

**Jain Plastic Surgery, P.C.**  
**2522 Warm Springs Road, Columbus, Georgia 31904**  
**(706) 322-9313 FAX: (706) 322-9314**

**Welcome to Our Office**

**TODAY'S DATE:**

Thank you for choosing our office. In order to serve you properly, PLEASE PRINT the following information.			
Name			AGE
Address		City/State/Zip	
SSN:	Birthdate:	Marital Status:	Gender:
Home Phone number:	Work Phone number:	Cell Phone number:	Pager:
Fax:	Email:	Other Contacts:	
Employer:		Address:	
Occupation:		Full/Part/Student/Retired/Other:	
Emergency Contact Name:		Relationship:	
ER Contact Home phone number:		ER Contact Work phone number:	
Spouse Name:	Spouse SSN:	Spouse Employment:	Spouse Employment ph#
Primary Care Physician:			Spouse Birthday:
Insured Party Primary Person:		Address:	
Primary Insurance:	Policy number:	Group number:	
Insured Party Secondary Person:		Address:	
Secondary Insurance:	Policy number	Group number:	
If patient is a child, who may authorize treatment:			Relationship:
Person financially responsible for treatment if not Self:			
Address of person financially responsible:			Phone:
If Workers Compensation, treatment authorized by:			Claim #:

## Referral Source

(Mark all that apply)

- Newspaper     Columbus and the Valley     Southern Views     Bayonet     Word of Mouth     Seminar     Web  
 Doctor     Other:

Friend/Relative: \_\_\_\_\_

If you were referred by a specific person, may we thank them?     Yes     No

## 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 (Laser, Peel, Etc.)
- Soft Tissue Fillers (Injections)

### Breast Procedures

- Breast Augmentation
- Breast Reconstruction
- Breast Reduction
- Mastopexy (Breast Lift)
- Nipple Reduction 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   | ■ For research  |
| ■ To obtain payment for our services  | ■ To avert a serious threat to health or safety                             |
| ■ In emergency situations   | ■ For organ and tissue donation   |
| ■ For appointment and patient recall reminders  | ■ For workers' compensation programs  |
| ■ To run our Practice more efficiently and ensure all our patients receive quality care | ■ 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 request restrictions                |
| ■ The right to amend                        | ■ The right to a paper copy of this notice         |
| ■ The right to an accounting of disclosures | ■ The right to request confidential communications |

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

### **PATIENT CONSENT FORM** (Acknowledgement of receipt of privacy practices summary)

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that it in your best interest.

We also want you to know that we support your full access to your personal health information, but this must be in writing. Under the law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Compliance Assurance Notification For Our 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. There will be a greater charge for more detailed or extensive forms.
- 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 7-10 business 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 – 28 hours.
- **No forms are completed on an emergent or rushed basis as our clinical and surgery schedules do not allow for this.**
- Forms should be given to the support staff in the front office. Our physician cannot receive forms during your examination. 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 the payment to: Jain Plastic Surgery, P.C., 2522 Warm Springs Road., Columbus, GA 31904. Forms should not be faxed to our office.
- If you are unable to pay the fee for the completion of the form you could seek to gain the same information from a copy of your Medical record. Please inquire about this option with our front office staff.
- **Forms received without payment will be returned to you uncompleted.**
- If you are a patient under Workers Compensation these forms are not paid under Workers Compensation these forms are not paid under Workers Compensation.
- Due to Federal Privacy guidelines, these forms can only be faxed or mailed to the patient. We are unable to fax or mail these forms to any other entity but the patient.

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

I have read and understand the policy listed above.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

**Jain Plastic Surgery, P.C.**  
**Insurance Assignment of Benefits**

I hereby authorize JAIN PLASTIC SURGERY, P.C. to provide treatment for my medical problems and to furnish information to insurance carriers concerning my illness and treatment and hereby assign to Dr. Jain all payments for medical services rendered to my dependent or myself. I understand that I am responsible for any amount not covered by my insurance. I also authorize photography for purposes of insurance billing, treatment planning and those related to medical education.

By signing this form, I am consenting to JAIN PLASTIC SURGERY, P.C. use and disclosure of my PHI (Personal Health Information) to carry out TPO (Treatment, Payment and Healthcare Operations).

