PREMIER IMAGE COSMETIC & LASER SURGERY, P.A.

WILLIAM E. SILVER, M.D. **LOUIS M. DEJOSEPH, M.D.** **MICHAEL A. TOLSON, M.D.**

4553 N. Shallowford Rd. Suite 20-B Atlanta, GA 30338 1100 Northside Forsyth Dr. Suite 310 Cumming, GA 30041
770-457-6303 FAX 770-457-2823 770-888-2999 FAX 770-888-4008
Toll Free: 1-888-455-FACE
Web Site: **www.allaboutcosmeticsurgery.com**

PATIENT INFORMATION

PHYSICIAN: circle one SILVER / TOLSON / DEJOSEPH DATE_____

Full Legal Name_____ **Nickname**_____

Sex_____**Age**_____**D.O.B.**_____ **Race**_____ **Social Security #** _____-_____-_____

Address_____ **City** _____**State**_____ **Zip code**_____

Would you like to receive promotional or informative correspondence via the US Postal Service? YES NO

Home Phone #_____**Cell Phone #**_____ **E-Mail**_____

Marital Status: **Please Circle One** **Single** (never been married) **Married Divorced Widowed Partnered**

Employer_____Occupation_____

Address_____ City_____

State_____ Zipcode_____ **Work Phone#**_____ **Ext.**_____

Spouse's Name_____ Spouse's Employer_____ Occupation_____

Children's names and ages_____

Address_____City_____State_____ZipCode_____

Have you ever been treated here before?____ Have any family or friends been treated here before? ____

If yes, name/relationship/doctor/approx.date_____

Emergency Contact (not living with you) _____
Address_____ Phone #_____

If patient is a minor, please complete this section:
Father's Name_____ Employer_____ Phone# _____
Mother's Name_____ Employer_____ Phone # _____

Person responsible for bill (if other than patient):
Name_____ Relationship _____ Address_____
City_____State_____ZipCode_____Employer_____Phone#_____

REFERRAL SOURCE (please complete)
YELLOW PAGES (**specify**)_____
FRIEND / PATIENT (**specify**)_____
TV OR RADIO AD (**specify**)_____
INTERNET (**specify**)_____
SEMINAR (**specify**)_____
SIGN / WALK-IN _____
PHYSICIAN (**Name & Specialty**)_____
Address _____ **Phone #**_____
OTHER_____

OUT OF STATE AND INTERNATIONAL PATIENTS, PLEASE LET US KNOW IF WE CAN ASSIST WITH YOUR TRAVEL PLANS

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Premier Image Cosmetic and Laser Surgery, P.A. 770/457-6303
Northside Dunwoody Surgery Center 770/455-1983
4553 North Shallowford Rd. Suite 20 B
Atlanta, GA 30338
www.allaboutcosmeticsurgery.com

Effective 4/1/2003

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!

The office/ surgery center is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of your Health Information for Treatment Purposes:

- A nurse obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.
- When calling to confirm your appointment, an employee may leave a voice message on a family machine.

Examples of Uses of your Health Information for Payment Purposes:

We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) request information from us regarding medical care given. We will provide information to them about you and the care given.

Examples of Uses for Your Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol, and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office/ surgery center. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office/ surgery center – we are not required to grant the request, but we will comply with any request granted.

- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office/ surgery center.

- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office/ surgery center.

- Appeal a denial of access to your protected health information, except in certain circumstances.

- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office/ surgery center. We may deny your request if you ask us to amend information that:

    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.

    - Is not part of the health information kept by or for the office/ surgery center.

    - Is not part of the information that you would be permitted to inspect and copy.

    - Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records.

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office/ surgery center.

- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office/ surgery center. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to a family member or friends relevant to that person's involvement in your care or in payment for such care; or uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.

- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office/ surgery center, except to the extent information or action has already been taken.

