Golden Isles Center for Plastic Surgery

MEDICAL INFORMATION SHEET		
NAME: AGE:		
Sign/Date:		
HEIGHT: WEIGHT:		
CHIEF COMPLAINT:		
OCCUPATION:		
GENERAL MEDICAL EVALUATION:	YES	NO
Who is your family/general medical doctor?		
How is your general health?		
Are you now being treated for any medical conditions?		
If yes, please specify:		
When was your last physical examination?		
Do you have children? Ages?		
WOMEN ONLY: Are you pregnant:		
Last menstrual period?		
Are you taking Birth Control Pills?		
Have you had a hysterectomy or tubal ligation?		
Have you had a mammogram?		
If yes, when and where was your last mammogram?		
CARDIOVASCULAR	YES	NO
Coronary or heart attack		
Congenital heart discase (at birth)		
Heart murmur		
Rheumatic Fever		
Palpitations or irregular heart beat		
Prolapsing valve		
High blood pressure		
Stroke		
RESPIRATORY:	YES	NO
Shortness of Breath		
Chronic lung disease		
Cough		
Asthma		
MEDICATIONS:	YES	NO
Have you taken any steroid (cortisone) preparations in the last year?		
Date of last tetanus shot?		
PREVIOUS SURGERYS		

PERSONAL MEDICAL CONDITIONS	YES	NO
Thyroid problems		
Seizures or epilepsy		
Liver disorder including hepatitis or cirrhosis		
Kidney/bladder disorders or chornic infections		
Spinal or back disorders		
Previous blood clots or thrombophlebitis		
Any bleeding disorders in self or in family		
Blood transfusions		
Diabetes		
Auto-immune diseases (lupus, theumatoid arthritis, HI		
Cold sores/fever blisters or herpes?		
Any unusual healing problems		
Do you form keloids or thick scars?		
If any of the above are "yes", explain:		
ALLERGIES	YES	NO
Any *medication* allergies		
If "yes", please list Medication and Reaction:		
Any problems with anesthesia?		
Tape Allergy?		
Are you allergic to latex?		
SOCIAL	YES	NO
Do you smoke?		
If so, how many packs per day?		
Do you use other tobacco products?		
If so, what type? How often?		
Do you drink more than two alcoholic beverages a day?		
Do you/or have you had a drug or alcohol dependency or treatment?		
MENTAL HEALTH	YES	NO
Have you received psychiatric treatment/couseling?		
If yes, were you hospitalized?		
Please explain:		
FAMILY HISTORY:	YES	NO
Any medical problems or illness in your family?		
Explain:		
Does anyone in your family have any problems with anesthesia?		
Explain:		

Type of surgery/reason	Hospital	Surgeon/Doctor	Date	Complications/problems

List any medications you currently take and the dosage:

GOLDEN ISLES CENTER FOR PLASTIC SURGERY, PC
DIANE G. BOWEN, MD

New Patient Information

Patient Name: _____ Today's Date: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail Address: _____

Date of Birth: _____ Sex: F M Race: _____ Marital Status: S M W D SSN# _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

How did you hear about our practice? Circle one: Friend Internet Referral Other_____

Primary Care Doctor: Dr._____ Phone Number: _____

Emergency Contact Name: _____ Relationship: _____ Phone #: _____

Address: _____ Other Phone#: _____

Insurance Subscriber Name: _____Date of Birth: _____ SSN#:_____

Relation to Patient: Spouse Parent Child Self Policy Effective Date: _____

Patient Pharmacy: _____ Location: _____

What is the best way to reach you? The information you are providing is your consent to communicate with you, per your preference. Circle one:

Text Message Email Cell Phone Home Phone

Please list any individuals GICPS may contact regarding Billing _____ Test Results_____ Appts _____

Name_____Contact Number _____

Name_____Contact Number_____

Patient signature_____Date_____

GOLDEN ISLES CENTER FOR PLASTIC SURGERY, PC
DIANE G. BOWEN, MD

FOR OUR PATIENTS WHO HAVE INSURANCE COVERAGE

INSURANCE COVERAGE IS A CONTRACT BETWEEN THE PATIENT AND THE INSURANCE CARRIER. Our office can only supply information to facilitate processing of your claim. Any discrepancies in reimbursement amounts therefore are the responsibility of the patient to resolve.

GOLDEN ISLES CENTER FOR PLASTIC SURGERY, P.C. IS NOT OBLIGATED TO FILE INSURANCE. Filing insurance for our patients is a courtesy we frequently undertake. We verify insurance benefits, we obtain pre-approval and/or pre-certification when necessary. However, at times, in spite of our best efforts, insurance carriers can misquote/misrepresent patient benefits. We recommend that our patients check their own policies or check with their insurance carriers.

PAYMENT OF BILLS IS ULTIMATELY THE RESPONSIBILITY OF THE PATIENTS. We would appreciate very much if our patients respond promptly to the insurance companies' request for information. Any unnecessary delay in claims processing secondary to a patient's failure to respond to the insurance company will result in the need to immediately pay his/her bill to Golden Isles Center for Plastic Surgery.

