook Circle
Suite B
Conyers, GA 30012

280 Elizabeth Street
Suite C
Atlanta, GA 30307

Panaceaplasticsurgery.com

Who are you here To see today?

❒ Nour Abboushi, MD

❒ Kimberly A. Singh, MD

❒ YES! **I would like to receive emails and monthly newsletters regarding promotions and packages from Panacea Plastic Surgery.**

Name: ____

Date of Birth: ________/_________/________ Age: __________ Sex: ❒M ❒ F

Address: __________________________________ City: _______________ State: _____

ZIP: ____________ Cell: ___________________ Home Phone:____________________

Employer: _____________________________ Work Phone: ____________________

SSN: ________________________ Email: __________________________________

Marital status: ❒Single ❒Married ❒Widowed ❒Divorced Consent to text: ❒Yes ❒No

Emergency Contact: ___________________________ Phone:____________________

Pharmacy Name: ______________________________ Phone : ____________________

MEDICARE AND OTHER INSURANCE CONSULTATIONS MUST COMPLETE THE FOLLOWING (THIS CAN BE EITHER REFERRING PHYSICIAN OR FAMILY PHYSICIAN). WE CANNOT FILE YOUR CLAIM WITHOUT THIS INFORMATION.

Physician: _____________________________________ Phone:____________________

Address: (city & State)____

Primary Insurance Company: ____

Secondary Insurance Company____

Insurance Policy Holder Information (If you have Medicare, you are the policy holder) (If you are the policy holder write "SELF"):

Policy Holder: ___________________________________ Relationship: _____________

SSN: ______________________ Cell: ____________________

New Requirements per Federal Government

Race: ❒ African American/Black ❒ White ❒ Asian ❒ Other Race
❒ American Indian or Alaska Native ❒ Native Hawaiian or Other Pacific Islander

Ethnicity: ❒ Hispanic ❒ Non-Hispanic

Language: ❒English ❒Other: (Please list) __________________

How did you hear about Panacea Plastic Surgery?

❒ Internet: _________________________ ❒ Insurance company: ____________________
❒ Other advertisement: ______________ ❒ Panacea Staff: _________________________
❒ Physician: ________________________ ❒ Hospital / Surgery Ctr: __________________
❒ Other: ___________________________ ❒ Friend / Family: _______________________

I hereby consent to treatment of myself, my child or above-named minor for whom I accept responsibility; and the release of medical information to any insurance carrier and/or direct payment to Panacea Plastic Surgery for any authorized treatment or examination rendered. I hereby acknowledge and accept final responsibility for payment or charges for medical services rendered.

____ __________________
Signature of patient or authorized person Date

MEDICAL HISTORY

Name: ______________________________ Ht: __________ Wt:____________

Reason for Consultation: ______________________________

Name of regular physician: ______________________________Specialty: ________________

Business Telephone: (   )__________-____________ Date of last physical examination:____________________

Were you referred by another physician? ❒No ❒Yes If YES, please list name: ______________________________

Do you or have you had:	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Anemia	❒	❒	Dry Eyes	❒	❒	Kidney Disease	❒	❒
Anesthesia Reaction	❒	❒	Epilepsy	❒	❒	Liver Disease	❒	❒
Arthritis	❒	❒	Fainting or blackouts	❒	❒	Lung Disease	❒	❒
Asthma	❒	❒	Fever blisters	❒	❒	Migraine Headaches	❒	❒
Back Pain	❒	❒	Fibromyalgia	❒	❒	Peptic Ulcer	❒	❒
Bleeding Tendency	❒	❒	Glaucoma	❒	❒	Pneumonia	❒	❒
Blood clots/DVT	❒	❒	Heart Disease	❒	❒	Shortness of breath	❒	❒
Breast Cancer	❒	❒	Heart Murmur	❒	❒	Stroke	❒	❒
Cancer	❒	❒	Hepatitis	❒	❒	Thyroid Disease	❒	❒
Chest Pain	❒	❒	Herpes simplex	❒	❒	Vision Deficits	❒	❒
Diabetes	❒	❒	High Blood Pressure	❒	❒	Wheezing	❒	❒
			HIV/Aids	❒	❒	Other	❒	❒