If you want to exercise any of the above rights, please contact Janet Davies, Practice Administrator at 770-457-6303, 4553 North Shallowford Rd suite 20 B, Atlanta, GA 30338, in person or in writing, during regular business hours (9:00 – 5:00 Monday – Friday). She will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities:

The office/ surgery center is required to:

- Maintain the privacy of your health information as required by law;

- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;

- Abide by the terms of this Notice;

- Notify you if we cannot accommodate a requested restriction or request; and

- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and

requesting a copy of our "Notice" or by visiting our office/ surgery center and picking up a copy.

To Request Information or File a Complaint:

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Janet Davies, Practice Administrator by calling 770/457-6303.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office/ surgery center by delivering the written complaint to Janet Davies. You may also file a complaint by mailing or e-mailing it to the Secretary of health and Human Services, whose street address and email address is: Office/ surgery center for Civil Rights – U.S. Department of Health and Human Services – 200 Independence Avenue SW – Room 509F, HHH Building – Washington, D.C. 20201.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office/ surgery center.

- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses:

Communication with Family:

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification:

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition or your death.

Research:

- We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief:

- We may use and disclose your protected health information to assist in disaster relief efforts.

Food and Drug Administration:

- We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation:

- If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health:

- As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contacting or spreading a disease or condition.

Abuse & Neglect:

- We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Law Enforcement:

- We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight:

- Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/ Administrative Proceedings:

- We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat:

- To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions:

- We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Other Uses:

- Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."

Website:

- This Notice will be on the company website.

Premier Image Cosmetic and Laser Surgery, P.A.
Northside Dunwoody Surgery Center

ACKNOWLEDGEMENT OF ACCEPTANCE OF PRIVACY PRACTICES

I, (print name) _____, accept and understand this office's Notice of Privacy Practices.

_____ _____
Signature of patient or patient representative Date

You may refuse to sign the above acknowledgement.

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgment of acceptance of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

___ Individual refused to sign

___ Communication barriers prohibited obtaining acknowledgement

___ Other (please specify)

_____

_____

_____

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PACTICES

I, (print name) _____, have received or have been offered a copy of this office's Notice of Privacy Practices.

_____ _____
Signature of patient or patient representative Date

THE REQUESTED PERSONAL INFORMATION IS A NECESSARY PART OF OUR EVALUATION. ALL INFORMATION GIVEN TO US IS CONFIDENTIAL.

PERSONAL HISTORY

Please list any medical problems or previous hospitalizations_____
_____

Have you had any serious past illnesses?_____

Please list any accidents or injuries_____

Please list any past surgeries (including minor surgery or surgery as a child)_____
_____

YES NO

___ ___ Do you have any allergies to medication? List medications _____
_____
___ ___ Do you have any food, environmental, or latex allergies? List reactions_____
_____
___ ___ Are you currently taking any drug or medications? How often? List (Include over the counter)_____
____ ___ Do you take vitamins or herbal products? List_____
____ ___ Do you drink more than 6 cups of coffee per day?
____ ___ Do you drink alcohol? How much? How often?_____
____ ___ Do you smoke? How much per day?_____
____ ___ Do you ever get cold sores or fever blisters?_____
____ ___ Do you have skin sensitivities, frequent rashes, or eczema?
____ ___ Have you ever taken Accutane?
____ ___ Do you have a skincare regimen you follow? Describe_____
_____
____ ___ Have you ever received local anesthesia? (Novacaine)
____ ___ Did you have a reaction to anesthesia?
____ ___ Are you a past/present carrier of a contagious disease? Please specify_____
_____
____ ___ Are you or could you be pregnant?
____ ___ Have you taken medicine such as Cortisone or steroid during the past year?
____ ___ Do you have a personal or family history of any bleeding or clotting abnormalities?
____ ___ Do you bleed for more than a half hour after a needle stick?
____ ___ Do you bleed a day or more after surgery or a tooth extraction?
____ ___ Do you bruise easily?
____ ___ Do you bruise without cause?
____ ___ Do you bruise larger than a half dollar?
____ ___ Do you bruise from injections?

