Augusta Plastic Surgery Associates, P.C. • Augusta Plastic Surgery Center, Inc.

569 Fury's Ferry Road • Martinez, GA 30907 • (706)724-5611 Fax: (706) 724-5435

Name: (Last) (First) (Middle)					Today's Date:
Address:				City/State/Zip:	
SSN:	Birthdate:	Marital Status:	Age:	Sex:	**Ethnicity:**
Home Phone:	**Work Phone:**		**Cell Phone:**		Employer:
Spouse's Name:	Spouse's Phone Number:			Spouse's Employer:	
May We Leave A Message On Your Answering Machine? ☐Yes ☐No	Contact Restrictions? ☐Yes ☐No If Yes, Describe:			**E-Mail:**	
Emergency Contact Name:	**Relationship:**			**Phone Number:**	

How did you hear about us: ☐TV ☐Family ☐Friend ☐Phonebook ☐Radio ☐Newspaper ☐Physician ☐Ask-A Nurse ☐ASPS ☐Magazine ☐Mailer/Promo Offer ☐Billboard ☐Website ☐Other:

Referring Physician: If other, please list.

If Patient Is Under 18, Complete This Section

Name of Parent OR Guardian Signing Patient In:

Mother:	SSN:
Birthdate:	Phone Number:
Father:	SSN:
Birthdate:	Phone Number:

INSURANCE INFORMATION

• ***Primary Insurance Co Name:***	Cardholder's SSN:
Cardholder's Name:	Relationship To Patient:
Cardholder's DOB:	Policy Effective Date:
Policy Number (ID/Suscriber #):	Group Number:
• ***Secondary Insurance Co Name:***	Cardholder's SSN:
Cardholder's Name:	Relationship to Patient:
Cardholder's DOB:	Policy Effective Date:
Policy Number (ID/Suscriber #):	Group #:
• *If Workers Compensation* Treatment authorized by:	Claim #:

***We must have ALL of your insurance and/or Workers Compensation information in order to prevent the delay/non-payment of your medical claims. In the event you do not accurately provide this information, you will be held financially responsible for unpaid claims.**

Patient, Parent OR Guardian Signature:	Chart Number: -25	Date:

NOTICE OF PRIVACY PRACTICES

Augusta Plastic Surgery Associates, P.C./Augusta Plastic Surgery Center, Inc.

569 Fury's Ferry Road, Martinez, GA 30907

706-724-5611

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.

Uses and Disclosures to Carry Out Treatment, Payment and Healthcare Operations:
Treatment - This facility may use or disclose your protected health information in consultation between healthcare providers relating to your treatment or for your referral to another healthcare provider for your treatment.
Payment - This facility may use or disclose your protected health information for billing, claims management, collection activities or obtaining payment.
Healthcare Operations - This facility may use or disclose your protected health information for reviewing the competence or qualifications of healthcare professionals or for conducting training programs in which students, trainees or practitioners participate. This facility may use or disclose your protected health information for accreditation, certification, licensing or credentialing activities. This facility may use or disclosure your protected health information to our business associates who participate in our healthcare operations. These disclosures will only be made after we have satisfactory assurances in the form of a Business Associates Agreement from the business associate. These assurances will include their agreement to comply with the HIPAA rules and the compliance of any subcontractor with which they do business.

Authorized Uses or Disclosures: The following uses or disclosures require a valid authorization as defined by the HIPAA standards:
Uses or Disclosures for Psychotherapy Notes - Not applicable to this facility.
Uses or Disclosures for Marketing Purposes – No disclosures for marketing purposes will be made unless you give us specific written consent.
Disclosures for a Sale of Protected Health Information - This facility will require an authorization for any disclosures that would constitute a sale of protected health information.
For any other use or disclosure you wish us to make, you can give us a written, valid authorization. Your authorization must have specific instructions for the use and disclosure you want us to make. You will have the right to revoke the authorization in writing at any time before the information is used or disclosed.

Uses or Disclosures Requiring an Opportunity for the Individual to Agree or Object: For disclosures to others involved with your healthcare or payment, we will inform you in advance and give you the opportunity to agree or object. These disclosures will be limited to the information necessary to help with your healthcare or payment. These disclosures will only be made if you do not object.

