THE GEORGIA INSTITUTE FOR PLASTIC SURGERY / PLASTIC SURGERY CENTER LAND, L.L.C.

5361 Reynolds Street • Savannah, GA 31405 Phone-(912) 355-8000 • Fax-(912) 356-0229

Patient Registration Form

Patient Information

Legal Name (Last, First, MI)		Suffix:	Preferred Name:
Date of Birth:	Age:	Marital Status: ❑ Single ❑Married ❑Divorced ❑Widowed ❑Separated ❑Partner ❑Other	
Street Address:	City:	State:	Zip Code:
Home Phone: ( ) Preferred ❑	Work Phone: ( ) Preferred ❑	Cell Phone: ( ) Preferred ❑	
Email Address:	May we contact you through Email? ❑ **YES** ❑ **NO**	Would you like to receive our Quarterly Newsletter through Email? ❑ **YES** ❑ **NO**	
Identified Gender: ❑ Male ❑Female	SSN:	Referring Physician:	Primary Care Physician:
Preferred Language:	Race:	Ethnicity: ❑ Hispanic ❑ Non Hispanic ❑ Unknown	
Does Patient Live in a Nursing Home or Assisted Living Facility? ❑ YES ❑ NO If YES, what is the Name of the Facility?			

Financially Responsible Party

Name of Responsible Party, if other than patient:			
Name:	Address:	City/State/Zip	Relationship to Patient:
Occupation:	Employer:	Email Address:	Date of Birth:
Home Phone: ( ) Preferred ❑	Work Phone: ( ) Preferred ❑	Cell Phone: ( ) Preferred ❑	

Emergency Contact

Name:	Relationship to Patient:	
Home Phone: ( ) Preferred ❑	Work Phone: ( ) Preferred ❑	Cell Phone: ( ) Preferred ❑

Insurance Information

PRIMARY Insurance Carrier:	Policy Number:	Group Number:		
Patient's Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other _____	Name of Subscriber (if other than Patient):			
Subscriber's Social Security #:	Gender: ❑ Male ❑Female	Date of Birth:	Subscriber's Employer:	Work Phone: ( )
SECONDARY Insurance Carrier:	Policy Number:	Group Number:		
Patient's Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other _____	Name of Subscriber (if other than Patient):			
Subscriber's Social Security #:	Gender: ❑ Male ❑Female	Date of Birth:	Subscriber's Employer:	Work Phone: ( )

Medicare

IF YOU HAVE MEDICARE COVERAGE OR ARE ELIGIBLE FOR MEDICARE COVERAGE, PLEASE COMPLETE THE QUESTIONS BELOW:

Are you still working? ❑ YES ❑ NO Retirement Date: _____
Do you have an Employer Group Health Coverage Plan? ❑ YES ❑ NO
Is your Spouse still working? ❑ YES ❑ NO Retirement Date: _____
Are you covered through your Spouse's Insurance? ❑ YES ❑ NO

By Signing Below, I acknowledge that the information I have provided is correct to the best of my ability.

Patient Signature: _____ **Date:** _____/_____/_____

Guarantor Signature (if other than patient): _____ **Date:** _____/_____/_____

MEDICAL AND SURGICAL HISTORY

THE GEORGIA INSTITUTE FOR PLASTIC SURGERY
THE PLASTIC SURGERY CENTER LAND, LLC

Please Fill Out COMPLETELY – Do Not Leave Anything Blank

Today's Date: _____ **Patient Name:** _____ **Date of Birth:**_____

Sex: Male / Female **Height:** _____ **Weight:** _____ **Age:** _____

Occupation: _____ Referred by: _____

All of Your Medical Doctors: _____

Chief Complaint: _____

SIGNIFICANT MEDICAL HISTORY:

Medical Allergies/Sensitivities: _____ Pregnant? N Y

List ALL Medications {including Aspirin, Diet Pills, Herbal Supplements, Prescriptions, Over-The Counter Meds}: _____

_____

_____

Are you a smoker? NO YES How many packs per day? _____ For how many years? _____

Have you ever used {circle}: LSD/speed/cocaine/marijuana None How much alcohol do you drink? _____

