

NorthEast Plastic & Reconstructive Surgery

Today's Date: ____/____/____

Name: _____

DOB: ____/____/____ Sex: Female Male

Marital Status (mark one): Single Married Separated Divorced Widowed

SS#: ____-____-____

Race: African American Caucasian Haw/Pac Isl/Hisp Other _____

Address: _____

City, State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ Work Phone: _____

Employment Status:

- Full Time | Self Employed | Student | Retired
 Part Time | Unemployed | Disabled | Other: _____

Referring Physician: _____ Primary Physician: _____

Name of Insurance Company: _____

Guarantor Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

- Full Time Part Time Other: _____

SS#: ____-____-____ DOB: ____/____/____ Sex: Female Male

1st Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

2nd Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Patient Information: I give permission to release the health information of:

(One Patient Per Form)

Patient Name: _____

Date of Birth: _____

Street Address: _____

Last 4 numbers of SSN: _____

City, State, Zip: _____

Telephone: () _____

Email address: _____

By providing your email address you acknowledge and accept the risks outlined in the Guidelines for E-mail with Patients, posted on carolinashealthcare.org.

Release Information From:

(List applicable Facility(s) and/or Practice(s))

(Phone number)

(Fax number)

Release Information To:

(Name of facility, person, company)

(Street Address or PO Box, City, State, Zip Code)

(Phone number)

(Fax number)

PURPOSE OF RELEASE (check reason): Request of individual/personal Continued patient care Insurance Legal purpose including discussions & proceedings Other

Fill in dates of treatment for records to be released:

Treatment dates: From _____ To _____

Facility Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies.

Office/Clinical Summary: May include most recent office visits, physical exam, consults, diagnostic test results.

Facility (check all that may apply):

- Facility Summary
 Discharge Summary
 History and Physical
 Consultation reports
 Operative Reports
 Laboratory reports
 Radiology/X-Ray Reports
 Pathology reports
 Emergency Record
 Cardiac Reports/EKG
 Other

- Entire record (Not including psychotherapy notes)
 Itemized Bill

Office/Clinic/Home Care (check all that may apply):

- Office/Clinical Summary
 Office/Home Visits
 Physical Exam
 Laboratory Reports
 Radiology Reports
 Other

- Entire Record (Not including psychotherapy notes)
 Itemized Bill

Behavioral Health/Sub. Use (check all that may apply):

- Facility Summary
 Clinical/Discharge Summary
 Assessments
 Physician Orders
 Progress/Therapy Notes
 Medications
 Lab reports
 Other

- Entire Record (Not including psychotherapy notes)
 Itemized Bill

FORMAT:

- CD (charges may apply)
 Email Address noted above, where permitted
 Paper copy (charges may apply)
 Other

DELIVERY METHOD:

- Reg.US Mail
 Pick-up
 Fax, where permitted
 Overnight/Express Mail Service, where permitted
 Secure email
 Other

PATIENT'S RIGHTS - I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.
This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.
Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.
Atrium Health will not share or use my health information without my permission other than by ways listed in Atrium Health's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at carolinashealthcare.org.
A fee may be charged for providing the protected health information.

This permission expires one year after the date of my signature unless another date or event is written here: _____

Signature: _____ Print Name: _____ Date: _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.

Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):

- Healthcare Agent/POA
 Parent
 Guardian
 Adult Child
 Executor/Administrator/Attorney in Fact
 Affidavit Next of Kin
 Spouse
 Other

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor: _____ Print Name: _____ Date: _____

Authorization given to patient / Date of release: _____ via Mail Fax Other _____ ID Verified DL/Other ID _____
Employee Name: _____ Date: _____

Patient Information or Sticker



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Name:
DOB:
Medical Record #:

Account #:



HEALTH REQUEST FOR TREATMENT AND AUTHORIZATION FORM

REQUEST FOR TREATMENT. The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health ("Atrium Health"), maintains certain providers, personnel and facilities needed in providing me medical care, and I authorize Atrium Health to perform on me the care ordered by my providers. I understand that I have the right to be informed by my providers of the nature and purpose of any proposed treatment or procedure and any available alternative methods of treatment, together with an explanation of the likely risks and benefits associated with them. This form is not a substitute for such explanations, which are the responsibility of my providers to provide according to recognized standards of medical practice, and I acknowledge that Atrium Health and its personnel are not responsible for providing me this information for non-Atrium Health providers. I consent to receive services by interactive audio, video, or data communications to carry out consultations, evaluations, screenings, diagnosis, treatment, monitoring, or other communications benefiting a patient if appropriate for my condition, and I understand the risks, benefits and alternatives of doing so. I choose to receive the services even if an insurance plan may not cover or continue to cover specific services, including the specific services rendered during the medical treatment.