Uses and Disclosures for Which an Authorization or Opportunity to Agree or Object is Not Required: The following uses or disclosures do not require an authorization or the opportunity for you to agree or object:
Uses and Disclosures Required by Law - This facility may use or disclose protected health information to the extent required by law. The use or disclosure will comply with and be limited to the relevant requirements of such law.
Uses and Disclosures for Public Health Activities - This facility may use or disclose protected health information for the purpose of preventing or controlling disease, injury or disability, including but not limited to, the reporting of disease, injury and vital events such as birth or death.
Disclosures About Victims of Abuse, Neglect or Domestic Violence - This facility may disclose protected health information about an individual whom this facility reasonably believes to be a victim of abuse, neglect or domestic violence.
Uses and Disclosures for Health Oversight Activities - This facility may disclose protected health information to a health oversight agency for oversight activities authorized by law including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary actions.
Disclosures for Judicial and Administrative Proceedings - This facility may, in response to an order of a court or administrative tribunal, provide only the protected health information expressly authorized by such order or a subpoena.
Disclosures for Law Enforcement Purposes - This facility may disclose protected health information as required by law including laws that require the reporting of certain types of wounds or other physical injuries.

Uses and Disclosures About Decedents: This facility may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. We may disclose protected health information to a funeral director, as authorized by law, to carry out their duties. This disclosure will be made in reasonable anticipation of death.

Uses and Disclosures for Cadaveric Organ, Eye or Tissue Donation Purposes: This facility may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of cadaveric organs, eyes or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Uses and Disclosures for Research Purposes: This facility may use or disclose protected health information for research when the research has been approved by an institutional review board or privacy board to protect your protected health information.

Uses and Disclosures to Avert a Serious Threat to Health or Safety: This facility may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, in good faith, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Uses and Disclosures for Specialized Government: This facility may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission if the appropriate military authority has published by notice in the Federal Register.

Disclosures for Workers' Compensation: This facility may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Patient Rights Under HIPAA: The following information describes your rights under the HIPAA Standards. This facility requires that all requests for the various rights be made in writing and we will provide our decision on your request in writing. You should be aware that there may be some situations when there could be limitations placed on your rights. We are required to permit you to request these rights, but we are not required to agree to your request except as discussed in the Right of Restriction section.

Right of an Individual to Request a Restriction of Uses and Disclosures - This facility will permit an individual to request that we restrict uses or disclosures of protected health information about the individual to carry out treatment, payment or healthcare operations or to others involved in your care or in payment. We will consider these requests, but we are not required to agree to them except as discussed in the next section.
Under your right of restriction, you may restrict certain disclosures of protected health information to a health plan for payment or healthcare operation where payment in full is made out of pocket for a healthcare item or service.
Confidential Communication Requirements -This facility will permit an individual to request and will accommodate reasonable requests to receive communications of protected health information from our facility by alternative means or at an alternative location.
Access of Individuals to Protected Health Information - An individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set except as prohibited by state or federal law or certain other exemption. Your access may be provided in electronic form if producible at your request or in another form or format. As permitted by state and federal law, we may charge you a reasonable cost based fee for a copy of your record. Questions about the fee should be addressed to our Privacy Officer listed at the end of this document.
Amendment of Protected Health Information - An individual has the right to ask to have this facility amend protected health information or a record about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.
Accounting of Disclosures of Protected Health Information - An individual has a right to receive an accounting of disclosures of protected health information made by this facility in the past six years, but not before April 14, 2003. The accounting will not include disclosures made for treatment, payment or operations as well as authorized disclosures or disclosures made for which you had an opportunity to agree or object. You may receive one free accounting in a 12 month period. There will be \\\\\a reasonable cost based fee for additional requests.
Right of Breach Notification - An individual has the right to and will receive a notification of any breach of their unsecured protected health information as defined by the Breach Notification Rule. We will fulfill our obligation to provide notice in accordance to HIPAA standards.
Copy of This Notice - You have a right to a copy of this notice. Even if you agreed to receive an electronic copy, you may request and receive a paper copy.

Our Duties: This facility is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This facility is required to abide by the terms of the notice currently in effect.
This facility is required to notify you of any change in a privacy facility that is described in the notice to protected health information that we created or received prior to issuing a revised notice. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain.