PAST MEDICAL HISTORY **{ Please check all that apply.}**			
Cardiovascular	**Pulmonary**	**Medical**	**Other**
☐ Heart Attack	☐ Asthma	☐ Diabetes	☐ Bleeding Tendencies
☐ High Blood Pressure	☐ Shortness of Breath	☐ Heart Burn/Reflux	☐ Blood clots in legs/lungs
☐ Irregular Heartbeat	☐ Emphysema/COPD	☐ Depression	☐ AIDS/HIV positive
☐ Chest Pain {angina}	☐ Bronchitis	☐ Steroid treatment	☐ Hepatitis
☐ Mitral Valve Prolapse	☐ Sleep Apnea	☐ Seizures	☐ Dry Eyes
☐ Abnormal EKG		☐ Mental Illness	☐ Kidney Disease
☐ **NONE OF THE ABOVE**	☐ **NONE OF THE ABOVE**	☐ **NONE OF THE ABOVE**	☐ **NONE OF THE ABOVE**

FAMILY HISTORY

Have you or anyone in your family ever had problems with anesthesia? YES / NO

If yes, who and what happened? _____

Any Family History of: Heart Disease Lung Disease Malignant Hyperthermia Other

Describe: _____

REVIEW OF SYSTEMS: Do you have any? (circle): fever chills nausea vomiting diarrhea **NONE**

PAST SURGICAL HISTORY: List all Operations you have had, including plastic surgery.	
OPERATION	**DATE**
☐ **I have NOT had any Operations**.	

Do you have any other health issues that we may need to be aware of? NONE / YES Explain: _____

_____

PATIENTS, PLEASE STOP HERE. THANK YOU!

Physician Signature: _____ _____/_____
Date **Time**

rev. 3.10.2015

HISTORY AND PHYSICAL

THE GEORGIA INSTITUTE FOR PLASTIC SURGERY
THE PLASTIC SURGERY CENTER LAND, LLC

Chief Complaint: _____

_____

PHYSICAL EXAM		
HEENT:	☐ PERRLA	☐ EOMs intact
HEART:	☐ RRR without murmur	
PULM:	☐ Lungs clear	
ABD:	☐ Soft, non-distended	
EXTREM:		
BREAST:	☐ No palpable masses	☐ Deferred
OTHER:		

IMPRESSION:_____

_____

PLAN: _____

_____

_____

☐ **PREVIOUS PAGE HISTORY REVIEWED AND UPDATED. The patient is cleared for surgery in an ambulatory surgical setting.**

PHYSICIAN SIGNATURE: _____ **Date/Time:** _____/ _____

OTHER COMMENTS:

_____

☐ **The History and Physical Exam remain valid from the above date.**

If not, list changes:

_____

_____

PHYSICIAN SIGNATURE: _____ **Date/Time:** _____/_____

☐ **SKIN LESION, SKIN CANCER, SOFT-TISSUE TUMOR REMOVAL DISCUSSION:**

Risks/Benefits/Alternatives discussed with patient: infection, bleeding, delayed healing in smokers, widened or hypertrophic scars, keloid scarring, additional surgery for positive margin or recurrence, scars at recipient site, scars and grafts that take over 2 years to mature, recurrence, option of no treatment.

The Georgia Institute For Plastic Surgery/The Plastic Surgery Center Land, LLC

Patient Record Of Disclosures

In general, HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner:

- ❑ ***Home Phone*** - It is ok to leave a message with detailed information.
- ❑ ***Cell Phone*** - It is ok to leave a message with detailed information.
- ❑ ***Work Phone*** - It is ok to leave a message with detailed information.
- ❑ ***Written Communication*** - It is ok to mail to my home address
- ❑ ***Fax Communication*** - It is ok to fax to this telephone number: _____
- ❑ ***Email*** -It is ok to email this address with detailed information: _____

You may leave a message with, discuss my treatment, appointments, financial obligations, or other scheduling that may occur or give other information as necessary with the following family, friends or personal representatives. I understand that The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC. will refuse to discuss my information with anyone not listed below, except in an emergency. I also understand this consent does not apply to medical providers.

Please Print:

_____

_____

_____

_____

_____

Patient Signature **Date**

_____

Please Print Name:

<u>Acknowledgement of Receipt of Notice of Privacy Practices</u>:

I have received a copy of the Notice of Privacy Practices for The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC, detailing how information may be used and disclosed as permitted under federal and state law. I understand this is an acknowledgement of receipt only. I may refuse to sign this acknowledgement if I wish.

