

Current Patient Information

Reason for today's visit (LIST PROCEDURES): _____

Date: _____

SSN#: _____ - _____ - _____

DOB: _____

DL# _____ State: _____

Age: _____ Marital Status: M / S / D / Other

Name: _____

Spouse/Significant Other's name: _____

Home address: _____

City: _____ State: _____ Zip code: _____

Home phone: () _____ - _____ Work phone: () _____ - _____

Email Address (used for confirming appointments and occasional special offers/programs): _____

Emergency contact (someone not living with you): _____

Relationship: _____ Phone #: () _____ - _____

Your Employer: _____ Phone # () _____ - _____

Employer's address: _____

City: _____ State: _____ Zip code: _____

Manager's name: _____

Primary Information:

How did you hear about us? (circle) Friend Prior patient Star 94 Q100 Website Magazine Newspaper Other

Please specify which person/website/magazine/etc you saw us in: _____

Where you referred to our office by a physician? Yes / No Doctor's name: _____

Primary Physician: _____

Primary Physician's address: _____

City: _____ State: _____ Zip code: _____

Phone: () _____ - _____ Fax: () _____ - _____

Personal Health History

Date: _____

Name: _____

DOB: _____

Please answer all questions as accurately as possible. If you do not understand the question, please ask for assistance.

Primary care doctor: _____

Last time seen: _____

Social History:

Smoking (type and amount per day): _____ Alcohol (type and amt/wk) _____

If former smoker, date quit: _____ Weight: _____ Height: _____

Drug Allergies: _____

List previous surgeries or major illnesses and dates: _____

List any medications you are taking, including non-prescription drugs, vitamins, and herbals: _____

Family History:

Has any relative ever had the following:

Breast cancer	N	Y	High blood pressure	N	Y	Kidney disease	N	Y
Melanoma	N	Y	Heart disease	N	Y	Depression	N	Y
Stroke	N	Y	Diabetes	N	Y	Blood clots (in legs or lungs)	N	Y

Past Medical History:

Have you ever had the following:

Heart disease	N	Y	Cancer	N	Y	Stomach Ulcer	N	Y
Arthritis	N	Y	Glaucoma	N	Y	Kidney Disease	N	Y
Rheumatic fever	N	Y	Asthma	N	Y	Thyroid Disease	N	Y
Anemia	N	Y	AIDS or HIV	N	Y	Bleeding tendency	N	Y
Tuberculosis	N	Y	Stroke	N	Y	Mitral Valve Prolapse	N	Y
Diabetes	N	Y	Hepatitis	N	Y	High Blood Pressure	N	Y
						Blood clots (in legs or lungs)	N	Y

Review of Systems:

Do you have now or have you had within the past year:

Constitutional:

Fever	N	Y
Weight loss	N	Y

Eyes:

Dry eyes	N	Y
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ENT:

Allergies	N	Y
Chronic cough	N	Y

Cardiovascular:

Chest pain	N	Y
Swollen feet/ankles	N	Y
Rapid heartbeat	N	Y

Respiratory:

Difficulty breathing	N	Y
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Gastrointestinal:

Chronic diarrhea	N	Y
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Jaundice

Genitourinary:

Painful urination	N	Y
Bloody urine	N	Y

Psychiatric:

Depression	N	Y
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Neurologic:

Dizziness	N	Y
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Musculoskeletal:

Joint pain	N	Y
Muscle pain	N	Y

Integument:

Skin rash	N	Y
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Hematologic/Lymphatic:

Swollen lymph nodes	N	Y
Easy bruising	N	Y
Easy bleeding	N	Y

Any other ailment not listed:

Women Only:

Age periods began: _____

Date of last mammogram: _____

Do you do regular self breast examinations? Y N

Number of pregnancies: _____

Did you breast feed? Y N

Breast lump or discharge? Y N

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X _____

Date: _____

Signature of patient or parent/guardian of minor

Insurance and Billing Information

Primary Insurance

Insurance Company Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone #: () _____ - _____

Insured Name: _____ Type: HMO / PPO / POS

ID # _____ Group # _____

Effective date: _____ Co-payment: _____ Deductible: _____

Relationship to Insured: _____

Secondary Insurance

Insurance company Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone #: () _____ - _____

Insured Name: _____ Type: HMO / PPO / POS

ID # _____ Group # _____

Effective date: _____ Co-payment: _____ Deductible: _____

Relationship to Insured: _____

Authorization to pay benefits to physician and statement of responsibility:

I hereby authorize payment directly to *Carmen M. Kavali MD PC* of any surgical and/or medical benefits, if any, otherwise payable to me for her services. I understand that I am ultimately fully responsible for payment of services rendered.

Signature: _____

Authorization to release medical information:

I hereby authorize *Carmen M Kavali MD PC* to release any information acquired during the course of my examination and treatment for the purposes of continuing my medical care or for billing/collection matters.

