

RENAISSANCE

PLASTIC SURGERY, P.C.

PATIENT REGISTRATION

PATIENT INFORMATION

NAME: _____ DATE: _____

SOCIAL SECURITY: _____ AGE: _____

DATE OF BIRTH: _____ MARITAL STATUS _____ RACE _____ SEX _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK: _____ CELL: _____

CAN WE CONTACT YOU AND OR LEAVE A MESSAGE AT THESE NUMBERS? YES NO

EMAIL ADDRESS: _____

CAN WE SEND CONFIDENTIAL INFORMATION TO YOU? YES NO

PATIENT EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____ STATE: _____ ZIP: _____

INSURANCE INFORMATION

1ST INSURANCE CO: _____ INSURED NAME: _____

INSURED DATE OF BIRTH: _____ SOCIAL SECURITY: _____ PHONE: _____

ADDRESS: _____ STATE: _____ ZIP: _____

2ND INSURANCE CO: _____ INSURED NAME: _____

INSURED DATE OF BIRTH: _____ SOCIAL SECURITY: _____ PHONE: _____

ADDRESS: _____ STATE: _____ ZIP: _____

RESPONSIBLE PARTY

RESPONSIBLE PARTY: _____ RELATIONSHIP: _____

EMERGENCY CONTACT: _____ PHONE: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? Radio _____ Newspaper _____ Magazine _____ Yellow Pages _____ Internet _____
Physician _____ Friend _____ Family _____

I hereby authorize payment directly to Renaissance Plastic Surgery, PC and/or Renaissance Surgical Centre', LLC for any surgical and/or medical benefits due. I further authorize release of any information, photographs, and or slides acquired in the course of my examination and/or treatment to recover such payments. I understand that payment is due at the time of service. I further understand and agree that my insurance is filed as a courtesy and that I am ultimately responsible for any balance due after the insurance company has made payment.

PATIENT SIGNATURE

4030 Riverside Park Boulevard

• Macon, GA 31210

DATE

478-474-2200

• Fax 478-314-0740

RENAISSANCE

MEDICAL/SURGICAL HISTORY

Patient Name

Date

Procedure

Describe in your own words the reason for your visit to our office. Also, give names of any physician contacted regarding this problem.

In this time of rapidly expanding medical knowledge and the increasing specialization associated therewith, there exists a very real risk of specialist physician not being aware of the general health and medical background of the patient. On occasion such information may critically affect what procedures we may safely undertake on you and under what circumstances. We, therefore, ask that you give us the following medical information.

Age:	Height:	Weight:	Occupation:
List all Drug Allergies:			
Do you have an allergy to Latex? <input type="checkbox"/> yes <input type="checkbox"/> no			
Are you a smoker? <input type="checkbox"/> yes <input type="checkbox"/> no Ex-smoker? <input type="checkbox"/> yes <input type="checkbox"/> no Non-smoker? <input type="checkbox"/> yes <input type="checkbox"/> no			
How much are (were) you smoking?		How long?	Quit: how long?
How much alcohol do you drink?		Caffeine?	
Please circle all of the following medical conditions you now have or have had in the past:			
Mitral Valve Prolapse / bleeding tendency / hepatitis / diabetes / blood transfusions . glaucoma / dry eyes / lung disease / TB / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / breast cancer / heart attack / stroke / epilepsy / heartburn / intestinal ulcers or bleeding / depression / mental illness / drug or alcohol addiction / cancer / kidney disease / breast disorders / skin cancer / melanoma / high blood pressure / rheumatoid arthritis / scleroderma / lupus / autoimmune disease / unexplained weight loss / chronic fatigue / positive HIV/AIDS test			
Any possibility that you may be pregnant at this time? <input type="checkbox"/> yes <input type="checkbox"/> no			last cycle
Number of pregnancies:		Last Tetanus shot:	
Have you had any serious injuries, broken bones, etc.? <input type="checkbox"/> yes <input type="checkbox"/> no			
Have you or anyone in your family had an unusual reaction to anesthesia (muscle weakness, jaundice, breathing problems, or unexpected fever)? <input type="checkbox"/> yes <input type="checkbox"/> no			
Do you have any: (circle one) loose or chipped teeth / dentures / caps / contact lens?			
Have you ever seen a Cardiologist? <input type="checkbox"/> yes <input type="checkbox"/> no			
Name:		Address:	
City:	State:	Zip:	Date of last EKG:
Family Physicians Name:		Date of last visit:	
Address:		City:	State: Zip:

