KALOS

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Ste. 850
Atlanta, GA 30305

Main: 404-963-6665
Fax : 404-506-9040

Website:
www.kalos-plasticsurgery.com

How did you hear about Kalos Facial Plastic Surgery?

- ☐ Internet
- ☐ Media Ad
- ☐ YellowPages
- ☐ Physician:

  _____
  Name
- ☐ Family/Friend:

  _____
  Name
- ☐ Hospital:

  _____
  Name

(For Office use only) Chart #:_____

Patient Information

Date:_____

Patient Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Employer/Occupation:_____ Email:_____

Date of Birth:_____ Age:_____ Sex: ☐ M ☐ F

Marital Status: Single Married Widowed Other

Emergency Contact:_____ Phone:_____

Relationship:_____

Physician Information:

Referring Physician:_____ **Location:**_____

Family Physician:_____ **Location:**_____

Primary Insurance Policy Holder Information (If you have Medicare you are the policy holder)
ARE YOU CURRENTLY ENROLLED OR PLAN TO ENROLL IN AN ACA PRODUCT? _____
Primary Ins.:_____ ID #:_____

Insured Name:_____ SS#:_____

Relationship: Self Spouse Child Other_____

Secondary Insurance Name:_____

I hereby consent to treatment of myself, my child or the above minor, for whom I accept responsibility, the release of medical information to any insurance carrier or direct payment to Kalos Facial Plastic Surgery for any treatment or examination rendered is authorized. I hereby acknowledge and accept final responsibility for payment or charges for medical services rendered.

_____ _____

Signature of Patient or Authorized Person **Date**

SIGNATURE IS REQUIRED FOR TREATMENT

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Medical History

General

Name _____ Date of Birth _____

Do you or have you had:

	No	Yes		No	Yes		no	Yes
Anemia	☐	☐	Dry Eyes	☐	☐	Kidney Disease	☐	☐
Anesthesia reaction	☐	☐	Epilepsy	☐	☐	Liver Disease	☐	☐
Arthritis	☐	☐	Fainting spells	☐	☐	Lung Disease	☐	☐
Asthma	☐	☐	Fibromyalgia	☐	☐	Migraine Headache	☐	☐
Back Pain	☐	☐	Glaucoma	☐	☐	Peptic Ulcer	☐	☐
Bleeding Tendency	☐	☐	Heart Disease	☐	☐	Pneumonia	☐	☐
Blood clots/DVT	☐	☐	Heart Murmur	☐	☐	Shortness of breath	☐	☐
Breast Cancer	☐	☐	Hepatitis	☐	☐	Stroke	☐	☐
Cancer	☐	☐	Herpes simplex/fever blisters	☐	☐	Thyroid Disease	☐	☐
Chest Pain	☐	☐	High Blood Pressure	☐	☐	Vision Deficits	☐	☐
Diabetes	☐	☐	HIV/Aids	☐	☐	Wheezing	☐	☐

If yes or other, please describe:

Previous Operations:

Surgery	Date	Surgery	Date

Do you take:

	No	Yes		No	Yes
Aspirin or Ibuprofen	☐	☐	Vitamins & Herbal Supplements	☐	☐
Coumadin (Warfarin)	☐	☐	Steroids in the past year	☐	☐
Arthritis Medicine	☐	☐	Retin A	☐	☐
Birth Control Pills	☐	☐	Accutane	☐	☐

List other medication you are currently taking:

Are you allergic to any medications? No ☐ Yes ☐ *If yes, please list:*

Have you formed excessive or unsatisfactory scars/keloids/hypertrophy in the past? No ☐ Yes ☐

Do you smoke or use any nicotine products/vaporizers? No ☐ Yes ☐ _____ *packs per day*

Do you drink alcohol? No ☐ Yes ☐ _____ *per week*

Women Only:

Have you ever been pregnant? No ☐ Yes ☐

Are you breast feeding? No ☐ Yes ☐

Are you pregnant now? No ☐ Yes ☐

_____ _____

Name Date of birth

**********Please put N/A if the information does not apply to your visit**********

Check the areas you would like to discuss:

