Killingsworth
CENTER FOR PLASTIC SURGERY

GENERAL PATIENT DATA

Patient Name: _____ ☐ M ☐ F Date: _____

Date of Birth: _____ SSN: _____ ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Email Address: _____ Cell Phone: _____

Home Phone: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Pharmacy: _____ Preferred Pharmacy Phone: _____

Address: _____ City: _____

State: _____ Zip Code: _____

I was referred to your office by: _____

I am here today because I: _____

My current goals for plastic surgery/procedures include: _____

_____

HEALTH HISTORY

I am **ALLERGIC TO THE FOLLOWING MEDICATIONS:** _____

_____

I have the following additional **ALLERGIES:** _____

_____

I **TAKE THE FOLLOWING MEDICATIONS:** _____

_____

I have had the following **SURGERIES:** _____

_____

I am presently under a **DOCTOR'S CARE** for the following conditions: _____

_____

I would describe my **PRESENT STATE OF HEALTH** as: _____

_____

I ☐ am / ☐ am NOT a **CURRENT** smoker.

I ☐ am / ☐ am NOT a **FORMER** smoker. Smoked: ____ PPD for ____ years

Killingsworth
CENTER FOR PLASTIC SURGERY

Whom may we contact in the event of an emergency?

Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I attest the above history is completed to the best of my knowledge. I understand and accept that my failure to disclose any of the above information can adversely affect a prescribed course of treatment to meet my goals, my safety, or the outcome of any treatment I elect to undergo with Dr. Christopher Killingsworth or any member of our staff.

Patient Signature: _____ **Date:** _____

Review of Systems (Please check any symptoms you are experiencing)

General/Constitutional
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Weight Changes

Skin
- ☐ Rash
- ☐ Itching
- ☐ Hives

Breast
- ☐ Breast Lumps
- ☐ Breast Pain
- ☐ Swelling
- ☐ Nipple Discharge

Ear/Nose/Throat
- ☐ Nose Bleeding
- ☐ Sore Throat
- ☐ Ear Pain

Cardiovascular
- ☐ Chest Pain with Rest
- ☐ Chest Pain on Exertion
- ☐ Difficulty Breathing
- ☐ Fluid Accumulation in the Legs
- ☐ Shortness of Breath at Rest

Endocrine
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Excessive Thirst

Respiratory
- ☐ Cough
- ☐ Shortness of Breath on Exertion
- ☐ Wheezing

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Blood in Stool
- ☐ Diarrhea
- ☐ Vomiting

Genitourinary
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood in Urine

Musculoskeletal
- ☐ Muscle Aches
- ☐ Back Pain
- ☐ Painful Joints

Neurologic
- ☐ Confusion
- ☐ Dizziness
- ☐ Headache

Psychiatric
- ☐ Depression
- ☐ Mood Swings
- ☐ Memory Loss

Killingsworth
CENTER FOR PLASTIC SURGERY

PATIENT PRIVACY AND CONSENT – FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby consent to the use or disclosure of my protected health information by the practice of Christopher Killingsworth, M.D. hereinafter referred to as ("Practice"), for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by the Practice may be conditioned upon my consent as evidenced by my signature on this document.

I understand that payment for procedures that are aesthetic or cosmetic in nature are my sole responsibility and will not be billed to any third party. I understand that payment for such procedures may be requested in advance of any treatment. I understand there are no warrantees, implied or otherwise, to the outcomes of any treatments or procedures.

I have been offered, read and/or understand the Practice's *Notice of Privacy Practices*, which has been offered to me by the practice, prior to signing this document. I understand that patient privacy rights and disclosure varies state by state. I also understand that the *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations. This *Notice of Privacy Practices* also describes my rights and the Practice's duties with respect to my protected health information. The *Notice of Privacy Practices* for the Practice is available at the office:

4150 Deputy Bill Cantrell Memorial Road – Suite 240 – Cumming, Ga – 30040

Terms of the *Notice of Privacy Practices* may change. If changes are made, I may obtain a revised *Notice of Privacy Practices* by calling the offices of the Practice and requesting a revised copy be sent in the mail, or by requesting one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative if the Patient is a Minor Date

_____

Printed Name of Patient or Personal Representative

_____

Relationship of Personal Representative to the Patient

_____

Signature of Practice Representative and Witness

Killingsworth
CENTER FOR PLASTIC SURGERY

FINANCIAL POLICY

Thank you for choosing Killingsworth Center for Plastic Surgery for your plastic surgery needs.

RESPONSIBILITY

As a recipient of our services, you are responsible for the charges associated with the services you receive. We will assist you in applying for financing if this is a need. This is a service we offer our patients. It is YOUR responsibility to fully understand the financing options before you apply. You remain legally and fully responsible for your entire bill. This includes payments made over the phone.

INSURANCE AND COSMETIC SURGERY

Cosmetic Surgery procedures are **NOT** covered under health insurance. Any attempt to obtain insurance payment for those services is fraudulent. Our office will not assist anyone attempting to defraud an insurance company, this office or any other entity. Attempting to defraud an insurance company, this office or any other entity may result in civil and/or criminal penalties.

TREATMENT COMPLICATIONS AND REFUNDS

The practice of medicine and surgery is not an exact science. Although good results are anticipated, there can be no guarantee or warranty, expressed or implied, by anyone as to the actual results that you may get. Surgical revisions and/or other medical treatment or management of problems and/or complications may be required. These will result in additional charges for which you will be responsible. Refunds will not be issued under any circumstances. For cases involving liposuction, patients will be eligible for revision only if they have not exceeded their goal weight post-procedure.