Complaints: If at any time you feel we have violated your HIPAA rights, please contact our **Privacy Officer, Trudy Paschal, or the Secretary of Health and Human Services. This facility will not retaliate against any individual for filing a complaint.**

Contact: You have the right to file a complaint with our Privacy Officer, Trudy Paschal, at the address and phone number at the top of this notice, or with the Office of Civil Rights, US Department of Health and Human Services, 61 Forsyth St., SW, Suite 3B70, Atlanta, GA 30323.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Patient or Patient's Personal Representative **Date**

Chart#:

Christopher J. Ewart, M.D. **Michael S. Tarakji, M.D.**

(Revised: 3/20/14)

AUGUSTA PLASTIC SURGERY ASSOCIATES, P.C. • AUGUSTA PLASTIC SURGERY CENTER, INC.

FINANCIAL POLICY

Thank you for choosing Augusta Plastic Surgery Associates, P.C./Augusta Plastic Surgery Center, Inc. as your health care provider. We are committed to providing you with high quality health care and compassionate services.
Please understand that payment of your bill is considered a part of your treatment. Therefore, we require you to read and sign our Financial Policy as well as complete our Patient Information and Insurance form before receiving any services.

REGARDING INSURANCE (TO INCLUDE MEDICARE AND MEDICAID)

All co-payments and deductibles are due prior to treatment. Our office will file your claims with your insurance as a courtesy to you and will assist you as much as possible with this process. However, we ask that you cooperate with us by making sure that you provide us with the correct information regarding your insurance policy and inform us of any changes to this information as they occur. Although we will be filing your claims, you need to realize that the insurance agreement is between you and your insurance company and we are not a party to that contract. Our bill for services is an agreement between you and the physician and/or surgery center.

You should also be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. As such, if for some reason your insurance company has not paid your account within 45 days of our filing, the balance will be automatically transferred to your responsibility. We will expect payment within 30 days of you receiving a statement from us. Your insurance company may require a referral from your primary care physician. If this is the case, it is your responsibility to obtain this prior to your initial visit and for each visit thereafter. Failure to do this may result in your being responsible for payment of the entire consultation and/or surgical fee at the time of each visit.

USUAL AND CUSTOMARY RULES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

COSMETIC PATIENTS

Most cosmetic procedures are not covered by insurance. These procedures are expected to be paid in full one week prior to surgery. Financing is available for those who qualify. A consultation fee of $50 will apply on your first office visit and is non-refundable. However, follow-up cosmetic visits are at no charge for up to one year after having a surgical procedure. Specific fees for cosmetic procedures will be discussed after you have completed your initial consultation. If you are having a cosmetic procedure performed along with a procedure that is to be covered by your insurance company, you are still responsible for any applicable co-payments, co-insurances and deductibles as specified by your insurance plan along with the fees for the cosmetic procedure. Billing and payment for cosmetic and insurance procedures (even when performed on the same date) are processed separately.

PAYMENT METHODS

We accept check, cash, credit cards (American Express, Discover, Visa and MasterCard) and ATM debit cards.

CLOSING

By signing below, you acknowledge that you understand and accept our Financial Policy. Your signature also authorizes us to file claims on your behalf to your insurance company, Medicare or Medicaid (whichever appropriate) and for those benefits to be made payable to Augusta Plastic Surgery Associates, P.C./Augusta Plastic Surgery Center, Inc. on your behalf.

X_____ _____
Signature of Patient or Responsible Party — Date

X_____ _____
Witness — Date

_____ Chart Number:
Patient's Name

Medical History

PATIENT PERSONAL HISTORY Date:_____
Confidential Records: Information contained herein will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your physician in his decision(s) regarding your care.

NAME: (Last)	(First)	(Middle)	
Age:	Height:	Weight:	Do You Have A Living Will/DNR? Yes or No
Are You Allergic To Latex? Yes or No		Have You Ever Had A Bad Staph Infection? Yes or No If Yes, When?	
List Of Allergies: (Write None If None)		Reason For Visit:	

List **ALL** Current Medications-Prescriptions & Over the Counter-Include Aspirin, Motrin, Ibuprofen & Vitamins:			
DRUG	**DOSAGE** (if known)	**DRUG**	**DOSAGE** (if known)

Which Pharmacy Do You Use?	Phone:
Primary Care Physician:	Phone:

Place a check in the box if you (or family member & list relation) have or have had. If so, give date of occurrence.									
	Yes	**No**	**Date**	**Family**		**Yes**	**No**	**Date**	**Family**
Abdominal Bleeding					Chest Pain/Tightness				
AIDS/HIV					Defibrillator				
Anemia					Diabetes				
Arthritis					Diet Pills				
Asthma					Diverticulitis				
Back Problems					DVT				
Bladder Infection					Eczema				
Bleeding Tendency					Epilepsy				
Blood Disorder					Frequent Headaches/Dizzy Spells				
Breast Cancer					Heart Attack				
Bronchitis					Heart Disease				
Cancer					Heart Murmur				