□ Nose	□ Chin Implant	□ Brow/Forehead Lift	□ Protruding ears	□ Botox
□ Face/Neck Lift	□ Liposuction	□ Chemical Peel/Laser	□ Moles, Cysts, etc.	□ Filler
□ Eyelids	□ Scar Revision	□ Dermabrasion	□ Other _____	

When did you begin to consider surgical correction? _____
What specifically would you like to have corrected? _____
Have you consulted another doctor about this? □No □Yes (Whom?) _____

Have you discussed this surgery with your family? □No □Yes Are they agreeable? □No □Yes
Are they willing to help you during recovery? □No □Yes
Has anyone in your family or a close friend had cosmetic or reconstructive surgery? □No □Yes
What was done and by whom? _____

Have you had an injury, to the face, nose, neck, or eyes? □No □Yes
When? _____If so, describe: _____
Have you been advised to have a surgical procedure that has not yet been performed? □No □Yes
Is having surgery your idea or someone else's idea? _____

Have you read articles in newspapers, magazines, or books about cosmetic surgery? □No □Yes
(list publications)_____
Do you understand that the goal of any cosmetic surgery is **improvement** in appearance, not perfection? □No □Yes

CHECK BELOW THE REASONS WHY YOU DESIRE SURGERY:

□ To improve my appearance	□ To eliminate self-consciousness about my appearance
□ To improve function	□ Because people tease me or make derogatory remarks
□ To give perfection to my looks	□ To make me look masculine or feminine
□ To help me look better for my age	□ My looks prevent achievement of certain goals
□ To give me a psychological uplift	□ To improve my relations with the opposite sex
□ To help obtain or keep a job	□ To cause other people to react better to me
□ To please or impress others	□ Because of a family resemblance I dislike
□ To achieve certain career goals	□ Have an inferiority complex about my appearance
□ Because I look tired	□ My looks prevent achievement of certain goals
□ To help solve personal problems	

_____

Indicate if any member of YOUR FAMILY has had trouble with:

	RELATIVE		RELATIONSHIP
Diabetes	□No	□Yes	_____
Heart Trouble	□No	□Yes	_____
High blood pressure	□No	□Yes	_____
Excessive scarring	□No	□Yes	_____
Cancer, including skin cancer	□No	□Yes	_____

PUBLIC STATEMENTS AGREEMENT

Benjamin Stong, M.D. (hereinafter collectively "Physician"), and _____ (hereinafter collectively "Patient"), agree to:

1. Patient exclusively and permanently assigns all property rights and copyrights to Physician for any statement created by Patient that relates in any way to Physician;
2. Physician shall provide professional services to Patient; and
3. Patient's assignment set forth above (#1) shall be valid for five (5) years from the last date of service by Physician to Patient.

Patient acknowledges that he/she has had ample time to review this Public Statements Agreement. Further, Patient understands that nothing in this Public Statements Agreement prevents Patient from making a statement about Physician. Statements can be either written or electronic.

_____ _____

Patient/Guardian Date

_____ _____

Physician Date

AGREEMENT AS TO RESOLUTION OF CONCERNS

Further, I understand that I am entering into a contractual relationship with Dr. Benjamin Stong, M.D. 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, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use American Board of Facial Plastic and Reconstructive Surgery board-certified expert medical witness (es) in the same specialty as Physician. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and / or code of conduct defined for expert witnesses by the AAFPRS.

In further consideration for this, I, (the Physician), agree to the same stipulations. Patient/guardian and Physician *acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.*

_____ _____

Physician Patient/Guardian

_____ _____

Effective from Date of Treatment: Date of Signature

Kalos Facial Plastic Surgery – Financial Policy

It's a fact, healthcare is changing rapidly. It has become increasingly difficult for doctors to collect payment from the wide array of insurance companies. Kalos Facial Plastic Surgery has put this policy together to help you, the patient, understand our financial policy (**please read thoroughly**).

1. As a courtesy, Kalos Facial Plastic Surgery will file a claim to the insurance company on your behalf for medically necessary office and surgical charges. However, if payment is not received within 60 days, payment of the balance will become your responsibility. Should this happen, you must collect reimbursement directly from your insurance company.