If yes please describe:

PREVIOUS OPERATIONS / SURGICAL PROCEDURES **(use the back of this page if necessary)**

______________________ Date____________ ______________________ Date____________

______________________ Date____________ ______________________ Date____________

______________________ Date____________ ______________________ Date____________

MEDICATIONS

Do you take:	**Yes**	**No**		**Yes**	**No**
Aspirin or Ibuprofen, NSAIDS	❒	❒	Vitamins & Herbal Supplements	❒	❒
Coumadin (Warfarin)	❒	❒	Steroids in the past year	❒	❒
Arthritis Medicine	❒	❒	Retin A	❒	❒
Birth Control Pills	❒	❒	Accutane	❒	❒

List other medications you are currently taking: (use the back of this page if necessary)

ALLERGIES:

Medications: ❒ No ❒Yes If Yes, please list: ______________________ Latex ❒No ❒Yes

Have you formed excessive or unsatisfactory scars/keloids/hypertrophy in the past? ❒Yes ❒No

FAMILY HISTORY:

Is there a history of the following in your immediate family? If so, please list the family member beside the disease.

	Yes	**No**		**Yes**	**No**
Heart Disease ________________	❒	❒	Diabetes________________	❒	❒
Stroke________________	❒	❒	Cancer________________	❒	❒
Anesthesia Reaction________________	❒	❒	Bleeding Disorder ________________	❒	❒

If other, please describe:

PERSONAL HISTORY:

Do you smoke? ❒No ❒Yes _____ packs per day. Do you drink alcohol? ❒No ❒Yes ____ per week.

For women only:

Have you ever been pregnant? ❒No ❒Yes # of children________

Did you breast feed? ❒No ❒Yes Date of Last Mammogram ________________ ❒Normal ❒Abnormal ❒N/A

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770-929-0634

HIPAA - PATIENT ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 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 acknowledgement. I understand that *Panacea 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 *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 do agree then you are bound to abide by such restrictions.

____________________________________ ________________________
Signature Date

____
Print Name

____
Relationship to Patient

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this *Patient Acknowledgement* but was unable to do so as documented below:

Date:	Initials:
Reason:	

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PATIENT RIGHTS

Panacea Plastic Surgery would like to assure you of your rights and responsibilities as a patient.

PATIENT RIGHTS

You have the right to:

- Considerate, respectful & dignified care provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.
- Personal & informal privacy, within the law.
- Information presented in a manner and form that you understand. You or an individual designated by you or a legally authorized person, have the right to be informed about your condition and the recommended procedures to be performed so that you can make the decision whether or not to undergo the procedure knowing the risks, benefits and alternatives. You also have the right to ask questions.
- Appropriate assessment & management of pain.
- The opportunity to participate in decisions involving your health care, unless contraindicated by concerns of your health.
- Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap or disability.
- Be able to participate or refuse to participate in any research without risk of compromising your right to access care, treatment and/or services.
- Know the identity & professional status of individuals providing service.
- Request a change in providers of care if other qualified providers are available.

PATIENT COMPLAINT OR GRIEVANCE

Panacea Plastic Surgery will promptly review, investigate, and resolve any patient grievances or complaints in a timely manner. If you feel you may have an issue, please contact the surgery center directly and ask to speak with the Practice Administrator.