MEDICAL/SURGICAL HISTORY

Patient Name

Date

List all surgeries that you have had (include plastic surgery):	Date:

Please list all medications which you are currently taking or have used in the past 6 months:

Be sure to list any of the following: birth control, aspirin or ibuprofen containing drugs, Redux Phen-Fen, diabetic medications, steroids, glaucoma drops, asthma medications, Digoxin, Lanoxin, nitroglycerin, Isordil, Inderal, other heart medication, Lasix, other diuretics, high blood pressure medications, Coumadin, Persantine, tranquilizers, anti depressants, pain pills or shots, epilepsy medications.

Medications:	Amount:	Frequency:

Is there any other information we should know about you or your family? yes no

Please circle all of the following medical conditions that anyone in your family presently or has had in the past:

bleeding tendency / hepatitis / diabetes / blood transfusions . glaucoma / dry eyes / lung disease / TB / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / breast cancer / heart attack / stroke / epilepsy / heartburn / intestinal ulcers or bleeding / depression / mental illness / drug or alcohol addiction / cancer / kidney disease / breast disorders / skin cancer / melanoma / high blood pressure / rheumatoid arthritis / scleroderma / lupus / autoimmune disease / unexplained weight loss / chronic fatigue / mitral valve Prolaspe

Family Member:	Alive	Deceased	Age	Cause
Father	<input type="checkbox"/>	<input type="checkbox"/>		
Mother	<input type="checkbox"/>	<input type="checkbox"/>		
Siblings	<input type="checkbox"/>	<input type="checkbox"/>		
Siblings	<input type="checkbox"/>	<input type="checkbox"/>		
Children	<input type="checkbox"/>	<input type="checkbox"/>		
Children	<input type="checkbox"/>	<input type="checkbox"/>		

Patient Signature:

Date:

RENAISSANCE

PLASTIC SURGERY, P.C.

QUESTIONNAIRE

Are you being seen today as a result of an accident? yes no if yes: _____ date

Please explain: _____

If you were injured on the job, what is the name of the Workers' Comp Insurance? _____

Contact Person: _____ Phone #: _____

Please check the areas you would like to discuss today:

- | | |
|--|--|
| <input type="checkbox"/> Nose | <input type="checkbox"/> Laser Hair Removal (Spa Service) |
| <input type="checkbox"/> Face Lift | <input type="checkbox"/> Laser Skin Rejuvenation (Spa Service) |
| <input type="checkbox"/> Eyelids | <input type="checkbox"/> Laser Wrinkle Reduction (Spa Service) |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Skin Care (Spa Service) |
| <input type="checkbox"/> Chin | <input type="checkbox"/> Microdermabrasion (Spa Service) |
| <input type="checkbox"/> Moles/Cysts | |
| <input type="checkbox"/> Liposuction | |
| <input type="checkbox"/> Scar Revision | |
| <input type="checkbox"/> Brow/Forehead Lift | |
| <input type="checkbox"/> Chemical Peel/Laser | |
| <input type="checkbox"/> Dermabrasion | |
| <input type="checkbox"/> Abdominoplasty | |
| <input type="checkbox"/> Breast Augmentation | |
| <input type="checkbox"/> Breast Reduction | |