2. The patient is responsible for paying all co-pay/co-insurance at the time of service (if applicable). We accept cash, check, and major credit cards.

3. It is the patient's responsibility to know if their doctor is "in" or "out-of-network"; the provider is not responsible for knowing your individual plan or benefit level. Please make sure to call your insurance carrier and verify your coverage; failure to do so may result in the charges becoming your responsibility.

4. Denial of payment from insurance companies for office visits and/or surgeries become the responsibility of the patient. You can appeal directly to your insurance company for reimbursement. We will be happy to provide any and all documentation to assist in your appeal.

5. Changes in insurance plan coverage, address or phone number without notification to Kalos Facial Plastic Surgery may result in denials becoming the responsibility of the patient. Notify us of all changes in benefits and addresses. Kalos Facial Plastic Surgery's inability to contact/correspond with you may result in your account being placed with a collection agency.

6. If you have Medicare, we need to know the name and address of your primary care physician. Please have this information with you.

7. If you have more than one insurance plan (for example, supplemental or secondary insurance), we MUST have a copy of all cards.

8. All unpaid balances after your insurance company has paid are due upon receipt. As a courtesy, Kalos Facial Plastic Surgery withholds action against your account for 30 days. After the time, if your account has not been paid in full, it will be turned over to a collection agency. (This does not include specific arrangements made prior to visit/surgery.)

9. If your insurance company requires a referral for your visit, it is your responsibility to obtain this from your primary care physician BEFORE the visit. Do not wait until the visit to obtain a referral; many offices will not provide fax referrals. If the referral is not obtained, your appointment will be rescheduled or you will need to pay for the visit and we will provide an itemization so you may file the claim with your insurance company. If you do not know if your insurance company requires a referral, please call them.

_____ _____

Patient Signature Date

Kalos Facial Plastic Surgery

Notification of Privacy Practices

The privacy of medical information is very important to us. We are committed to protecting the personal information of our patients. A medical record is prepared and maintained by our office on all patients to ensure quality care and to comply with certain legal requirements. Under the HIPAA Privacy Rule, we are required to keep each patient's medical information private, give notice describing our legal duties, privacy practices, and patient's rights regarding their medical records, and follow terms of the privacy notice now in effect. This notice is kept on file in the front office and with the compliance officer. Each patient is given a copy of the notice to read, and must sign an acknowledgement of their awareness of the policy. This is placed in their medical record. We reserve the right to make changes to the privacy policies at any time as permitted by the law. Patients will be notified of changes.

USE AND DISCLOSURE OF MEDICAL INFORMATION

We will not use or disclose any private medical information for any purpose not listed without specific written authorization by the patient or legal guardian. The following is a list of how we are permitted to use medical information without the written consent of the patient.

1. **Treatment** - We may disclose information to doctors, nurses, technicians, medical students, or others who are taking care of the patient. We may also share information with other providers to assist them in the treatment of a mutual patient.
2. **Payment** - Medical information may be disclosed when requested by insurance companies for payment of claims. Limited information can be disclosed to collection agency for purposes of receiving payment from the patient. Worker's compensation claims are subject to the laws set forth by the state and may require the release of protected health information in order for claims to be paid.
3. **Health Care Operations** - Use and disclosure for operations includes improving quality, evaluating employee performance, training purposes and obtaining accreditation, licenses, and credentials needed to perform day to day business.
4. **Notification** - Medical information may be released to notify or help notify a family member, a personal representative, or person responsible for the patient's care about the location of the patient, general condition, or death. If the patient is present then permission will be obtained or documented. In case of an emergency, when the patient is unable to give permission, only the information that is necessary for treatment will be disclosed according to our professional judgment.
5. **Fundraising** - We limit our use of medical information for affiliated fundraising foundations to general, not personal, terms. In any fundraising materials, we provide a description of how the patient may choose not to receive fundraising materials.
6. **Research** - Medical information for research purposes in limited circumstances where approved by
7. a review board that has examined the research proposal and established protocols to ensure the privacy of the information.

