Golla
CENTER FOR PLASTIC SURGERY & SPA

Date of Appointment: ____ / ____ / ____

Email Address: _____

How did you hear about us? _____

Have you been seen here before? ☐ YES ☐ NO

If YES, WHEN?: _____

PATIENT INFORMATION

Name: _____ Date of Birth: ___ / ___ / ___

AGE: ___ SSN: ___ - __ - ____ GENDER: ☐Male ☐Female

Marital Status: ☐Married ☐Single ☐Divorced

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: HOME ____ - ____ - _____ WORK ____ - ____ - _____ CELL ____ - ____ - ____

EMPLOYER: _____

EMPLOYMENT STATUS: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone Number: ____ - ____ - _____

PRIMARY CARE PHYSICIAN (PCP): _____

PCP ADDRESS: _____

PCP PHONE NUMBER: ____ - ____ - _____

REASON FOR REFERALL: _____

_____

_____

PERSON RESPONSIBLE FOR YOUR BILLS

☐ SELF (PATIENT OVER THE AGE OF 18)

☐ OTHER

Name: _____ Date of Birth: ___ / ___ / ____

Relationship to Patient: _____

Address: _____

Phone Number: Home: ____ - ____ - ____ WORK: ____ - ____ - ____ CELL: ____ - ___ - ____

EMPLOYER: _____

PRIMARY INSURANCE

Insurance Name: _____

Co-Pay Amount: PCP : _____ Specialist :_____

Insurance ID#:_____

Group #:_____ Effective Date:_____

Subscriber Name: _____Birth Date: _____ Age: _____

Sex: Male Female

Address:_____ City: _____ State: __ Zip Code: _____

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

Employer: _____

Employment Status: ☐ Full Time ☐Part Time☐ Not Employed

Relationship to Patient (Only if different):_____

SECONDARY INSURANCE

Insurance Name: _____

Co-Pay Amount: PCP $: _____ Specialist $:_____

Insurance ID#:_____

Group #:_____Effective Date:_____

Subscriber Name: _____Birth Date: _____ Age: _____

Sex: Male Female

Address:_____ City: _____ State: _____ Zip Code: _____

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

Employer: _____

Employment Status: ☐Full Time ☐ Part Time ☐Not Employed

Relationship to Patient (Only if different):_____

WORKER'S COMPENSATION

Is Claim Worker's Compensation (WC)? Yes _____ No _____

If yes, Date of Injury:_____

If yes, Worker's Compensation Claim Number: _____

Worker's Compensation Carrier: _____

Worker's Compensation Insurance Mailing Address: _____

_____

AUTO CLAIM INSURANCE

Is Claim due to a motor vehicle accident: ☐ YES ☐ No

If yes, Date of ACCIDENT OR iNJURY:_____

If yes, Motor Vehicle claim number: _____

Insured: _____ Policy Number: _____

Motor vehicle Carrier: _____

Contact Person with Carrier: _____ Phone Number:_____

Insurance Mailing Address:_____

_____

HEALTH HISTORY

Patient Name:_____ Birth Date: _____Date:_____
Referring Physician: _____ Address:_____
Pharmacy Name: _____ Phone Number: _____
Reason for today's visit: _____
Please describe this problem: _____
_____

PRIOR SURGERIES	CURRENT/PRIOR ILLNESSES/INJURIES

Please list all medications (prescriptions and non-prescriptions) that you take. (Include herbal remedies, vitamins, over-the-counter, street drugs, prescriptions, etc.)

MEDICATIONS	DOSAGE	MEDICATIONS	DOSAGE

Do you take any blood thinning products such as Vitamin E, Plavix, Coumadin, Aspirin?

☐YES ☐NO

Do you have any food, environmental, or drug allergies? ☐ No ☐Yes

Latex Allergy? ☐ NO ☐YES

ALLERGY	TYPE	REACTION

Do you smoke cigarettes? ☐NO ☐Former ☐Yes
If YES, how much per day? _____ How long have you smoked? _____

TYPE OF SMOKING (cigarette, pipe, marijuana, chew, etc)	HOW MUCH	HOW LONG

Do you drink alcohol? ☐ No, never have ☐Socially only ☐Daily
IF YES, ☐Beer/Wine? ☐Hard Liquor?

