GALLAHER
GALLAHER PLASTIC SURGERY & SPA MD

Patient Registration				**Today's Date:**	
Patient Name:	First	MI	Last	Birth Date:	
Address:				SS#:	
City, State, Zip:				Sex: M F	Marital Status: M S D W Sep
Home Ph: ( )				Family Physician:	
Work Ph: ( )				Occupation:	FT PT
Cell/Other Ph: ( )				Patient Employer:	

By filling out your email address, I give Dr. Gallaher permission to contact me via email with future communications, marketing emails or scheduling information. Email Address: _____

Referral Source:
As a referral is a great compliment for a physician, I would like to know how you found my practice, so I can express my gratitude.

Patient	Physician	www.gallaherplasticsurgery.com	Name of Referral (or specific source)
Word of Mouth	Internet		

Spouse/Parent Name:	Home Ph: ( )
Address:	Work Ph: ( )
City, State, Zip:	Cell/Other Ph: ( )
Spouse/Parent Employer:	Occupation: FT PT

Emergency Contact:	Home Ph: ( )
Relationship to patient:	Cell/Other Ph: ( )

Emergency Contact needs to be a person we can contact who does not share the same home phone number.

Primary Insurance:	Insured SS#:
Insured name & relationship to patient:	Insured DOB:
Secondary Insurance:	Insured SS#:
Insured name & relationship to patient:	Insured DOB:

I authorize Gallaher Plastic Surgery & Spa MD to disclose information concerning medical findings and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Gallaher Plastic Surgery & Spa MD's determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.
I also agree to be responsible for all charges incurred if not covered by my insurance company or other agency. This office agrees to file my insurance claim, if any, providing that my coverage is current and accurate. All co-pays must be paid at the time of service. I authorize release of any medical information necessary to process any claims. I authorize payment of any benefits to Gallaher Plastic Surgery & Spa MD

Signature:_____ Date:_____
(Subscriber, parent, guardian, or patient if over 18 years of age)

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Office Policies

Welcome to our practice. Please take a few moments to review some of our office policies. Refer to our practice literature for additional information. If you have any questions, please do not hesitate to ask. If you should have any changes in your personal data including medical history, please see that we are notified. In addition, be certain we have a current copy of your insurance card.

Cosmetic/Self-Pay Payment Policy for Surgical Procedures:

- Consultation fees are due at the time of service.
- For surgical procedures, there is a $1000.00 non-refundable deposit due prior to the scheduling of surgery.
- Payments are due in full two (2) weeks prior to surgery. If payment is not received by the deadline, your surgery will be removed from our schedule and will need to be rescheduled.
- If you cancel OR RESCHEDULE your surgery within 5 business days of your procedure date, we will charge you 25% of your quoted amount as an inconvenience fee at our discretion.

Revision Policy for Cosmetic/Self-Pay Payment Surgical Procedures:

Occasionally, a surgical procedure may require a revision for the treatment of unexpected complications or for optimal results. In such cases, it is the patient's responsibility for any cost incurred in relation to the revision. These costs include but are not limited to the surgical facility, supplies or implants, and anesthesia fees. Professional fees MAY be waived if the required revision is within the first 12 months after surgery.

Insurance Payment Policy:

- Please be certain we have a current copy of your insurance card.
- If Dr. Gallaher feels your procedure will considered for insurance coverage, your copayment will be expected at the time of service.
- If we have been provided with proper insurance information, we will gladly submit your claim for services to both your primary and secondary insurance companies (if applicable).
- You will be responsible for any copayment or amount applied to your deductible.
- Occasionally, minor surgical procedures are done in our office-based operating suite. Professional services will be submitted to your insurance company.

No Show/Cancellation/Refund Policies:

- If you do not cancel or reschedule your appointment with at least 24 hours' notice, we may assess a $50.00 "late cancellation" service charge to your account.
- If you do not cancel or reschedule your appointment with at least 24 hours' notice, we may assess a $50.00 "no-show" service charge to your account.
- Gallaher Plastic Surgery & Spa MD does not issue cash, check, or credit card refunds for purchased or pre-purchased merchandise, products, or services. No refunds will be issued for services rendered.

Payment can be made by personal check, cash, VISA, MasterCard, Discover, American Express and CareCredit.

Please sign below as indication that you have read, understand, and accept these office policies.

Name:_____ Date: _____

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PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I,_____, consent to the taking of photographs or videotapes of me or parts of my body, by Gallaher Plastic Surgery & Spa MD or a designee, in connection with any plastic surgery procedure(s) deemed necessary. I further consent to the release by Gallaher Plastic Surgery & Spa MD or to the American Society for Aesthetic Plastic Surgery, Inc. ("ASAPS"), the American Society of Plastic Surgeons ("ASPS"), or the American Board of Plastic Surgery ("ABPS") of such photographs, videotapes or case histories for use in examination, testing, credentialing and/or certifying purposes.

I understand that such photographs, videotapes or case histories may be published by Gallaher Plastic Surgery & Spa MD, ASAPS, ASPS, ABPS and/or any party acting under their license and authority in any print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations, and teaching courses, for the purpose of informing the medical profession or the general public about plastic surgery methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) years from the date written below.

