



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 also describes your legal rights and our obligations regarding the use and disclosure of 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
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:* _____

For Golden Isles Center for Plastic Surgery Personal Only: (Complete if acknowledgment is not obtained) A good faith attempt was made to obtain the patient's signature acknowledging the opportunity to receive their notice. An acknowledgment was not obtained because _____

Signature of GICPS Representative: _____ *Date:* _____



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



Lesion Policy

The purpose of health insurance is to cover health issues that are medically indicated. The majority of insurances will not cover cosmetic treatments.

If you have been referred by your doctor for examination of a changing mole, cyst or lesion, Dr. Bowen will evaluate the lesion and with your input determine if it merits biopsy. If the lesion appears to be non-cancerous growth, she will inform you of her medical opinion. If you would still like to have it biopsied because it is unattractive or bothersome, it will be considered a cosmetic procedure.

If you decide to have the lesion removed and have it sent to pathology for examination and it is determined to be a cancer, then the biopsy will be considered an insurance matter and your initial payment will be reimbursed as needed.

I have read the above stated lesion policy and understand that should my specific area of question be diagnosed as cosmetic by Dr. Diane Bowen, I will be required to pay for the removal of the lesion.

Signature of Patient

Date

Printed Name of Patient



AMERICAN SOCIETY OF
PLASTIC SURGEONS

Golden Isles Center for Plastic Surgery

MEDICAL INFORMATION SHEET				PERSONAL MEDICAL CONDITIONS		YES	NO
NAME:		AGE:		Thyroid problems			
Sign/Date:				Seizures or epilepsy			
HEIGHT:		WEIGHT:		Liver disorder including hepatitis or cirrhosis			
				Kidney/bladder disorders or chronic infections			
				Spinal or back disorders			
OCCUPATION:				Previous blood clots or thrombophlebitis			
GENERAL MEDICAL EVALUATION:		YES NO		Any bleeding disorders in self or in family			
Who is your family/general medical doctor?				Blood transfusions			
How is your general health?				Diabetes			
Are you now being treated for any medical conditions?				Auto-immune diseases (lupus, rheumatoid arthritis, HIV)			
If yes, please specify:				Cold sores/fever blisters or herpes?			
				Any unusual healing problems			
				Do you form keloids or thick scars?			
When was your last physical examination?				If any of the above are "yes", explain:			
Do you have children? Ages?				ALLERGIES		YES	NO
				Any <i>medication</i> allergies			
WOMEN ONLY: Are you pregnant?				If "yes", please list:			
Last menstrual period?				Any problems with anesthesia?			
Are you taking Birth Control Pills?				Tape Allergy?			
Have you had a hysterectomy or tubal ligation?				Are you allergic to latex?			
Have you had a mammogram?				SOCIAL		YES	NO
If yes, when and where was your last mammogram?				Do you smoke?			
CARDIOVASCULAR		YES NO		If so, how many packs per day?			
Coronary or heart attack				Do you use other tobacco products?			
Congenital heart disease (at birth)				If so, what type? How often?			
Heart murmur				Do you drink more than two alcoholic beverages a day?			
Rheumatic Fever				Do you/or have you had a drug or alcohol dependency or treatment?			
Palpitations or irregular heart beat				MENTAL HEALTH		YES	NO
Prolapsing valve				Have you received psychiatric treatment/counseling?			
High blood pressure				If yes, were you hospitalized?			
Stroke				Please explain:			
RESPIRATORY:		YES NO		FAMILY HISTORY:		YES	NO
Shortness of Breath				Any medical problems or illness in your family?			
Chronic lung disease				Explain:			
Cough				Does anyone in your family have any problems with anesthesia?			
Asthma				Explain:			
MEDICATIONS:		YES NO					
Have you taken any steroid (cortisone) preparations in the last year?							
Date of last tetanus shot?							
PREVIOUS SURGERYS							
Type of surgery/reason		Hospital		Surgeon/Doctor		Date	
List any medications you currently take and the dosage:							

Insurance Information

Insurance Company _____

Policy or ID # _____

Claims Address

Street/PO Box _____ City _____ State _____ Zip _____

Telephone Number _____ Fax _____

Effective Date _____ Expiration Date _____

Responsible Party (if "Self", leave all fields but Relationship Blank)

