North Charlotte Plastic & Reconstructive Surgery

Erik J. Miles, M.D., F.A.C.S.
9735 Kincey Ave, Suite 104
Huntersville, NC 28078
(704)896-5556

# PATIENT REGISTRATION FORM

Today's Date (mm/dd/yyyy):_____

## PATIENT PERSONAL INFORMATION

Suffix: Dr. Mrs. Miss Ms. Mr. (Circle One)

First Name:_____ SSN:_____

Middle Name:_____

Last Name:_____ Marital Status:_____

DOB:_____ Age:_____ Employed: ☐ Yes ☐ No

Gender: ☐ Female ☐ Male Student: ☐ Yes ☐ No

Who may we thank for referring you to Dr. Miles' Office today?_____

## PATIENT CONTACT INFORMATION

Address 1:_____ Employer/School:_____

Address 2:_____ Occupation:_____

City:_____ Home Phone:_____

State:_____ Cell Phone:_____

Zip:_____ Work Phone:_____

E-Mail:_____ Fax:_____

Are there any contact restrictions? ☐ Yes ☐ No If "Yes", please list:_____

Employer:_____

Address:_____City:_____State:_____Zip Code:_____

## INSURANCE INFORMATION

Do you have health insurance? ☐ Y ☐ N Secondary insurance? ☐ Y ☐ N Other? ☐ Y ☐N

Primary Health Insurance Company Name:_____

Address:_____City:_____State:_____Zip Code:_____

Policy Number:_____Group Number:_____Phone Number:_____

Do you have a co-payment? ☐ Yes ☐ No Is a referral required? ☐ Yes ☐ No

Name of Subscriber:_____ Relationship (if not self):_____

Subscriber DOB:_____ Subscriber SS#:_____

Subscriber Employer:_____

## EMERGENCY CONTACT INFORMATION

Name:_____ Relationship to Patient:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____

Address:_____City:_____State:_____Zip Code:_____

**Patient/Guardian Signature**:_____

**Erik J. Miles, M.D., F.A.C.S.**
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# Health History Form

Name: _____Today's date:_____
Last First Middle

Height:_____ Weight:_____ Date of Birth: _____Age_____
dd/mm/yyyy

Reason for Consultation: _____

Current or past medical conditions: _____

_____

Previous Plastic Surgery Procedures: _____

_____

Other Surgery Procedures: _____

_____

Current Medications and Dose/Frequency:_____

_____

Current Herbal Medication/Supplements:_____

_____

Drug Allergies (describe reaction) :_____

_____

Social History:

Do you smoke? ❒ Yes ❒ No How long and how much?_____
Do you drink alcohol? ❒ Yes ❒ No How long and how much?_____
Do you use illicit drugs? ❒ Yes ❒ No List:_____

Physician Information:

Primary Physician: _____ Phone number:_____

Pharmacy: _____ Phone number:_____

Please describe any additional information relevant to your medical history that you feel might be important.

_____

_____

Mark any symptoms or medical conditions you have experienced.

