

# STATESBORO PLASTIC SURGERY

(912) 681-3330

(Please Print Legibly & Fill In or Correct All Fields)

## Patient's Name

Last

First

Middle

Address

Street & Apt #

City

State

Zip

Home Phone

Cell Phone

Other Phone

Any restrictions for contacting you?

No

Yes

E-mail

Race

Ethnicity

Language

Age

Birthdate

SS#

Sex

Female

Male

Marital Status

Single

Married to:

Other:

## Patient's Employer

Occupation

Work Phone

Ext:

Is it okay to call you at work?

Yes

No

Address

Street & Suite #

City

State

Zip

## Emergency Contact

(Not in your household)

Relationship to Patient

Home Phone

Work Phone

Other Phone

Address

Street & Apt #

City

State

Zip

## Please list your Primary Care Provider

## How did you hear about us?

Google

Facebook

Instagram

Driving by

Seminar

Doctor

Friend/Relative

Website

Other

## Parent Information if the patient is a minor under the age of 18

Guardians Name

Date of Birth

Phone Number

Guardians Employer

Work #

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Bisseck to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Bisseck and myself. I further understand that any portion of the bill that the insurance company or responsible party does not cover is my responsibility. For any disputes of financial policy, the patient waives his/her right to privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) guidelines. I hereby agree that if my bill has to be turned over to a third party collection agency for non payment, there will be a collection fee added to my bill. This is pursuant to Georgia Statutory Law "O.C.G.A. -13-1-11".

Signature

Date

# STATESBORO PLASTIC SURGERY – HISTORY & PHYSICAL

Name:	Date:
What are you being seen for today?(Please be specific)	
If this is a result of an accident, give the date of injury.	
--Please describe how the accident occurred.	

**Are you allergic to any medications? NO  YES  Please List:**

PAST MEDICAL HISTORY				CURRENT MEDICATIONS			
	Yes	No		Yes	No		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/> <input type="checkbox"/> <b>CHECK HERE IF YOU ARE NOT ON ANY MEDS</b>
Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> 1. _____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/CVA/TIA	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/> <input type="checkbox"/> 2. _____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/> <input type="checkbox"/> 3. _____
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/> <input type="checkbox"/> 4. _____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> 5. _____
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<u>Other (please list below)</u>	<input type="checkbox"/> <input type="checkbox"/> 6. _____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/> 7. _____
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/> 8. _____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/> 9. _____
Cancer _____			Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> <input type="checkbox"/> 10. _____
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	COPD	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> 11. _____

ROS	Please check all CURRENT positive findings
Constitutional	Weight loss <input type="checkbox"/> Fevers <input type="checkbox"/> Chills <input type="checkbox"/> Poor appetite <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight gain <input type="checkbox"/> Insomnia <input type="checkbox"/> Night sweats
Eyes	Blurry vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Eye discharge <input type="checkbox"/> Eye redness <input type="checkbox"/> Decrease in vision <input type="checkbox"/> Dry eyes <input type="checkbox"/> Double vision
ENT	Sore throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Ear pain <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ear discharge <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Tinnitus <input type="checkbox"/> Sinus problems
Cardiovascular	Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Rapid heart rate <input type="checkbox"/> Heart murmur <input type="checkbox"/> Poor circulation <input type="checkbox"/> Swelling in the legs or feet
Respiratory	Shortness of breath <input type="checkbox"/> Chronic cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> History of Tuberculosis <input type="checkbox"/> Excess sputum production
Gastrointestinal	Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in the stool <input type="checkbox"/> Frequent heartburn <input type="checkbox"/> Trouble swallowing
Skin	Rash <input type="checkbox"/> Hives <input type="checkbox"/> Hair loss <input type="checkbox"/> Skin sores or ulcers <input type="checkbox"/> Itching <input type="checkbox"/> Skin thickening <input type="checkbox"/> Nail changes <input type="checkbox"/> Mole changes
Musculoskeletal	Joint pain <input type="checkbox"/> Muscle aches <input type="checkbox"/> Frequent leg cramps <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Bone pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Back pain
Endocrine	Goiter <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Increased thirst <input type="checkbox"/> Change in skin pigment <input type="checkbox"/> Excess sweating
Neurological	Seizures <input type="checkbox"/> Tremors <input type="checkbox"/> Migraines <input type="checkbox"/> Numbness <input type="checkbox"/> Dizziness/Vertigo <input type="checkbox"/> Loss of balance <input type="checkbox"/> Slurred speech <input type="checkbox"/> Stroke
Psychiatric	Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Alcohol or drug dependence <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Panic attacks <input type="checkbox"/> Use of anti-depressants
Genitourinary	Increased urinary frequency <input type="checkbox"/> Blood in the urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Painful urination <input type="checkbox"/> Urinary retention <input type="checkbox"/> Frequent UTIs
Hem/Lymphatic	Low blood count <input type="checkbox"/> Easy bruising <input type="checkbox"/> Swollen lymph nodes <input type="checkbox"/> Transfusions <input type="checkbox"/> Prolonged bleeding <input type="checkbox"/> Blood clots
Allergic/Immun	Allergic reactions <input type="checkbox"/> Hay fever <input type="checkbox"/> Frequent infections <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV positive <input type="checkbox"/> Positive tuberculin skin test (PPD)