ASSIGNMENT OF INSURANCE BENEFITS. I/we hereby assign all my rights to Atrium Health under any policy of insurance, including but not limited to, major medical insurance, hospital or outpatient benefits, sick benefits, injury benefits due to me because of liability of a third party, such as auto insurance or Workers' Compensation insurance, and the proceeds of all claims resulting from the liability of the third party payable by any person, employer or insurance company to or for the patient up to the full amount of the medical bill, and hereby authorize direct payment to Atrium Health and/or my providers of all benefits to which I am entitled. This assignment includes payment of hospital, outpatient, surgical, and medical benefits as well as any professional group contracted by Atrium Health for professional services they may perform for me, including but not limited to radiology and imaging, anesthesia and pain services, pathology, radiation oncology, and emergency medicine services. In addition, I/we further warrant and represent that any insurance which I/we assign is valid insurance and in effect and that I/we have the right to make this assignment. I understand that I am financially responsible to Atrium Health, my providers, and those professional groups or entities included in this assignment for amounts due that are not covered by this assignment. For example, I know that sometimes insurance companies will not pay for services ordered by my providers and which I have authorized. I understand that these payment denials occur for a variety of reasons. My insurance policy may not include the particular service as a benefit. In other cases, a service will not be covered by my insurance company because it decides the service is not necessary, despite my provider's decision to order the service. In any event, even if a service is not covered by insurance, I agree to pay for all charges for all services rendered, including the specific services rendered as part of medical treatment. If Atrium Health deems necessary, I authorize Atrium Health to file member grievances on my behalf with my health plan for any denied claims. I appoint representatives of Atrium Health to act as my representative in pursuing such grievances. I further agree that in the event benefits paid under this assignment or any other amounts paid by me/us or on my/our behalf exceed the amounts due Atrium Health, my providers, or those professional groups or entities for services in connection with this medical treatment, any such excess amount may be applied to any other indebtedness that I or my spouse or any child for whom I am financially responsible may have to Atrium Health or any other facility or entity related to Atrium Health, my providers, or other professional groups or entities included in this assignment.

NOTICE OF INDEPENDENT CONTRACTORS. I understand that Atrium Health has contracted with certain independent professional groups for such groups to provide exclusively certain medical services at Atrium Health facilities, including but not limited to radiology and imaging, anesthesia and pain services, pathology, radiation oncology, and emergency medicine services. I understand that professional groups providing those services are independent contractors, are not employees or agents of Atrium Health, and are not subject to control or supervision by Atrium Health in their delivery of professional services.

USE OF MEDICAL INFORMATION. I understand that Atrium Health and my providers and independent professional groups providing medical services can use my information for treatment, payment, and health care operations, as further outlined in the Atrium Health Notice of Privacy Practices. As clarification, I understand that Atrium Health and my providers may give any medical information relating to my medical treatment to any insurance company, governmental or charitable and social service agencies and their agents, and professional review organizations with whom I may have insurance coverage or who may be assisting in payment of my medical treatment. I also understand that Atrium Health and my providers may release any medical information to any health care provider or medical facility to which I may be referred or transferred for further medical care or support services. I authorize Atrium Health and my provider to take and produce pictures, recordings, and/or videos of me for treatment and health care operation purposes. I can object to, or rescind my permission for, pictures, recordings, and videos being taken or produced for reasons other than treatment and health care operations at any time. In addition, I authorize Atrium Health and my providers to release any medical information necessary to prove Atrium Health's damages in any legal proceeding brought to enforce any unpaid balance on any of my accounts.

PHONE AND TEXT MESSAGE COMMUNICATIONS. I authorize Atrium Health and its representatives (including third-party agents) to contact me by phone using pre-recorded messages and/or automated dialing systems at any phone number associated with me or my personal representatives, including wireless numbers, in connection with any matter relating to my treatment, payment, or account, or to advise me of products or services that may be of interest to me. I can only decline to receive further calls or messages by following the reasonable instructions specifically provided by Atrium Health. I understand that I am not required to agree to receive phone calls and messages in order to receive treatment or other Atrium Health services. By providing my email address and cell phone number, I give permission for Atrium Health (including its agents and contractors) to send me information, reminders, and messages using those means of communication. I authorize Atrium Health to send me unencrypted messages using these means of communication, and I understand and accept the risks associated with doing so.





