Patient Name: (verify & update) «Person_First_Middle_Last»		Marital Status	Separated☐ Widowed☐ Divorced☐
SS#:	Sex:	Date of Birth:	Age:
Street Address:			Zip:
Full Mailing Address:			
Home Phone:	Work Phone:		Cell Phone:
Email Address:			
Referring Physician:		Primary Care Physician:	
Employer Name:		Employer Phone Number:	

Financial Responsible Party Information (If patient is under 18 or under the care of a legal guardian)

Responsible Party Name:	Date of Birth:	SS#
Relationship to patient:	Home phone:	Work phone:
Responsible Party Full Address:		

Emergency Contact Information

Emergency Contact Name:	Home Phone #	Work or Cell #

How did you hear about Advanced Cosmetic Surgery?

Anderson Talking Phone Book☐ Spartanburg Talking Phone Book☐ Radio☐ Yahoo☐
Google☐ ACS Website☐ Looking Your Best☐ Greenville Yellow Pages☐ Patient☐ Other☐

Is insurance to be filed for this service?	Reason for consultation with Advanced Cosmetic Surgery

Insurance Information – Primary Insurance

Primary Insurance Name	Primary ID Number
Insured's Name	Group #
Employer Name	Employment Status of Insured None ☐ COBRA coverage ☐ Retired ☐ Part time☐ Full time☐
Policy Holder Date of Birth Policy Holder SS#	Relationship to patient

Insurance Information – Secondary Insurance

Secondary Insurance Name	Secondary ID Number
Insured's Name	Group #
Employer Name	Employment Status of Insured ☐ Full time☐emitPart ☐ Retired ☐ coverage COBRA None ☐
Policy Holder Date of Birth	Relationship to patient

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. In the event that my insurance company does not pay Advanced Cosmetic Surgery in 60 days, I understand that I will be responsible for all charges and will assist in collecting payment from my insurance company. I will also assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Advanced Cosmetic Surgery (ACS). I also authorize agents of any hospital, treatment center or previous physicians to furnish ACS copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and / or reports related to my treatment to any federal, state, or accreditation agency, or any physician or insurance carrier as needed. I also agree to review of my records for purposes of internal audits, research and quality assurance reviews within ACS.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing / physician services including major medical benefits are hereby assigned to ACS. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims or services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to ACS.
4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payors, (b) governmental bodies (such as the Food and Drug Administration and the Health Care Financing Administration), (c) representatives and agents of my health benefit plan, (d) persons conducting quality or peer review or patient satisfaction surveys, and (e) other clinical and non-clinical parties that have a contractual relationship with Advanced Cosmetic Surgery.
5. Any and all proceeds, whether by settlement or otherwise, from any lawsuit or claim by the undersigned against any third party who is, or may be, liable or responsible for the injuries for which treatment is being provided are assigned to Advanced Cosmetic Surgery for payment of any or all services.
6. Any and all Personal Injury Protection (PIP) benefits, underinsured motorist benefits, uninsured motorist benefits, or similar insurance benefits payable with respect to the treatment or services provided by Advanced Cosmetic Surgery are assigned to Advanced Cosmetic Surgery for payment of any or all services.

THIS AGREEMENT / CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.
I have read the above statements and accept the terms. A duplicate of the statement is considered the same as original.

Date	Patient Signature	Date	Responsible Party Signature
«Date»		«Date»	

Advanced Cosmetic Surgery
29 Rocky Slope Road
Greenville, South Carolina 29607

Patient Health Questionnaire – Please answer all!

Date: **«Date»**

Name **«Person_First_Middle_Last»**	Age	Ht	Wt	Wt 1 Year Ago

When was your last chest x-ray?	When was your last electrocardiogram?
When was your last physical exam?	Physician's Name
Address of physician	Phone # for Physician
Emergency Contact Name:	Address: Phone:
Are you under a doctor's care? ☐ Yes ☐ No	If yes, for what condition(s)?