**SOCIAL HISTORY:**

Marital Status \_\_\_\_\_ Occupation \_\_\_\_\_ Non-Smoker  Ex-Smoker  (how long ago quit?) \_\_\_\_\_

Current Smoker  Light Smoker  Heavy Smoker (How many packs/day and how long?) \_\_\_\_\_

Alcohol consumption: Never  Occasional  Frequent \_\_\_\_\_ Illegal drugs use: Yes  No

# STATESBORO PLASTIC SURGERY – HISTORY & PHYSICAL

## Patient Past Surgeries/Hospitalizations (IF NONE PLEASE WRITE NONE ON THE FIRST LINE)

Surgery/Hospitalization	Date	Anesthesia complications	Notes

## Female Questions

	Yes	No	N/A	Details
Do you have children? If yes, please list number of pregnancies & ages of children.				
Do you have regular periods?				
Are you going through menopause?				
Are you pregnant or lactating?				
During pregnancy, did you ever get hyperpigmentation or masking?				
Have you had any mammograms?				Results:
Current Bra Size				

## Patient Family History

	YES	Family Member
Pt denies any contributing family hx	<input type="checkbox"/>	
Abnormal Bleeding	<input type="checkbox"/>	
Abnormal Clotting	<input type="checkbox"/>	
Anesthesia Problems	<input type="checkbox"/>	
Autoimmune Disorder	<input type="checkbox"/>	
Brain Tumor	<input type="checkbox"/>	
Breast Cancer	<input type="checkbox"/>	
Cleft Lip	<input type="checkbox"/>	
Cleft Palate	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	
Drug Allergies	<input type="checkbox"/>	
Endocrine Disease	<input type="checkbox"/>	
Hearing Loss	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	
Hemophilia	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	
Liver Disease	<input type="checkbox"/>	
Lung Cancer	<input type="checkbox"/>	
Malignant Hyperthermia	<input type="checkbox"/>	
Other Cancer	<input type="checkbox"/>	
Ovarian Cancer	<input type="checkbox"/>	
Prostate Cancer	<input type="checkbox"/>	
Skin Cancer	<input type="checkbox"/>	
Skin Disease	<input type="checkbox"/>	
Substance Abuse	<input type="checkbox"/>	

Body Size	Details
Height (ft)	
Height (in)	
Weight (lbs)	
Recent weight changes	



Dear Patient,

We would like to take this opportunity to welcome you to Statesboro Plastic Surgery and to familiarize you with some of our policies. Enclosed you will find your new patient paperwork. Please complete it before you arrive for your appointment.

Our office is open from 8:30AM to 5:00PM, Monday through Thursday and 8:30AM to 1:00PM on Friday. Some of the services we offer include; Breast Augmentation, reduction and lift; liposuction; tummy tuck; Juvederm and Botox injections; laser hair reduction; mole evaluation; various hand treatments and surgeries, including carpal tunnel syndrome.