When did you begin to consider surgical corrections? _____

Have you consulted another physician about this? yes no

Have you discussed this surgery with your family? yes no

Are they agreeable? yes no

Have you had cosmetic or reconstructive surgery? yes no

Were there complications? yes no

Did you have a normal recovery? yes no

Were you satisfied with the results? yes no

**RENAISSANCE SURGICAL CENTRE, LLC
PATIENT RIGHTS**

1. Patient Rights

- a. The Center is owned by the physicians of the affiliated Medical Practice. Patients have the right to choose another facility for his/her procedure.
- b. The privacy of all patients shall be respected at all times. Patients shall be treated with respect, consideration and dignity.
- c. Patients shall receive assistance in a prompt, courteous, and responsible manner.
- d. Patient disclosures medical records are considered confidential. Except as otherwise required by law, patient records and/or portions of records will not be released to outside entities or individuals without patients' and/or designated representatives' express written approval. Patients are given the opportunity to approve or refuse the release of their medical records.
- e. Patients have the right to know the identity and status of individuals providing services to them.
- f. Patients have the right to change providers if they so choose. Patients are informed of the credentials of all staff who will be providing care during the patients' stay.
- g. Patients, or a legal authorized representative, have the right to thorough, current and understandable information regarding their diagnosis, treatment options and prognosis, if known, and follow-up care. All patients will sign an informed consent form after all information has been provided and their questions answered.
 - When it is medically inadvisable to give such information to the patient, the information is provided to a person designated by the patient or to a legally authorized person.
- h. Unless participation is medically contraindicated, patients have the right to participate in all decisions involving their healthcare.
- i. Patients have the right to refuse treatment and to be advised of the alternatives and consequences of their decisions. Patients are encouraged to discuss their objectives with their provider.
- j. Patients have the right to refuse participation in experimental treatment and procedures. Should any experimental treatment or procedure be considered, it shall be fully explained to the patient prior to commencement.
- k. Patients have the right to make suggestions or express complaints about the care they have received and to submit such to the Administrative Director or Administrative Director who will complete an "Incident Notification" and bring the issue to the attention of the Medical Director in a timely manner so the grievance may be addressed.
- l. Patients have the right to be provided with information regarding emergency and after-hours care.
- m. Patients have the right to obtain a second opinion regarding the recommended procedure. Responsibility for the expense of the second opinion rests solely with the patient.
- n. Patients have the right to a safe and pleasant environment during their stay.
- o. Patients have the right to have visitors at the Center as long as visitation does not encumber Center operations and the rights of other patients are not infringed.
- p. Patients have the right to have procedures performed in the most painless way possible.
- q. Patients have the right to an interpreter if required.
- r. Patients have the right to be provided informed consent forms as required by the laws of the State of Georgia.
- s. Patients have the right to truthful marketing and/or advertising regarding the competence and capabilities of the Center and its staff.
- t. Patients have the right to have copies of their "Advance Directives" and "Living Wills" in their medical records. In the event of an emergency, the patient will be transferred to the appropriate facility. The Advance Directive / Living Will will be provided to the destination facility.
- u. Patients will be provided, upon request, all available information regarding services available at the Center, as well as information about estimated fees and options for payment.
- v. If applicable, patients will be informed of the absence of malpractice insurance coverage.
- w. Patients have the right to approve the release of their medical records to other care providers, legal representatives and other persons authorized by the patient.

Patient Name: _____

Date: _____

Patient Signature: _____

**RENAISSANCE SURGICAL CENTRE, LLC
PATIENT RESPONSIBILITIES**

2. Patient Responsibilities

- a. Patients are expected to provide complete and accurate medical histories, to the best of their ability, including providing information on all current medications, over-the counter products and dietary supplements and any allergies or sensitivities.
- b. Patients are responsible for keeping all scheduled pre- and post-procedure appointments and complying with treatment plans to help ensure appropriate care.
- c. Patients are responsible for reviewing and understanding the information provided by their Physician or nurse. Patients are responsible for understanding their insurance coverage and the procedures required for obtaining coverage.
- d. Patients are responsible for providing insurance information at the time of their visit and for notifying the receptionist of any changes in information regarding their insurance or medical information.
- e. Patients are responsible for paying all charges for co-payments, co-insurance and deductibles or for non-covered services at the time of the visit unless other arrangements have been made in advance with the Administrative Director.
- f. Patients are responsible for treating Physicians, Staff and other patients in a courteous and respectful manner.
- g. Patients are responsible for asking questions about their medical care and to seek clarification from their Physician of the services to be provided until they fully understand the care they are to receive.
- h. Patients are responsible for following the advice of their provider and to consider the alternatives and/or likely consequences if they refuse to comply.
- i. Patients are responsible for expressing their opinions, concerns or complaints in a constructive manner to the appropriate personnel at the Center.
- j. Patients are responsible for notifying their health care providers of patient's Advance Directives, Living Wills, Medical Power of Attorney or any other directives that could affect their care. In the event of an emergency, the patient will be transferred to the appropriate facility. The facility will be notified of the existence of the Advance Directive, if applicable, and will be provided with a copy.
- k. Patients are responsible for having a responsible adult transport them from the Center and remain with the patient for twenty-four (24) hours, if required by the Physician.