_____

Patient Signature **Date**

_____

Signature of Patient Representative **(Required if patient is a Minor or an Adult who is unable to sign this form)**

Relationship: ❑Self ❑Mother ❑ Father ❑Power Of Attorney ❑Guardian ❑Spouse

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(For Internal Use Only)

If Patient or Patient's Representative Refuses to sign Acknowledgement of Receipt of Notice, please document the date and time the notice was presented to the patient and sign here:

Presented by:_____ Date:_____ Time:_____

<u>Advance Directive/Living Will</u>

Do you have an Advance Directive (Living Will, DNR-Do Not Resuscitate)? ❑ Yes ❑ No

For a copy of the Georgia Advanced Directives for Healthcare, please visit www.aging.dhr.georgia.gov and click on "Publications" on the left, or call DAS at (404)-657-5319

The Georgia Institute For Plastic Surgery / The Plastic Surgery Center Land, L.L.C.

Notice of Privacy Practices

March 5, 2019

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Your rights regarding your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:
You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints:
If you would like to submit a comment or complaint about our privacy practices, you may do so in writing outlining your concerns to:

Grievance Officer – Dawn Penick
The Georgia Institute For Plastic Surgery
5361 Reynolds Street
Savannah, GA 31405
912-355-8000 / 800-260-7135

Or you can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:

200 Independence Avenue, S.W.,
Washington, D.C. 20201,
877-696-6775
or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

You will not be penalized or otherwise retaliated against for filing a complaint.

The Georgia Institute For Plastic Surgery and
The Plastic Surgery Center Land, LLC
Payment Policy / Assignment of Benefits / General Disclosures

Patient Information Label

I hereby authorize and assign payment of my insurance benefits to be paid directly to The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC., any medical or surgical benefits that the professional corporation may be entitles to under my medical-surgical plan. I understand I am financially responsible for non-covered services and for any balance due for services excess of the benefits provided by my policy. I authorize the release of any medical or other information necessary to process insurance claims on my behalf. I further permit a copy of this authorization to be used in place of the original. This authorization is to apply to all private insurance claims and Medicare benefits I may use.

Financial Liability: All services rendered by the physicians in this office are on a fee for service basis. Deductible and co-insurance obligations associated with your chosen plan are your responsibility. These will be collected at the time of service for office visits. For cosmetic surgery or other scheduled procedures, these will be collected at least two weeks prior to the procedure/surgery. I understand that I will be responsible for any charges if any of the following apply:

- My health plan requires prior referral by a Primary Care Physician (PCP) before receiving services at The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC. And I have not obtained such a referral, or I receive services in excess of the referral, and/or
- My health plan determines that the services I receive at The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC. are not medically necessary and/or not covered by my Insurance plan, and/or
- My health plan coverage has lapsed or expired at the time I receive services at The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC., and/or
- I have chosen not to use my health plan coverage, and/or
- The physician I see does not participate with my health care plan.
- If for any reason my account should become delinquent, I or my responsible party agrees to pay for all rebilling charges, collection costs, and reasonable legal fees.

Ancillary Services

- I understand I may need certain ancillary medical services while I am a patient at The Georgia Institute For Plastic Surgery and/or The Plastic Surgery Center Land, LLC.; such as pathology specimen examination, cytology, imaging services, lab work, and cardiac tests. I understand that these services are not provided by any physician of this practice and that I may incur additional charges as a result of the ancillary services. I understand that these services will be billed to me directly or may require payment from me at the time of service. In addition, I may receive in-patient or out-patient hospital care at an area hospital. If so, I will receive a hospital bill for those services. Hospital bills are separate from our doctor services. I am responsible for providing the name of the preferred hospital, laboratory or any other preferred facility/physician in network with my insurance plan.

Release and Authorization of Information

- I authorize release of information to my primary care physician and/or referring physician
- I authorize release of information to my employer if this is a work-related condition.
- I understand photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize the taking of photographs at the direction of my surgeon and under such conditions as may be approved by him/her. I understand these photographs will be used solely for documentation purposes and will be kept confidential.
- I have read the Patient Financial Policy and I agree to abide by all terms. A copy of this policy is available on our website, in our lobby, or you may request a hard copy from the front desk.
- **Medicare Signature On File** ***(Medicare Patients Only)****:* I request that payment of authorized Medicare benefits be made either to me or on my behalf to all providers who treat me for any services furnished to me by these providers. I authorize the holder of my medical and other information to release to Medicare and it's agents any information needed to determine these benefits or benefits for related services.
- **Tricare Assignment Of Benefits** ***(Tricare Patients Only)****:* I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signature of Patient or Representative — Date / Time

Signature of Patient of Witness — Date / Time

The Georgia Institute For Plastic Surgery and The Plastic Surgery Center Land, LLC
Office Financial Policy

We would like to share the following policies with you so that you understand your responsibility regarding the charges for services rendered to you by these offices. Our doctors and staff are committed to providing our patients with the best possible care. In order to achieve this, we need your assistance and understanding of our medical policy.

