



WILLIAMS
PLASTIC & RECONSTRUCTIVE SURGERY, PC

PATIENT INFORMATION

TODAY'S DATE _____

MR. MRS. MS. MISS

PATIENT'S NAME (FIRST, MI, LAST) _____

*IF PATIENT IS A MINOR AN ADDITIONAL GUARANTOR INFORMATION FORM MUST BE COMPLETED IN ADDITION TO THE FOLLOWING

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____ COUNTY _____

SOCIAL SECURITY # _____ BIRTH DATE _____ AGE _____

MARITAL STATUS: SINGLE MARRIED WIDOW DIVORCED SEPARATED SEX: MALE FEMALE

HOME PHONE # (_____) _____ WORK PHONE # (_____) _____ EXT _____

CELL PHONE # (_____) _____ E-MAIL _____

PREFERRED DAYTIME CONTACT: HOME WORK CELL

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____

EMERGENCY CONTACT HOME PHONE (_____) _____

EMERGENCY CONTACT ALTERNATE PHONE (_____) _____ CELL WORK

PATIENT EMPLOYMENT INFORMATION: FULL TIME PART TIME F/T STUDENT P/T STUDENT RETIRED OTHER

OCCUPATION _____ COMPANY NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

ETHNICITY: AFRICAN-AMERICAN ASIAN CAUCASIAN HISPANIC OTHER _____

IS YOUR VISIT THE RESULT OF AN ACCIDENT? YES NO

WAS AN AUTOMOBILE INVOLVED? YES NO DATE OF ACCIDENT _____

WERE YOU INJURED ON THE JOB? YES NO DATE OF INJURY _____

IF OTHER, GIVE A BRIEF DESCRIPTION OF THE ACCIDENT _____

_____ DATE OF INJURY _____

NAME OF REFERRING DOCTOR _____

NAME OF MEDICAL DOCTOR _____

HOW DID YOU HEAR ABOUT US? _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER _____ SECONDARY INSURANCE CARRIER _____

IF DIFFERENT FROM PATIENT, INSURED PARTY'S INFORMATION MUST BE COMPLETED FOR INSURANCE PURPOSES:

NAME _____ GENDER: MALE FEMALE

ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURED'S EMPLOYER _____ INSURED'S I.D # _____

INSURED'S BIRTH DATE _____ INSURED'S SOCIAL SECURITY # _____

INSURED'S PHONE # (_____) _____ RELATION TO PATIENT _____



WILLIAMS

PLASTIC & RECONSTRUCTIVE SURGERY, PC

AUTHORIZATIONS & PAYMENT AGREEMENT

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

- Consultation Charge Policy:** 24 hour notice of cancellation is required to avoid being charged a consultation fee. If failure to give the required notice or without canceling, you do not keep your reserved appointment, your credit card on file will be charged the appropriate consultation fee (\$40 for non surgical consults, \$75 for surgical consults). If in the future you decide to schedule surgery with our office the consultation fee charged will be deducted from your surgical fees. There is no charge for rescheduling a consultation, however, we kindly ask that you provide 24 hours notice if rescheduling is necessary.
- Unless other arrangements have been made in advance by you or your health coverage carrier, payment in full is expected at the time of service. **ANY COSMETIC SURGERY REQUIRES PAYMENT IN FULL A MINIMUM OF TWO WEEKS PRIOR TO SURGERY.** For your convenience, we will accept VISA and MasterCard.
- Your insurance policy is a contract between you and your insurance company and is only meant to help you with your medical costs; it is not a pay-all. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer we will refund any overpayment to you.
- We have made prior arrangements with many insurers and other health plans to accept assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-payment and your deductible at the time of service. A \$5 billing fee will be added to any co payment not paid at the time of service.
- When assignment is accepted, I hereby authorize payment directly to Williams Plastic & Reconstructive Surgery, P.C. for benefits (including Medicare benefits or major medical) payable under the terms of my insurance or governmental coverage for any services furnished me by Williams Plastic & Reconstructive Surgery, P.C.
- If you have insurance coverage with a plan with which we do not have a prior agreement, in most cases, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, our charges for your care and treatment are due at the time of the service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and signing this Authorizations and Payment form for payment.
- If this account is turned over to collections for non-payment, the patient or responsible party agrees to pay all costs of collection including, but not limited to, 30% collection agency fees, reasonable attorney fees and/or court costs.
- I hereby authorize any physician, hospital, or medical care facility to provide information on my medical history and treatment to Williams Plastic & Reconstructive Surgery, P.C. I also authorize Dr. Joel Williams to release my medical records, if needed, to any physician, hospital, medical care facility or my insurance company for processing of claims.
- PHOTOGRAPH CONSENT:** I hereby grant permission to Williams Plastic & Reconstructive Surgery P.C. and staff to take photographs of me to use for documentation in the doctor's records and/or submit to my insurance carrier for prior authorization for surgery or for proof of disability. These photographs may be used for educational purposes, i.e., publications and/or lectures, both on a National, State and Local level.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM.

