5670 Peachtree Dunwoody Rd NE
Suite 1240, Atlanta, GA 30342
(404) 777-9791

SILK

PLASTIC SURGERY
& WELLNESS

NEW PATIENT INTAKE FORM

REFERRAL NAME: _____

☐ physician ☐ friend ☐ online ☐ other: _____

DEMOGRAPHICS

Full legal name: _____

Preferred name: _____

Date of Birth: _____ Age: _____

Gender / pronouns: _____ Ethnicity: _____

Home address: _____

City, State, Zip: _____

E-mail address: _____

Cell #: _____ Work #: _____

Please check ways that we can leave information for you:
☐ email ☐ voicemail on cell ☐ appointment reminders sent via text messaging

EMERGENCY CONTACT

Emergency contact name: _____

Relationship: _____

Cell phone: _____

Alternative phone: _____

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AUTHORIZATION OF RELEASE OF INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulates how your protected health information is used and disclosed. Our practice and staff are committed to complying with all applicable laws and regulations. By completing the appropriate lines below, you are allowing our practice and staff to release limited health care information. You may revoke this consent, at any time, in writing, to our practice. I hereby give my consent to speak with my family members/spouse regarding office visits, procedures, appointment scheduling, collection of demographic information and insurance billing inquiries.

Please list the names of individuals to whom we are permitted to share information, along with their relationship to you. Feel free to include as many or as few as you wish. You may also leave this blank if you prefer not to share your protected health information with anyone.

Name: _____ Relationship: _____

Phone: _____ Email: _____

Name: _____ Relationship: _____

Phone: _____ Email: _____

Please note any physicians you would like us to allow access to your medical records:

Physician name & specialty: _____

Physician name & specialty: _____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Silk Plastic Surgery, LLC to bill my insurance carrier if applicable for any services rendered by them or any agents of their practice. With this authorization, I assign any and all benefits payable for services rendered by the physicians and associates at Silk Plastic Surgery. I understand that I am responsible for any amount not covered by my insurance plan. I hereby authorize the release of all medical information necessary to the treatment I will receive, including imaging, laboratory, pathology, clinical documentation, and operative reports. A copy of this authorization shall be valid as the original.

_____

Patient/Legal Guardian Signature Date

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AUTHORIZATION FOR MEDICAL PHOTOGRAPHY AND ITS USES

Medical photography is an essential part of plastic and reconstructive surgery. It helps us document your physical changes into your medical record in an honest and transparent manner. These photographs will be part of the medical record and may be subject to release under lawful purposes of disclosure as permitted by HIPAA privacy laws and malpractice laws. I understand that I have the right to refuse to sign this authorization, as well as the right to revoke this authorization in the future. **Please check to authorize any or all the following**:

☐ I hereby authorize my physician(s) and their associates to take pre-operative, intra-operative, and/or post-operative photographs or videos to be obtained and kept confidential for **my medical record** at Silk Plastic Surgery.

☐ I hereby authorize my physician(s) to use the above photos or videos for **professional medical purposes**, including but not limited to patient education in our office, professional conferences and medical journal publications. Please initial here if you would like to preview the photos before any use at professional conferences or medical publications. _____ (initials)

☐ I hereby authorize my physician(s) to use the above photos or videos on **our website or on social media** to educate prospective patients. Before after photos are an essential tool in helping patients find their surgeons. All efforts will be made to de-identify the photos of any prominent tattoos, moles, jewelry, etc. Please initial here if you would like to preview the before/after layout for your approval before it gets published. _____ (initials)

_____ _____
Patient/Legal Guardian Signature Date

RESPECTFUL CONDUCT AGREEMENT

Silk Plastic Surgery is committed to providing high quality healthcare. We believe this is best achieved through healthy relationships and open communication between patients and our team. Every patient and staff member should expect a safe, caring, and inclusive environment in our office. This agreement states that both parties agree to communicate respectfully and professionally, avoiding aggressive, racist or discriminatory language; be open and honest in their interactions, sharing relevant information and concerns; respect each other's time, opinions and boundaries; and work together to resolve any conflicts or misunderstandings in a constructive and respectful manner. Any violation of this agreement may lead to patients being asked to make other plans for their care. You will be given the chance to explain your point of view, and we will always carefully consider your response before any decisions are made. If you witness or are the target of any of these behaviors, please report it to a member of your care team. By signing below, you acknowledge that you have read, understand, and will comply with the terms of this Agreement.

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FINANCIAL POLICY

Our team understands the impact that the cost of your healthcare may have and want to address some current issues related to the cost of services in this office. Considerable care has been taken to set our fees. These fees accurately reflect the complexity of the care rendered, and the skill and expertise required to provide such care.

Most physician fees are above the rate at which insurance companies choose to pay. We cannot and do not allow the payment or allowance of insurance companies to set the amount that we charge for our services. Our policy requires payment at the time of service for office visits and procedures. We are happy to assist you with an itemized statement to help you file your own insurance claim. As a courtesy to you, our office will file your claim to your insurance company, which typically has a 2–4-week turnaround time.