Self Pay Accounts

Self-pay patients are required to pay $150 at the time of check in and with EACH visit that follows. You are responsible for payment of the balance of your bill should the charges exceed the $150 you pay at each visit. We designate accounts as self-pay under the following circumstances:

- Patient is covered by an insurance with which our physicians do not participate.
- Patient does not have a valid insurance referral on file, such as HMO or Tricare Prime.
- Patient does not have any health insurance coverage.

Cosmetic Accounts

Cosmetic patients are required to pay a $60 consultation fee at the time of check-in. Although you visiting us for something not related to insurance we still require the same information be provided as insurable patients. We have found it necessary to require this information in the event that you need to be seen in our practice at any point for something non-cosmetic. All cosmetic surgical fees are due in full 2 weeks prior to the planned surgical date. Checks are not accepted after this cut off date. All anesthesia and overnight nursing fees are non refundable if you cancel or reschedule within 2 business days of your scheduled surgery.

Payment Due at the Time of Service

- We accept cash, checks, debit and all credit cards. Returned checks are subject to a fee of $35.
- Copayments must be paid on the date service is received. A $10.00 billing fee may be charged to your account if the co-pay is not paid on the applicable date of service.
- You will be responsible at the time of service for the annual deductibles, co-payments, co-insurance, and charges for non-covered or cosmetic services.
- If your co-pay is a percentage and you do not have secondary insurance, a minimum payment of $35 may be required at the time of the appointment.
- Patient balances are due at the time of check-in, unless payment agreements have been arranged.
- In the event surgery is needed pre-payment is required before the surgery can be performed. You understand that you may be given a quote of cost prior to procedures. You further understand that this quote is just an estimate of charges and not a contract. You understand that during the course of any procedure surgical plans may change and that you will be responsible for any additional charges beyond the quoted charges that are assigned to you by your insurance company based on the contract that is in effect at the time of services rendered.
- Any account not paid in full within 90 days will be referred to our collection management company. In the event your account is turned over to a collection agency, a charge equal to 25% of the outstanding balance will be added to your account to cover the additional collection cost and fees. We reserve the right to terminate you as a patient of this practice if your account gets turned over to collections.

Proof of Insurance

- It is the policy of our office to follow all federal and state laws and reporting requirements regarding identify theft. As of September 1, 2009, The FTC applied its new "Red Flags Rule" regulations to physician practices. According to FTC Rule, physician practices that accept insurance must have adequate written polices and procedures in place to protect against identity theft. **As a patient, you will be asked to provide a valid photo identification card, insurance card, and a photograph may be taken for our records. You must bring your insurance card and photo identification to every appointment. We will request to see these at EVERY visit. If you do not have a VALID PHOTO ID you will not be seen and will be rescheduled.**
- It is your responsibility to inform the scheduling and registration staff when your appointment may be the responsibility of a third party (auto, liability, or worker's compensation insurance) instead of the patient's health insurance.
- It is your responsibility to notify the practice of changes to your health insurance, address, phone and employment.

Divorce & Custody

- In cases of divorce, the individual who receives care is responsible for payment of co-pays, co-insurance, deductible and non-participating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.
- The parent who brings the child to the office for care is assumed responsible for payment at the time of service no matter if the account is self-pay, participating or non-participating insurance. The practice does not honor divorce specifics.

The Georgia Institute For Plastic Surgery and The Plastic Surgery Center Land, LLC
Office Financial Policy

Referrals

- If your insurance requires a referral to a specialist, you are required to obtain the referral from you primary care physician PRIOR to your appointment. If you do not have a current, valid referral, we may ask you to either reschedule your appointment or pay for the visit at the time of service. If you are unsure if you need a referral, call the member services number on the back of your insurance card.
- IT IS YOUR RESPONSIBILITY TO VERIFY NETWORK PARTICIPATION OF YOUR PHYSICIAN WITH YOUR INSURANCE CARRIER. As a courtesy we will bill your insurance carrier. However, if we are not a participating/contracted provider with your carrier, you will be billed for services rendered.

Billing Practices

- We are a Medicare participating provider. We will bill Medicare. You will be responsible at the time of service for the annual deductibles, co-payments, and charges for non-covered or cosmetic services.
- If you have Medicare as well as secondary coverage with a commercial plan, we will bill the carrier. If no payment is received from your secondary/supplemental carrier within 60 days after we file a claim, you will be sent a bill and will be responsible for the balance.
- If you have a commercial insurance plan under which you are covered, we will bill the carrier for all covered, medically necessary services rendered. We will bill both your primary and secondary insurance plans. It is your responsibility to make sure that we are an "in-network" provider.
- Completion of disability or cancer policy forms will have a fee of $25 for each occurrence.
- Copying of medical records for personal use will incur an additional fee as allowed by law.