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Gallaher Plastic Surgery & Spa MD or

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because ASAPS, ASPS, and ABPS are not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA and may be redisclosed by ASAPS, ASPS or ABPS.

I release and discharge Gallaher Plastic Surgery & Spa MD, ASAPS, ASPS, ABPS, and all parties acting under their license and authority from all rights that I may have in the photographs, videotapes or case histories and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these materials in any medium.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____

Patient *Date*

WITNESS/PHYSICIAN:_____

I have read the above Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf, and I grant this consent as a voluntary contribution in the interest of public education.

_____ _____

Patient/Guardian *Date*

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HISTORY AND PHYSICAL

PATIENT'S NAME: _____ **DATE:**_____

AGE: _____ **HEIGHT:** _____ **WEIGHT:** _____

The following questions are to be filled out by the patient. Check box **YES** or **NO**.
Any positive response will be discussed with you by your doctor.

LUNGS	**YES**	**NO**
COPD	☐	☐
Cough or Fever at present time	☐	☐
Bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Lung cancer	☐	☐
Do you smoke	☐	☐
If yes,_____packs of cigarettes per day for the past_____years.		

HEART		
Heart disease	☐	☐
Heart murmur	☐	☐
High blood pressure	☐	☐
Skipped heart beats	☐	☐
Chest pain	☐	☐
Hardening of the arteries	☐	☐
Heart failure	☐	☐
Heart attack	☐	☐
Rheumatic fever	☐	☐

BLOOD		
Bruise or bleed easily	☐	☐
Abnormal bleeding in family	☐	☐
Sickle cell trait/disease	☐	☐
Other blood cell disease	☐	☐
Prolonged bleeding with tooth extraction	☐	☐

LIVER		
Drink alcoholic beverages	☐	☐
Hepatitis	☐	☐
Jaundice	☐	☐
Other liver disease	☐	☐

KIDNEY		
Born with kidney disease	☐	☐
Kidney infections	☐	☐
Kidney stones	☐	☐

Any history of mental illness?	☐	☐

NERVOUS SYSTEM	**YES**	**NO**
Abnormality of nervous system	☐	☐
Brain disease	☐	☐
Spinal cord disease	☐	☐
Nerve disease	☐	☐
Epilepsy	☐	☐
Stroke	☐	☐

ENDOCRINE		
Diabetes Type 1____ Type 2_____	☐	☐
Thyroid disorder	☐	☐

EYE		
Glaucoma	☐	☐
Contact lenses	☐	☐

STOMACH, BOWEL, GALL BLADDER		
Any stomach disease	☐	☐
Bowell disease	☐	☐
Gall Bladder disease	☐	☐

AIRWAY		
Problems opening mouth wide	☐	☐
Problems turning head in any direction	☐	☐

REPRODUCTIVE		
Are you pregnant?	☐	☐
Planning pregnancy preoperatively?	☐	☐
Have you breast fed in last 3 mos?	☐	☐
Diseases of the reproductive system?	☐	☐
Children?		

MUSCULOSKELETAL		
Joint damage/injury	☐	☐
Tendon damage/injury	☐	☐
Nerve damage/injury	☐	☐

THIS FORM MUST BE COMPLETED FRONT AND BACK.

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HISTORY AND PHYSICAL

Do you have any past or present health problems not indicated above? If yes, please describe: _____

_____

_____

Do any diseases run in your family? If so, name them:

_____

_____

_____

SURGICAL HISTORY: List previous operations and approximate dates: _____

_____

_____

_____

	YES	NO
Complications after surgery?	☐	☐
Bleeding or blood clot(s)?	☐	☐
Infection?	☐	☐

Other: _____

_____

ANESTHETIC HISTORY

	YES	NO
Any problems resulting from local or general anesthetic administered to you?	☐	☐
Nausea and/or vomiting?	☐	☐
Any family members with problems related to anesthesia?	☐	☐

Date of last general anesthetic: _____

If you answered yes to any of the above anesthetic questions, please explain:

_____

_____

DRUG ALLERGIES (List): _____

_____

What kind of reaction? _____

_____

_____

Who is your primary care physician?

_____Phone#: _____

LIST ALL PRESENT MEDICATIONS by name and the reason for taking them. Especially important are: Coritsone, hormones or birth control pills, cold medications, aspirin or aspirin-containing medications, tranquilizers, sedatives, antidepressants, blood thinners (anticoagulants), heart medications, and water pills (diuretics).

_____

_____

_____

_____

_____

Any history of Arthritis? _____

If so, type of Arthritis: _____

If you are taking Arthritis medication, please list: _____

_____

_____

Name of the physician treating Arthritis:

_____

List any vitamins and/or herbal supplements you are presently taking:

_____

_____

Any other disclosures you feel may be important:

_____

_____

Patient's Signature_____ Date: _____

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WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of Gallaher Plastic Surgery & Spa MD and hereby acknowledge receipt of their Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of Gallaher Plastic Surgery & Spa MD's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

AND

I authorize release of my personal health information (including appointment reminders) to the following individual(s):

Name:_____Relationship:_____

Name:_____Relationship:_____

Voice mail messages regarding my appointment may be left at the following number:_____

Signature:_____ Date:_____

GALLAHER PLASTIC SURGERY & SPA MD
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse protected health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI by alterative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of April 23, 2015 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.