ADLER & GILES
COSMETIC SURGERY SPECIALISTS

DR. GILES' CONSULTATION OVERVIEW

REGISTRATION	■ If you have not received registration forms in the mail, please arrive at our office 15 minutes prior to your scheduled appointment to complete these forms. Otherwise, please bring your completed forms with you at your designated appointment time.
SURGEON CONFERENCE	■ The doctor will talk with you about your wishes and desires. He will examine you and give you his opinion about how to achieve your goals. We believe you need to be well-informed about the actual process of preparing for, and recovering from, cosmetic or reconstructive surgery. Choosing a surgeon is an intensely personal decision. We encourage you to take time to ask the doctor and his staff any questions you may have. We believe the formation of a personal bond is an integral part of the surgery and healing process.
COST/TIMING	■ When you briefly meet with the Scheduling Coordinator, she will discuss fees and costs. If you have a specific date in mind, we will do our best to accommodate your schedule. If you are still in the information gathering phase, she will try to be sure all of your questions are answered.
BEFORE AND AFTER ALBUM	■ We invite you to review Dr. Giles' surgery results in our before and after photo album. All of the patients in the album have given us permission to share their results with you.
FOLLOW UP	■ Your consultation includes a second visit if you have further questions for the physician or any member of our staff.
CERTIFICATION	■ Our Operating Rooms are certified by the Accredidation Association for Ambulatory Health Care, Inc. (AAAHC).
ONSITE OVERNIGHT FACILITY	■ Should your procedure require an overnight stay, our Renaissance Waterfront Suites provide a comfortable, private and exclusive setting for your recovery.

P. Dudley Giles, M.D.

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(772) 546-3223

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FINANCIAL POLICIES*

- As patients approach surgery, they frequently need information about the various payment options and have questions about their potential insurance benefits. We hope the following information will be helpful.
- Our financial coordinators are readily available to meet with you personally to provide the specific information you desire. They specialize in this area and will use their expertise to help you obtain the maximum benefits from your policy.

PAYMENT OPTIONS

- Payment for cosmetic plastic surgery is due in full at the time of your preoperative visit, which is normally two weeks prior to surgery. We provide a number of payment options which may be used individually or combined according to your wishes.

  CASH OR CHECK: Personal check, cashier's check, or cash.

  CREDIT CARDS: Visa, Master Card or American Express.

- OPTIONAL FINANCING PLANS: We will be happy to assist you with applying for financing should you so desire.

INSURANCE COVERAGE

- The benefits paid by insurance companies for plastic surgery vary greatly from carrier to carrier and plan to plan. Therefore, we make every effort to determine in advance if insurance coverage exists. Most cosmetic procedures are not covered by insurance. We know you realize that you are ultimately responsible for the full payment of your account, but we have found that our knowledge and experience can be an important factor in assisting you to collect your maximum benefits.
- Please discuss all arrangements regarding payment of your account with us.

CANCELLATION POLICY

- We understand that a situation may arise that could force you to postpone your surgery. Please understand that such changes affect not only your surgeon but other patients as well. Dr. Giles's time, as well as that of the operating room staff, is a precious commodity, and we request your courtesy and concern.

  If you need to cancel your surgery after your preoperative visit but more than 6 business days before surgery, you are entitled to a 50% refund. Should you find it necessary to cancel your surgery after your preoperative visit and 6 business days or less before surgery you are entitled to a 25% refund.

  If you cancel your surgery after your pre-operative appointment and reschedule with-in the next 30 days, there will be a $500.00 administrative fee that you will be responsible for paying prior to your surgery.

- If you have any questions or need assistance with financial matters, please ask Sandy Hall to help you.

P. Dudley Giles, M.D.

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PATIENT REGISTRATION

NAME: ______________________________

STREET ADDRESS: ______________________________

CITY & STATE: ______________________________ ZIP CODE: ______________

HOME PHONE: ______________________ CELLULAR PHONE: ______________

WORK PHONE: ______________________ MAY WE CALL YOU AT WORK? __________

E-MAIL ADDRESS: ______________________________

OTHER ADDRESS: ______________________________

____

OTHER HOME PHONE: ______________________ FAX: ______________

SOCIAL SECURITY NUMBER: ______________________ SEX: ______________

OCCUPATION: ______________________ EMPLOYER: ______________

DATE OF BIRTH: ______________________ MARITAL STATUS: ______________

SPOUSE/PARENT'S NAME: ______________________________

SPOUSE/PARENTS WORK PHONE: ______________________________

REFERRED BY: ______________________________

PERSON RESPONSIBLE FOR PAYMENT: ______________________________

DATE: ______________ SIGNATURE: ______________________________

CONSULTATION MEDICAL HISTORY

PATIENT'S NAME______________________________ DATE ____________

AGE ______________ HEIGHT ________________ WEIGHT ______________

DATE OF LAST PHYSICAL ___________ DATE OF LAST MAMMOGRAM___________

NAME, ADDRESS AND TELEPHONE # OF DOCTOR ___________________________

____

DRUG ALLERGIES ____

DRUG SENSITIVITIES ____

HAVE YOU **EVER** HAD A COLD SORE, SHINGLES OR HERPES? _______________

PREVIOUS SURGERY (PLEASE LIST)

