Jain Plastic Surgery, P.C.

(706) 322-9313 FAX: (706) 322-9314

Welcome to Our Office. Thank you for choosing Jain Plastic Surgery. In order to serve you properly, PLEASE PRINT and complete the following information forms. Thank you for choosing Janin Plastic Surgery.

TODAY'S DATE:_____

Name			AGE
Address		City/State/Zip	
SSN:	Birthdate:	Marital Status:	Gender:
Home Phone number:	Work Phone number:	Cell Phone number:	Email:
Spouses Name:	Spouses Birthday:	Spouses SSN:	
Employer:	Address:		
Occupation:		Full/Part/Student/Retired/Other:	
Emergency Contact Name: ER Contact Home phone number:		Relationship: ER Contact Work phone number:	

Primary Care Physician:

If patient is a child, who may authorize treatment:	Relationship:

Person financially responsible for treatment if not Self:

Address of person financially responsible:	Phone:

Referral Source

(Please mark all that apply)

□ Newspaper □ Billboard and Signs □ Newspaper □Word of Mouth □ Seminar □ Our Website

□ Doctor (Which one) □ Magazine (Which one) □ Ad on another website □ Facebook □ TV □ Other:

Name_____ Name_____

□ Friend/Relative:□_____

Areas of Interest: (mark all that apply)

Facial Procedures

- ❒ Blepharoplasty (Eyelid Lift)
- ❒ Botox
- ❒ Brow or Forehead Lift
- ❒ Earlobe Repair
- ❒ Facial Liposuction (Neck, Jowls)
- ❒ Face or Neck Lift
- ❒ Lip Enhancement
- ❒ Otoplasty (Ear Pinning)
- ❒ Rhinoplasty (Nose Reshaping)
- ❒ Skin Resurfacing (La er, Peel, Etc.)
- ❒ Soft Tissue Fillers (Injections) (Voluma, Juvaderm, Restalyne, Kebella)

Breast Procedures

- ❒ Breast Augmentatio
- ❒ Breast Reconstruction
- ❒ Breast Reduction
- ❒ Mastopexy (Breast Lift)
- ❒ Nipple Reduct on or Inversion

Body Procedures

- ❒ Abdominoplasty (Tummy Tuck)
- ❒ Brachioplasty (Arm Lift)
- ❒ Belt Lipectomy
- ❒ Liposuction (Thighs, Abdomen, Etc.)
- ❒ Thigh or Buttock Lift

Other Procedures

- ❒ Skin Care
- ❒ Lesions / Moles
- ❒ Telangectasia (spider veins)
- ❒ Laser Hair Removal
- ❒ Laser Tattoo Removal

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices is contained in a condensed version of our Notice of Privacy Practices. Our full-length notice is in The HIPAA Compliance Plan Notebook: Date of Last Revision: 03/18/2003

This information is made available on request by a patient

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.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information: Here are a few examples (for more detail please refer to the Notice of Privacy Practices
that follows this summary):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights please see the detailed Notice of Privacy Practices that follows this summary.

COMPLIANCE ASSURANCE NOTIFICATION FOR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Forms Completion Policy

While disabled from working, many of our patients and/or family members ask that their doctors assist them in the completion of special forms which cover payments for credit cards, car payments, mortgage payments, insurance, short-term or long term disability income and Family Medical Leave Act, etc. The staff of Jain Plastic Surgery is happy to assist with the completion and the time involved in their completion our office is forced to implement the following policy. Please read the following carefully:

- There is a minimum charge of $25.00 per form for completion of FMLA and Disability forms.
- For more extensive or detailed paperwork, there will be a greater charge
- Forms are completed only after the payment is received.
- Forms are completed in the order that they are received.

Once the form and payment are received please allow 7-10business days for the completion by our office.

We do not interrupt patient care to fill out forms. Please make sure to plan accordingly.

- The forms cannot be completed until the physicians note from your most recent office visit is transcribed. On average, this is 24-48 hours. No forms are completed on an emergent or rushed basis as our clinical and surery schedule do not allow for this.