DATE OF YOUR LAST PHYSICAL?_____DATE OF MOST RECENT BLOODWORK_____
DATE OF YOUR LAST CHEST X-RAY_____HAVE YOU HAD AN ABNORMAL CHEST X-RAY?_____DATE OF LAST EKG_____HAVE YOU HAD AN ABNORMAL EKG_____

FAMILY PHYSICIAN_____PHONE#_____
SPECIALTY_____

DO YOU HAVE OR HAVE YOU EVER HAD:

YES	NO		YES	NO	
_____	_____	Heart disease or heart trouble	____	____	Mitral valve prolapse
_____	_____	High blood pressure	____	____	Diabetes
_____	_____	Lung disease	____	____	Muscle weakness
_____	_____	Hay fever	____	____	Difficulty urinating
_____	_____	Kidney disease	____	____	Jaundice
_____	_____	Liver disease	____	____	Headache or dizzy spells
_____	_____	Epilepsy/seizures/neurological problems	____	____	Bowel/colon disease or problems
_____	_____	Thyroid or goiter problems	_____	____	Shortness of breath
_____	_____	Chest pain	_____	____	Back or neck trouble
_____	_____	Chronic cough	_____	____	Ulcers/stomach trouble
_____	_____	Recent respiratory infection	_____	____	Do you use eye drops?
_____	_____	Skin trouble/infections/rashes/irritations	_____	____	Treatment of genital area
_____	_____	Keloid or ugly scars	_____	____	Are you easily depressed
_____	_____	Glaucoma	_____	____	Hiatal hernia
_____	_____	Phlebitis	_____	____	Blood transfusion
_____	_____	Problems lying flat	_____	_____	Ankle swelling
_____	_____	Nosebleeds	_____	_____	Facial fractures
_____	_____	Fainting	_____	_____	Anemia
_____	_____	Asthma	_____	_____	Drug or alcohol dependency
_____	_____	Have you considered seeing a psychologist/ therapist	_____		Height
_____	_____	Are you seeing a therapist now?			
_____	_____	Are you on a special diet?	_____		Weight
_____	_____	Recent weight loss (amount)_____			
_____	_____	Any exposure to a communicable disease in the last 3 weeks? Explain_____ _____			

DO YOU HAVE ANY OF THE FOLLOWING: Dentures_____Partial plate_____Bridgework_____

ARE YOU WEARING ANY OF THE FOLLOWING: Contacts___False eyelashes___Hearing aid____ Wig/hairpece_____ Permanent eyeliner or other Permanent cosmetics _____

FAMILY HISTORY: Diabetes____Bleeding____Heart disease____Anesthesia problems_____ Other_____

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW?_____
_____

Signed_____
(Patient or Guardian)

IN WHICH PROCEDURES ARE YOU INTERESTED IN:

_____RHINOPLASTY
_____SEPTOPLASTY (correct breathing problems)
_____FACE OR NECK LIFT
_____MID FACELIFT
_____EYELID SURGERY
_____FOREHEAD / BROW LIFT
_____ENDOSCOPIC / MINIMAL INCISION SURGERY
_____BREAST SURGERY (AUGMENTATION)
    _____BREAST UPLIFT
    _____BREAST REDUCTION
    _____NIPPLE SURGERY
_____ABDOMINOPLASTY (TUMMY TUCK)
_____LIPOSUCTION:
    _____STOMACH
    _____THIGHS
    _____HIPS
    _____BACK / LOVE HANDLES
    _____ANKLES
    _____KNEES
_____THIGH LIFT
_____ARM LIFT
_____CHEEK AUGMENTATION
_____CHIN ENLARGEMENT
_____CHIN REDUCTION
_____FACIAL / NECK LIPOSUCTION
_____DEEP SMILE LINES
_____REMOVAL OF FACIAL LESIONS
_____SCAR REVISION
_____LASER SKIN RESURFACING
_____CHEMICAL PEEL
_____LIP ENLARGEMENT
_____LIP REDUCTION
_____REMOVAL OF PROMINENT VEINS ON FACE
_____CORRECTION OF PROTRUDING EARS
_____DERMABRASION
_____COLLAGEN INJECTIONS
_____BOTOX
_____ADVANTA
_____ALLODERM
_____FAT TRANSFER
_____RESTYLANE
_____LINES AROUND LIPS
_____LINES AROUND EYES
_____COSMETIC DENTISTRY
_____SKIN CARE PRODUCTS
_____LASER FACIALS
_____MICRODERMABRASION
_____LASER HAIR REMOVAL
_____HAIR REPLACEMENT SURGERY