OPERATION YEAR ANESTHESIA (LOCAL/GENERAL)

____

____

____

SERIOUS ILLNESSES OR HOSPITALIZATIONS (PLEASE LIST)

____

____

____

LIST ALL THE MEDICATIONS YOU ARE NOW TAKING AND THEIR DOSAGES
INCLUDE OVER THE COUNTER DRUGS (I.E. ASPIRIN, TYLENOL, ADVIL) VITAMINS & HERBS

____

____

____

COULD YOU POSSIBLY BE PREGNANT? NO ____________ YES ______________

NUMBER OF PREGNANCIES ____________ NUMBER OF LIVE BIRTHS ____________

HAVE YOU EVER BEEN TOLD YOU HAVE A BODY DYSMORPHIC DISORDER? NO ___YES ___
IF YES, PLEASE EXPLAIN. ____

*******PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM*******

ADLER • GILES [illegible]IC AND COSMETIC SURGE[illegible] [illegible]CIALISTS
AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION

Patient Name:____

Date of Birth:____________________ Medical Record #:____________________

1. I authorize Adler • Giles Plastic and Cosmetic Surgery Specialists to disclose my health information specific to the following date or time period:________________________
2. Individual or entity authorized to receive my health information:________________________
____
3. Purpose for which disclosure is to be made:
____
4. Information to be disclosed:

___ Practitioner Summary
___ History & Physical Exam
___ Office Chart Notes
___ Emergency Room Report
___ Laboratory Report
___ Radiology Report
___ Medical Clearance Report
___ X-ray Records
___ Consultation
___ Rx

I understand that this will include health information relating to (check if applicable):

___ HIV (Human Immunodeficiency Virus) infection
___ Treatment for alcohol and/or drug abuse
___ Mental Health
___ Genetic Testing

5. Referring physicians will receive information on care provided following your visits or any other physician you designate. Designated Physician:________________________
6. Our current policy is to call your home for appointment remainders and for follow up medical care. If you do not want us to call your home, please provide us with an alternate plan to contact you. Alternate plan:________________________
____
7. I understand that if the person(s) or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations. Therefore, I release Adler • Giles Plastic and Cosmetic Surgery Specialists, its employees, and my physician(s) from all liability arising from this disclosure of my health information.
8. I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire in 90 days from the date signed below. I understand that I may revoke this authorization by notifying, in writing, the Medical Records Department, knowing that previously disclosed information would not be subject to my revocation request.
9. I understanding that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

____ ____
Signature: Patient or Legal Representative Date Signature of Witness Date

____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of this facility's health care operations. The Notice of Privacy Practices also describes my rights and the facility's duties with respect to my protected health information. The Notice of Privacy Practices is posted in the office of Adler • Giles Plastic and Cosmetic Surgery Specialists located at 323 Osceola St., Stuart, Florida, 34994.

____ ____
Signature of Patient or Personal Representative Name of Patient or Personal Representative

____________________ ____
Date Description of Personal Representative's Authority

Rev. 5/8/04

WHAT IS YOUR DAILY CONSUMPTION OF THE FOLLOWING?
TOBACCO ____________________ ALCOHOL ____________________

IF YOU EVER SMOKED IN THE PAST, HOW MUCH PER DAY__________ (pack/s)
FOR HOW LONG ________ (years) WHEN DID YOU STOP?

DO YOU USE RETIN-A / RENOVA / ALPHA HYDROX / GLYCOLIC ACID / OTHER __________
HOW OFTEN?________WHAT %______________

CHECK IF YOU HAVE EVER HAD ANY OF THE FOLLOWING: IF YES, PLEASE EXPLAIN.

Condition	NO	YES	Explanation
MALIGNANT HYPERTHERMIA	NO______	YES______	____________________
RADIATION THERAPY FOR ACNE	NO______	YES______	____________________
CANCER(INCLUDING SKIN CANCER)	NO______	YES______	____________________
BLOOD TRANSFUSION	NO______	YES______	____________________
DIABETES	NO______	YES______	____________________
GLAUCOMA	NO______	YES______	____________________
HEART DISEASE	NO______	YES______	____________________
MITRAL VALVE PROLAPSE/HEART MURMUR	NO______	YES______	____________________
HIGH BLOOD PRESSURE	NO______	YES______	____________________
LUNG DISEASE/ASTHMA/TUBERCULOSIS	NO______	YES______	____________________
KIDNEY DISEASE	NO______	YES______	____________________
BLOOD/BLEEDING DISORDERS	NO______	YES______	____________________
THYROID DISEASE	NO______	YES______	____________________
MENTAL ILLNESS/DEPRESSION	NO______	YES______	____________________
GASTROINTESTINAL/REFLUX	NO______	YES______	____________________
HEPATITIS/LIVER DISEASE	NO______	YES______	____________________
SLEEP APNEA	NO______	YES______	____________________
DID YOU EVER USE PHEN/PHEN	NO______	YES______	____________________
LATEX, SOY, OR EGG ALLERGY	NO______	YES______	____________________

OTHER ____

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