Questions or Concerns?

You and your family should feel you can always voice your concerns. If you share a concern or complaint, your care will not be affected in any way. The first step is to discuss your concerns with your doctor, nurse, or other caregiver. If you have concerns that are not resolved, please contact the Administrator at 478-474-2200, ext. 100.

Should you continue to remain concerned you may contact the State Health Planning Agency, Health Care Section, and Regional Director, Two Peachtree Street, NW, Suite 33- 250, Atlanta, GA 30303-3142, (404) 657-5430 or 800-878-6442 or your Ombudsman at www.cms.hhs.gov/center/ombudsman.asp.

Disclosure of Ownership Interest

Renaissance Surgical Centre LLC operates an outpatient surgical facility licensed by the State.

This facility is owned by; Drs. Christopher L. McLendon and Roy Powell Jr. These physicians have become owners due to their commitment of providing quality health care and services to their patients at a more affordable cost.

You have the right to choose where to receive services, including entities in which your physicians do not have financial relationship. Reasonable alternative sources of services for Drs McLendon and Powell are:

- Coliseum Hospital
- Macon Northside Hospital

Alternative sources of services for Dr. Paul Syribey are

- Coliseum Hospital
- Macon Northside Hospital
- Medical Center of Central Georgia

Patient Name: _____

Date: _____

Patient Signature: _____

RENAISSANCE

TYLENOL AND/OR EXTRA-STRENGTH TYLENOL IS OKAY TO TAKE.

Patient Name

Date

THE FOLLOWING MEDICATIONS THIN THE BLOOD AND RAISE THE RISKS OF EXCESSIVE BLEEDING DURING AND AFTER THE OPERATION:

ALEVE	EXCEDERIN
ASPIRIN	EXTRA STRENGTH BUFFERIN
ADVIL	4-WAY COLD TABLETS
ALKA SELTZER	FIORINAL
ANACIN	GEMNISYN
APC	GOODY'S POWDER
APECTOL	IBUPROFEN
ARTHRITIS STRENGTH BUFFERIN	INDOCIN
ASA COMPOUND	LIQUIDSRIN TABLETS
ASCRIPIN	MIDOL
ASPERGUM	MOTRIN
BUFF-A-COMP	NAPROSYN
BC	NORGESIC
BUFFERIN	NOVAHISTINE W/APC
BUTAZOLIDIN	PERCODAN
BUTABITAL W/APC	PHENAPHEN
CAPRON CAPSULES	PHENSOL
CETASID	RELAFEN
CONTAC	ROBAXISAL
CONGESPIRIN	SK-65 COMPOUND
COPE CORICIDIN	STANBACK
CORCIDIN	SUPAC
CORCIDIN D	SUPER ANAHIST
COUNTERPAIN	SYNALGOS
DARVON	TRIGISIC
DEFORTE-DEFULE	TRIAMINIC
DOLOBID	VANQUISH
DRISTAN	VITAMIN E
ECOTRIN	ZACTRIN
EMPIRIN	ZORPHRIN
EQUAGESIC	

DO NOT TAKE any of these medications or any medications containing aspirin or blood thinning agents for at least ten (10) days prior to surgery. **PLEASE DO NOT TAKE DIET PILLS OR HERBAL MEDICINES FOR 30 DAYS PRIOR TO SURGERY.**

_____ Initials

Please note: this list does not include all medications containing Aspirin! If you are currently taking any medications not listed above, consult with your physician at Renaissance Plastic Surgery, P.C. prior to scheduling surgery. _____ Initials

I have been instructed not to smoke _____ days prior to my surgery. I understand that I will be tested the morning of surgery, and if the test results are positive for nicotine my surgery will be cancelled. _____ Initials

RENAISSANCE

PLASTIC SURGERY, P.C.