BY SIGNING BELOW I AGREE THAT I HAVE READ AND UNDERSTAND THE AUTHORIZATIONS AND PAYMENT AGREEMENT OF WILLIAMS PLASTIC AND RECONSTRUCTIVE SURGERY, PC AND AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND AND AGREE THAT SUCH TERMS MAY BE AMENDED FROM TIME-TO-TIME BY THE PRACTICE.

Date

Signature of Patient or Responsible Party



Patient Consent for Use & Disclosure of Protected Health Information

I hereby give my consent for Williams Plastic and Reconstructive Surgery, PC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Williams Plastic and Reconstructive Surgery, PC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Williams Plastic and Reconstructive Surgery, PC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Williams Plastic and Reconstructive Surgery, PC, Privacy Officer at 1506 Professional Court, Dalton, GA 30720.

With this consent, Williams Plastic and Reconstructive Surgery, PC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Williams Plastic and Reconstructive Surgery, PC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Williams Plastic and Reconstructive Surgery, PC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Williams Plastic and Reconstructive Surgery, PC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Williams Plastic and Reconstructive Surgery, PC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Williams Plastic and Reconstructive Surgery, PC may decline to provide treatment to me.

Print Patient Name

Print Legal Guardian Name

Signature of Patient or Legal Guardian

Date



WILLIAMS
PLASTIC & RECONSTRUCTIVE SURGERY, PC

History & Physical

PATIENT NAME: _____ DATE: _____ AGE: _____

REFERRING DOCTOR: _____

REASON FOR VISIT TODAY: _____

PLACE A CHECK IN THE BOX INDICATING ANY OF THE FOLLOWING CONDITIONS YOU NOW HAVE, HAVE HAD IN THE PAST, OR HAVE NOT HAD:

YES NO

- WEIGHT LOSS OR GAIN _____
- EVER TAKEN PHENTERMINE OR OTHER WEIGHT LOSS MEDICATION _____
- FEVER OR CHILLS, NIGHT SWEATS _____
- SKIN DISORDERS OR ALLERGIES _____
- PROBLEMS WITH EYES OR EARS _____
- PROBLEMS WITH MOUTH, COLD SORES OR FEVER BLISTERS _____
- PROBLEMS WITH THROAT OR NECK _____
- BREASTS _____
- HEART ATTACK, CHEST PAIN, HIGHBLOOD PRESSURE, RHYTHM DISORDERS _____
- LUNG PROBLEMS, ASTHMA, EMPHYSEMA, SHORTNESS OF BREATH _____
- SLEEP APNEA, USE OF CPAP _____
- STOMACH PROBLEMS, ULCERS, ACID REFLUX _____
- INTESTINAL OR COLON PROBLEMS, CONSTIPATION _____
- RECTAL BLEEDING OR CHANGES IN BOWEL HABITS _____
- URINARY, KIDNEY PROBLEMS _____
- DIZZINESS, BLACK-OUTS OR HEADACHES _____
- STROKE, MINI-STROKE (TIA) OR SYMPTOMS _____
- SEIZURE OR NEUROLOGICAL PROBLEMS _____
- MUSCULAR OR BONE PROBLEMS _____
- DEPRESSION, ANXIETY OR PSYCHIATRIC PROBLEMS _____
- DIABETES OR THYROID PROBLEMS _____
- BLOOD CLOTTING OR BLEEDING PROBLEMS _____
- SWOLLEN LYMPH NODES _____
- IMMUNE DISORDERS OR FREQUENT INFECTIONS _____
- HIV OR AIDS _____
- LIVER, JAUNDICE OR HEPATITIS PROBLEMS _____