| ✘ | | ✘ | | ✘ | |
|---|---|---|---|---|---|
| | **General** | | **Abdomen** | | **Genitourinary** |
| | Weight loss/gain | | Frequent abdominal pain | | Kidney stones |
| | Frequent or Recent Fever/Chills | | Heartburn/reflux/ulcer | | Difficulty urinating |
| | Fatigue | | Frequent nausea/vomiting | | Prostate problems (men) |
| | Insomnia | | Frequent diarrhea | | Sexually transmitted disease |
| | Chronic pain | | Frequent constipation | | Urinary incontinence |
| | Motion sickness | | Liver problems | | |
| | Prolonged/frequent illness | | Gall bladder problems | | **Hematological** |
| | | | Jaundice (yellowing)/Liver problems | | Easy bruising |
| | **Head and Neck** | | Abdominal malignancy | | Hematoma |
| | Frequent headaches/migraines | | Rectal disease | | Anemia |
| | Facial trauma | | Hernia | | HIV/AIDS |
| | Facial fractures | | | | Hepatitis |
| | Neck Injury | | **Lungs** | | Bleeding disorder |
| | Limited neck movement | | Abnormal chest x-ray | | Blood transfusion |
| | Jaw pain | | Shortness of breath | | Use of blood thinners |
| | Decreased vision | | Asthma | | |
| | Dry eyes | | Emphysema | | **Skin** |
| | Glaucoma | | Pneumonia | | Keloids/hypertrophic scarring |
| | Cataracts | | Tuberculosis | | Skin cancer |
| | Decreased hearing | | Collapsed lung | | Poor wound healing |
| | Balance problems | | Pulmonary embolism | | Sun damage/sunburns |
| | Sore throat | | Lung cancer | | Tanning bed history |
| | Hoarseness | | Chronic cough | | Acne |
| | Sinus problems/sinusitis | | | | Latex sensitivity |
| | Snoring/Sleep apnea | | **Musculoskeletal** | | Tape sensitivity |
| | Nose bleeds | | Arthritis | | Alopecia |
| | Neck masses/lumps | | Poor circulation | | Psoriasis |
| | Head and neck cancer | | Leg cramps/"restless legs" | | Tattoos |
| | Facial paralysis/Bell's Palsy | | Varicose veins | | Hydradenitis |
| | | | Amputation/deformities | | |
| | **Heart** | | Phlebitis/blood clots | | |
| | High blood pressure | | Frequent back pain | | |
| | Low blood pressure | | Fibromyalgia | | |
| | Heart disease | | | | |
| | Heart murmur | | **Neurological** | | ***Females only:*** |
| | Heart palpitations | | Seizures | | Family history of breast cancer |
| | Irregular heartbeat | | Stroke | | Breast biopsy |
| | Heart attack | | Brain aneurysm | | Breast cancer |
| | Chest pain/Angina | | Fainting/dizziness | | Breast pain |
| | Heart valve problem | | Paralysis | | Nipple discharge |
| | Artificial heart valve | | Amnesia | | Fibrocystic breast disease |
| | Abnormal stress test | | | | Skin/nipple changes |
| | Cardiac catheterization | | **Psychiatric** | | Abnormal mammogram |
| | Stent placement | | Depression | | |
| | Pacemaker | | Anxiety | | Irregular menses |
| | | | Fear of needles | | Abnormal pap smear |
| | **Endocrine** | | Body dysmorphic disorder | | Dyspareunia (painful intercourse) |
| | Diabetes | | Panic attacks | | |
| | Thyroid problems | | Attempted suicide | | Pregnancy |
| | Steroid use | | Treatment for addiction | | Breastfeeding |
| | | | | | |

*Please explain any positive responses marked above.*

**Plastic Surgery History**

| | Procedure | Date | Complications (if any) |
|---|---|---|---|
| | Breast Augmentation | | |
| | Breast lift alone | | |
| | Breast lift with augmentation | | |
| | Breast reduction | | |
| | Gynecomastia surgery *(men)* | | |
| | | | |
| | Facelift | | |
| | Browlift | | |
| | Eyelid surgery | | |
| | Otoplasty (ear surgery) | | |
| | Rhinoplasty (nose surgery) | | |
| | Chin augmentation | | |
| | Lip enhancement | | |
| | Hair transplantation | | |
| | Botox ® | | |
| | Dermal fillers | | |
| | Fat injections to face | | |
| | Skin laser treatment | | |
| | Dermabrasion | | |
| | Microdermabrasion | | |
| | Chemical peel | | |
| | Laser hair removal | | |
| | | | |
| | Liposuction | | |
| | Abdominoplasty (tummy tuck) | | |
| | Buttock augmentation | | |
| | Body lift | | |
| | Arm lift | | |
| | Thigh lift | | |
| | Vaginal rejuvenation | | |
| | | | |
| | Reconstruction of congenital malformation | | |
| | Breast reconstruction: | | |
| | TRAM | | |
| | Latissimus dorsi | | |
| | Tissue expander/implant | | |
| | Other | | |
| | Head and neck reconstruction | | |
| | Abdominal reconstruction | | |
| | Reconstruction of an extremity | | |
| | Hand surgery | | |
| | Chronic wound treatment | | |
| | Skin graft | | |
| | | | |
| | Secondary /revision plastic surgery | | |
| | *If yes, please explain:* | | |
| | Other procedures (please list) | | |
| | | | |
| | | | |

# North Charlotte Plastic & Reconstructive Surgery, P.A.

## FINANCIAL POLICY

We believe that part of a good health care practice is to establish and communicate a financial policy to our patients. An informed and responsible patient should never have a credit problem with our practice.

**PAYMENT** is expected on the same day of each visit prior to the physician encounter. We accept cash, checks, debit card, Visa, MasterCard, Discover, and American Express. CareCredit accepted for balances of $300.00 or more.