\_\_\_\_\_

Date

Signature \_\_\_\_\_

Witness My hand and Seal

Print Name of Patient/Guardian \_\_\_\_\_

PLEASE PRESENT CURRENT INSURANCE CARDS AND PHOTO IDENTIFICATION  
FOR COPYING.

**Contact Consent**

With my consent JAIN PLASTIC SURGERY, P.C. may call my home or other designated location and leave a message on a voice mail or in person on reference to any items that assist the practice in carrying out TPO (Treatment, Payment and Healthcare Operations), such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. With whom may we leave a message?

Person (s) \_\_\_\_\_

Phone Number \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PATIENT NAME \_\_\_\_\_ Date \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

**CHIEF COMPLAINT (Why are you seeing Dr. Jain today?)**

\_\_\_\_\_

**PAST MEDICAL HISTORY**

List Surgeries that you have had: \_\_\_\_\_

\_\_\_\_\_

Have you had any problems with anesthesia? \_\_\_\_\_

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List Reasons that you were Hospitalized \_\_\_\_\_

**List all current medications and dosage**

(1) \_\_\_\_\_ (2) \_\_\_\_\_

(3) \_\_\_\_\_ (4) \_\_\_\_\_

(5) \_\_\_\_\_ (6) \_\_\_\_\_

**FAMILY HISTORY**

Is there a family history of skin cancer or breast cancer? Yes \_\_\_ No \_\_\_

If so, please list age and relationship of each person? \_\_\_\_\_

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Diabetes \_\_\_\_\_ Heart \_\_\_\_\_

Vascular/stroke \_\_\_\_\_

**SOCIAL HISTORY**

Marital Status: Married  Single  Divorced  Widowed

Do you have children? Yes  No  How many? \_\_\_\_\_

Do You Smoke? Yes  No  How much? \_\_\_\_\_

When did you quit? \_\_\_\_\_

Do you drink Alcohol? Yes  No  How much? \_\_\_\_\_

How often? \_\_\_\_\_

**MENTAL HISTORY**

Have you been diagnosed with Depression, Anxiety, Schizophrenia or any other mental disorder? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please list name of treating physician: \_\_\_\_\_.

**ALLERGIES TO MEDICATIONS:** \_\_\_\_\_

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**Please check if you have any problems with the following:**

<b>HEENT</b>	<b>GI</b>
<input type="checkbox"/> Eyes	<input type="checkbox"/> Appetite
<input type="checkbox"/> Ears	<input type="checkbox"/> Weight, Sudden Increase or Decrease
<input type="checkbox"/> Headaches	<input type="checkbox"/> Indigestion
<input type="checkbox"/> Mouth, Teeth	<input type="checkbox"/> Nausea, Vomiting
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Diarrhea
<b>LUNGS</b>	<b>GU</b>
<input type="checkbox"/> Cough	<input type="checkbox"/> Blood In Urine
<input type="checkbox"/> Coughing Up Blood	<input type="checkbox"/> Pain When Urinating
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Coughing Up Much Phlegm	
<input type="checkbox"/> Asthma/Emphysema	<b>MENSTRUAL REPRODUCTIVE</b>
<b>CARDIOVASCULAR</b>	<input type="checkbox"/> Last Monthly Period
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Periods Regular
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Heavy Periods
<input type="checkbox"/> Chest Pain	<b>MUSCULOSKELETAL</b>
<input type="checkbox"/> Ankle Swelling	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Heart Attacks	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Shortness of Breath	
<input type="checkbox"/> Palpitations (Rapid Heart Beat)	<b>NEUROLOGICAL</b>
<input type="checkbox"/> Exercise Tolerance Good?	<input type="checkbox"/> Strokes
	<input type="checkbox"/> Seizures
<b>SKIN</b>	<input type="checkbox"/> Passing Out
<input type="checkbox"/> Rashes	
<input type="checkbox"/> Lesions That Do Not Heal	<b>BLOOD SYSTEM</b>
<input type="checkbox"/> Changes in Moles	<input type="checkbox"/> Low Blood Count
<input type="checkbox"/> Development of thick scars	<input type="checkbox"/> Bleed easily from gums when brushing
	<input type="checkbox"/> Bruise easily

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

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