GEORGIA CENTER for Ear, Nose & Throat
FACIAL PLASTIC SURGERY

Cosmetic Client Profile

By completing this client profile, you will be helping us to correctly evaluate your skin care needs. All information will be kept in strict confidence.

Today's Date_____

Name: _____ Age: _____ Date of Birth: _____

Address: _____SS#_____

City: _____ State: _____Zip: _____

Home Phone: _____Cell: _____Work: _____

Email: _____

Contact Preference: Phone ____Mail _____Email_____ Can we leave a message Y___N_____

How did you hear about us? _____

Upcoming Special Event: Wedding _____Prom _____Modeling _____ TV/Film

_____Other_____ Event Date:_____ Time:_____

Please List any prior cosmetic procedures (both surgical and non-surgical) and dates:

_____

_____

_____

Have you ever been treated by a dermatologist? Y___ N____

If yes for what condition:

_____

_____

_____

Do you wear contact lenses? Y_____N____

Within the last year have you taken or used the following Retin A: Y____ N_____

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Which of the following would you like to discuss today or would like to obtain more information about? (Check all that apply)

Yes_____ No_____ Botox (cosmetic)
Yes _____No_____ Facial Redness
Yes _____ No_____ Facial Fillers (Juvéderm, Radiesse, Restylane)
Yes _____No_____ Brown Spots
Yes _____No_____ Sun damage
Yes _____No_____ Erbium Laser Peel
Yes _____No_____ Broken Capillaries
Yes_____ No_____ Fractional CO2 Laser Peel Laser Hair Reduction
Yes_____ No_____ Laser rejuvenation procedures
Yes_____ No_____ Skin toning or pore size reduction
Yes_____ No_____ Kybella
Yes_____ No_____ Brow lift
Yes_____ No_____ Fine lines and wrinkles
Yes_____ No_____ Neck Lift
Yes_____ No_____ Blepharoplasty (eyelid surgery lower and/or upper)
Yes_____ No_____ Skin care program evaluation
Yes____ No_____ Rhinoplasty (nose surgery)
Yes_____ No_____ Ul-Therapy

When was your last treatment/ procedure? _____

Please specify treatment type: _____

I am here today because I am most concerned about: _____

_____

Select all that applies to your current or past medical history

Yes___ No____ Lupus or other auto-immune deficiency
Yes___ No____ Scars that turn white or brown
Yes___ No____ Currently pregnant or breastfeeding,
Yes___ No____ Dark spots after pregnancy or skin injury
Yes__ No_____ Bleeding abnormalities

Yes___ No____ HIV
Yes___ No____ Rheumatoid arthritis
Yes ___ No ___ "Gold" therapy
Yes___ No ____ Hepatitis
Yes___ No ____ Use of Accutane in last year
Yes___ No ___ Light Sensitive Epilepsy
Yes___ No ___ Psoriasis or Vitiligo
Yes___ No ___ Hirsutism
Yes___ No ___ Keloid or very thick scarring
Yes___ No ___ Transplant anti-rejection drugs
Yes___ No ___ Pulmonary embolism (blood clot)
Yes___ No ___ Diabetes
Yes___ No ___ Implants (location)_____
Yes___ No ___ Leg ulcer or phlebitis
Yes___ No ___ Coumadin anti-clotting agents
Yes___ No ___ Polycystic ovarian disease (PCOD)
Yes___ No ___ Cystic Acne
Yes___ No ___ Herpes simplex or fever blisters
Yes___ No ___ Other type of STD

Any other disorder not listed above

_____

Yes___ No ___ Waxing, plucking, electrolysis within the last 4 weeks
Yes___ No ___ Chemical peels, dermabrasion. Laser resurfacing facelift
Yes___ No ___ Tattoos, or permanent make-up
Yes___ No ___ Collagen Injection (location: _____)
Yes___ No ___ Spray tan (professional) in the last 21 days
Yes___ No ___ Self-tan, tanning lotions, sprays, tanning beds, sun exposure in the last 14 days.

In Case of emergency: Primary Contact:

Name_____
Phone #_____ Relationship _____
Secondary Contact:
Name_____
Phone #_____ Relationship _____

I, the undersigned, consent to treatment necessary for the care of the above patient. I hereby authorize the release of any or all medical records to the referring physicians, my insurance

carriers, or those involved in payment of my account. I further acknowledge full financial responsibility for any services rendered and understand that payment of charges incurred in the office is due at the time of service and note that the $50 consult fee is **NON** refundable . I also understand that charges not covered by insurance remain my responsibility and assign insurance benefits to Aaron M. Fletcher M.D. PC. In the event an account is not paid within 90 days, the undersigned agrees to pay all costs of collection including attorney's fees and hereby waives all rights of exemption under the constitution of the state of Georgia.

Consent

I hereby consent to the use and disclosure of my personal health information for the purpose of treatment, payment and health care operations. My signature below indicates that I have been given an opportunity to read the Notice of Information Practices and to have any questions answered before signing. I understand that I may request restrictions on the use and disclosure of my health information at any time by completing and signing the restrictions request section of this form. I further understand that the practice is not required to accept my restriction request. I understand that I may revoke this consent at any time by signing a revocation request available through the office manager of this practice. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance to this consent

Who can we disclose your medical information to?

On the lines below list the names of individuals that are allowed to know your medical information. be specific.

_____

_____

_____

_____

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Patient Photograph Consent and Release Form

Today's Date_____

Patient's Name: _____ Date of Birth _____

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the members of Georgia Center for Ears, Nose & Throat and Facial Plastics medical staff. I hereby give my consent for Georgia Center for Ears, Nose & Throat and Facial Plastics, to use the photographs under one of the following circumstances.

