REGISTRATION **LOW COUNTRY PLASTIC SURGERY & ZEN FUSION SPA**
(Please Print)

BRENDAN E. SMITH, M.D.
16 OKATIE CENTER BLVD. SOUTH, SUITE 101
OKATIE, SC 29909
843-705-8940

Spa clients may skip the insurance info. Since we do utilize advanced medical spa technologies, complete paper work is needed to ensure you have no contraindications and to help us tailor treatments for the best results. Please alert us of any changes in the future.

DATE: ____________________________ **HOME PHONE:** (_____)___________ **CELL #:** (_____)_____________

PATIENT INFORMATION (your information will not be shared, per the privacy policy on pages 5 and 6)

Name: ____ Soc. Sec #: _________________________________
Last Name First Name Initial
Address: ____
City: ____ State: _____________ Zip: ________________
Sex: M F Age: _________ Birthdate: ________________ E Mail:______________________________
Marital Status: Single Married Widowed Separated Divorced
Patient Employed By: ____ Occupation: _____________________
Business Address: ____
City: ____ State: ______________ Zip: ___________
Business Phone: (________)___________________________
Were you injured on the job? : ______________________ Were you injured in an auto accident? : ____________________
Date you were injured? : _____________________________
How did you get the name of our office? ____
EMERGENCY CONTACT: ____________________________ Relationship:__________ Phone: (____)________________

PRIMARY INSURANCE

Person Responsible for Account: ____
Last Name First Name Initial
Relation to Patient: ____________________ Birth date: _________________ Soc Sec #: ___________________________
Address (If different from patient's): ______________________________________ Phone: (____)_____________________
City: ____ State: ____________ Zip: ___________________
Person Responsible Employed By: _____________________________________ Occupation: ________________________
Business Address: ____ Phone: (____)_________________
Insurance Company: _______________________________________ Subscriber #: ________________________________
Contract #: ________________________ Group #: ___________________

ADDITIONAL INSURANCE

Is the patient covered by additional insurance? Yes No
Subscriber Name: _________________________________ Relation to Patient_______________ Birth Date: ____________
Address (If different from patient's): ____ Phone (_____)_________________
City: ____ State: _____________ Zip: ________________
Insurance Company: ____ Subscriber #: ____________________________
Contract #: _______________________________ Group #: _________________________

I hereby authorize the release of medical record information to my insurance company, its assigns, representatives, or any physician or medical facility providing medical care. I also authorize my insurance company to pay any benefits payable under my policy to Low Country Plastic Surgery. By signing below I acknowledge that I am financially responsible for all charges incurred whether or not paid by my insurance company.

____ ____
PATIENT SIGNATURE DATE

____
RELATIONSHIP TO PATIENT

FINANCIAL POLICY OF LOW COUNTRY PLASTIC SURGERY

Low Country Plastic Surgery is committed to providing you the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask us if you have any questions about our fees, financial policy, or your responsibility.

Full payment is expected at the time the service is rendered unless you have health care coverage through a plan with which the physician participates. In this case, all patient deductibles, co-payments, coinsurance and/or non-covered services are due at the time of service. **Co-payments are to be paid at the time of check-in. If your co-payment cannot be paid at the time of your visit, your appointment will need to be rescheduled.**

Low Country Plastic Surgery accepts cash, checks, MasterCard/Visa, and American Express as payment for services rendered. **Cosmetic procedures and injections are to be paid at the time services are rendered.**

If surgery is recommended, you must pay any deductible and/or co-payment, which have not been satisfied at the time your surgery is scheduled. If you are having a cosmetic procedure, a $500.00 deposit is required at the time of scheduling your procedure and the entire balance is due 14 days prior to your actual surgery date. If you do not have insurance coverage, you will be required to pay for your procedure in full prior to your procedure being performed.

If you have been involved in an automobile accident, please know that we **DO NOT GET INVOLVED IN ANY THIRD PARTY LITIGATION.** Any money that you receive from an automobile insurance policy will be between you and the insurance company.

As our services are provided to you, not your insurance company, payment for service is your responsibility. Therefore, all charges that are filed to your insurance carrier and are not paid within 60 days from the date of filing become your responsibility.