**PAYMENT** will include any unmet deductible, co-insurance, co-payment amount, outstanding balance, cosmetic or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a waiting period, payment in full is expected at the time of your visit. A $50.00 consultation fee is assessed to all cosmetic consultations. Please be prepared to pay this on the day of your visit.

We are a participating provider for most insurance carriers. We will file all primary and secondary insurance claims for you. We do NOT file with third parties; however, we will provide you with the information for you to do so. Please remember that insurance is a contract between the patient and the insurance company and ultimately you are responsible for payment in full to our office.

**FINANCING:** We do offer financing plans through Care Credit. Applications are available in our office or on the web at www.carecredit.com. Financial arrangements must be made prior to services being rendered.

**LAB/HOSPITAL CHARGES:** Any service(s) provided by a lab or hospital is a contract between you and that lab or hospital. Any dispute with that lab or hospital should be handled with that facility and is not the responsibility of our practice. It is your responsibility to know which procedures your insurance will and will not cover at these facilities and to request an Explanation of Benefits (EOB) from your insurance carrier.

**RETURNED CHECKS** will incur a $25.00 service charge. You will be asked to bring cash or money order to cover the amount of the check plus the service charge.

**DISABILITY FORMS, FMLA FORMS, INSURANCE FORMS, COPIES OF MEDICAL RECORDS, ETC**., require office staff time and time away from patient care for the physician. Therefore we require a minimum of 5 business days to complete the forms and requests. A processing fee of $20 will be assessed for these services for each occurrence.

**COLLECTIONS:** Patients, whose accounts have been turned over to our collection agency and/or attorney, will be responsible for the account balance and all costs associated with collection, including but not limited to, attorney fees.

**CANCELING COSMETIC SURGERY**: If you cancel your surgery without rescheduling, all but your 10% deposit will be refunded within 30 days of the cancellation. Refer to your "Cosmetic Estimate" for more detailed information.

**AUTHORIZATION / FINANCIAL INFORMATION**

I hereby authorize the release of medical information to my insurance carriers concerning my and/or my dependent's medical condition and treatment for the purpose of claim payment.

I assign all insurance carriers' payments, for medical services rendered to myself and/or dependents to North Charlotte Plastic & Reconstructive Surgery, P.A.

I agree that if my insurance carrier sends payment to me for medical services rendered instead of North Charlotte Plastic & Reconstructive Surgery, P.A., I will immediately pay the amount due to North Charlotte Plastic & Reconstructive Surgery, P.A.

I agree it is my responsibility to understand my insurance benefits and to notify North Charlotte Plastic & Reconstructive Surgery, P.A., immediately of any changes to my insurance coverage.

I fully understand that I am financially responsible for any co-payments, deductibles, co-insurance, cosmetic, or non-covered services as determined by my insurance carrier.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Patient/Guardian Signature | Date | Witness Signature | Date |

# North Charlotte Plastic & Reconstructive Surgery, P.A.

## CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

I authorize North Charlotte Plastic & Reconstructive Surgery, PA to use and disclose the health and medical information of

_____ for the purpose of treatment, payment and health care operations.
*(Print Patient Name)*

**Treatment** (includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers our practice by telephone as the on-call physician).

**Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claim, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization).

**Health Care Operations** (includes the necessary administrative and business functions of our office).

You may review North Charlotte Plastic & Reconstructive Surgery, PA's "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in the consent prior to signing the consent.

_____Please initial here to verify that you have reviewed a copy of our privacy notice

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the notice may change also. A summary of the notice will be posted in our office, indicating the effective date of the notice, in the upper right corner. We will also provide you with a copy of the notice at your request.

As more fully explained in the notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you with emergency treatment. Other physicians, who provide call coverage, for our office, are required to use and disclose your protected health information consistent with this notice.

I understand that I have the right to revoke the consent provided that I do so in writing, except to the extent that North Charlotte Plastic & Reconstructive Surgery, P.A. has already used or disclosed the information in reliance on this consent.

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Signature Date

# North Charlotte Plastic and Reconstructive Surgery, P.A.

**Erik J. Miles, M.D., F.A.C.S.**

9735 Kincey Ave, Suite 104, Huntersville, NC 28078 (704)896-5556


## NOTICE OF PRIVACY PRACTICES

**This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.**

This Notice describes how we may use and disclose your protected health information to provide treatment, obtain payment and conduct health care operations and for other purposes permitted or required by law. It also describes your rights concerning your protected health information. "Protected health information" is information about you, including demographic information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to follow the practices described in this Notice. We may change the terms of this Notice at any time. The new Notice will be effective for all protected health information we maintain at that time including health information we created or received before we made the changes.

