QUEEN CITY PLASTIC SURGERY

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

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

Age: _____ SSN#: _____ Email: _____

Address: _____ City:_____ State: _____ 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#: _____

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

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

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

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 or vape? Yes / No If "Yes", how many/often: _____
If "No", have you EVER smoked or vaped? Yes / No If "Yes", how long 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 _____

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Patient Financial Policy

Statement of Financial Responsibility

Full payment is due at the time of service unless you are covered under an insurance policy in which we participate. As a courtesy, we will file your claim to the respective insurance company. 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. Many insurance plans require you to have specific doctors, pre-certification and/or a referral. You are responsible for knowing and understanding the details of your plan. You are responsible for verifying that we are in-network with your insurance prior to your appointment.

Payment Policy

At the time of service, we will determine the portion of the bill for which you are responsible. 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. We accept payment in the form of cash, check, or credit card. There is a $30 charge for a returned check.

Missed or Canceled Appointments

Please call 24 hours in advance to cancel or reschedule your appointment. Missed appointments or same day cancellations/reschedules will incur a **$50.00** charge. Missed or same day canceled/rescheduled procedure appointments will result in a **$100 charge**.

Financial Policy for Cosmetic Patients

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. 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.

Billing Statement

You will receive monthly statements detailing any outstanding balances on your account. The amount shown in the "Patient Responsibility" column is your obligation and is due and payable upon receipt. Accounts over 120 days without satisfactory payment will be turned over to a collection agency.

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

Printed Name	Signature of Responsible Party	Date

QUEEN CITY
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 marketing
- for purposes of medical education, 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 the 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: _____

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..

- ❑ 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 an additional and separate authorization specific to psychotherapy notes. I understand that if the person or organization, or 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 or disclose your health information will expire on ___.

Finally, I have read and understood 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

QUEEN CITY
PLASTIC SURGERY

Cancellation and No Show Policy

We have reserved your appointment time just for you. In order to accommodate all of our patients, we ask that you make every effort to keep your reserved time. We understand that situations arise in which you must cancel or reschedule your appointment. We request that if you must change your appointment you provide more than 24 hours notice.

Office appointments which are canceled or rescheduled with less than 24 hours notification are subject to a $50.00 fee. Procedure cancellations require 5 day advance notice and are subject to a $150.00 fee.

Patients and cosmetic consultations who do not show up for their appointment without prior notification will be considered a No Show and are subject to a $50.00 fee. Any cosmetic consultation fees will be forfeited as a No Show fee.

The cancellation fee and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

If you have any questions regarding our Cancellation and No Show policy, please call us at 704-372-5685.

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

Patient Name (Please print)_____ Date of birth _____

Signature_____ Date _____