All new patients are asked to complete our "Patient Registration Form" prior to seeing the physician. We request our established patients inform us of any changes in his/her name, address, telephone number, employer and/or insurance status. We will verify this information with you at each visit.

Please verify your insurance coverage and bring your insurance card(s) to our office each time you visit.

If it becomes necessary for your account to be placed in collections due to nonpayment, the patient and/or guarantor are responsible for all associated collection costs.

Thank you for understanding our Financial Policy. We appreciate your compliance with this policy. Please let us know if you have any questions or concerns regarding this policy.

Patient/Guarantor Signature____

Relationship to Patient______________________________ Date: _____________________

Witness ____ Date: _____________________

HEALTH HISTORY

Please Complete This Form

Have you been diagnosed, been treated for in the past or are being treated for any of the following conditions? Please circle Yes or No.

Asthma	Y	N	Anesthesia Sensitivity	Y	N	Hepatitis	Y	N
Pneumonia	Y	N	Heart Conditions	Y	N	Ulcer	Y	N
Tuberculosis	Y	N	High Blood Pressure	Y	N	Arthritis	Y	N
Rheumatic Fever	Y	N	Stroke	Y	N	Kidney Disease	Y	N
Bronchitis	Y	N	Epilepsy	Y	N	Thyroid Disease	Y	N
Heart Disease	Y	N	Hernia	Y	N	Diabetes	Y	N
Anemia	Y	N	HIV/AIDS	Y	N	Cancer	Y	N
Bleeding Disorders	Y	N	Venereal Disease	Y	N	Glaucoma	Y	N
Intestinal Disorder	Y	N	Psychiatric/Emotional	Y	N	Hives/Eczema	Y	N
Mitral Valve Prolapse	Y	N	Breathing/Lung Problems	Y	N	Bladder Infections	Y	N
Skin Problems	Y	N	Heart Attack	Y	N			

If you answered yes to any of the above questions, please explain:______________________________________

____

Please list any other disease/condition/chronic illness not listed above:___________________________________

____

Are you or could you be pregnant? ____

Please list ALL allergies (Medication, Food, Environmental,Topical) or sensitivities:_______________________

____

Please list ALL medications you are currently taking including over the counter medications, supplements and herbs:____

____

Have you ever been hospitalized or undergone any type of surgery? Please list with dates:__________________

____

____

__

Have you ever had any type of reaction to anesthesia (local, general, conscious sedation)?__________________

Do you have any special needs that we need to be aware of?____

Primary Care Physician:____________________________________ Phone:____________________________

Height:________ Weight:_________ Smoking:___________________ Alcohol:_____________________

Caffeine:_____________________ Recreational Drugs:_______________________

Family History

Has any blood relative had any of the following:

			Relationship				Relationship
Cancer	Y	N		Stroke	Y	N	
Diabetes	Y	N		Epilepsy	Y	N	
Heart Disease	Y	N		Anemia	Y	N	
High Blood Pressure	Y	N		Bleeding Disorder	Y	N	

Patient Signature:_______________________________________ Date:________________________

Zen Fusion Spa @ Lowcountry Plastic Surgery Cosmetic History & Skin Care Profile

Brendan E. Smith, M.D.
Office - 843.705.8940 Fax – 843.705.6816

16 Okatie Center Blvd. South Suite 101 Okatie, SC 29909

If you could see any improvements in your skin, facial feature, or body what would you like to see change? ____________________

____

Have you ever used Accutane or Soriatane, if so when did you last use it?________________________________

Have you used any topical lotions, creams or skin treatments given to you by your doctor or pharmacist? If so, please list what treatments and when last used. ____

____

Do you have or have you had within the past 2 weeks any irritations, abrasions or blemishes in the areas we will be working? If so, please list with location and description.________________________________

Have you ever had a cold sore of fever blister? If so, are you more prone to them after sun exposure or an illness? (list last occurrence)

____

Does your skin form thick or raised scars? ________________Does it look stained after an acne lesion or other minor injury heals? If so, is it red or brown? ____

Have you had any cosmetic procedures on the area in which we will be working on? Please include injectables, laser treatments/IPL/Infrared/Plasma, peels, etc.If so, list the date last performed. Also list if you have had a facial, microdermbrasion, peel or waxing in the last 2 weeks on the area being treated.________________________________

