Queen City Plastic Surgery - Patient Information **Date:** _____

Name (Last, First): _____ Date of Birth: _____

Age: _____ SSN#: _____ Email: _____

Address: _____ City: _____ St: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

CURRENT INSURANCE INFORMATION:

Primary Insurance: _____ ID #: _____ Group#: _____
Policy Holder's name and DOB _____
Secondary Insurance: _____ ID #: _____ Group#: _____

PRIMARY CARE PHYSICIAN: _____
Address: _____
Phone: _____ Fax: _____

OTHER PHYSICIANS SUPERVISING YOUR MEDICAL CARE:
Name: _____ Specialty: _____ Ph#: _____
Name: _____ Specialty: _____ Ph#: _____

PHARMACY INFORMATION:
Name: _____ PH#: _____ Zip Code: _____

Emergency Contact: _____ Phone#: _____
Relationship to patient: _____

Reason for today's visit: _____

How did you hear about us? (please circle one)

Referring Physician	Current /Former Patient	Sign on Building	Insurance Website	Radio
Social Media	Website	Internet Search	RealSelf.com	Google Ad
Employee Referral	Other Source:			

Patient Medical History and Intake Form

Please CIRCLE any medical conditions you may have been told you have or have had in the past:

Diabetes
Heart Disease
GI Problems
Chronic Pain Syndrome
Hepatitis
Stroke
Seizures
Depression
Asthma
Emphysema (COPD)
Tuberculosis
HIV/AIDS
Blood Clots (DVT)
Hypothyroid
Cancer (Type) _____
Sickle Cell Anemia
Kidney Disease/Failure
Bleeding Problems
High Blood Pressure
Stomach Ulcers

Other: _____

Please indicate your current medication usage including any over-the-counter medications, supplements, or herbal remedies

MEDICATION/SUPPLEMENT	DOSAGE	HOW OFTEN?	PHYSICIAN
1.			
2.			
3.			
4.			
5.			
6.			

Have you ever had surgery in the past? If yes, please complete the table below.

DATE	SURGERY/ILLNESS	HOSPITAL/PHYSICIAN
1.		
2.		
3.		
4.		

Are You Allergic to Any Medications? Yes / No (Please list below if you have any medication allergies)

Please List Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

Allergic to Latex? Yes / No Have you ever had a reaction to local or general anesthesia? Yes / No

Do You Smoke? Yes / No If Yes, How many packs a day do you smoke: _____
If No, Have you ever smoked? Yes / No How many years ago did you quit? _____

How often do you consume alcoholic beverages? _____ per_____

FAMILY HISTORY:
Please mark any health problems of blood relatives (Parents, Grandparents, Children, Sister, Brother Etc.)

Cancer:	Yes / No	Relative: _____
Heart Disease:	Yes / No	Relative: _____
Stroke:	Yes / No	Relative: _____
Diabetes:	Yes / No	Relative: _____
Sickle Cell Anemia:	Yes / No	Relative: _____
Keloid Scar	Yes / No	Relative: _____

For **FEMALE** Patients:
Are you Pregnant? _____ Number of Live Births? _____ Age of youngest child: _____
Last Mammogram _____

QUEEN CITY
PLASTIC SURGERY

Release of Medical Records

I give permission to release the health information of:
Patient name: _____
Address_____
Date of birth_____ Telephone _____

Send To : Queen City Plastic Surgery at 3025 Springbank Lane, Charlotte, NC 28226.
Phone 704-372-5685 / Fax 704-372-5686

I authorize Queen City Plastic Surgery to use and/or disclose a copy of the specific health information identified above. By initialing the spaces below, I specifically authorize the use of disclosure of the following health information created and maintained by Health Care Component of Queen City Plastic Surgery.

- ❑ Entire Medical Record
- ❑ Pathology Reports
- ❑ Clinical Notes
- ❑ Lab Reports
- ❑ Radiology Reports
- ❑ Other _____

The following items must be checked to be included in this request for use or disclosure:

- ❑ HIV/AIDS related information
- ❑ Mental Health
- ❑ Genetic Testing Information
- ❑ Drug and Alcohol Treatment Information

Authorization for use or disclosure of psychotherapy notes shall not be combined with any other authorization for use and disclosure of protected health information. You must complete and additional and separate authorization specific to psychotherapy notes. I understand that if the person or organization, ot health plan covered by federal privacy regulations, then this information may be redisclosed and no longer be protected by these regulations. I understand that I may refuse to sign this authorization and QCPS will not condition treatment, payment, enrollment of eligibility benefits on my refusal.
I understand that I may revoke this authorization in writing at any time, provided that I do in writing, except to the extent action has been taken upon this authorization. Unless revoked earlier, this authorization to use of disclose your health information will expire on ____.
Finally, I have read and understand this information. I have received a copy of this form if the request for use of disclosure is being made by a Health Care Component of Queen City Plastic Surgery. I am the patient or I am authorized to act on behalf of the patient to sign this document authorizing the use or disclosure of Protected Health Information under the above terms.

_____ _____
Print Name Date

_____
Signature

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PLASTIC SURGERY

AUTHORIZATION FOR RELEASE OF
PATIENT PHOTOGRAPHS AND/OR VIDEO IMAGES,
INCLUDING PRE AND POSTOPERATIVE INSTRUCTIONS

Please read this information carefully and completely, and if you consent, please sign below.

INTRODUCTION

Medical and non-medical photographs/slides and video may be taken before, during, or after a surgical or non-surgical procedure or treatment. Consent is required to distribute such images. Additionally, patients may consent to release these medical photography/slides, images, and videos for a stated purpose.

CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Dr. Enam Haque. and/or his associates to use my first name, testimonials, pre-operative, intra-operative, and post-operative photographs, slides, and/or videos for professional purposes, deemed appropriate including but not limited to showing these images on public or commercial television, print, internet, social media, and electronic digital networks, for purposes of medical education, advertising, patient education, lay publication, or during lectures to medical or lay groups.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and /or my interview. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

3. REVOCABILITY

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 25 years from date signed.

4. NO TREATMENT CONDITIONS

I understand that the practice cannot condition treatment on whether or not I sign this authorization.

Date:_____

Patient Signature: _____ Printed:_____

Witness: _____ Printed:_____

QUEEN CITY
PLASTIC SURGERY

Date of Service: _____

_____ _____

Print Name of Patient Date of Birth

Statement of Financial Responsibility

Queen City Plastic Surgery appreciates the confidence you have shown in choosing us to meet your cosmetic and reconstructive needs. We are committed to your treatment being successful. Toward that end, please understand that payment of your bill is considered part of your treatment. The services you are participating in imply a financial responsibility. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. This form should be signed prior to treatment.

Full payment is due at the time of service unless other arrangements have been made. Please be sure to have a form of payment with you at the time of your visit. If you do not have a form of payment on your person at the time of your visit, we would be happy to reschedule your appointment.

Insurance Information

Our practice accepts insurance from most major insurance companies. As a courtesy, we will file your claim to the respective insurance company. To avoid any misunderstandings regarding payment for professional services, QCPS requests that you authorize all insurance company payments directly to our practice. If you choose not to do so, all charges will be due and payable by you at the time of service. You will be responsible for any portion of your bill which is denied, applied to deductible, considered a copayment or coinsurance portion or is considered non-covered by your insurance plan.

Payment Policy

At the time of service, we will determine the portion of the bill for which you are responsible. Prior to leaving, you will be responsible for paying your portion of the charge or pre-authorizing QCPS to charge your debit or credit card for the portion not covered by insurance. In an effort to control health care costs and better serve our patients, it is our policy to minimize billing patients.

All self-pay patients will be required to pay at the time of service. Co-pays must be paid at the time service is rendered. These co-pays are a required part of your contract with your insurance carrier and increase the cost of billing unnecessarily if not paid at the time of service. Patients should receive a written notice from their insurance carrier when a claim is closed and payment is made to the practice. Our staff will apply this payment to your account upon receipt, but there may be a delay of a few days in posting.

Insurance and Cosmetic Surgery

Cosmetic Surgery procedures are often not covered by insurance. As a courtesy, Queen City Plastic Surgery will try to pre-authorize a procedure if the patient wishes. If the requirements of medical necessity, as outlined in your insurance plan/contract, are met, we will submit a claim after surgery. Any claims submitted to your insurance carrier will carry charges for services, including office consultation, for which you are responsible.

If the requirements for medical necessity are not met, your surgery will be considered cosmetic and you will be responsible for full payment.

Financial Policy for Cosmetic Patients

Surgery scheduling requires planning and coordination between multiple service providers. For this reason, please understand the importance of our booking and cancellation policy.

In order to book a cosmetic procedure, a 50% deposit is required.. The balance of your financial responsibility is due a minimum of 2 weeks (14 days) before your surgery date. After this period, only a credit card or cash will be accepted. If payment is not received 2 weeks before surgery, your surgery date may be rescheduled.

Cancellations made more than 14 days prior to your surgery will result in a 15% cancellation fee. Cancellations made less than 14 days before your surgery date will result in the loss of your 50% deposit.

Enam Haque, MD, FACS PLASTIC AND RECONSTRUCTIVE SURGERY
3025 Springbank Lane, Suite 240 | Charlotte, NC 28226 | 704.372.5685 p 704.372.5686 f | QCPLASTICSURGEONS.COM

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Billing Statement

The amount shown in the "Patient Responsible" column is your obligation and is due and payable upon receipt. If payment is late or prior payment arrangements have not been made, a 1.5% monthly finance charge will be assessed to all balances over 30 days past due. Accounts over 120 days without satisfactory payment will be turned over to a collection agency. Outstanding accounts result in a loss of time and money, therefore patients with delinquent accounts will be required to make payment at the time of service. Several payment options are available for your convenience.

Billing Questions

Questions or concerns regarding your account or insurance claim should be directed to our front office coordinator. QCPS firmly believes that a good doctor-patient relationship is based on understanding and good communication. The front office staff has been instructed to make every effort to clarify any misunderstandings you have concerning your balance and resolve your financial questions and concerns. Please notify us immediately if you feel an error appears on the statement or if you have any questions or concerns.

I, _____, understand that the service (s) being provided to me today may not be covered in whole or in part by insurance company.

I agree to be personally and fully responsible for payment of any co-payment at time of service and on receipt of a bill for any deductible/co-insurance as determined by my insurance carrier. I understand that if charges are filed to my insurance and are denied or paid only in part, the remaining balance will be billed directly to me.

I am aware that I will receive monthly statements detailing any outstanding balances on my account as my account ages. I further understand that a 1.5% finance charge will be added to any balance over 30 days. In the event of a default, I promise to pay legal interest on the indebtedness, together with such collection cost and reasonable attorney fees as may be required to effect collection of this note. I have read the Financial Policy. I understand and agree to this Financial Policy.

Printed Name	Signature of Responsible Party	Date
Printed Name	Signature of Co-Responsible Party	Date
Printed Name	Authorization for Assignment of Benefits	Date

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