Office of Regulatory Services
Department of Healthcare Resources
2 Peachtree Street, Suite 33.250
Atlanta, GA 30303-3142
404-657-6487
http://ors.dhr.georgia.gov/portal/site/DHR-ORS/

Composite State Board of Medical Examiners
2 Peachtree Street, NW, 10th Floor
Atlanta, GA 30303-3465
404-656-3913
http://medicalboard.georgia.gov

All Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsman. Visit the Ombudsman's webpage at:
www.cms.hhs.gov/center/ombudsman.asp

PRIVACY & CONFIDENTIALITY

Panacea Plastic Surgery complies with federal HIPAA (Health Insurance Portability & Accountability Act) regulations to maintain the privacy of your health information.

PATIENT RESPONSIBILITIES

You are responsible for:

- Providing accurate complete information regarding your present health status (including past & present medications), past medical history, & for reporting any unexpected changes to the appropriate practitioner(s).
- Inform the healthcare provider about any advance directive (living will) that might affect your care.
- Following the treatment plan recommended by the primary practitioner.
- Following the rules & regulations of the facility affecting patient care & conduct.
- In the case of a pediatric patient, a parent or guardian is to remain in the facility for the duration of the patient's stay in the facility.
- Being considerate & respectful of the rights of other patients & facility personnel.
- Providing a responsible adult to transport you home after surgery & an adult to be responsible for you at home for the first 24 hours after surgery/anesthesia.
- Indicating whether you clearly understand a contemplated course of action & what is expected of you.
- Your actions if you refuse treatment, leave the facility against the advice of the practitioner, and/or do not follow the practitioner's instructions relating to care.
- Assuring financial obligations of your health care are fulfilled as expediently as possible.

By signing this document, I acknowledge that I have read and understand its contents

By: ____
(Patient/Patient Representative Name) (Date)

____
(Patient/Patient Representative Signature) (Date)

<u>Photography Consent</u>

I, ______________________________, consent to the taking of photographs by Panacea Plastic Surgery (Dr. Nour Abboushi, Dr. Kimberly Singh) or designee of me or parts of my body in connection with the plastic surgery procedure(s) intended or performed. I understand that photographs may be taken before, during, and after my procedure(s) as a routine part of my medical care. I further understand that these photographs will be kept strictly confidential.

Signature:_____________________________ Date:______________________

Release of Photographs Consent

Additionally, I authorize the use of my photographs in the formats listed below. I waive any right to inspect or approve the finished product, advertising, or other copy that may be used in connection with the options below. I understand that I will never be identified by name in any use of these photographs, but that in some circumstances the photographs may portray features which make my identity recognizable.

(Please initial **YES** or **NO**)

____ YES ____ NO

To use your photos on our website or affiliated websites (ex. Realself) for prospective patients to see and understand outcomes from surgery with Panacea Plastic Surgery.

I release and discharge Panacea Plastic Surgery from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.
I certify that I have read the above Authorization and Release and fully understand its terms.

Print Name: _________________________________ Date: _______________
Signature: __________________________________
Witness: ___________________________________

Financial Policy and Disclosure

Please Sign and Date

The Financial Policy and Disclosure helps us provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients.

Patients are responsible for the payment for all services provided by Panacea Plastic Surgery.

Insurance Policy

• If you are an insurance patient, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information.
• If a service is provided that is not covered by your insurance company, you will be responsible for the payment.
• If we have not received a payment from your insurance company within thirty (30) days, you will be responsible for the balance due.

• Deductibles, co-payments, and coinsurance will be collected before services are rendered.
• In special cases, we may need your help in contacting your insurance company for the payment of your services.

Self-Pay Policy

• Self pay services are not allowed to be sent to your insurance company.

Overdue and Credit Balances

• All over-due patient balances will be sent to collections.
• All accounts sent to collections will be charged a $25 collection fee in addition to the account balance.

To help in this policy, we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when changes are made.
3. Making the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or for the full amount if you are a Self-Pay Patient.

In order to provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the physician(s) or clinical staff. Please discuss any account information with the front desk, the Billing specialist or manager. Thank you

______________________________ ______________________________

Responsible Party's Signature Date

Your cooperation is greatly appreciated.