List any operations or serious illnesses

_____ Date

_____ Date

_____ Date

_____ Date

Daily Consumption of Tobacco

Daily Consumption of Alcohol

Have a history of the following:

Heart attack, Stroke, rheumatic fever, high/low blood pressure, chest pain, other cardiac related	☐ Yes	☐ No
Do your ankles swell?	☐ Yes	☐ No
Do you get short of breath when lying down, or use extra pillows when sleeping?	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Hives, flashes, or skin disease?	☐ Yes	☐ No
Fainting spells or seizures?	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No
Hepatitis, jaundice, cirrhosis	☐ Yes	☐ No
Stomach ulcers	☐ Yes	☐ No
Arthritis, rheumatism	☐ Yes	☐ No
Kidney problems	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Persistent cough	☐ Yes	☐ No
Cough up blood	☐ Yes	☐ No
Venereal disease	☐ Yes	☐ No
Emotional illness	☐ Yes	☐ No
Abnormal bleeding associated with tooth extractions or surgery	☐ Yes	☐ No
Blood disorders, such as anemia	☐ Yes	☐ No
Treatment for a tumor or growth of the nose, throat, or mouth	☐ Yes	☐ No

Are you taking any:

Antibiotics	☐ Yes	☐ No
Blood Thinners	☐ Yes	☐ No
Diet Pills	☐ Yes	☐ No
Medicine for High Blood Pressure	☐ Yes	☐ No
Cortisone (steroids)	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No
Tranquilizers	☐ Yes	☐ No
Anti Depressant	☐ Yes	☐ No
Nitroglycerin	☐ Yes	☐ No
Digiralis, Lanoxin, or other heart medication	☐ Yes	☐ No
Insulin, orinase or similar	☐ Yes	☐ No
Hormones	☐ Yes	☐ No
Any other medications	☐ Yes	☐ No

If YES to ANY of the above, give

Name of drug	Dose	How often?

If yes to ANY of the above, please elaborate:

Are you pregnant?	☐ Yes	☐ No
Do you take birth control pills	☐ Yes	☐ No
Are you breast feeding	☐ Yes	☐ No

An Allergy Sensitivity To:

Local Anesthetics?	☐ Yes	☐ No
General Anesthetics?	☐ Yes	☐ No
Penicillin or other antibiotics	☐ Yes	☐ No
Iodine or adhesive tape	☐ Yes	☐ No
Morphine, codeine, Demerol	☐ Yes	☐ No
Other	☐ Yes	☐ No

If YES to ANY of the above GIVE NAME OF DRUG(S)

Family History	Age	State of Health	List any medical problems	Age at Death	Cause
Father					
Mother					
Sisters					
Brothers					
Children					

Consent for Photographs / Films / Video

I authorize **Thomas C. McFadden, M.D**. of **Advanced Cosmetic Surgery** and associates or assistants of his choice, to take photographs/ films / video of the treatment site for purposes as listed below on **«Person_First_Middle_Last»**.

I understand that the photos /films / videos, if taken, are the property of Advanced Cosmetic Surgery (Thomas C. McFadden, Jr., M.D.) I may obtain a copy of any photographs taken upon my request with a consent to release medical records on file (as per Health and Insurance Portability and Accountability Act).

Please initial next to each statement, either agreeing to have photographs / films / video taken for each purpose or opting to disagree and not allow photographs / films / video to be taken for that purpose.

Photographs are sometimes taken in some cases for insurance purposes (some procedures would require records and photographs to be sent to the insurance company in order for medical necessity to be established).

Patient / Legal Guardian's Initials ↓

_____ **YES, photographs / films / video may be taken for insurance purposes.**

_____ **NO, photographs / films / video may not be taken for insurance purposes. I understand that my insurance company may not certify certain procedures as medically necessary without this information.**

Photographs / films / video are sometimes taken in certain cases for teaching purposes. This would include showing photographs to other patients that may need the same or similar procedures. Your name and any identifying information would not be disclosed.

