Joel L. Shanklin, M.D.
Luke J. Curtsinger, III M.D.
Meghan K. McGovern, M.D.
Michael R. Huntly, M.D.

900 Mohawk Street Suite A
Savannah, GA 31419
(912) 920-2090
www.greatsurgeonsgreatresults.com

Patient Information

Patient Name:_____ Date of Birth:_____ Age:_____

Address:_____ SSN:_____

City:_____ State:_____ Zip:_____ Gender:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email:_____ Primary care physician?_____

How did you hear about our office?

___Yellow Pages ___Another Patient/Friend: _____
___Radio
___Billboard ___Dr. Referral: _____
___Google
___Website ___Other:_____

Emergency Contact Information

Name:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

IF THE PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING SECTION:

Name of Parent/Guardian: _____ DOB:_____ Age: _____

SSN:_____ Sex: ___M ___ F

Address:_____ City:_____ State:_____ Zip:_____
(if different than above)

PLEASE READ CAREFULLY AND SIGN BELOW:

I,_____ , represent to the physicians and staff that I am at least eighteen (18) years of age, if not, I am accompanied by a legal guardian. I hereby consent to and authorize examination and the treatment by my doctor and such assistant or staff, as may be assigned by him/her. I authorize payment of any medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. I understand that there may be a consultation fee for the initial visit for uninsurable consultations, which is due when services are rendered. I also understand that copays are due at the time of each visit.

Signature: _____ **Date: _____**

RELATIONSHIP TO PATIENT: ___PATIENT ___SPOUSE ___LEGAL GUARDIAN ___POWER OF ATTORNEY

Insurance Information

Primary: _____ Effective Date: _____

Member ID/Policy #:_____ Group #:_____

Policy Holders Name: _____ Relationship to Patient: _____

Policy Holders SS#: _____ Date of Birth: _____ Sex:___ M ___F

Policy Holders Employer: _____ Copay: ___No ___Yes: $_____

Is this a: __PPO __POS __HMO Does your visit require a referral: ___No ___Yes

Authorization/Referral #_____ **Preferred Lab**:_____

Secondary: _____ **Effective Date:** _____

Member ID/Policy #:_____ Group #:_____

Policy Holders Name: _____ Relationship to Patient: _____

Policy Holders SS#: _____ Date of Birth: _____ Sex:___ M ___F

Policy Holders Employer: _____ Copay: ___No ___Yes: $_____

Is this a: __PPO __POS __HMO Does your visit require a referral: ___No ___Yes

Authorization/Referral #_____ **Preferred Lab**:_____

ACCIDENTS (If your injury is a result of an accident, please fill out this section)

___Worker's Comp ___Auto ___Other:_____ Date of Accident: _____

Was injury reported to employer: ___Y ___N
Accident Details: _____

Insurance Co Name: _____ CLAIM # _____
Insurance Co Address:_____ Employer: _____
_____ Employer Phone: _____
Insurance Co Phone: _____
Policy Holders Name: _____ Attorney: _____
Policy Holders Address: _____ Attorney Phone: _____
_____
Policy Holders Phone: _____

*****If left unmarked or unsure of lab, we will utilize the services of Southeastern Pathology as they are contracted with the majority of insurance carriers and commercial labs.*****

PAYMENT POLICY:

HMO, PPO or other managed care patients: You will be responsible for paying your annual deductible, co-payment and co-insurance for any insurable charges.

Commercial Patients: Patients who are covered by private or commercial plans in which our physicians are out of network will be held responsible for all out-of-network charges accrued. All applicable co-payments will be collected at the time services are rendered.

IMPORTANT: Please present your insurance card (s) and your photo ID to the receptionist. The receptionist will make a copy and return them to you promptly.

Medical and Surgical History

PRINT NAME: _____

Occupation: _____ Height: _____ Weight: _____lbs # of Children: _____

Medical Allergies:_____

Environmental/Food Allergies: _____

Right Handed_____ Left Handed_____ Ambidextrous_____ Age: _____

Please list ALL medications you are currently taking. Please include vitamins, birth control, aspirin, diet pills, herbal supplements, and any health food store or over the counter supplements.

Name:	Dosage:	Frequency:

Please list ALL surgeries, medical problems, and illnesses that you have had including plastic surgery.