Please describe any family health issues below

FAMILY HISTORY	NONE	UNKNOWN	ILLNESS/CAUSE OF DEATH
Mother			
Father			
Sibling(s)			
Other hereditary illness			

Patient Signature: _____ Date:_____

Physician Signature: _____ Date: _____

Do you have or have you ever had any of the following:

SYMPTOM/ILLNESS	NO	YES, EXPLAIN	SYMPTOM/ILLNESS	NO	YES, EXPLAIN
Constitutional			**Skin**		
Fever or Chills			Breast Abnormalities		
Weight Loss			Nipple Discharge		
Hematologic			Last Mammogram		**Date:**
Hepatitis			Changes in Moles		
HIV/Other Blood Diseases			Lesions		
Bleeding Disorders			Rashes		
Endocrine			History of Keloids		
Thyroid Problems			**Neurological**		
Diabetes			Neurological Problems		
Musculoskeletal			Headaches		
Arthritis			**Genitourinary**		
Mobility/Joint Problems			Genital or Oral Herpes		
Gastrointestinal			Sexually Transmitted Disease (STD)		
Constipation			Blood in Urine		
Diarrhea			Urinary Tract Infection		
Blood in stool			Problems Urinating		
Nausea/Vomiting			Prostate Problems		
Liver Problems			Kidney Problems		
Cardiovascular			**Eyes**		
Heart Problems			Vision Problems		
Deep Vein Thrombosis/DVT			**ENT**		
Blood clots in Lungs/Legs			Hearing Problems		
High blood Pressure			Sinus Problems		
Respiratory			**Psychiatric**		

Asthma			Mood Swings		
Sleep Apnea			Anxiety/Depression		

Please list any other conditions/illnesses not indicated above: _____
_____
_____

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes in my health.

Patient Signature: _____ Date:_____
Physician Signature: _____
Date Reviewed: _____

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know your Patient Health Information (PHI) is going to be used in Golla Center for Plastic Surgery and Spa and your rights concerning those records before we will begin any health care operations. We must require you to read and sign this consent form stating you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient allows this office to submit requester PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during car. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the Surgeon/Physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature:_____ Date:_____

HIPPA PRIVACY POLICY PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day to day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at anytime to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing and at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name:_____ Date: _____

Patient Signature: _____

Golla
CENTER FOR PLASTIC SURGERY & SPA

GOLLA CENTER FOR PLASTIC SURERGY AND SPA
PHOTOGRAPHY AND VIDEO CONSENT FORM

I, _____ give Golla Center for Plastic Surgery and Spa permission to use any photographs, videos or recordings of my voice for the purpose of medical teachings, publication in medical textbooks or journals, or for commercial and advertising or educational programs in any media.

I understand that there is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed. I also understand that my refusal to consent to photographs, video's or recordings of my voice for the purpose of medical teachings, publication in medical textbooks or journals, or for commercial and advertising or educational programs in any media will in no way affect the medical care I will receive.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to the above.

Patient Name: _____ Date:_____

Signature: _____

GOLLA CENTER FOR PLASTIC SURGERY AND SPA
CASE STUDY CONSENT FORM

I, _____give Golla Center for Plastic Surgery and Spa permission to use my medical information for medical case studies (a case study is typically used to share new unique information experienced by one patient during his/her clinical care that may be useful for other physicians and member of a health care team). Your personal information obtained will be kept confidential and protected, but will be used in medical publications and shared with other health care providers.

I also understand that my refusal to consent to participate in a case study will in no way affect the medical care I will receive.

By singing this form I acknowledge that I have completely read and fully understand the above release and agree to the above.

Patient Name: _____ Date:_____

Signature:_____

INSURANCE DEDUCTIBLE, CO-INSURANCE, AND CO-PAYS

At Golla Center for Plastic Surgery & Spa we are contracted by your insurance company to collect deductibles, co-insurance, and co-payments. If you are scheduled for elective surgery we will collect these payments prior to the date of your surgery.

If your insurance coverage has a deductible and/or coinsurance/co-pay, you will be receiving a phone call from our surgery scheduler, at 412-963-6677, to discuss payment arrangements.

If you receive a message from her, please return her call as soon as possible. If you have any questions about your insurance benefits, you are welcome to call us at any point prior to or after your surgery.

Any payment amount discussed or arranged is only an estimation based on the available information to us, from your insurance company.

Once we have collected your payments, the procedure(s) will be submitted to your insurance company for the remaining balance. It is possible that you may still have a balance due, in which case you will receive a bill. In the event that you have over paid, you will receive a prompt refund.

Signature of Responsible party: _____

Date: _____

Payment Policy

Thank you for choosing us as your medical or surgical provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. I f your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Non-payment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of Responsible Party: _____ Date: _____