Warner Robins Body Sculpting & Cosmetic Center

105 BRIARCLIFF RD, SUITE B WARNER ROBINS, GA 31088 (478) 922-8902

Patient Information

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

_____ Office Phone: _____

City: _____ State: _____ Fax Number: _____

Zip: _____ County: _____ E-mail: _____

Occupation: _____

Date of Birth: _____ Age: _____ SSN: _____

Marital Status : Single Married Divorced Widowed

If Patient is a Minor (Under the Age of 18):

Father: _____ Mother: _____

Spouse: _____ Employer: _____ Office Phone: _____

Nearest Relative: _____ Relationship: _____ Phone: _____

Primary Insurance Company Name: _____

Name of Insured: _____ Relationship to Patient: _____

Address: _____ Home Phone: _____

_____ Employer _____

Birth Date: _____ Office Phone: _____

SSN: _____ Occupation: _____

Secondary Insurance Company Name: _____

Name of Insured: _____ Relationship to Patient: _____

Address: _____ Home Phone: _____

_____ Employer _____

Birth Date: _____ Office Phone: _____

SSN: _____ Occupation: _____

_____ Date: _____

Signature of Patient or Responsible Person

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Patient Medical History Today's Date:_____

Patient name: _____ Age: _____ Date of birth: _____

Height: _____ Weight: _____ Sex: Male Female

Primary Care Physician: _____ Phone: _____

Why are you here to see Dr. Jones? _____

Previous Surgeries: (Please use back of the Form if Necessary)

Operation	Year	Physician	Type of Anesthesia

Previous Non-Surgical Hospital Admissions:

Problem	Year	Physician	Complications

Past Injury or Car Accidents:

Type of Accident	Date	Type of Injuries	Outcome

Weekly consumption: Alcoholic beverages: _____ Tobacco: _____ Coffee/Tea/Cola: _____

Have you or a family member ever had any of the following (Please indicate person):

Tuberculosis: _____ Cancer (kind): _____ Cataracts: _____

Heart disease: _____ High blood pressure: _____ Glaucoma: _____

Lung disease: _____ Kidney disease: _____ Diabetes: _____

Are you ALLERGIC to any medications? _____ If yes, please list: _____

Are you currently under the care of a physician? _____ For what condition? _____

Date of last physical exam: _____ Name of examining physician: _____

Recent lab tests, x-rays, mammogram results, and dates:

List all current prescriptions and non-prescription medications:

Do you take aspirin or any aspirin-containing products? Please list:

Have you ever had problems with excessive bleeding or do you bruise easily? _____

Explain: _____

Have you ever been tested for AIDS or Hepatitis? _____ Date of test: _____

Women Only: Number of Pregnancies: _____ Number of Children: _____ Are you pregnant now? _____

Social History: Religious preference: _____ Hobbies: _____

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Our Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE FOR OFFICE VISITS

We accept cash, checks, or VISA/MasterCard/American Express/Discover

Regarding Insurance

We may or may not accept assignment of insurance benefits on your particular insurance. We cannot bill your insurance company unless you give us your correct information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits, we require that you pre-pay the deductible and co-pays or provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 45 days, the balance will automatically be transferred to your credit card or billed by statement. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Regarding Insurance Plans where we are a participating provider. All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Regarding Cosmetic Surgery

For financial purposes, cosmetic surgery is any procedure that insurance will not cover. Neither Dr. Jones nor the nurse will discuss financial matters or concerns, rather, the office staff will discuss the fee estimate for cosmetic surgery with you. The total fees will be broken into two categories, the surgical fee and the hospital fee. The hospital fee will include charges for the facility and anesthesia. The hospital fee is separate and independent from Dr. Jones fees. The hospital fee is always the responsibility of the patient, whether at the time of the initial surgery or any revisional surgery. The surgical fee will be paid in full to Dr. Jones at the date of your scheduled pre-op visit. Payment can be in the form of a credit card, cash or cashier's check. The hospital fee will be paid in full at the date of your scheduled surgery, to the hospital. If either of these amounts is not paid prior to the surgery, the surgery date will be re-scheduled.

Adult Patients

Adult patients are responsible for full payment at time of service.

Minor Patients

The adult accompanying a minor and the parent (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at time of service.

Missed Appointments

Unless canceled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy.

I have read the Financial Policy. I understand and agree to this financial policy:

X _____ Date: _____
Signature of Patient or Responsible Party

X _____ Date: _____
Signature of Co-Responsible Party

X _____ Date: _____
Witness

Release of Information and Assignment of Benefits

I authorize Warner Robins Body Sculpting & Cosmetic Center to release my medical information to my insurance company in order to process my insurance claim.

X _____
Signature

I authorize my insurance company to send my insurance payments directly to Warner Robins Body Sculpting & Cosmetic Center for services rendered in his office.

X _____
Signature

ANY REMAINING BALANCE AFTER NINETY (90) DAYS WILL BE CHARGED A MONTHLY SERVICE CHARGE AND MONTHLY INTEREST UP TO THE MAXIMUM INTEREST RATE ALLOWED BY LAW.

X _____ X _____
Signature Witness

A photocopy of this assignment shall be considered legal and valid.

Please charge all fees or outstanding balances to my credit card:

VISA MasterCard AmEx Discover

Card Number: _____ Expiration Date: _____

X _____
Signature

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Consent Release

I, _____, hereby consent to the following:
Patient Name

Patients of Warner Robins Body Sculpting & Cosmetic Center contacting me at home or at work regarding the same or a similar surgery performed on me.

Phone Number(s) Home: _____ Work: _____

Having the office of Warner Robins Body Sculpting & Cosmetic Center contact me so that I can then call the patient interested in the same or a similar surgery performed on me at my convenience.

Speaking with a patient of Warner Robins Body Sculpting & Cosmetic Center about my surgery, regardless of the type of surgery the patient is having.

Having photographs of myself shown to other patients, and to be used for medical and non-medical publications.

Having before and after photographs of myself shown on the Internet or the website, for the illustration of surgery results.

X _____ Date: _____
Patient or Guardian Signature

X _____ Date: _____
Witness