Date:	Surgery/Illness:	Comments:

Have you or anyone in your family ever had problems with anesthesia: ___Yes ___No Who:_____
What Happened:_____

Physical Work: ____Omit ___Light ___Moderate ___Heavy Hours Per Day:_____
Exercise: ___Omit ___Light ___Moderate ___Heavy Hours Per Day:_____
Aspirin: ___None ___Yes Qty/Day:_____ How Many Years:_____
Alcohol: ___Never Beers/wk:_____ Liquor/wk:_____ Wine/wk:_____ How Many Years:_____
Tobacco: ___Never ___Discontinued ___Current Type:_____ Qty:_____ How Many Years:_____
Caffeine: ___None ___Yes Cups/day:_____ How Many Years:_____
Have you ever used: ___LSD ___Speed ___Cocaine ___Marijuana ___None

Please Describe What Brings You Here:
Consultation for:_____
Follow up for:_____
Date symptoms began:_____
Frequency of Symptoms:__Constant __Intermittent __Occasional __Rare __Recurrent
Intensity of Symptoms: __Mild __Moderate __Severe __Excruciating
Duration:_____ **Location**:_____
Type of Pain: __None __Aching __Burning __Continuous __Cramping __Deep __Delayed __Dull __Gnawing

__Gradual __Intermittent __Periodic __Sharp __Shifting ____Sudden __Superficial __Other:_____
How did symptoms start:_____
How did symptoms progress:_____
What brings it on:_____
What makes it worse:_____
What relieves it:_____
Associated Symptoms:_____
Pain radiates to:_____
Antibiotic usage:_____

For Patients Interested in Breast Surgery:
Bra Size:_____ Desired Bra Size:_____ Date of last Mammogram:_____ normal or abnormal?

Review of Systems:

EXTREMITIES
__Hand infection
__Hand injury
__Muscle or joint pain
__Leg swelling
__Swollen/Red joint
__Hand pain
__Hand numbness
__Hand weakness
__Waking up from hand pain/numbness
__***Negative For All***

NEUROLOGICAL
__Loss of facial expression
__Weak grip
__Paralysis
__Stroke
__Epilepsy
__Head/Spinal Injury
__Myasthenia gravis
__Mental Illness
__Seizures
__Tingling/Burning/Numbness
__Depression
__***Negative For All***

SKIN
__Abscess
__Wound
__Burns
__MOHs excision
__Human bite
__Animal bite
__Varicose veins
__Laceration
__Suspicious lesions/moles
__Skin cancer
__Skin color changes
__Tendency to sunburn
__***Negative For All***

CARDIOVASCULAR
__MI/Heart attack
__Cardiovascular disease
__Coronary or peripheral artery disease
__High blood pressure
__Abnormal EKG
__Mitral valve prolapse
__Blood clots in lungs or legs
__Irregular heartbeat
__Aneurysm
__Rheumatoid fever
__***Negative For All***

PULMONARY
__Asthma/wheezing
__Bronchitis
__Tobacco Use
__Shortness of breath
__Sleep apnea
__***Negative For All***

ENDOCRINE
__Thyroid disorder
__Diabetes
__***Negative For All***

HEENT
__Nasal deformity
__Facial fractures
__Dry eyes
__Nasal obstruction
__Double vision
__Recent head trauma
__Problem with proper fitting teeth
__***Negative For All***

CONSTITUTIONAL
__Pain
__Weakness/Fatigue
__Fever/Chills
__Weight Loss
__***Negative For All***

BREASTS
__Breast deformity
__Small breasts
__Normal breast size
__Breast skin changes
__Breast masses
__Neck pain from large breasts
__Breast pain
__Back pain from large breasts
__Bra strap creating grooves in shoulder
__Personal/Family history of breast cancer
__***Negative For All***

ABDOMEN
__Heartburn/Reflux
__Nausea/Vomiting
__History of GI Problems
__Hernias
__Liver Disease/Jaundice
__Renal/Kidney disorder or infection
__Currently Pregnant
__LMP
__***Negative For All***

HEMATOLOGICAL
__Blood disorder
__Spontaneous or Prolonged bleeding
__Aids/HIV
__Hepatitis
__***Negative For All***

SURGICAL COMPLICATIONS
__Wound complications
__Bleeding complications
__Post op swelling of limbs
__Anesthesia complications
__Postop shortness of breath
__Postop fevers
__Difficulty voiding
__History of Postop vomiting/nausea
__***Negative For All***

Patient Signature:_____ Date:_____

Consent to Communicate

Patient Name:_____
Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call
____Call Home	____Yes ____No	____Yes ____No	____	
____Call Cell	____Yes ____No	____Yes ____No	____	
____Call Work	____Yes ____No	____Yes ____No	____	
____Send Email -			____	
	____Email Appointment Reminders or Additional Scheduling Information			
	____Email Office Specials			
	____Email Medical Information			
____Regular Mail			____	
____Text Message If ok, Please list Cell Carrier (e.g., AT&T):_____			____	
	____Text Appointment Reminders or Additional Scheduling Information			
	____Text Office Specials			
	____Text Medical Information			

(Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message)

If it's ok to leave a message with another person, please list them:

Name	Relationship	Ok to Release Results	Comments
		__ Yes __ No	
		__ Yes __ No	

Signature:_____ **Date:_____**

Consent to Photograph or Film

I, _____, Do _____ /Do Not _____ give permission for photographs and other ausiovisual and graphic materials to be used by Coastal Empire Plastic Surgery, P.C. and/or Shanklin Plastic Surgery Center for marketing, education, or promotion purposes. Although the photographs or accompanying material WILL NOT contain my name or any other identifying information, I am aware that I may or may not be identified by photos.