Please initial one of the following:

_____ **Internet**: Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Georgia Center for Ears, Nose & Throat and Facial Plastics, can be used on the company's website in order to inform the public about plastic surgery methods. Further, I release and discharge Georgia Center for Ears, Nose & Throat and Facial Plastics, and any employees of Georgia Center for Ears, Nose & Throat and Facial Plastics , and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered to me. Including any claims for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name or any other identifying marks at any time during the use or publication of these materials by any party.

_____ **All Media**: Photographs taken of me or parts of my body as well as details regarding services that I have received at Georgia Center for Ears, Nose & Throat and Facial Plastics can be used in any print or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet and television, in order to inform the public about plastic surgery methods. Further, I release and discharge Georgia Center for Ears, Nose & Throat and Facial Plastics and any employee of Georgia Center for Ears, Nose & Throat and Facial Plastics and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs. And details regarding medical services rendered to me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name or any other identifying marks at any time during the use or publication of these materials by any party.

_____ **Medical Care Only**: Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Georgia Center for Ears, Nose & Throat and Facial Plastics. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Georgia Center for Ears, Nose & Throat and Facial Plastics. By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent may be revoked at any time by written request or by completion of a new form.

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Non-Refundable Less than 48 Hours Before Appointment

To secure an appointment with Dr. Fletcher, for Facial Plastic Surgery or consult a deposit must be made in advance. The consultation deposit of $50.00 is non-refundable and is applied to any cosmetic services received.

Missed Appointments Are Subject to Fees

Georgia Center for ENT and Facial Plastic Aesthetic and Plastic Surgery is committed to providing all our patients with exceptional care. When a patient cancels an appointment without giving enough notice, they prevent another patient from being seen. Please call us at (678) 902-9495 by 12:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 12:00 p.m. on Friday. If prior notification is not given, you will be charged $200 for the missed appointment.

Repetitive cancellations or no-shows by a patient is grounds for termination from the practice.

Surgery and Office Procedures

Payments

As patients approach surgery and in-office procedures, they frequently need information about the various payment options and have questions about their potential insurance benefits. We hope the following information will be helpful. Our practice administrator is readily available to meet with you personally to provide the specific information you desire.

Payment of Balance

Deposit and When Payment Is Due

To schedule and hold a cosmetic surgery date or an office procedure date, a **nonrefundable $250.00 to 500.00 deposit** is required for in-office procedures like Smart Liposuction, Keloid Removal, Balloon Sinuplasty, for cosmetic surgical procedures, a **nonrefundable deposit of 20%** of the total surgery cost is required to hold a surgery date. Deposits not applied to the proposed procedure(s) within 1 year will be forfeited. We do not accept financing for this portion of the surgical fee. This amount is deducted from the total surgery fee. Payment for your procedure by any payment method is due in full **10 business days** prior to your surgery date. This may coincide with your preoperative appointment. We provide several payment options that may be used individually or combined according to your needs.

Payment Options

We prefer payment in cash (or check if cleared in advance by management). Cash payments may receive a 2% discount. We accept credit cards as well. Credit options include Debit Card, Visa, MasterCard, Discover and American Express.

Optional Financing Plans

We also work with third-party patient financing plans for which you must apply ahead of time.

To apply for financing, use this options:

- CareCredit: (800) 677-0718 or **www.CareCredit.com**

****All discounts, incentives or promotions cannot be applied when financing any portion of the surgical balance. ****

Insurance Coverage

Most aesthetic surgery procedures are considered elective and are not covered by insurance. Additionally, our practice does not participate as a member of any insurance plan or program including Medicare and Medicaid for Facial Plastic Procedure

Refunds

Once services are rendered or products sold, there are no refunds. Surgery and nonsurgical procedures come with no warranty (guaranteed or implied) of any certain result. Perceived lack of improvement in one's condition does not translate into or equal any type of refund.

Rescheduling and Cancellation Policy

We understand that a situation may arise that could force you to reschedule, postpone or cancel your surgery or procedure. Please understand that such changes affect not only your surgeon and anesthetist, but other patients as well. We appreciate your courtesy.

- Due to the necessary time and inconvenience, a **$100 fee** will be added to the total surgery or procedure cost (and an additional $100 fee will be added to the anesthesia cost, if applicable) if the surgery or procedure is rescheduled by the patient less than 2 weeks from the procedure or surgery date.
- If you cancel an in-office procedure more than 15 days in advance (e.g., Keloid Removal, Smart Liposuction etc.), we will withhold the **$200-$500 nonrefundable deposit**.
- If you reschedule or cancel your surgery more than 15 days in advance, we will refund all deposited monies **except for the original 20% nonrefundable deposit**, which will be applied to

the payment for your rescheduled surgery or procedure or reused for processing fees if you have not rescheduled within 90 days. In addition, $100 will be kept for anesthesia, as above.

- If you reschedule or cancel your surgery or procedure within 2 weeks without an approved medically acceptable reason, submitted in writing and acceptable to the practice, **75% of the overall surgical fee** is forfeited and **$400 fee for anesthesia** is also forfeited for the anesthetist's inconvenience.
- While this may appear to be a charge for services that were not provided, this fee is necessary to reserve time in the OR and in the practice, which is done when you schedule.
- We will also withhold 5% if you paid with a credit card for processing fees we are charged by these companies.

If you have any questions or need assistance with financial matters, please ask us to help you.

_____ _____

Signature (patient or Parent Guardian if patient is under 18 years old) Date