Medical History

	Yes	No	Date	Family		Yes	No	Date	Family
Heart Stent					MRSA				
Hepatitis					Muscle Weakness/Paralysis				
Hiatal Hernia					Obesity				
Hidradenitis					Pneumonia				
High Cholesterol					Pulmonary Embolism				
Hives					Radiation Treatment				
Hypertension					Recent Weight Loss/Diet				
Kidney Disease					Reflux				
Kidney Stones					Skin Cancer				
Leukemia					Skin Disease				
Lung Disease/Shortness of Breath					Sleep Apnea				
Melanoma					Stomach Ulcers				
Migraines					Stroke				
Mitral Valve Prolapse					Thyroid Disease				
Motion Sickness					X- Other Major Illnesses				

If ANY of the above questions were answered YES, please list the Dates, Any Complications, and Form of Disease (if applicable).

Please list any surgeries you have had. If NONE, please write the word NONE.			
DATE	**SURGERY**	**DATE**	**SURGERY**

Do You Smoke?	If So, How Much?	How Many Years?
Do You Drink?	If So, How Much?	Do You Drink Over 6 Cups of Coffee A Day?
Taken Steroids?	If So, When?	Date Last Chest X-Ray:

List Any Serious Illness Or Injuries You Have Had:
REVIEWED & UPDATED:

Augusta Plastic Surgery Associates, P.C.
Augusta Plastic Surgery Center, Inc.

ADVANCED DIRECTIVES

DEFINITION:

An advance directive for healthcare means a written document voluntarily executed by a declarant in accordance with the requirements of Code Section 31-32-5. Advance directives are legal documents that allow you to plan and make your own end-of-life wishes known in the event that you are unable to communicate.

Since the enactment of the Patient Self Determination Act of the Omnibus Budget Reconciliation Act of 1990 (OBRA90) Sections 4206 & 4751, Georgia's laws on advance directives changed significantly on July 1, 2007.

- The Georgia Advance Directive for Health Care Act replaced the Georgia Living Will as the new Chapter 32 of Title 31 of the Official Code of Georgia.
- Chapter 36 of Title 31 of the Official Code of Georgia creating the Durable Power of Attorney for Healthcare was repealed and that chapter reserved, meaning that for now, no law will be found in Chapter 36, but the space and the Chapter number will be reserved for future use.
- The Living Will and Durable Power of Attorney for Healthcare will no longer be available as options for advance directives in Georgia.
- Validly executed Living Wills created between March 28, 1986, and June 30, 2007, remain valid until revoked.
- If one chooses to complete a Georgia Advance Directive for Healthcare, it will replace any other advance directive for healthcare, durable power of attorney for healthcare, healthcare proxy or living will that currently is in place. One may choose not to complete this form and his/her current living will and/or durable power of attorney for healthcare form, if valid now, remains valid.
- A Georgia advance directive for healthcare is never required.

_____ I have an advanced directive/living will and have provided a copy for my medical record.

_____ I have an advance directive/living will, but cannot provide a copy for my medical record.

_____ I have asked for and received more information on advanced directives/living wills.

_____ I have been offered additional information regarding advanced directives/living wills and have declined at this time.

_____ _____

Signature of Patient Date

_____ _____

Witness Date

Revised: 12/2/14

Augusta
PLASTIC SURGERY
Restore. Reshape. Refresh.

Patient Name:_____ **Chart #:**_____

PATIENT PHOTOGRAPHY/VIDEOGRAPHY RELEASE FORM

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery. The photographs will be taken by one (or more) members of the Augusta Plastic Surgery Associates, P.C. staff. I hereby give my consent for Augusta Plastic Surgery Associates, P.C. to use the photographs under of the following circumstances:

Medical Care / Insurance Purposes: Photographs taken of me or parts of my body will be used for the purpose of my medical care with Augusta Plastic Surgery Associates, P.C. to include providing the photographs to my insurance company for prior authorization and/or payment of my claim(s) (if applicable). The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Augusta Plastic Surgery Associates, P.C. However, they also may be shared with my insurance company if applicable as mentioned above for prior authorization and/or payment of my claim(s).