Patient / Legal Guardian's Initials ↓

_____ **YES, photographs / films / video may be taken for teaching purposes.**

_____ **NO, photographs / films / video may not be taken for teaching purposes.**

Photographs / films / video are sometimes taken to use in advertising for Advanced Cosmetic Surgery (Thomas C. McFadden). Your name and identifying information would not be disclosed.

Patient / Legal Guardian's Initials ↓

_____ **YES, photographs / films / video may be taken for advertising purposes for Advanced Cosmetic Surgery (Thomas C. McFadden, Jr., M.D.).**

_____ **NO, photographs / films / video may not be taken for advertising purposes**

Photographs / films / video are sometimes taken to use on Advanced Cosmetic Surgery's (Thomas C. McFadden, Jr., M.D.) website. Your name and any identifying information would not be disclosed.

Patient / Legal Guardian's Initials ↓

_____ **YES, photographs / films / video may be taken for use on the website for Advanced Cosmetic Surgery (Thomas C. McFadden, Jr., M.D.).**

_____ **NO, photographs / films / video may not be taken for use on the website for Advanced Cosmetic Surgery (Thomas C. McFadden, Jr., M.D.).**

I understand each statement above and have answered YES or NO to each statement. I understand that if I do not understand why a photograph / film / video is being taken I DO have the opportunity and right to ask what purpose that photo / film / video will be used for and may decline to have photograph / film / video taken at that time, even if I have consented on this form.

SIGNATURE Patient / Legal Guardian	**Date «Date»**	**Relationship to patient (self, parent, legal guardian)**
PRINT patient / Legal Guardian name		**Witness Signature and Date**

HIPAA Notification Form

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Patient Name:	Patient Signature:	Date
«Person_First_Middle_Last»		«Date»

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implanted a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

FOR EMPLOYEE USE ONLY

A good faith effort was made to give our HIPAA Privacy Notification to the patient named above but it was refused. No signature on file.

Print Employee Name:	Employee Signature:	Date
		«Date»

PLEASE READ CAREFULLY

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian shall be understood to mean **«Person_First_Middle_Last»**.

"Physician", shall be understood to mean Dr. Thomas McFadden, Jr. and Advanced Cosmetic Surgery.

I understand that I am entering into a contractual relationship with Dr. Thomas McFadden for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the Physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I, initiate or pursue a meritorious medical malpractice claim against Dr. Thomas McFadden, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Society of Plastic Surgeons and American Board of Plastic Surgery.

I agree that the expert will be obligated to adhere to the guidelines or code of conduct defined by the American Society of Plastic Surgeons and American Board of Plastic Surgery, as well as the expert's state medical board, and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members.

. I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/Guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, personal representatives, spouses and other dependents.

Physician and Patient/Guardian agree that these provisions apply to any claim for medical malpractice whether based on theory of contract, negligence, battery or any other theory of recovery.

Patient/Guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions and to ask questions about it.

_____ _____

Physician Patient/Guardian

«Date»

_____ _____

Effective from Date of Treatment Date of Signature

MUTUAL AGREEMENT TO MAINTAIN PRIVACY

Dr. Thomas C. McFadden, Jr. and Advanced Cosmetic Surgery (collectively labeled "Physician") agree to provide treatment to **«Person_First_Middle_Last»** ("Patient"). The Physician takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician believes this is improper and may not be in the patients' best interest. Accordingly, Physician agrees not to provide any list for marketing or be paid for selling patient lists or protected health information to any part for the purpose of marketing directly to patients. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Physician has invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about the Physician-his practice, expertise, and/or treatment-on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be in force and enforceable for a period of five years from Physician's last date of service to Patient. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship

Patient and Physicians acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

SO AGREED THIS _____ DAY OF _____, 20_____.

«Person_First_Middle_Last» _____
(Patient Name) (Patient Signature)

Dr. Thomas C. McFadden, Jr.
Advanced Cosmetic Surgery