REVIEW POLICY

We strive to provide you with exceptional care and results. We appreciate your referrals and review of our practice. In the rare instance that you are dissatisfied, we will address your concerns in a private and personal manner that will always protect your private information. In addition, you understand the reputation of our business is important and that negative reviews online can be viewed as slanderous and detrimental to our business. As our patient, you agree not to post negative reviews online.

SURGERY SCHEDULING, RE-SCHEDULING & CANCELLATION POLICIES

SCHEDULING AN IN-OFFICE PROCEDURE

In order to schedule your office procedure/surgery with Killingsworth Center for Plastic Surgery, we require that you pay 30% of your procedure fee as a deposit. The remaining balance will be due, in-full, three weeks prior to your procedure at your pre-op appointment. Because there are processing fees that are incurred when scheduling a surgery, $750 of this 30% deposit will be non-refundable if a surgery is cancelled and *not* re-booked 21 business days or more prior to your scheduled surgery date. Surgeries that are re-scheduled will incur a fee as listed below:

RESCHEDULING SURGERY

It is important that when you schedule your surgery with Killingsworth Center of Plastic Surgery you have thoroughly reviewed your personal calendar to make sure that your scheduled surgery date is ideal for you. Costs incurred by our office to re-schedule your procedure will be assessed according to the schedule below if another patient cannot be moved into your surgical appointment time. If your time can be filled with another patient, the fee will be waived.

*If surgery is rescheduled 14 business days or more prior to your surgery date, you will be charged a $500 re-schedule fee. Payment will be collected prior to your procedure.

*If surgery is re-scheduled 2-13 business days prior to your surgery date, you will be charged a $1,000 re-schedule fee.

*If surgery is re-scheduled 48 hours or less prior to your surgery date, you will be charged a $1,500 re-schedule fee.

CANCELLING SURGERY

It is important to understand that surgical times are in high demand. By cancelling your appointment with less than a 30 day notice, Killingsworth Center for Plastic Surgery may incur the cost of an empty OR suite, staffing, supplies and anesthesia costs as stated above. In addition to this, there are billable services that occur as we prepare for your surgery and are included in your surgery fee. If you choose to cancel your procedure, as a patient you are still financially responsible for these services. An itemized bill of these services will be provided to you within 14 days of receiving your cancellation request.

***All cancellation requests are required in writing to the office. You can either email Kyndal@KillingsworthPlasticSurgery.com or Fax to (678) 208 – 6375.**

*If surgery is cancelled and not re-scheduled 30 business days or more prior to surgery, your 50% surgery deposit will be refunded, with the exception of the $750 non-refundable fee.

*If surgery is cancelled and not re-scheduled within 15-20 business days prior to surgery, you will be charged 25% of your surgery, operating room, and anesthesia fee.

*If surgery is cancelled and not re-scheduled within 2-14 business days prior to surgery, you will be charged 50% of your surgery, operating room, and anesthesia fees.

*If surgery is cancelled and not re-scheduled in less than 48 hours prior to your surgery, you will be charged 75% of your surgery, operating room, and anesthesia fees.

**Any refund from cancellations will be subject to our financial review process. Once reviewed, your refund will be processed and will be received within 60 business days.

***Reconstructive surgery billed through insurance will incur a $250 cancellation fee if surgery is cancelled within 14 business days of scheduled surgery date. This fee will be in addition to the cosmetic cancellation fee (above) if the surgery is a combination of insurance and cosmetic surgery.

PROCESSING FEES

If you request FMLA, disability, or any other paperwork to be completed, please bring all documents with you to your pre-op appointment. Complete all line items requiring information pertaining to the employee. Failure to do so may delay completion of your paperwork. Be aware that the office will complete your paperwork within 15 business days, and there is a $50 processing fee due when you submit your paperwork.

Patient Signature: _____ **Date:** _____

Patient Name: _____ **Date:** _____

Killingsworth
CENTER FOR PLASTIC SURGERY

ASSIGNMENT OF BENEFITS STATEMENT

I request that payment of authorized benefits be made payable to Christopher Killingsworth M.D. for any services furnished to me by Killingsworth Center for Plastic Surgery. I authorize Christopher Killingsworth M.D. and associates, to release to the Insurer and its agents any information needed to determine these benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

_____ _____

Patient Signature or Parent/Guardian if the Patient is a Minor Date

"**PLEASE PROVIDE YOUR MEDICARE & INSURANCE CARDS**"

I request that payment of supplemental insurance benefits be made payable to Killingsworth Center for Plastic Surgery for any services furnished to me by Christopher Killingsworth M.D. to release to my insurance company named below, and its agent, any information needed to determine these benefits payable to related services.

Name of Insurance Company: _____

I request that payment of authorized Medicare benefits be made payable to Christopher Killingsworth M.D. for any services furnished to me by Killingsworth Center for Plastic Surgery. I authorize Christopher Killingsworth M.D. and associates, to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA – 1500 Form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare Carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Patient Signature Date

MEDICARE SUPPLEMENT INSURANCE ASSIGNMENT OF BENEFITS

I request that payment of supplemental insurance benefits be made payable to Killingsworth Center for Plastic Surgery for any services furnished to me by Christopher Killingsworth M.D. to release to my insurance company named below, and its agent, any information needed to determine these benefits payable to related services.

Name of Insurance Company: _____

_____ _____

Patient Signature Date