**SPECIAL ASSISTANCE:** If you require special assistance (wheelchair, transfer to exam table, language, etc.) please let our office know prior to your arrival for the appointment so that we may make arrangements to get you the assistance you need, if possible.

**WAIT TIME/APPOINTMENT RESCHEDULES:** Everyone here at Statesboro Plastic Surgery understands that your time is just as valuable as ours. We make every effort to keep your time to an absolute minimum. However, from time to time, it may be necessary for us to reschedule your appointment, or the wait to see the doctor may be extended as our physician is on-call for emergencies with the local hospital. In these rare instances we kindly ask for your understanding and cooperation. These situations are unexpected and unpredictable but, be assured that we will make every effort to minimize your inconvenience.

**MISSED APPOINTMENTS:** *If you are unable to keep your scheduled appointment, please give our office at least a 24 hour notice. A \$25.00 fee will be charged for no-shows.*

**PAYMENTS AND INSURANCE:** *Full payment is required when a cosmetic consultation is scheduled and for all non-insured patients a payment is due at the time of service. For your convenience, we accept cash, MasterCard, Visa, American Express, and Discover credit cards. Cosmetic consultations and new patient fees are between \$50.00 and \$150.00.*

As a courtesy to our patients, we file all insurance claims, even if we are not providers for the insurance. It is your responsibility to furnish our office with a current copy of your insurance card(s). For patients whose insurance has a co-pay, the co-pay must be paid on the day of service. For patients without insurance or insurance that we are not providers for, payment in full is due at the time of service unless PRIOR arrangements are made with management.

**ACCIDENTS (someone else may be responsible for payments):** In accidents, legal cases, etc., where you, the patient, believes someone else is responsible for the medical expense, **YOU AS THE PATIENT ARE RESPONSIBLE FOR PAYMENT.**

This office cannot be expected to wait for court conclusions or disputed insurance settlements. We will, however, help with any paperwork, etc. needed for reimbursement from the third party believed to be liable for the medical expenses.

**\*\*\*PLEASE NOTE\*\*\*** any accidents, such as cuts, burns, falls, etc., filed with health insurance may result in a follow-up form from your insurance. This **MUST** be filled out and returned immediately! All outstanding balances will become your responsibility until these forms are filled out and returned. We **DO NOT** file AUTO or THIRD PARTY liability insurance but we will provide you with a claim form to send to your insurance. If you are unsure if this policy applies to you please contact our office.

**REQUEST FOR MEDICAL RECORDS:** For patients requesting copies of their medical records, there **will be a \$25.00 charge.**

**WORKERS' COMP:** In a **Workers Compensation case**, we must have an authorization from your employer or their insurance carrier to provide medical services. If your claim is denied you are responsible for payment of the services provided.

Thank you for selecting our office, we look forward to serving you in the future. If we may be of any further assistance, please contact our office at (912)681-3330.

## **PAYMENT POLICIES FOR COSMETIC PATIENTS & PROCEDURES**

Before we can schedule you for surgery, a 30% deposit must be paid. This deposit is **NON-REFUNDABLE**.

The total cost of the procedure must be paid **NO LATER THAN 1 WEEK PRIOR TO YOUR SURGERY**. If we have not received your payment by that time, your procedure will be cancelled and your deposit will not be refunded.  
Payment cannot be made on the day of surgery.

If you are not able to mail us your payment or come to the office, we can take your credit card over the phone.  
There will be a 3% fee added to the charge for all credit card payments over a \$1,000.00.

### **No Show/Late Cancellation Policy**

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case-by-case basis.