____

Do you bruise easily? __________ Have you taken aspirin, ibuprofen, vitamin E or fish oil/omega oil in the past 48 hours?_________

<u>Depending on how your skin reacts to sun and your ethnic background, the protocol of your procedure may differ.</u>

Do you turn brown within several hours after sun exposure?
- ❑ Never
- ❑ Seldom
- ❑ Sometimes
- ❑ Often
- ❑ Always

How does your face react to sun exposure?
- ❑ Very sensitive
- ❑ Sensitive
- ❑ Normal
- ❑ Very resistant
- ❑ Never had any problems

Non-exposed Skin Tone:
- ❑ Reddish
- ❑ Very Pale
- ❑ Pale with Beige tint
- ❑ Light Brown
- ❑ Dark Brown

Do you have freckles on non-exposed skin?
- ❑ Several
- ❑ Many
- ❑ Few
- ❑ Incidental
- ❑ None

What are your results when you stay in the sun for too long?
- ❑ Redness/blistering/ peeling
- ❑ Blistering followed by peeling
- ❑ Burn some followed by peeling
- ❑ Rarely burn
- ❑ Never burn

To what degree do you turn brown?
- ❑ Hardly/or not at all
- ❑ Light color tan
- ❑ Reasonable tan
- ❑ Tan very easy
- ❑ Turn dark brown

What is the ethnic background (not race) of your :

Maternal Grandmother?

____

Maternal Grandfather?

____

Paternal Grandmother?

____

Paternal Grandfather?

____

Have you exposed the areas that are to be treated in the sun and how often do the areas receive sun exposure?
- ❑ Never
- ❑ Hardly ever
- ❑ Sometimes
- ❑ Often
- ❑ Always

When did you last expose your body to sun or tanning booth/tanning cream?
- ❑ Over 3 months ago.
- ❑ 2-3 months ago.
- ❑ 1-2 months ago.
- ❑ Less than 1 month ago.
- ❑ Less than 2 weeks ago.

Please check any that apply to you that you have interest in learning how to remedy.
- ❑ Acne
- ❑ Brown Spots
- ❑ Chronic Pain
- ❑ Clogged Pores
- ❑ Dark Circles
- ❑ Dry/Rough Skin
- ❑ Enlarged Pores
- ❑ Facial Redness/ Rosacea
- ❑ Fine Lines/Wrinkles
- ❑ Headaches/ Migraines
- ❑ Loose/Slack Skin
- ❑ Muscle pain or Tightness
- ❑ Puffy Eyes
- ❑ Scarring
- ❑ Sparse Eyelashes
- ❑ Spider Veins
- ❑ Stubborn fat
- ❑ Thinning Hair
- ❑ Uneven Skin Tone
- ❑ Unwanted Hair

Effective December 26, 2007

LOW COUNTRY PLASTIC SURGERY

NOTICE OF PRIVACY PRACTICES

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.

Understanding Your Medical Record/ Health Information

As your healthcare provider, we will maintain a record of your visit that contains your symptoms, reports of examinations and test results, diagnoses, treatments, correspondence with other providers and plans for future care or treatment.

Your Health Information Rights

Your health record is the physical property of this practice, however, the information it contains belongs to you. You have the following rights and we request that you notify the Privacy Officer of this Practice of your requests for any of these actions:

a. Request Restrictions: You have a right to request restrictions on the use of your information.
b. Obtain a Paper Copy of this Notice: You have the right to receive a paper copy of this Notice.
c. Inspect and Copy: You have the right to inspect and receive a copy of you health information. If you request a copy of your information, you may be charged a reasonable fee for photocopying, retrieval, labor, postage, and supplies used.
d. Amend: You have the right to request that we amend your health information.
e. Obtain an Accounting of Disclosures: You have the right to request an accounting of certain disclosures of information that have been made about you. This listing includes disclosures of your information for other than treatment, payment or healthcare purposes and is within a specified period of up to six years. The first listing of disclosures is provided as a complimentary service to you, but you may be charged a reasonable fee for additional requests made within a twelve-month period.
f. Request Communications of Your Health Information: You have the right to request that you receive communications regarding you information in a certain manner or certain location.
g. Revoke Your Authorization for Disclosure: You have the right to revoke an authorization for disclosure of information that was previously given.