Atrium Health

AUTHORIZATION TO RELEASE MEDICARE AND MEDICAID INFORMATION. I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct.

PAYMENT GUARANTY. I (patient and/or responsible party/ies) agree to pay all charges for services rendered by Atrium Health and my physicians and other providers for my medical treatment. This guaranty includes charges for services not covered by any insurance, regardless of the reason that insurance coverage is denied. I agree to pay the Hospital account I incur in accordance with the rates and terms of the Hospital at the time of my discharge. If I fail to pay all charges and Atrium Health or my providers use an attorney to collect unpaid charges, I agree to pay the reasonable cost of the attorney's services in addition to the unpaid charges. I consent and authorize Atrium Health and its agents and subcontractors to contact outside data sources of its choosing, including credit reporting agencies, for purposes related to my account, including evaluating and assessing my credit worthiness, my charity eligibility, and the viability of collecting any amounts due for the treatment I receive, whether at this time or on subsequent visits. I understand and agree that Atrium Health may assign my accounts as it deems necessary for purposes of collecting any amounts I owe, including to collection agencies and attorneys.

PERSONAL PROPERTY. I understand that Atrium Health is not responsible for money, valuables and other personal property in my possession and has no liability for their loss.

APPOINTMENT AND RELEASE FOR FINANCIAL PURPOSES. I appoint the Financial Counseling staff of Atrium Health as my (and the patient's) agent and personal representative for the purpose of initiating applications for Medical Assistance programs and/or conducting any and all activities associated with determining eligibility for such benefits, including, but not limited to, including Medical Assistance, Aid to Families with Dependent Children, and Special Assistance. The Financial Counselor may have access to and copy any records or information to which I would be entitled. I authorize and direct the County Department of Social Services to send copies of all notices, requests for information, and actions taken in my case including approvals and denials, and to provide such information to the Financial Counselor electronically or via telephone if requested. I authorize the Hospital, at its own expense, to obtain legal representation to assist in the evaluation, application or appeal processes. The doctrine of informed consent has been explained to me.

I have read the foregoing request and authorization in its entirety and agree to be bound by all terms and conditions herein. I acknowledge that this consent is voluntary and that it may be revoked by me in writing at any time except to the extent that action has already been taken in reliance on it. Unless otherwise revoked, this consent shall be valid for one (1) year from the date of a authorization, or until final determination of any benefits application as described above, whichever is later; however, the consent will not expire for services, claims processing or collection activities for admissions or visits occurring while this consent was in effect. The undersigned hereby consents to such medical treatment as my provider(s) order and indicate the same by my (our) signature below. Witness my (our) hand(s) and seal(s) below.

Name of Patient: _____ (Seal) Phone number: _____

Patient/Responsible Party Signature (Seal) Relation, if not Patient:
_____ Spouse
_____ Parent/s
_____ Other (Specify: _____)

Date Time

Witness Date Time

I have been provided access to Atrium Health's Notice of Privacy Practices

Patient/Authorized Representative Signature Relation, if not Patient:
_____ Spouse
_____ Parent/s
_____ Other (Specify: _____)

Date Time

Reason Patient Unable/Unwilling to sign _____

REQUEST FOR TREATMENT AND AUTHORIZATION FORM

PATIENT LABEL



NorthEast Plastic & Reconstructive Surgery

Patient Name: _____

Today's Date: __/__/__

Primary Care Physician: _____

Date of Birth: __/__/__

Referring Physician: _____

Reason for today's visit:

For Physician Use Only

(HPI: Location, Duration, Timing, Severity, Quality, Modifying Factors, Signs & Symptoms, Context)

Current Medications:

Allergies:

Past Surgeries & Approximate Dates:

Previous Medical History:

NorthEast Plastic & Reconstructive Surgery

Medical History

Please mark Yes or No if you have had any of the following:

Stroke

Yes No

Heart Disease

Yes No

Stomach Ulcers

Yes No

Hepatitis

Yes No

Arthritis

Yes No

Anemia

Yes No

Other:

HIV &/or AIDS

Yes No

Glaucoma

Yes No

Cancer

Yes No

Asthma

Yes No

Sleep Apnea

Yes No

Blood Clots

Yes No

Bleeding Tendency

Yes No

Thyroid Disease

Yes No

Rheumatic Fever

Yes No

High Blood Pressure

Yes No

Tuberculosis

Yes No

Diabetes

Yes No

Social History:

Do you currently smoke? Yes No If yes, amount per day: _____

Are you a former smoker? Yes No If yes, when did you quit? _____

Do you drink alcohol? Yes No If yes, amount per week: _____

Occupation: _____

Marital Status: M S D W

Recreational Activities:

NorthEast Plastic & Reconstructive Surgery

Family Medical History

Please mark Yes or No if any blood relative has had any of the following:

Breast Cancer

Yes No

Heart Disease

Yes No

High Blood Pressure

Yes No

Hemophilia

Yes No

Problems w/Anesthesia

Yes No

Melanoma

Yes No

Colon Cancer

Yes No

Diabetes

Yes No

Please note that a blood relative would be your:

Mother

Father

Paternal Grandparents

Maternal Grandparents

Aunt

Uncle

Brother

Sister

Review of Systems

Please mark Yes or No if you had any of the following symptoms in the past year:

Weight Changes

Yes No

Chest Pain

Yes No

Jaundice

Yes No

Seizures

Yes No

Joint Pain

Yes No

Chronic Cough

Yes No

Easy Bruising

Yes No

Fever Blisters

Yes No

Swollen Feet/Ankles

Yes No

Nausea/Vomiting

Yes No

Rapid Heart Beat

Yes No

Depression

Yes No

Easy Bleeding

Yes No

Muscle Pain

Yes No

Shortness of Breath

Yes No

Trouble Urinating

Yes No

Dry Eyes

Yes No

Fever/Chills

Yes No

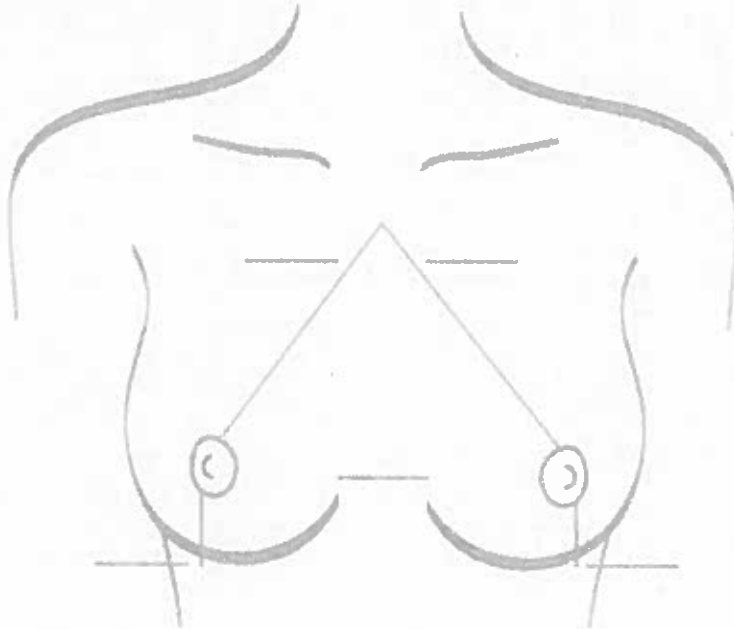
I affirm that the above information is correct and I am not withholding any of my previous medical history, to the best of my ability.

Signature: _____

Relation to Patient: _____

Date: _____

NorthEast Plastic & Reconstructive Surgery



| Breast Parameters | | | |
|------------------------------|---|----------|---|
| Left | | Right | |
| Suprasternal Notch to Nipple | | | |
| _____ cm | | _____ cm | |
| Breast Width | | | |
| _____ cm | | _____ cm | |
| Nipple to Inframammary Fold | | | |
| _____ cm | | _____ cm | |
| Grade Ptosis | | | |
| 0 | 1 | 2 | 3 |
| Grams to be removed: | | | |
| _____ | | | |
| Cup Size: _____ | | | |

For Women Only:

Have you ever had a mammogram? Yes No (If yes, when? _____)

Do you do regular self breast exams? Yes No

Have you ever had breast lumps or discharge? Yes No

Are you pregnant? Yes No

Last Menstrual Period: _____

Do you plan on having more children? Yes No

Number of Pregnancies: _____

Number of Live Births: _____

Did you breast feed? Yes No

Bra Size _____

Have you had a C-Section? Yes No

I affirm that the above information is correct and I am not withholding any of my previous medical history, to the best of my ability.

Signature: _____

Date: _____