Cancellation Policy

As a courtesy to our physicians and patients we request a 24 hour (1 business day) cancellation notice for most office visits. Any procedure and/or surgery require 48 hours (2 business days) or more cancellation notice. Please note that weekends and holidays are not considered business days. All anesthesia and overnight nursing fees are non refundable if you cancel or reschedule within 2 business days of your scheduled surgery. If you miss your appointment, or do not cancel with the required notice, additional fees may apply. You may be required to prepay before being rescheduled.

- Office Visit First Occurrence: $25
- Office Visit Second Occurrence: $50
- New Patient Visit: $75
- Procedure/Surgery: Per Dept. Policy

Auto Accidents/Other Accidents

When your injuries are the result of an accident and an attorney will be handling your case in court or another party's insurance company is presumed responsible for your charges, the patient is still responsible for payment of the bill. The Georgia Institute For Plastic Surgery and The Plastic Surgery Center Land, LLC cannot be expected to wait for the conclusion of long-term court cases or settlement of a disputed insurance claim before being paid. **You will be required to make a payment of $350 before being seen and with EACH visit that follows. You also are responsible for payment of the balance of your bill should charges exceed the $350 you pay at each visit.**

Worker's Compensation

Patients who are injured on the job should report the injury directly to their employer. The employer will be responsible for directing the employee to a doctor who is listed on the PANEL OF PHYSICIANS. Before we will be able to see you as a patient, we will require you to fax or bring in a letter verifying that your employer will be responsible for your charges. If a patient comes in for a visit with out this information, we will have to reschedule the appointment or you will have to pay $350 to be seen. This information is necessary to avoid the patient being responsible for the bill.

THE GEORGIA INSTITUTE FOR PLASTIC SURGERY

feel better about yourself©

CODE OF CONDUCT FOR PATIENTS AND VISITORS

In an effort to provide a safe and healthy environment for staff and patients, The Georgia Institute For Plastic Surgery expects patients and all visitors to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

The following behaviors are prohibited and may result in your immediate dismissal from the practice:

- Physical assault or inflicting bodily harm.
- Rude behaviors in person or through written, verbal or electronic communication, including but not limited to the following: profanity, harassment, offensive or intimidating statements or gestures and threats of violence.
- Racial or cultural slurs or other derogatory remarks associated with race, language, or sexual orientation.
- Requests that would constitute illegal or unethical behavior on the part of The Georgia Institute For Plastic Surgery.

PLEASE BE COURTEOUS WITH THE USE OF CELL PHONES AND OTHER ELECTRONIC DEVICES. WE RESPECTFULLY ASK THAT YOU PUT YOUR DEVICES AWAY WHILE INTERACTING WITH THE STAFF, NURSES AND PHYSICIANS.

WE ARE MAKING EVERY EFFORT TO REDUCE WAIT TIMES AND MAKE ALL OF OUR PATIENTS' VISITS TO THE GEORGIA INSTITUTE FOR PLASTIC SURGERY STRESS FREE AND ENJOYABLE AS POSSIBLE.

TO ASSIST IN THAT GOAL, WE HAVE THE FOLLOWING EXPECTATIONS:

- Please communicate **all issues** that you wish to discuss with the doctor **at the time your appointment is scheduled**, so that an appropriate amount of time can be allotted.
- Please arrive on time for your appointment. New patients should arrive 10-15 minutes early for your appointment. **Arriving more than 15 minutes late may result in having to reschedule**.
  *Please call us if you anticipate being late.
- Please provide a 24-hour notice of cancellation whenever possible. We understand that last minute situations arise. Any notification, even late notice is appreciated.
- Multiple missed appointments may result in a fee.
- Please ensure a parent or responsible adult attends all appointments with patients that are 17 years and below. This is necessary to obtain legal consent for all procedures and treatments. A form to **designate a responsible party** to give consent in a parent's absence must be completed. This form is available online or from our front office staff.
- Payment of co-pays and/or deductibles is expected at the time services are rendered. Failure to do so may result in having to reschedule your appointment.

I agree to the The Georgia Institute For Plastic Surgery "Code of Conduct for Patients and Visitors".

_____ _____

Patient Signature **Date**

_____ _____

Staff Witness Signature **Date / Time**