Our Responsibilities

Our Practice is required to:

a. Confidentiality: Maintain the privacy of your health information.
b. Provide a copy of this notice: We will provide you with a copy of this notice of our legal duties and privacy practices with respect to the information we collect and maintain about you.
c. Abide by the terms of this notice.
d. Unable to restrict: We will notify you if we are unable to agree to a requested restriction of your information.
e. Provide alternative means or alternative locations: We will accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations. We reserve the right to charge our privacy practices and to make new provisions effective for all protected health information we keep. Should our information practices change, we will notify you of these changes when you return to our office. We will not use or disclose you health information without your authorization, except as described in this notice.

For More Information

a. If you have a question or would like additional information you may contact our privacy officer Stephanie (843-705-8940).
b. If you have a concern about the privacy of your information, you may contact our privacy officer. You may file a complaint with our office or you may also file a complaint with the secretary of Health and Human Services in the U.S. Office of Civil Rights. All complaints must be in writing. The privacy officer will supply information about this procedure.
c. The Privacy Rule, developed under the authority of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), prohibits the alleged violating party from taking retaliatory action against anyone filing a complaint with the Office for Civil rights. You should notify the office immediately in the event of retaliatory action.

Examples of Disclosures of Information

Treatment:

1. We will use your health information for treatment purposes. As an example, information given to a nurse or a physician will be recorded in your health record and used to determine the best treatment for you. Members of the healthcare team will document your treatment goals, actions taken and clinical observations.
2. We will provide your other healthcare providers with copies of various reports that will help them to treat you for any subsequent conditions that may arise.

a. Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatments and supplies used.

b. Healthcare Operations: The physicians and members of your healthcare team may use the information to evaluate the quality of care you received as well as the care received by others similar to you. This information will be used to improve the effectiveness of healthcare operations and services we provide.

c. Business Associates: There are some services provided through contracts with business associates. As an example, we contract with a company that provides information services for the computer system we operate. When these services are contracted, we may disclose your health information to this business associate so that they can perform the work we require. To protect your health information, the business associate must appropriately safeguard your information.

d. Notification: We may disclose information to notify or assist in notifying a family member, personal representative or other person responsible for your care, information about your general condition.

e. Communication with Family: We will use good judgment in disclosing to a family member or any other person you identify health information relevant to that person's involvement in your care or payment related to your care.

f. Research: We will disclose only limited information to approved researchers that participate in research approved by our institutional review board. We will obtain a written authorization from you to disclose information for other research purposes.

g. Funeral Directors: We may disclose health information to funeral directors consistent with state law that allows them to carry out their duties.

h. Organ Donation: If you are an organ donor, we may disclose your information to organizations that help procure, bank or transport organs for tissue donation and transplantation purposes.

i. Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

j. Fund Raising: We may contact you as part of a fund raising effort.

k. Food and Drug Administration: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post-marketing surveillance information to enable product recalls, repairs or replacement.

l. Workers Compensation: In accordance with state law, we may disclose health information as is required for processing a claim under worker's compensation.

m. Public Health: Under South Carolina law, we may disclose your health information to the health department in order to prevent or control disease, injury or disability.

n. Correctional Institution: If you are an inmate of a correctional institution, we may disclose to the institution or its agents health information that is needed for your health or the health and safety of other individuals.

o. Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

p. Lawsuits and Similar Proceedings: We may disclose your healthcare information in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your healthcare information in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, nut only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

q. Health Investigation: Federal and state laws make provisions for your health information to be released to appropriate health authorities provided that a member of our staff or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise endangered one or more patients, workers or the public.

r. Other disclosures: All other uses and disclosures of your information will only be made with your written authorization. If you have authorized us to use or disclose information about you, you may revoke this authorization at any time.

s.

Acknowledgement of Receipt of Privacy Practices

By signing below, I acknowledge that I have received the Notification of Privacy Practices for Low Country Plastic Surgery and all of my questions have been answered. We will keep this signed form on file for a minimum of six (6) years.

______________________________ ______________

Signature of Patient or Legal Guardian Date

______________________________ ______________

Print Name of Patient or Legal Guardian Date