Informed Consent: Patient Computer Imaging

In the course of consultation and discussion with my physician, I may have been shown, or may be shown or provided certain brochures, pictures of actual patients, or pictures on an electronic computer imaging device. I do understand that those pictures and alterations of those pictures seen are solely for the purpose of illustration, discussion, and to provide improved communication. I do understand that the outcome of any type of surgical procedure is directly related to my individual characteristics and health. I further understand and acknowledge that because of obvious significant differences in how living tissues react to surgery, there may be no relationship between the electronic images created and my actual surgical results. Use of the computer imaging system offers an opportunity for me to discuss my desires and to allow improved communication with the medical staff.

I certify my understanding that there is no warranty, expressed or suggested, as to my own final appearance after elective surgery by the use of these electronically altered images.

_____ I hereby grant permission for the use of any illustrations, photographs, or imaging records created in my case for use in presentations at any time during or after treatment, with complete confidentiality of my identity.

_____ I do not grant permission for the use of any illustrations, photographs, or imaging records created in my case for use in presentations at any time during or after treatment.

Patient Name

Date

RENAISSANCE

PLASTIC SURGERY, P.C. SURGICAL CENTRE', LLC

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED TO OUR PRACTICE. PLEASE PUT AN X IN THE SPACE PROVIDED THAT BEST DESCRIBES YOUR STATUS IN REGARDS TO YOUR INSURANCE COVERAGE.

_____ *The Non-Medicare Patient*

I hereby assign to Renaissance Plastic Surgery and Renaissance Surgical Centre' any and all benefits from my insurance plan/plans and authorize and direct such benefits to be paid directly to Renaissance Plastic Surgery and Renaissance Surgical Centre. I certify that the information given by me in applying for payment under my insurance plan is correct and complete. I authorize release of all records required to act on this release and assignment.

_____ *The Medicare Patient*

I request that payment of authorized Medicare benefits be made on my behalf to Renaissance Plastic Surgery and Renaissance Surgical Centre' for any services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. I certify that the information given by me in applying for payment under the Medicare program is correct and complete. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I have read the information above and all my questions have been answered by the staff at Renaissance Plastic Surgery and Renaissance Surgical Centre.

Patient: _____

Signature: _____

Witness: _____

Date: _____

RENAISSANCE

PLASTIC SURGERY, P.C.

IMPORTANT PLEASE READ CAREFULLY

We appreciate your choosing Renaissance Plastic Surgery for your care. However, we do not participate with every insurance company. If you are a member of a **PPO, POS, HMO, or any managed care program**, please check with your insurance manual and/or insurance representative at your place of employment to see if we are on your provider list. If we are not, that does not mean that we will not file your insurance, but you could be penalized by your insurance company on claims. That holds true for any hospital that your company requires you to use for surgery. If we perform any insurance covered procedures in our office, a pathology specimen may be sent. We **ROUTINELY** send these to Macon Northside Hospital. If the lab or hospital our facility uses is out of network you may be penalized either by nonpayment or reduction in benefits. **THIS INFORMATION IS TO BE OBTAINED BY THE PATIENT AND PROVIDED TO OUR OFFICE.**

IT IS THE RESPONSIBILITY OF THE PATIENT TO INSURE THAT ALL REFERRAL REQUIRMENTS ARE MET AT EACH VISIT. IF YOUR INSIRANCE COMPANY REQUIRES THIS TYPE OF COORDINATION OF CARE, PLEASE MAKE SURE THAT THE REFERRAL IS IN PLACE BEFORE YOUR VISIT. FAILURE TO DO SO; MAY RESULT IN A HIGHER OUT OF EXPENSE FOR YOU.

I have read the above and understand that I am responsible for any nonpayment or reduction in benefits to Renaissance Plastic Surgery, P.C., Renaissance Surgical Centre', LLC, and/or any facility used as a result of not using a participating physician, laboratory, or facility as required by my insurance company.

Patient Signature

Responsible Party

Date