GALLAHER
GALLAHER PLASTIC SURGERY & SPA MD

Patient Registration

Today's Date:	First	MI	Last
Birth Date:	SS#:	Sex: M F	Marital Status: M S D W Sep
Address:			
City, State, Zip:			

Home Phone:	( )			Family Physician:	Family Physician Phone:
Cell Phone:	( )			Occupation:	FT PT
Work Phone:	( )			Patient Employer:	

As a referral is a great compliment for any practice, we would like to know how you found the practice:

Word of Mouth	www.gallaherplasticsurgery.com	Physician	Name of Physician, Patient, or other specific source:
	Internet	Patient	

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

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

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

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

If Applicable, please fill out:	
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 approved, this office agrees to file my insurance claim, providing that my coverage is current and accurate. I authorize release of any medical information necessary to process any insurance claims, and authorize payment of any benefits to Gallaher Plastic Surgery & Spa MD.

Signature:_____ Date:_____

(Patient if over 18 years of age, parent, guardian, or subscriber)

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Office Policies

Welcome to Gallaher Plastic Surgery & Spa MD. Please take a few moments to review some of our office policies. 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 notify us as soon as possible.

Cosmetic/Self-Pay Payment Policy for Surgical Procedures & CoolSculpting Procedure:

- 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. If you must reschedule your surgery date, there is a $1000.00 non-refundable rescheduling fee to do so. If there is a need to cancel or reschedule your surgery, call our Patient Care Coordinator at least 2 business days prior to your pre-op appointment date, and a onetime waiving of the rescheduling fee can be done.
- For Coolsculpting procedures, there is a $500.00 non-refundable deposit due prior to scheduling of the CoolSculpting procedure.
- Payments are due in full on the day of your preop appointment. If payment is not received on the day of your preop appointment, your surgical procedure will be removed from our schedule and will need to be rescheduled.
- If you cancel OR RESCHEDULE your surgical procedure 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/or anesthesia fees. Professional fees MAY be waived if the required revision is within the first 12 months after surgery.

Insurance Payment Policy:

- If the Physician feels your procedure will be considered for insurance coverage, your copayment will be expected at the time of service.
- 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 if the Physician feels your procedure is considered for insurance coverage.

No Show/Cancellation/Refund Policies for all Appointments:

- 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 in-office procedure with the Physician with a 5 business days' notice, we may assess a $100.00 "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. If you do not show for your in-office procedure with the Physician, we may assess a $100.00 "no-show" service charge to your account.
- Gallaher Plastic Surgery & Spa MD does not issue cash, check, patient financing, or credit card refunds for purchased or pre-purchased merchandise, products, or services. Pre-purchased merchandise, products, or services can be switched over to in-store credit at any time. Product will only be honored to be exchanged if product is unopened. Defective products must be returned to the office to receive an equal exchange. Any product purchased over 60 days is ineligible to be returned and/or exchanged. No refunds will be issued for services rendered.

Payments accepted are cashier's check, money order, cash, VISA, MasterCard, Discover, American Express, CareCredit, and PatientFi. We DO NOT accept personal checks.

Please sign below as an indication that you have read, understood, and accepted these office policies.

Signature:_____ Date: _____

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I, _____, permit Gallaher Plastic Surgery & Spa MD, its employees, agents, and/or any party or entity acting under its license and authority (collectively, the "Practice") to take photos and/or videos before, during, and after my surgery, procedure, or service. These may be of me or parts of my body (the "Images"). I agree that the Practice can share them with staff, other health professionals, professional certifying board(s), and the public. This may be done for educational, informational, and/or marketing purposes. I understand that in some circumstances the Images may portray features that may make my identity recognizable.

I understand that once the Images are published, I lose control over their use. I have no control over where or how they are used, published, shared, and/or printed. I agree to give up all rights to the Images. I release any claim I may have to the rights to such Images, including any payment for their use, publishing, or distribution.

I understand that Images posted online and on social media may be saved. They may be available forever. They may be found in online searches. I realize that people may print, share, distribute or repost the Images without the Practice's consent. They may be used in social media. Neither I nor the Practice have any control over this. I agree that the Practice is not responsible for third-party use. I release the Practice from any claim that might arise from any third-party use or distribution.

I understand that I have the right to revoke this authorization in writing to the Practice at any time, but if I do so, such revocation will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will exist indefinitely. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from the Practice.

I understand that the information disclosed, or some portion thereof, may be protected by state and/or federal law, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and I hereby waive such protections to the extent I may legally do so. I further understand that there is the potential for information disclosed under the terms of this authorization to be redisclosed by the recipient and no longer protected by HIPAA.

I agree that the Practice can use the Images in the following context **(please initial <u>ONLY ONE</u> of the following):**

_____ALL MEDIA: Photographs taken of me or parts of my body as well as details regarding medical services that I have received may be used in print and broadcast media. This includes newspapers, pamphlets, educational films, the internet (including social media and applications), and television.

_____WEBSITE ONLY: Photographs taken of me or parts of my body as well as details regarding medical services that I have received may be used on the Practice's website.

_____ ALBUM ONLY: Photographs taken of me or parts of my body as well as details regarding medical services that I have received may be used in printed and/or digital photograph albums. The albums will only be used to show other patients the Practice's methods.

I agree to the foregoing specified use of the Images. I have fully read and understand the above terms. I have made my decision carefully and understand the risks.

PATIENT SIGNATURE: _____ Date: _____
Printed Name: _____

WITNESS SIGNATURE: _____ Date: _____
Printed Name: _____

For patients under the age of 18:

I, the parent or guardian of _____, a minor, am authorized to sign this release on his or her behalf. I agree to the educational use of his or her images.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____
Printed Name: _____

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HISTORY AND PHYSICAL

PATIENT NAME: _____ **DATE:**_____

PREFERRED PHARMACY NAME, ADDRESS AND PHONE NUMBER: _____

_____

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 months	☐	☐
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: Cortisone, 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: _____

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 among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another. 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, utilization review, and disclosures to consumer reporting agencies (limited to specified identifying information about the individual and his or her payment history). 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 administrative, financial, legal, and quality improvement activities that are necessary 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 requested 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 January 25, 2024 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.

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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: _____

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

Signature: _____Date: _____