Relationship _____

Last Name _____ First Name _____ M.I. _____

_____ Date of Birth

_____ Social Security #

Male Female

Address

Street _____ City _____ State _____ Zip _____

Telephone Numbers _____ Home _____ Cell _____

Responsible Party Employer Address

_____ Employer _____ Status FT PT Student Retired

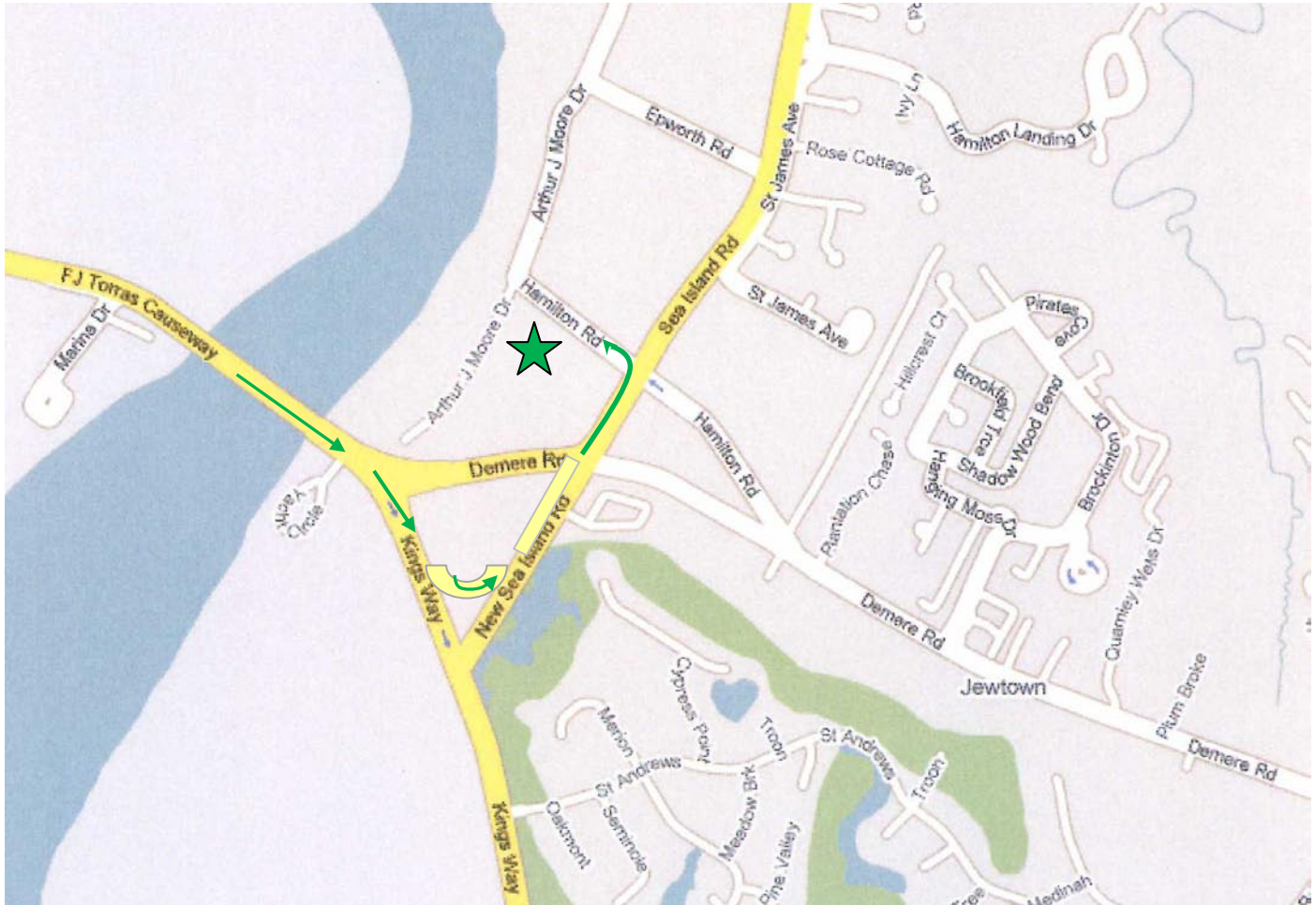
Street _____ City _____ State _____ Zip _____

Work Telephone _____ Extension _____ Occupation _____

I, the undersigned, have completed the above information and verify that it is accurate

Name _____ Date _____

Map to Dr. Diane Bowen's office 1015 Arthur Moore Drive



- Take the Causeway
- Bear right onto Kings Way exit
- You will bear to the left, almost immediately, onto the completed portion of the new traffic circle. This will put you onto Sea Island Road.
- Go straight on Sea Island Road through the traffic light.
- Take the first left onto Hamilton Road
- Dr. Bowen's office is the second driveway on the left.