North Charlotte Plastic and Reconstructive Surgery
9735 Kincey Avenue, Suite 104
Huntersville, NC 28078
(704) 896-5556

Patient Information Form

Last Name: _____ First Name: _____ MI: ____ Today's Date: _____

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

Home Phone: _____ Cell Phone: _____ Cell Carrier: _____

Marital Status: _____ SSN: _____ Gender: _____

Ethnicity: Hispanic or Latino ☐ **No** ☐ **Yes** Race: _____ Preferred Language: _____

DOB: _____ Age: _____ Email Address: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Primary care physician: _____

Referring provider / other: _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Assignment and Release

I have insurance coverage and assign directly all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured / Guardian Date

Primary Insurance

Company Name: _____ Policy #: _____ Group ID: _____

If responsible party is someone beside the patient, please fill in the following fields:

Policy holder's name: _____ Relationship to patient: ☐ Spouse ☐ Other: _____

Phone #: _____ DOB: _____ SSN: _____

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

Secondary Insurance

Name: _____ Policy #: _____ Group ID: _____

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WHAT IS THE NATURE OF YOUR VISIT? _____

Section I: Surgery History

Have you ever had any plastic surgery procedures? ☐ **Yes** ☐ **No**, if yes please describe:

_____

_____

Have you had any other surgeries? ☐Y ☐N , if yes, please describe.

_____

_____

Section II: Medical History

Height: _____

Weight: _____

Are you pregnant? ☐ **Yes** ☐ **No**

Have you or do you still have:	**Yes**	**No**	**Description**
Asthma	☐	☐	
High Blood Pressure	☐	☐	
Weight Loss/Gain	☐	☐	
Chronic Pain	☐	☐	
Facial Trauma	☐	☐	
Neck Injury	☐	☐	
Dry Eyes	☐	☐	
Snoring/Sleep Apnea	☐	☐	
Neck Masses/Lumps	☐	☐	
Facial Paralysis/Bell's Palsy	☐	☐	
Heart Disease	☐	☐	
Hepatitis or Liver Trouble	☐	☐	
Irregular Heartbeat	☐	☐	
Heart Attack	☐	☐	
Kidney Trouble	☐	☐	
Artificial Heart Valve	☐	☐	
Stent Placement	☐	☐	
Pacemaker	☐	☐	
Heartburn/Reflux/Ulcer	☐	☐	
Diabetes	☐	☐	
Stroke	☐	☐	

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Shortness of Breath	☐	☐	
Emphysema	☐	☐	
HIV / AIDS	☐	☐	
Sexually transmitted disease	☐	☐	
Cancer	☐	☐	
Skin Cancer	☐	☐	
Breast Cancer (Be Specific)	☐	☐	
Melanoma	☐	☐	
Breast Biopsy	☐	☐	
Breast Pain	☐	☐	
Skin/Nipple Changes	☐	☐	
Abnormal Mammogram	☐	☐	
Thyroid Trouble	☐	☐	
Arthritis	☐	☐	
Frequent Back Pain	☐	☐	
Poor Circulation	☐	☐	
Frequent Nausea/Vomiting	☐	☐	
Chronic Cough	☐	☐	
Hematoma	☐	☐	
Rheumatic Fever	☐	☐	
Pneumonia	☐	☐	
Pulmonary Embolism	☐	☐	
Bleeding Disorder	☐	☐	
Use of blood thinners	☐	☐	
Anemia	☐	☐	
Poor Wound Healing	☐	☐	
Tuberculosis	☐	☐	
Seizures	☐	☐	
Stroke	☐	☐	
Sun Damage/Sunburns	☐	☐	
Latex Sensitivity	☐	☐	
Tape Sensitivity	☐	☐	
Hydradenitis	☐	☐	
Glaucoma	☐	☐	
Vericose Veins	☐	☐	
Phlebitis/blood clots	☐	☐	
Fainting/Dizziness	☐	☐	
Anxiety	☐	☐	

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Panic Attackes	☐	☐	
Body dysmorphic disorder	☐	☐	
Fear of Needles	☐	☐	
Depression	☐	☐	
Pregnancy	☐	☐	
Breastfeeding	☐	☐	

Others Not Listed: _____

Section III: Social History

1. Do you smoke? ☐ **Yes** ☐ **No** How Much?:_____
2. Do you drink? ☐ **Yes** ☐ **No**, How Often?:_____

Section IV: Family History

Have any blood relatives had any of the following?	Yes	No	Description
Cancer	☐	☐	
Breast Cancer	☐	☐	
Heart Disease	☐	☐	
Blood Clots	☐	☐	
Skin Cancer	☐	☐	
Other:	☐	☐	

Section V: Women Only

Date of last mammogram: _____ Did you breast feed: ☐ **Yes** ☐ **No**

Do you do regular breast self-examinations? ☐ **Yes** ☐ **No** Breast lump or discharge: ☐ **Yes** ☐ **No**

Section VI: Medications

Are you taking any medications? ☐ **Yes** ☐ **No**, if yes please list

_____

_____

_____

Current Herbal Medications/Supplements? ☐Yes ☐No , if yes please list

_____

_____

Section VII: Allergies and Sensitivities

_____

_____

_____

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

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Consent to Communicate

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐	
☐ Send Email	-	☐	-
☐ Email Appt Reminders			
☐ Email Medical Info			
☐ Email Marketing Info			
☐ Send Regular Mail	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):			
☐ Send Text Page	-	☐	-
☐ Text Appt Reminders – if so, list cell carrier:			
☐ Text Marketing Info – if so, list cell carrier:			

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

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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.

Signature: _____