Signature: _____

Authorization to treat a minor:

I hereby consent to examination and treatment of _____, a minor, by *Carmen M Kavali MD PC*

Signature: _____

Relationship to minor: _____

Relationship to minor: _____

Authorization for Surgical Assistant Services

During your surgical procedure Dr. Kavali may require the service of an assistant. A RNFA (registered nurse first assistant); CSA (Certified surgical assistant); or PA-C (Certified physician’s assistant) will be used on those procedures where Dr. Kavali believes an assistant to be medically necessary and required to provide adequate care to you during your surgical procedure. Using an assistant also makes your total operative time lower, saving you out-of-pocket costs during cosmetic procedures. (Assistant time is much less expensive than additional OR/anesthesia time.)

If your procedure is covered by insurance, the surgical assistant will file a claim with your **insurance** plan on your behalf. If there is a patient responsibility balance remaining after the insurance payment, you will be responsible for that balance. If your insurance does not cover this service, the assistant will bill you.

If your surgery is **cosmetic**, a \$100/h fee will be added to your total surgery cost for the surgical assistant’s work. This fee will be itemized in the financial quote for your surgery.

Insurance Policy

At this time Dr. Kavali is not contracted with most insurance companies, but chooses to accept most patients’ out-of-network benefits. In some cases, your insurance company may mail payment directly to you (the patient or policy holder), instead of to Dr.Kavali. In the event that you receive payment directly from the insurance company, your signature on this Insurance Policy document indicates that you understand that such payment is for the services rendered by Dr.Kavali and is not money that is actually due to you. Your signature on this Insurance Policy indicates that you agree to forward any payment received, along with the explanation of benefits directly to Dr.Kavali immediately upon receipt. You understand that failure to comply with this agreement may result in additional fees and penalties to you, and is a violation of the Official Code of Georgia 16-8-4.

It is your responsibility to read and understand your own insurance policy. Certain services and procedures may/may not be covered, depending upon your individual insurance policy.

If an insurance company indicates that a physician’s fees are above the “usual and customary”, please understand that most physician’s fees are above the rate which insurance companies choose to pay. The rate is most often much lower than the fees normally charged by any physician. We have taken great care in setting our fees to accurately reflect the complexity of the care rendered and the skill and expertise required for your care. Our fees are comparable with those of other surgeons in the Atlanta area. We will not allow the payment or allowance of insurance companies to dictate how our fees are set, and we hope that you will understand this.

Our agreement is with YOU and NOT with your insurance company. We will certainly assist you by filing your claim to your carrier, but you are ultimately financially responsible for the service that you receive. Payment to our office is neither contingent nor dependent upon your insurance company.

Pre-surgery payments: Prior to surgery we check with your insurance company to verify your deductible, copay and co-insurance information.

At least 10 days prior to your surgery date your estimated deductible or co-insurance will be due.

A monthly billing fee of 1.5% of the balance will be added to all account balances beyond 30 days from the date of service. There will be a \$50 overdraft fee charged for any returned check. Accounts that remain delinquent may be turned over to a collection agency or have a suit filed in the Magistrate Court. Any collection fees incurred will be your responsibility.

If you have any questions about our financial policy or your insurance reimbursement, please feel free to discuss them with our business office staff. Your signature below acknowledges the fact that you have read, understand, and accept your financial responsibility under this policy.

Signature: _____

Date: _____

Authorization for and release of medical photographs, slides, and/or videotapes

Instructions

This is a consent that has been prepared to help inform you concerning permission to take photographs, slides, and/or videotapes and these images for a purpose as defined within this consent document.

It is important that you read this information carefully and completely.

Introduction

Medical photographs/slides and videotapes may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images.

Additionally, you may consent to release these medical photographs/slides, and videotapes for a stated purpose.

_____ Consent to take photographs/slides/videotapes

Initials

I hereby authorize Carmen M. Kavali, MD. and/or her associates or licensees to take pre-operative, intra-operative, and post-operative photographs, slides, and /or videotapes. I additionally consent to photographs, slides, and /or videotapes of my interview. Such photography or videography will be discussed with me prior to being done.

_____ Consent for release of photographs/slides/videotapes

Initials

I hereby authorize Carmen M. Kavali, MD. and/or her associates or licensees to use pre-operative, intra-operative, and post-operative photographs/slides, and /or videotapes for professional medical purposes deemed appropriate, including, but not limited to, showing these images on public or commercial television, electronic digital networks, for purpose of medical education, patient education, lay publication, or during lectures to medical or lay groups.

I hereby grant permission for the use of any record, illustration, photograph or other imaging record created in my case, for use in examination, testing, credentialing and/ or certifying purpose by the American Board of Plastic Surgery, Inc.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/ or my interview.

Date: _____ Signature: _____

Witness: _____