**A prepayment of \$100.00 will be required for all initial Cosmetic Consultation appointments and is Non-refundable if less than 24 hours' notice is given.**

**A charge of \$50.00 will be assessed for each no show or late cancellation for all cosmetic appointments if less than 24 hour notice is given.**

By signing below I am agreeing that I have read and understand the above information. I completely understand the payment policies and procedures described to me by the office staff as well as in the document. I have no remaining questions about when payment is due and what types of payments are accepted.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Financial Policy Regarding Revision and Complications

Every plastic and reconstructive surgeon has a few patients who will require revision or have some complications requiring additional surgery. As you have been or will be told, one cannot guarantee a result. In cosmetic procedures there are certain problems that will happen statistically no matter how good the care or how careful the doctor and team. Examples of problems that may be encountered are bleeding or an unfavorable scar after a surgical procedure. In both of these cases, it may be necessary to return the patient to surgery, either on an emergency basis (as in the case with bleeding) or an elective basis (as in the case of scarring). It is our policy as a predetermined courtesy to our patients not to charge a surgeon's fee for complications or revisional surgery within 6 months from the original surgery date. We do, however, expect the patient to pay whatever other expenses arise as a result of treatment in hospital or outpatient settings. If the revisional surgery occurs, the patient is responsible for the expense of the facility and anesthesia. Sometimes the patient will have insurance that will cover these revisions or complications. It depends upon the individual policy and how it is written. When a person does have insurance, the insurance company is billed for the surgeon's fee as well as the facility fees.

We hope that no complication arises and no revisional surgery is necessary in your case. However, no plastic surgeon can guarantee this to their patients. It is important for the patient undergoing an elective surgical procedure to understand this financial policy. If you have any questions regarding this policy, the office staff would be happy to discuss it with you.

My signature below indicates that I understand and agree to the above policy.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES  
PATIENT ACKNOWLEDGMENT FORM**

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that the privacy policy has been made available to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature

## Picture Release

I am a patient of Statesboro Plastic Surgery. I give my permission to Statesboro Plastic Surgery to utilize my preoperative and postoperative photographs to be shown for one or more of the following purposes: (i) my medical record, (ii) promotional brochures, (iii) patient education materials, (iv) instructional videos, (v) medical journals, (vi) websites, (vii) social media (the practice and individual staff members), and (viii) other formats.

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

By making this authorization, I understand that:

- I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- I will not be paid in any way for the use of pictures/digital images or videos of me.
- The information released in response to this authorization may be re-disclosed to other parties.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
- This authorization shall be in force and effect until revoked by me in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Online Communication

Online communication is a form of communication using “secure” Web sites or e-mail applications that apply appropriate encryption technology designed to protect the transmission of confidential information

The details of online communication have been explained to me in terms I understand.

Alternative methods of communication (telephone, in-person, mail) are still available to me.

I understand that all medical communications carry some level of risk. While the likelihood of risks associated with the use of online communication in a secure environment is substantially reduced, the risks are nonetheless real and very important to understand. These risks include but are not limited to:

- *It is easier for online communication to be forwarded, intercepted, or even changed without my knowledge.*
- *Online communication is easier to falsify than handwritten or signed hard copies. Backup copies may exist on a computer or in cyberspace, even after both of us have deleted our copies.*
- *It is my responsibility to use a secure network.*
- *Online communications become part of my medical record.*

I agree to take precautions to keep online communication confidential, including but not limited to the following:

- *I will keep my password confidential.*
- *I will store messages on a secure computer.*
- *I will not leave messages on my screen for others to read.*
- *I will update my contact information as soon as it changes.*

I understand that I am responsible for taking steps to protect myself from unauthorized use of online communication. Statesboro Plastic Surgery is not responsible for breaches of confidentiality caused by an independent third party or me.

I agree to follow the procedure Statesboro Plastic Surgery implements to allow SPS to verify my identity in connection with online communication. I acknowledge that failure to comply with these procedures may terminate our online communication. I understand that online communication cannot be used for emergencies or time sensitive matters

I understand that online communication cannot be used to communicate highly sensitive medical information, such as treatment or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

I have informed Statesboro Plastic Surgery of any information I do not want transmitted via online communications.

I understand that it is my responsibility to determine if an unanswered online communication was received.

I acknowledge that I have read and fully understand this consent form, including the risks associated with the online communication. Statesboro Plastic Surgery has answered all of my questions.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_