Photographs and/or video taken of me or parts of my body as well as details regarding medical services that I receive at Augusta Plastic Surgery Associates, P.C. may be used in order to inform the public about plastic surgery methods. **All images will have identifying features removed within reason. My name will NOT be associated with the images.** I can **at any time** request the removal of any images of myself that have been used. Further, I release and discharge Augusta Plastic Surgery Associates, P.C., its employees, surgical facility used and the American Society of Plastic Surgery, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs and details regarding medical services rendered me including any claim for payment in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

Before and after photos may be used on the **APS website, social media, in-office photo albums, or for medical care and insurance purposes.** If you wish **NOT** to participate, please indicate below which uses you wish to **opt out of**. For example, you may list *social media*. You can also request that we please *get your approval before using any photos*:

_____

Please note that viewing "before and after" photographs of other patients prior to any surgical procedure is very important to patients in their decision process and we would appreciate you assisting them by allowing us to use your photos in our photo album and/or on our website.

Patient or Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Authorization- Compound

This authorization form permits:

Augusta Plastic Surgery
569 Fury's Ferry Road
Martinez, GA 30907

to use or disclose protected health information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Name _____ Birth Date _____
Address _____
City/State/ Zip _____

Receiving Entity: Please check the boxes for those entities or persons you wish to get the described information about you.	Description of information to be given to checked Entity or Person.
Voice Mail - Number _____	☐ Appointment time ☐ Results of lab test or x-rays ☐ Other _____
Email (unsecured) _____	☐ Appointment time ☐ Results of lab test or x-rays ☐ Other _____
Unencrypted email to treating physicians _____	☐ Appointment time ☐ Results of lab test or x-rays ☐ Other _____
Employer _____ School _____	☐ Appointment or absentee information ☐ Return to work or school information
Spouse (Provide name) _____	☐ Financial information ☐ Medical information- please list _____ _____
Parent (Provide name) _____	☐ Financial information ☐ Medical information- please list _____ _____
Other (Provide name) _____ Relationship _____	☐ Financial information ☐ Medical information- please list _____ _____
Other (Provide name) _____ Relationship _____	☐ Financial information ☐ Medical information- please list _____ _____

Purpose

The purpose of this authorization is to meet the patient's request for information disclosures and uses.

Expiration date or event: This authorization shall be enforce until revoked by the patient or _____

Verification method or code: This practice will verify the identity of any entity requesting protected health information. Verification information shall include the last four digits of patient's, or guardian, Social Security Number.

_____

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____Date _____
Signature of Patient or Personal Representative (as defined by HIPAA)

Description of Personal Representative's Authority (attach necessary documentation)

_____

****

Office Use Only:

Receiving Employee_____ Date received_____

☐ Copy given to patient

Augusta
PLASTIC SURGERY
Restore. Reshape. Refresh.

Patient Name: _____

Date: _____

What is the reason for your visit today?

_____

Other than the services you are inquiring about today, what additional services would you like to learn about? Please check all that apply.

- ☐ Injectable Treatments - Botox
- ☐ Dermal Fillers - Juvederm
- ☐ Skin Care products
- ☐ Skin Resurfacing
- ☐ Lip Augmentation
- ☐ Fat Injections
- ☐ Eyelids (Blepharoplasty)
- ☐ Forehead (Brow Lift)
- ☐ Rhinoplasty
- ☐ Ear Tack (Otoplasty)
- ☐ Breast Augmentation
- ☐ Breast Lift
- ☐ Breast Asymmetry
- ☐ Breast Reconstruction
- ☐ Gynecomastia (Males)
- ☐ Liposuction - specify area(s):
- ☐ Abdominoplasty (Tummy Tuck)
- ☐ Arm Lift (Brachioplasty)
- ☐ Thigh Lift (Thighplasty)
- ☐ Buttock Augmentation
- ☐ Carpal Tunnel Hand Surgery
- ☐ Skin Cancer
- ☐ Hair Removal
- ☐ Labiaplasty
- ☐ Permanent Make-up
- ☐ Other: _____

How did you hear about Augusta Plastic Surgery?

- ☐ My physician:
- ☐ My Insurance Company
- ☐ Friend
- ☐ Family member
- ☐ Internet web search
- ☐ Social media
- ☐ Magazine
- ☐ Billboard
- ☐ The Yellow Pages
- ☐ Other: _____

Would you like us to email you our newletter and information about upcoming events and/or specials?

- ☐ Yes
- ☐ No Thank you

Email address: _____

Patient Signature: _____

Administrator Notes:

_____

_____

_____

_____