8. **Funeral Director, Coroner, Medical Examiner** - Information may be released to assist in performing their duties for a patient that has died.
9. **Court Orders, Judicial and Administrative Proceedings** - Under limited circumstances, such as court order, warrant, or grand jury subpoena, we may share medical information about a patient. We may also share limited information with law enforcement concerning a suspect, fugitive, material witness, crime victim, missing person, or inmate under lawful custody of a correctional facility. We may also disclose information to law enforcement when required by certain laws such as reporting of certain types of wounds, crimes on premises, and crimes in emergencies.
10. **Public Health Activities** - As required by law, medical information may be disclosed when preventing or controlling a disease, injury or disability, including child abuse or neglect. Information may also be disclosed to the PDA for purposes of reporting adverse events associated with product defects or problems, and to enable product recalls. We may also, when authorized by law to do so,
11. notify persons who may have been exposed to a communicable disease or otherwise be at risk of spreading or contracting a disease or condition.
12. **Victims of Abuse, Neglect or Domestic Violence** - We may disclose medical information to appropriate authorities if we reasonably believe that a person is a possible victim of abuse, neglect, domestic violence, or other crimes. We may share information if it is necessary to prevent a serious threat to the health or safety of the patient or others.

13. **Health Oversight Activities** - We may disclose information to an agency providing health oversight activities authorized by law including civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions.

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____

Name Birthdate

_____ _____

Signature Date

Surgery Financial Policy

Deposit

- 25% of the surgery total is collected as a deposit to book your surgery and reserve your date.
- 10% of the deposit is non-refundable, but it can be transferable to other services offered at Kalos Facial Plastic Surgery, The Kspa and Kalos Hair Restoration.

Surgery Balance

- The remaining surgery balance is due at least 14 days prior to the surgery date.
- Acceptable forms of payment are: *cash, credit/ debit card (Visa, Mastercard, Discover, Amex), cashier's check, money order, Alphaeon and CareCredit financing.*
- If using Alphaeon or CareCredit financing, you will need to set up an account and be approved prior to 14 days before surgery.

Rescheduling of Surgery

- To reschedule your surgery, **please notify us at least 14 days in advance**.
- Your deposit will be applied to your rescheduled surgery date

Surgery Cancellation

- If surgery is canceled more than 14 days (two weeks or more) prior to the surgery, you will be refunded all fees, except for the non-refundable 10% deposit.
- If you cancel between 0-13 days (less than two weeks) before surgery, all fees will be refunded, except your 25% deposit. The 25% deposit will still be transferable to other services.

Revision Policy

- If a revision procedure should be necessary, the patient is responsible to pay the related facility and anesthesia fees. If there happens to be a surgeon's fee, the rate would be determined upon follow-up consultation.
- Results from cosmetic procedures are not 100% guaranteed. In most cases, payment is non-refundable after completion. Refunds and no charge revision procedures are at the sole discretion of the doctor. Additional treatments and touch ups are not routinely included with any treatment.
  **** I fully understand and agree to the financial policy of Kalos Facial Plastic Surgery**

Patient Signature Date

Photography Consent

I, _____, consent to the taking of photographs by Kalos Plastic Surgery (Dr. Benjamin Stong MD) or designee of me or parts of my body in connection with the plastic surgery procedure(s) intended or performed. I understand that photographs may be taken before, during, and after my procedure(s) as a routine part of my medical care.

Signature:_____ Date:_____

_____

Release of Consent

I authorize the use of my photographs in the formats listed below. I waive any right to inspect or approve the finished product, advertising, or other copy that may be used in connection with the options below. I understand that I will NEVER be identified by name in any use of these photographs, and that my identity will remain confidential if I so wish.

For our office photo gallery to help future patients understand and see outcomes from surgery with Kalos Plastic Surgery.

To be used on our website or affiliated accounts for prospective patients to see and understand outcomes from surgery with Kalos Plastic Surgery.

I certify that I have read the above Authorization and Release and fully understand its terms.

Print Name: _____ Date: _____

Signature: _____

Witness: _____

This consent may be revoked at any time with a written consent.