OUR OFFICE REQUIRES A TIMELY PAYMENT OF ANY BALANCES that are due after payment has been received from the insurance company. All balances should be paid within 90 days of your surgical procedure. Payments can be made by cash, check or credit card VISA or Mastercard. Our insurance department will be available for questions about balances and payments

If you would like for your balance to be charged to your credit card please circle YES NO
If YES then please provide the following: MC VISA Card # Expiration Date

INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize Golden Isles Center for Plastic Surgery, PC to furnish information to insurance carriers concerning my illness and treatments. I consent and understand that Dr. Bowen uses both medical and surgeon assistants as needed to provide the highest level of care. I hereby assign to the physician(s)/assistants all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. Interest will be charged on all unpaid balances at the rate of 1.2% per month. I also understand that this account will be placed with a collection agency after 120 days, and that I will be responsible for all collection costs as allowed by Georgia law.

I, the undersigned, have read the above statements and agreed to abide by the conditions stated.

SIGNATURE **DATE**

GOLDEN ISLES CENTER FOR PLASTIC SURGERY, PC
DIANE G. BOWEN, MD

Summary Of Notice of Privacy Practices

Our Legal Duty: We have a duty to protect the confidentiality of medical information about you. We are required to provide you with a Notice of Privacy Practices explaining ways we may use and disclose your medical information. The Notice is posted in our Lobby for patient view and also describes your legal rights and our obligations regarding the use and disclosure o f your medical information.

Parties Following The Notice: The Notice will be followed by the Golden Isles Center For Plastic Surgery and its affiliates, together with their health care professionals, staff; and those participating in managed care networks with the Golden Isles Center For Plastic Surgery; and other legal entities that provide services to the Golden Isles Center for Plastic Surgery.

How We May Use and Disclose Medical Information About You: We may use or disclose identifiable health information about you for many reasons, including, but not limited to the following:

Treatment	Activities of managed care networks in which we participate
Payment	Activities of our affiliates
Health care operations	To military command authorities
Appointment reminders	To avert a serious threat to health or safety
Public health purposes	Worker's compensation
Auditing	Law enforcement purposes
Electronically	How Medical Information is transmitted (EMR – Electronic Medical Record) To Health Professionals, Pharmacies, etc.
Research	Health oversight activities
As required by law	National security/protective services
Lawsuits and disputes	

In general, other uses and disclosures of your medical information will require your written authorization. We may use or disclose certain limited information about you. Unless you object or request a limitation of the disclosure, for; Individuals involved in your care or payment

You have the following rights with respect to your health information:

* The right to request confidential communications and alternative means of communication with you.
* The right to request restrictions on certain uses of your health information.
* The right to inspect and copy certain medical information that we maintain about you.
* The right to request an amendment of your information.
* The right to an accounting of certain disclosures of your health information.

Changes to the Notice: We reserve the right to change the Notice. We will post any revised Notice in the Golden Isles Center for Plastic Surgery office.

Complaints: If you believe your rights have been violated, you may file a written complaint with the Golden Isles Center for Plastic Surgery Privacy Officer, or with the Secretary of the U. S. Department of Health and Human Services.

ACKNOWLEDGMENT **Patient Name**:_____

Patient Acknowledgment: I acknowledge that I have been provided with an opportunity to receive the Notice of Privacy Practices for the Golden Isles Center for Plastic Surgery. In reviewing the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents. ***Signature of Patient***:_____ **Date**:_____

Personal Representative_____

ISLAND SURGERY CENTER, LLC/
Golden Isles Center for Plastic Surgery, PC
PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

I. Uses and Disclosures of Protected Health Information

The Island Surgery Center, LLC/Golden Isles Center for Plastic Surgery, PC may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the *facility* has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

A. Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription or to a laboratory to order a blood test. We may also disclose protected health information to physicians who may be treating you or consulting with the facility with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. Payment. Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurance company to get approval for the procedure that we have scheduled. For example, we may need to disclose information to your health insurance company to get prior approval for the surgery. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide to you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. This may include disclosure of demographic information to anesthesia care providers for payment of their services.

are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. **In Connection With Judicial And Administrative Proceedings**. We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. **For Law Enforcement Purposes**. We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries.
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the facility has a suspicion that your health condition was the result of criminal conduct.
- In an emergency to report a crime.

G. **To Coroners, Funeral Directors, and for Organ Donation.** We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

H. **For Research Purposes**. We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

I. **In the Event of a Serious Threat to Health or Safety.** We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

J. **For Specified Government Functions**. In certain circumstances, federal regulations authorize the facility to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

K. **For Worker's Compensation.** The facility may release your health information to comply with worker's compensation laws or similar programs.

B. **The right to request a restriction on uses and disclosures of your protected health information.** You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The facility is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the facility does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

C. **The right to request to receive confidential communications from us by alternative means or at an alternative location.** You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

D. **The right to request amendments to your protected health information.** You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.

E. **The right to receive an accounting.** You have the right to request an accounting of certain disclosures of your protected health information made by the facility. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a facility directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. **The right to obtain a paper copy of this notice.** Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.