- Forms should be given to the support staff in the front office. Please do not give to our our physican nor clinical staff

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- If you need a form filled out, these can be dropped off with the payment at the front office or they can be mailed with payment to: Jain Plastic Surgery, P.C., 2522 Warm Springs Road, Columbus Georgia 31904. Please do not fax forms to our office.
- If you are unable to pay the fee for the completion of the form you could seek to gain the same by requesting a copy of your medical record. Please inquire about this option with our front office.
- **Forms received without payment will be returned to you uncompleted.**

Thank you for your cooperation.
Jain Plastic Surgery, P.C.

I have read and understand the policy listed above.

_____ DATE_____

SIGNATURE OF PATIENT OR GUARDIAN

PATIENT NAME _____ **Age** _____ **Date**_____

Why are you seeing Dr. Jain today?

_____

Marital Status:Married □ Single □ Divorced □ Widowed □**.** Do you have children? Yes□ No□ How many? _**__**

Have you been diagnosed with Depression, Anxiety, Schizophrenia or any other mental disorder? Yes □ No □
Please list name of treating physician: _____.

Past Surgical History

_____ _____ _____
_____ _____ _____

Have you had any problems with anesthesia? _____

Past hospitalizations

_____ _____ _____

List current medications and dosage

_____ _____ _____
_____ _____ _____
_____ _____ _____

FAMILY HISTORY	**Yes**	**No**	**Relationship**
Skin cancer			
Breast cancer			
Diabetes			
Heart Disease			
Vascular Disease/Stroke			

Are you allergic to Betadine? Yes □ No □ **Are you allergic to Latex?** Yes □ No □
Are you allergic to any medications? Yes □ No □
Please list.

_____ _____ _____
_____ _____ _____

Do You use nicotine products? Yes □ No □ Smoke or non-smokeless_____ Packs per day or how often do you use nicotine products? _____ Vapor Inhaler_____ When did you quit? _____

Do you drink Alcohol? Yes □ No □ How much?_____ How often? _____

Do you have any history of narcotic addiction? Yes □ No □
Do you make thick scars? Yes □ No □**.** **Have you ever been diagnosed with "resistant staph infection" (MRSA)** Yes □ No □

Height _____ Weight _____

Please check if you have any problems with the following:

HEENT	**GI**
☐ Eyes	☐ Weight:Sudden Increase or Decrease
☐ Ears	☐ Indigestion
☐ Headaches	☐ Nausea, Vomiting
☐ Mouth, Teeth	☐ Diarrhea
☐ Thyroid	
LUNGS	**GU**
☐ Cough	☐ Blood In Urine
☐ **C**oughing Up Blood	☐ Pain When Urinating
☐ Shortness of Breath	☐ Frequent Urination
☐ Asthma/Emphysema	
	MENSTRUAL REPRODUCTIVE
	☐ Last Monthly Period
CARDIOVASCULAR	☐ Heavy Periods
☐ High Blood Pressure	☐ Postmenapausal
☐ Rheumatic Fever	
☐ Chest Pain	**MUSCULOSKELETAL**
☐ Ankle Swelling	☐ Arthritis
☐ Heart Attacks	☐ Back Pain
☐ Shortness of Breath	
☐ Palpitations(Rapid Heart Beat)	**NEUROLOGICAL**
☐ Exercise Tolerance Good?	☐ Strokes
	☐ Seizures
SKIN	☐ Passing Out
☐ Rashes	
☐ **Non-healing** Lesions/sores	**BLOOD SYSTEM**
☐ Changes in Moles	☐ Low Blood Count
☐ Development of thick scars	☐ Bleed easily from gums when brushing
	☐ Bruise easily

I certified that the completion of the medical documentation above is accurate and I'am aware that the treating physician has the necessary information from me to make an informed decision regarding my past medical history.

Signature _____ Date _____

Jain Plastic Surgery, P.C.