You may obtain a copy of our Notice of Privacy Practices at any time by calling our office or requesting one at your next appointment.

**Uses and Disclosures of Health Information**

**Treatment**: We will use and disclose your health information to provide, coordinate and manage health care and related services for you. For example we will disclose information to a specialist to whom you have been referred to ensure the provider has enough information to diagnose and/or treat you. We may also disclose information to a laboratory that, at our request, becomes involved in your treatment.

**Payment:** We may use and disclose your information to obtain payment for services we provided to you. For example we will send the necessary information to your health or dental insurance company to obtain payment for the treatment provided.

**Healthcare Operations:** We will use and disclose your health information to conduct the business activities of this office. These activities include, but are not limited to, quality assessment and improvement activities, review of the performance and qualifications of employees, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to begin your treatment. We may notify you of your appointment.

We will share your protected health information with business associates that perform specific functions for our practice such as billing. When a business arrangement of this type requires the use of your information, we will have a written contract with the third party to protect the privacy of your protected health information.

**Others Involved in Your Health Care:** We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree. If we determine it is in your best interest based on our professional judgement or experience with common practices, we may allow another person to pick up filled prescriptions, medical supplies, x-rays or other forms of health information.

We may use or disclose protected health information to notify or assist in notifying a family member, a personal representative or any other person responsible for your care of your location, your general condition or death. If you are present prior to the use or disclosure of your protected health information, we will provide you with the opportunity to object to such uses or disclosures. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family members or others involved in your health care.

**Emergencies:** In the event of your incapacity or in emergency circumstances, we may use or disclose your protected health information to treat you.

**Uses and Disclosures of Protected Health Information Based upon Your Written Authorization**: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that an action has already been taken in reliance on the authorization.

**Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object**

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

**Required By Law:** We may use or disclose your protected health information to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

We must make disclosures to you and, when required, to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule, Section 164.500 et. seq.

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. Additionally, we may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

**Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

**Military Activity and National Security:** When the appropriate conditions apply, we may disclose, to military authorities, protected health information of individuals who are Armed Forces personnel. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities including for the provision of protective services to the President or others legally authorized.

**Workers' Compensation:** we may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

**Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

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**Your Rights**

Your rights with respect to your protected health information and how you may exercise those rights are outlined below.

**You have a right to obtain a copy and/or inspect your health information:** Health information includes treatment records, billing records and any other records used by us to make decision about your treatment. You may obtain a form from our office to request access. A reasonable cost-based fee will be charged for expenses such as staff time, copies and postage. Contact us as indicated at the end of this Notice to obtain information about our fees or if you have any questions about your access.

**You have a right to request a restriction on the use and disclosure of your protected health information:** You may ask us not to use or disclose some part of your protected health information for the purposes of treatment, payment or operations. You may also request that we not disclose some part of your information to family and others who may be involved in your care or for notification purposes as otherwise described in this Notice. We are not required to agree to the restrictions but if we do, we are obligated to abide by the agreement except in cases of emergency. You may request a restriction by sending your request in writing to our Privacy Contact.

**You have a right to request to receive confidential communications by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also 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 request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

**You may have the right to request an amendment to your protected health information.** You may request that we amend protected health information about you. Your request must be in writing with an explanation as to why the information should be amended. 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. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures made by our Business Associates or us. It excludes disclosures for treatment, payment or healthcare operations as described in this Notice of Privacy Practices, to you, to family members or friends involved in your care, for notification purposes or as a result of an authorization signed by you. You have the right to receive specific information regarding these disclosures that occurred after October 01, 2007 for up to the previous 6 years. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. If you request an accounting more than once in a 12 month period, we will charge you a reasonable cost-based fee for responding to the additional request.

**You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice electronically.

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**Questions and Complaints**

If you have any questions, concerns or want more information about our privacy practices please contact us using the information below.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we have made regarding your access to your health information or any other request you have made in the exercise of your rights, you may send your complaint to us using the information below. You may also submit a written complaint to the Secretary of Health and Human Services. Contact us for the address of the Department of Health and Human Services.

We support your right to the privacy of your health information and we will not retaliate against you in any way for filing a complaint.

**Contact our office:**

North Charlotte Plastic & Reconstructive Surgery
9735 Kincey Ave, Suite 104, Huntersville, NC 28078
Huntersville, NC 28078
Office: 704-896-5556
Fax: 704-896-5585

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