LIST ANY MEDICATIONS THAT YOU ARE TAKING (INCLUDING HERBS, VITAMINS OR OVER THE COUNTER MEDICINE):

LIST ANY MEDICATIONS THAT YOU ARE ALLERGIC TO, OR STATE "NONE": _____

LIST ANY SURGERIES YOU HAVE HAD IN THE PAST: _____

DID YOU HAVE ANY COMPLICATIONS WITH ANESTHESIA? YES NO

LIST ANY PRIOR HOSPITAL ADMISSIONS & REASON: _____

TOBACCO USE: NONE CIGARETTE, PIPE, OR CIGAR SNUFF CHEWING

ALCOHOL NO YES _____

DRUGS OR SUBSTANCE ABUSE: NONE PILLS SMOKE INJECTION

CHECK ANY CONDITION THAT A BLOOD RELATIVE HAS HAD: NONE DIABETES HIGH BLOOD PRESSURE CANCER
 HEART DISEASE COMPLICATIONS WITH ANESTHESIA

FAMILY HISTORY OF BREAST CANCER (CHECK ALL THAT APPLY) NONE GRANDMOTHER MOTHER
 DAUGHTER SISTER AUNT

FOR WOMEN ONLY

LAST MAMMOGRAM _____ WHERE _____ RESULTS _____

NUMBER OF PREGNANCIES _____ NUMBER OF CHILDREN _____ AGES _____

LIST ANY GYNECOLOGICAL PROBLEMS, OR STATE "NONE": _____

PATIENT'S SIGNATURE

DATE

REVIEWED BY

DATE

FOR OFFICE USE ONLY



WILLIAMS

PLASTIC & RECONSTRUCTIVE SURGERY, PC

Directions to Williams Plastic Surgery

FROM I-75S

Take the ROCKY FACE EXIT. Turn RIGHT onto US-41. You will pass through four traffic lights. Upon reaching the fifth traffic light, turn right onto THORNTON AVENUE. At the next traffic light turn RIGHT onto PROFESSIONAL BLVD. You will turn at the next RIGHT, which is PROFESSIONAL COURT. Williams Plastic Surgery is located on the hill in the cul-de-sac.

FROM I-75N

Take the ROCKY FACE EXIT. Turn RIGHT onto US-41. You will pass through three traffic lights. Upon reaching the fourth traffic light, turn right onto THORNTON AVENUE. At the next traffic light turn RIGHT onto PROFESSIONAL BLVD. You will turn at the next RIGHT, which is PROFESSIONAL COURT. Williams Plastic Surgery is located on the hill in the cul-de-sac.

FROM CLEVELAND HWY

Turn onto US-41 (heading towards I-75). You will pass through one traffic light. Upon reaching the second traffic light, turn LEFT onto THORNTON AVENUE. At the next traffic light turn RIGHT onto PROFESSIONAL BLVD. You will turn at the next RIGHT, which is PROFESSIONAL COURT. Williams Plastic Surgery is located on the hill in the cul-de-sac.

Please call if alternate directions are needed. 706.278.2700