Jain Plastic Surgery, P.C., and its associates, may utilize and bill for providers that may not be in your specific provider network. These charges are normally paid by your medical insurance company from your "Out of Network" benefits criteria. You may be held responsible for all allowed charges. If this is a concern, our insurance and billing personnel will be glad to speak with you prior to your visit. I understand that I am responsible for any amount not covered by my insurance. Failure to pay these will result in my added responsibility to pay any and all collection costs.

_____
Initials

Consent for Services and Insurance Assignment of Benefits

I hereby authorize and consent to Jain Plastic Surgery, P.C. and its associates to provide any necessary treatments for my illness and/or medical/cosmetic services. Furthermore, I authorize Jain Plastic Surgery, P.C. and its associates to furnish private health information to insurance carriers concerning my illness and treatments for processing of Pre-Certifications, notifications and medical claims. I also authorize photography for the purposes of insurance billing, treatment planning and those related to medical education.
I hereby assign to Dr. Jain, Jain Plastic Surgery, P.C. and/or its associates, all payments for medical services rendered to me or my dependent. I understand that I am responsible for any allowed amounts not covered by my insurance, including deductibles, co-pays, co-insurance and other provided services.

_____ _____
Signature of Patient/Guardian Printed Name of Patient/Guardian

_____ _____
Date Witness Signature

PLEASE GIVE CURRENT INSURANCE CARD(s) and PHOTO IDENTIFICATION TO OFFICE.

Communication Authorization

When it comes to medical treatment, we strive to communicate with you in a timely and professional manner. You authorize Jain Plastic Surgery P.C. to leave messages with, discuss my treatment, appointments or other scheduling issues that may occur or give other information as necessary to the following family, friends or personal representatives. I understand that Jain Plastic Surgery, P.C. and its associates, will refuse to discuss my information with any non-medical provider not listed below, except in the case of an emergency.
Please list below those individuals with whom you authorize our office to discuss aspects related to your care.

Name: _____ Name: _____
Relation to Patient: _____ Relation to Patient: _____

Name: _____ Name: _____
Relation to Patient: _____ Relation to Patient: _____

Ways that Jain Plastic Surgery P.C. and associates can contact me (check all that apply):

□ Home Telephone □ Okay to leave message
□ Work Telephone □ Okay to leave message
□ Mobile Telephone □ Okay to leave message
□ Text Message to mobile number
□ Email Message
□ Written communication to home address

Patient Signature: _____ Date: _____

I,_____, authorize Jain Plastic Surgery, P.C. , and/or their representative(s), to take photographs, slides or videotapes of me or parts of my body for surgical procedure(s):, and for medical purposes to be used for my care, medical presentations and/or articles.

In addition, I authorize the use of these images, without compensation to me, to be used in advertisements, including web based advertisements for prospective patients.

I understand that:

1. Such photographs, slides or videotapes may be published by Dr.Jain and/or Jain Plastic Surgery, P.C. in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about dermatology methods. I understand that such uses may also include marketing on behalf of Dr.Jain, for which Dr.Jain may receive direct or indirect remuneration.

2. I will not be identified by name; however, I also understand that in some circumstances the photographs, slides, or videotapes may display features that identify me.

3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to **Jain Plastic Surgery, P.C. 2522 WarmSprings Road, Columbus Ga 31904.** A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization.

4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Jain and/or Jain Plastic Surgery, P.C.

5. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.

6. A copy of this Authorization is valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

I release and discharge Dr. Jain and/or Jain Plastic Surgery, P.C. from all liability, including liability for negligence that in any way arises out of:

- any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization; and

- any claim that I may have or may have had relating to such use and disclosure of those photographs, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public education and I certify that I have read this Authorization and Release carefully and fully understand its terms.

If I have questions about the use or disclosure of my photographs, slides, or videotapes, I can contact **Dr. Jain** at 706.322.9313.

Signature _____ Date _____

Witness _____

PHOTOGRAPHIC AUTHORIZATION AND RELEASE