I have read and understand this agreement, and all my questions have been addressed and answered to my satisfaction. I agree to the terms of this policy

Signature:_____ **Date:_____**

Patient Name: _____

PLEASE REVIEW CAREFULLY-This notice describes how medical information about you may be used and disclosed, and how you can get access to this information.

Treatment – Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment, or who may be consulted by staff members.

Payment – Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services provided, and the medical condition being treated.

Health Care Options – Your health information may be used as necessary to support day to day activities and management of Coastal Empire Plastic Surgery. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement – Your health information may be disclosed to law enforcement agencies to support government audits and inspectors, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting – Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the states public health department.

Type of Facility – Private for profit physician owned facility.

Other uses and disclosures require your authorization. Disclosure of your health information or its uses for any other purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Appointment reminders – Your health information may be used by staff to send you appointment reminders.

Information about Treatments – Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights – You have certain rights under federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your private health information
- The right to amend or submit corrections to your health information
- The right to receive an accounting of how and whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Coastal Empire Plastic Surgery Duties:
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices:
As permitted by law, we reserve the right to amend or modify our practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information:
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulations, we require that request to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Medical Records Clerk or the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Advance Directives: Do you have an advance directive? ____Y ____N If yes, please provide a copy.

It is the policy of Coastal Empire Plastic Surgery to ask each patient about advance directives they may have executed and place a copy in the medical record. However, it will not be enforced as long as the patient is present and being treated. If an emergent event occurs, the patient will be treated and stabilized then transferred to St. Joseph hospital where a copy of the advance directives will be sent along with other pertinent patient information. If you are interested in information regarding advance directives, you can contact:

Georgia Division of Aging Services:
2 Peachtree St. NW, Suite 9.398, Atlanta GA 30303-3142, or call the divisions information and referral specialist at (404) 657-5319. Copies of the advance directive forms and its instructions are available at no cost to you at the following websites:
http://aging.dhr.georgia.gov/DHR-DAS/GEORGIA%20ADVANCE%20DIRECTIVE%20FORHEALTH%20CARE-07.PDF
http://gha.org/publications/public/other/AdvanceDirective.pdf

Any grievances may be filed in writing at anytime to:
Attn: Office Manager
Coastal Empire Plastic Surgery
900 Mohawk St, Suite A
Savannah, GA 31419

All grievances will be reviewed within 2 business days. Notification of the grievance process includes: whom to contact to file a grievance; that he or she will be provided with a written notice of the grievance determination that contains the name of the facility contact person, the steps taken on his or her behalf to investigate the grievance, the results of the grievance and the grievance completion date within 5 business days.

Complaints Against the Surgery Center:
DCH-HFRD Complaint Dept.
2 Peachtree St NW, Suite 31.477
Atlanta, GA 30303-3142
(404) 657-5726 or 5728
1-800-878-6442

Complaints Against the Physician:
Composite State Board of Medical Examiners
Attn: Ms. Gladys Henderson, Complaints Unit
2 Peachtree St NW, 36th FL
Atlanta, GA 30303-3142
(404) 657-6487

Or Medicare recipients may contact The office of the Medicare Beneficiary Ombudsman at http://www.medicare.gov/navigation/help-and-support/ombudsman.asp

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes of office policy. I understand that this consent shall remain in force from this time forward. I received the previous information verbally and in writing.

Signature:_____ **Date:**_____

Patient Billing Information:

We are a plastic surgery office as well as an ambulatory surgery center (ASC). If you are scheduled for a procedure in our office, it may be necessary for this procedure to be performed at our ASC. Charges for use of the ASC (operating room & surgical supplies) are billed SEPARATELY from the surgeon's fee as well as any general anesthesia charges.

Example:
If you have a MINOR procedure, you will be billed for the physician fee under Coastal Empire Plastic Surgery, and you will be billed for the ASC under Shanklin Plastic Surgery Center.
If you have a MAJOR procedure, you will be billed for the physician fee under Coastal Empire Plastic Surgery, and you will be billed for the ASC and general anesthesia charges under Shanklin Plastic Surgery Center.
We do not separate statements for the physician and ASC. All charges will be reflected on one statement.

For additional questions, contact:
Patient Acct. Manager- Barbara Keel, CPC
Coastal Empire Plastic Surgery, PC
Shanklin Plastic Surgery Center, LLC
(912) 920-5624
bkeel@ceplastic-surg.com

Signature:_____ **Date:**_____

Shanklin Plastic Surgery Center

900 Mohawk St Ste A
Savannah, GA 31419

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/ OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits. In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above-named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tortfeasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.
I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.
Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.
I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____

Patient Signature

_____

Print Name

_____

Date