

LOWCOUNTRY PLASTIC SURGERY CENTER, LLC

Registration Information

PATIENT INFORMATION

Name: _____ Social Security Number: _____

Birthdate: _____ Age: _____ Driver's License Number: _____

Address: _____ Home Phone: _____

City, State, Zip: _____ Cellular Phone: _____

E-mail address _____

Are you a student? _____ If yes, are you full time _____ Marital Status: S M D Sep W

Employer: _____ Occupation: _____ FT PT

Employer Address: _____ Work Phone: _____

City, State, Zip: _____ Alternate Phone: _____

Is your condition related to: _____ Employment _____ Auto Accident _____ Other Accident _____ Cosmetic

Referral Source: _____ BellSouth YP _____ BellSouth Mt Pleasant YP _____ Newspaper ad _____
_____ The Talking YP _____ The Talking YP Mt Pleasant _____ Friend _____
_____ Emergency Room _____ Internet _____ Physician _____

INSURED/RESPONSIBLE PARTY INFORMATION

Name: _____ Relationship to Patient: _____

Birthdate: _____ Age: _____ Social Security Number: _____

Address: _____ Home Phone: _____

City, State, Zip: _____

Employer: _____ Occupation: _____

Employer Address: _____ Work Phone: _____

_____ Alternate Phone: _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Policy Holder's Name: _____

Policy Number: _____ Group Number: _____

Address: _____ Phone Number: _____

City, State, Zip: _____ Fax Number: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Policy Holder's Name: _____

Policy Number: _____ Group Number: _____

Address: _____ Phone Number: _____

City, State, Zip: _____ Fax Number: _____

Do you have another health benefit plan? No Yes _____

EMERGENCY CONTACT INFORMATION (Someone who does not live with you)

In case of emergency, notify: _____

Relationship: _____ Phone Number(s): _____

I authorize you to give me reasonable and proper medical care by today's standards. I, the patient or responsible party, authorize release of medical information for the purpose of processing medical claims.

SIGNATURE: _____

DATE: _____

LOWCOUNTRY PLASTIC SURGERY CENTER, LLC

Statement of Financial Responsibility

I understand that it is my responsibility to supply LOWCOUNTRY PLASTIC SURGERY CENTER, LLC with any current insurance information and/or any referral authorization forms that may be necessary for my insurance. I am aware that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. If this account becomes delinquent, I understand that a billing charge (\$25.00) as well as late fees and interest may be added to the balance due. In the case of default of payment, the undersigned guarantor agrees to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. I authorize LOWCOUNTRY PLASTIC SURGERY CENTER, LLC to receive all payments for medical services rendered to my dependents or myself. These authorizations will remain on file for all future treatment. I AM AWARE THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCES.

Reconstructive procedures are typically covered by insurance; however, this coverage cannot be determined until preauthorization is filed with your carrier. Prior authorization will allow you to better understand both your coverage and your financial responsibility.

I understand that Medicare and most insurance companies do not cover cosmetic surgical procedures or office visits. I also understand that my insurance carrier may consider some services performed by LOWCOUNTRY PLASTIC SURGERY CENTER, LLC as "not covered." Therefore, I will be fully responsible for payment of these charges. I also understand that insurance companies require beneficiaries to pay deductibles, company insurance, co-payments, and any non-covered services at the time services are rendered.

IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. WE GLADLY ACCEPT CASH, CHECK, AND CREDIT CARDS. All returned checks are subject to a \$25.00 service charge. Any refunds over \$500 due to the patient will be paid within 30-45 business days.

I am aware that I am responsible for any portion of my charges not paid by my insurance carrier, and that a finance charge may be assessed on any balance over 90 days delinquent.

Notice of Privacy Practices Acknowledgement

We are required to provide a Notice of Privacy Practices to you by the Health Insurance Portability and Accountability Act (HIPAA). My signature below constitutes my acknowledgement that I have received the Notice of Privacy Practices and have been provided an opportunity to review it. I further authorize Lowcountry Plastic Surgery to contact my emergency contact as needed.

Release of Information

I authorize LOWCOUNTRY PLASTIC SURGERY CENTER, LLC to obtain information from other physicians that they may feel is beneficial in their evaluation or treatment. I authorize the physicians of LOWCOUNTRY PLASTIC SURGERY CENTER, LLC to furnish information to insurance carriers or other doctors concerning my illness and treatments. They may also obtain pre-certification, preauthorization, and predetermination when necessary.