WHAT SPECIFICALLY DO YOU WISH TO HAVE CHANGED?_____
_____

WHEN DID YOU BEGIN TO CONSIDER SURGICAL CORRECTION?_____
_____

HAVE YOU CONSULTED WITH ANY OTHER DOCTORS ABOUT THIS?(WHEN)_____
_____

HAVE YOU DISCUSSED THIS SURGERY WITH YOUR FAMILY? ____YES ____NO
ARE THEY AGREEABLE? ____ YES ____NO
HAVE YOU HAD PREVIOUS COSMETIC SURGERY? ____YES ____NO
WHEN AND WHAT WAS DONE?_____
_____
WHERE WAS THE SURGERY PERFORMED?_____
BY WHOM?_____
WERE YOU SATISFIED WITH THE RESULTS?____IF NOT,WHY?_____
_____
HAVE YOU HAD ANY OTHER SURGERY OR INJURY TO THE AREA?_____DESCRIBE WHAT AND WHEN_____
HAS ANYONE IN YOUR FAMILY OR A CLOSE FRIEND HAD COSMETIC OR RECONSTRUCTIVE SURGERY?_____WHAT WAS DONE?_____
WHEN?_____BY WHOM?_____

INSURANCE INFORMATION

Do you have insurance coverage?_____

Name of insurance company_____

Name of Policy Holder_____ Date Of Birth_____

ID#_____Group#_____

Address for claims_____

Phone #_____
(Please have your insurance card ready to present to the receptionist.)

AUTHORIZATION AND ASSIGNMENT OF BENEFITS (Please sign both)

I authorize William E. Silver, M.D., Michael A. Tolson, M.D., and Louis M. DeJoseph, M.D. to furnish information to insurance carriers only concerning my illnesses and treatments.

Date_____Signature_____

I assign to William E. Silver, M.D., Michael A. Tolson, M.D., and Louis M. DeJoseph, M.D. all payments for medical services rendered to me or my dependent. I understand that I am responsible for any amount not covered by assigned insurance.

Date_____Signature_____

A photocopy of this authorization and assignment shall be considered as valid as the original.

It is customary to pay for professional services when rendered. Itemized receipts will be furnished on request. Patients are asked to file for routine office visits with their respective insurance companies. In the event of surgery, it is the patient's responsibility to furnish us with appropriate insurance forms on which to file surgery charges. The patient is responsible for all fees, regardless of insurance coverage.

PHOTOGRAPHY CONSENT

I hereby give my permission to William E. Silver, M.D., Michael A. Tolson, M.D., and Louis M. DeJoseph, M.D. or any assistant he may designate, to take photographs for diagnostic purposes, to enhance the medical report, during surgery, and postoperatively for evaluation purposes. I agree that these photographs will remain his property.

Date_____Signature_____

I further authorize him to use such photographs for teaching purposes or to illustrate scientific papers, books, or lectures if, in his judgement, medical research, education, public education, or science will be benefited by their use. It is specifically understood that in any such publication or use, I shall not be identified by name.

Date_____Signature_____