Timely payment for services will help prevent delinquent accounts or any consequences to your credit rating. A delinquent account may be turned over to a collection agency. If this happens, the patient will be responsible for all costs of collection. If you have any questions about our financial policy, please feel free to discuss this with our staff.

I have read and understand my financial responsibilities under this policy.

_____ _____

Patient/Legal Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices (Notice) provides information on how we may use and disclose your protected health information. You have the right to review this Notice before signing this acknowledgment. As indicated in the Notice, its terms may change. If changes occur, you may obtain a revised copy.

By signing this form, you:

1. Acknowledge that you have been informed of the uses and disclosures of your protected health information as described in our Notice.
2. Confirm that you have received a copy of our Notice.
3. Understand the contents of our Notice and how it applies to you.
4. Have had all your questions regarding the Notice answered.

_____ _____

Patient/Legal Guardian Signature Date

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INSURANCE INFORMATION

Insurance Provider: _____

Policy Holder: _____Policy Holder D.O.B: _____

Relationship to member: _____

Group #: _____ Membership #: _____

Effective date: _____ Social Security #: _____

If your visit is filed through insurance, please check with your insurance company to see if you will need a referral from your primary care physician or other referring physician PRIOR to your visit. If your insurance company requires a referral, you are responsible for providing this referral or will be held responsible for any charges your insurance company may incur to you for not having such referral.

If you are a member of an HMO, POS or PPO in which we participate, your deductible and/or co-pay is required at the time of service.

Our office, as a courtesy, will file your claim to your insurance company. We must make it clear that insurance contracts are between you and your insurance company. You are responsible for any amount not paid by your insurance company. By signing below, you agree to the following conditions:

1. You are required to sign informed consent and medical records release forms for documents required by this office and your insurance company.
2. Co-pay / Co-insurance, deductible payments and fees for non-covered services are due at the time of service
3. Your insurance company should provide an Explanation of Benefits to our office and the patient within 30 days of your office visit. If your insurance has not paid within 75 days, then you will be responsible for paying the balance due. Any balance not paid within 90 days will result in an account going into default.
4. Our office cannot guarantee that your insurance company will pay for the services provided.
5. If your insurance claim is denied, you are responsible for the full amount of your balance.
6. Our office will not enter a legal dispute with your insurance company over any claim. This is ultimately your responsibility and obligation.

Patient name (print): _____

Patient/Legal Guardian signature: _____

Witness: _____ Date: _____

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MEDICAL INFORMATION

MEDICAL HISTORY

Check all that apply:

- ☐ High blood pressure
- ☐ Diabetes
- ☐ Heart disease
- ☐ Pacemaker/defibrillator
- ☐ Asthma
- ☐ Lung disease
- ☐ Cancer
- ☐ Breast Cancer
- ☐ High cholesterol
- ☐ Complication w/ anesthesia
- ☐ Blood clot/bleeding disorder
- ☐ Heartburn / GERD
- ☐ HIV
- ☐ Anxiety
- ☐ Depression
- ☐ Other psychiatric condition
- ☐ Neurologic disorder
- ☐ Musculoskeletal disorder
- ☐ Thyroid disorder
- ☐ Stroke
- ☐ Sleep apnea
- ☐ Skin cancer
- ☐ Skin condition _____
- ☐ Other: _____

SURGICAL HISTORY

Procedure: _____ Year: _____
Procedure: _____ Year: _____
Procedure: _____ Year: _____
Procedure: _____ Year: _____
Procedure: _____ Year: _____

MEDICATIONS

_____ _____
_____ _____
_____ _____

MEDICATION ALLERGIES

_____ Reaction: _____
_____ Reaction: _____
_____ Reaction: _____

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REVIEW OF SYSTEMS

Height: _____ Weight: _____

☐ Weight gain/loss	☐ Wheezing	☐ Dizziness
☐ Skin lesions	☐ Abdominal pain	☐ Numbness
☐ Vision changes	☐ Chronic constipation	☐ Fatigue
☐ Sinus issues	☐ Chronic diarrhea	☐ Insomnia / trouble sleeping
☐ Chronic cough	☐ Heartburn	☐ Easy bleeding / bruising
☐ Chest pain	☐ Urinary incontinence	☐ Other: _____
☐ Shortness of breath	☐ Joint pain / stiffness	☐ Other: _____

FAMILY HISTORY

☐ Cancer _____ ☐ Other: _____

☐ Gene mutation _____ _____

☐ Clotting/Bleeding disorder _____ _____

☐ Malignant hyperthermia _____ _____

SOCIAL HISTORY

Occupation: _____

Marital Status: _____ # of children: _____

Exercise: _____ Frequency: _____

Smoking (tobacco, marijuana): _____ Amount: _____/day

Alcohol: _____ Drinks: _____/day

Last mammogram: _____

PHARMACY INFORMATION

Pharmacy name: _____

Address: _____

Phone number: _____