Patient's Name: _____ Birthdate _____

Signature: _____ Date: _____

If Legal Guardian, Relationship to Patient _____

LOWCOUNTRY PLASTIC SURGERY CENTER, LLC

AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS, SLIDES AND/OR VIDEOTAPES

INSTRUCTIONS

This is a consent document that has been prepared to help inform you concerning permission to take photographs, slides, and/or videotapes and to use these images for a purpose as defined within this consent document.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

INTRODUCTION

Medical photographs/slides and videotapes may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images.

Additionally, patients may consent to release these medical photography/slides, and videotapes for a stated purpose.

1. CONSENT TO TAKE PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize John M. Hensel Jr., MD and or his/her associates or licensees to take pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes. I additionally consent to photographs, slides, and/or videotapes of my interview.

I understand that such photographs shall become the property of Lowcountry Plastic Surgery Center, LLC and will be retained by Lowcountry Plastic Surgery Center, LLC.

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize John M. Hensel Jr., MD and or his/her associates or licensees to use pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate, including but not limited to showing these images on electronic digital networks, for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups.

I understand that neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features which shall make my identity recognizable.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and /or my interview.

Patient Signature: _____ Date: _____

Witness: _____

LOWCOUNTRY PLASTIC SURGERY CENTER, LLC

HISTORY INTAKE FORM

Please answer all of the questions as accurately as possible. If you do not understand the question, please ask for assistance.

Name: _____ Birthdate: _____ Age: _____
Primary Care Doctor: _____ Referring Doctor: _____
Reason for Consultation: _____
Last Physical Exam _____
Drug Allergies: _____

Previous Surgeries and Major Illnesses with Dates

Medications (Including Non-Prescription Drugs, Vitamins And Herbals)

| | | | |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

PAST MEDICAL HISTORY

Have you ever had any of the following?

| | | |
|-----------------------------|-----------------------------------|-----------------------------------|
| Glaucoma..... no yes | Asthmano yes | Stomach Ulcer.....no yes |
| Anemia no yes | Tuberculosisno yes | Kidney Disease.....no yes |
| Diabetes no yes | Heart diseaseno yes | Hepatitisno yes |
| Cancer..... no yes | Rheumatic Feverno yes | Strokeno yes |
| AIDS or HIV+ no yes | Mitral Valve Prolapseno yes | Arthritisno yes |
| Thyroid Disease..... no yes | High Blood Pressureno yes | Psychiatric Treatmentno yes |

REVIEW OF SYSTEMS

Do you have now or have you had within the past year any of the following?

_____ **Check here if none of the following.**

| | | | |
|-------------------------------|--------------------------|--------------------------|-----------------------------|
| Fatigue yes | Nosebleeds yes | Chest painyes | Muscle pain.....yes |
| Fever..... yes | Vision changes..... yes | Rapid heartbeatyes | Swollen feet/ankles.....yes |
| Weight gain yes | Dry eyes yes | Abdominal painyes | Skin rashyes |
| Weight loss yes | Watering eyes yes | Nausea/Vomitingyes | Skin lesion (mole).....yes |
| Diabetes yes | Glasses yes | Diarrheayes | Dizziness.....yes |
| Easy bleeding yes | Contact lenses yes | Constipationyes | Numbnessyes |
| Easy bruising yes | Neck pain yes | Hernia.....yes | Seizuresyes |
| Swollen lymph nodes yes | Chronic cough..... yes | Joint pain.....yes | Anxietyyes |
| Recent infection yes | Wheezing yes | Back painyes | Depressionyes |

SOCIAL HISTORY

Smoking (type and amount per day): _____ Alcohol (type and amount per day): _____
If former, smoker date quit: _____ Height: _____ Weight: _____

FAMILY HISTORY

Has any blood relative had any of the following?

| | | |
|---------------------------------------|---------------------------------|---------------------------|
| Breast Cancer no yes | Strokeno yes | Diabetesno yes |
| Melanoma no yes | High Blood Pressureno yes | Kidney Disease.....no yes |
| Cancer (list type below) no yes | Heart Diseaseno yes | Depressionno yes |
| Other medical problems _____ | | |

FOR WOMEN ONLY

Age period began _____ Number of pregnancies _____ Nipple discharge yes
Date of last mammogram _____ Did you breast feed?.....yes Breast mass yes
Do you do regular breast self-examinations?yes Breast pain yes

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X _____

Signature of patient or parent if minor

_____ Date