NORTHWEST ARKANSAS

Center for Plastic Surgery

D. Heath Stacey, MD | J. Alex Kelamis, MD

Patient Information as of ____________ *(enter today's date)*

(Please print legibly and fill in or correct all fields)

Patient's Name ____________
First Middle Last

Address ____________
Street & Apt. # City State Zip

Home Phone ____________ Cell Phone ____________ Email ____________

Preferred Contact Method:
☐ Email Text ☐
☐ Home Cell ☐

May we send text reminders? YES NO

May we add you to our email list? YES NO

Any contact restrictions? ____________

Pharmacy Preference ____________

Age ______ Birthdate ____________ SS# ____________ Gender: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married to: ____________ Other: ____________

Patient's Employer ____________ Occupation: ____________

Address ____________
Street & Apt. # City State Zip

Work Phone ____________ Ext. ______ Who is your primary care physician? ____________

How did you hear about us? ☐ Google ☐ CitiScapes Magazine ☐ Peekaboo Magazine ☐ Doctor ____________

☐ Friend/Relative ____________ ☐ Other ____________

If you were referred by a specific person, may we thank them? YES NO

Emergency Contact: ____________ Relationship to patient: ____________

Home phone: ____________ Work phone: ____________ Other phone: ____________

Areas of interest: (mark all that apply)

Facial Procedures

- ☐ Blepharoplasty
- ☐ Botox
- ☐ Brow or Forehead Lift
- ☐ Earlobe Repair
- ☐ Facial Liposuction (Neck, Jowls)
- ☐ Face or Neck Lift
- ☐ Lip Enhancement
- ☐ Otoplasty (Ear Pinning)
- ☐ Rhinoplasty (Nose Job)
- ☐ Skin Resurfacing (Laser, Peel, Etc.)
- ☐ Wrinkle Fillers (Injectables)

Breast Procedures

- ☐ Breast Augmentation
- ☐ Breast Reconstruction
- ☐ Breast Reduction
- ☐ Mastopexy (Breast Lift)
- ☐ Nipple Reduction or Inversion

Body Procedures

- ☐ Abdominoplasty (Tummy Tuck)
- ☐ Brachioplasty (Arm Lift)
- ☐ Liposuction (Thighs, Abdomen, Etc.)
- ☐ Thigh or Buttock Lift
- ☐ Fat Grafting

Other Procedures

- ☐ Skin Care
- ☐ Telangectasia (spider veins)
- ☐ Laser Hair Removal
- ☐ Leg Veins
- ☐ Lesions / Moles
- ☐ Wound Repair

I understand that office visit charges are payable on the day service is rendered.

Signature ____________ Date ____________

Patient Name: ______________________________

Medical History:

	No	Yes	Details
Abdominal Bleeding			
Asthma			
Breast Cancer			
Cancer			
Chest Pain / Tightness			
Diabetes			
Heart Disease			
Heart Murmur			
Hepatitis			
High Blood Pressure			
Kidney Stones			
Skin Cancer			
Stroke			
Abnormal Scarring			
Thyroid Disorder			
Tuberculosis			
Ulcers			
Other:			

Past Surgeries:

	Operations:	Date:	Details:
1.			
2.			
3.			
4.			
5.			

Medications (including vitamins and over-the-counter items):

	Medications:	Dosage:
1.		
2.		
3.		
4.		
5.		

Drug Allergies: ______________________________

Patient Initials: __________

Northwest Arkansas

Center for Plastic Surgery

D. Heath Stacey, MD | J. Alex Kelamis, MD

Patient Name: ______________________________

Family History Information:

	No	Yes	Details
Abdominal Bleeding			
Anesthesia Problems			
Autoimmune Disorders			
Breast Cancer			
Cancer			
Diabetes			
Endocrine Disease			
Hearing Loss			
Heart Disease			
High Blood Pressure			
Hemophilia			
Kidney Disease			
Liver Disease			
Lung Disease			
Skin Cancer			
Skin Disease			
Substance Abuse			
Other:			

Social History:

Alcohol:	No / Daily / Social	How much?
Smoking:	Yes / No	How much?
Recreational Drugs:	Yes / No	What?
Do you exercise?	Yes / No	How often?

Female Questions:

Do you have regular periods?	Yes / No / NA
Are you going through menopause?	Yes / No
Are you pregnant or lactating?	Yes / No
Last Mammogram	Date:

Patient Initials: ____________

NORTHWEST ARKANSAS

Center for Plastic Surgery

D. Heath Stacey, MD | J. Alex Kelamis, MD

Patient Name: ______________________________

Photo Release for Treatment Plan / Medical Records

I authorize Dr. Stacey and/or Dr. Kelamis and/or Northwest Arkansas Center for Plastic Surgery, Ltd., and/or [his/her/their] representative(s), to take photographs, slides or videotapes of me or parts of my body for the following procedure(s) and for medical purposes to be used for my care, specifically for medical records.

Procedure: ______________________________

The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ('HIPAA"). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.

A copy of this Authorization is valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this Authorization, as provided by federal and/or state law.

I release and discharge Dr. Stacey and/or Dr. Kelamis and/or Northwest Arkansas Center for Plastic Surgery, Ltd. from all liability, including liability for negligence, that in any way arises out of any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization.

This Authorization is made as a voluntary contribution in the interest of public education and certify that I have read this Authorization and Release carefully and fully understand its terms.
If I have questions about the use or disclosure of my photographs, slides, or videotapes, I can contact the clinic at 479-571-3100.

Patient Signature ______________________________ Date ______________

Witness ______________________________ Date ______________

Northwest Arkansas

Center for Plastic Surgery

D. Heath Stacey, MD | J. Alex Kelamis, MD

Patient Name: ______________________________

Notice of Privacy Practices
Patient Acknowledgement Form

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

Patient Signature ______________________________ Date ____________________

Northwest Arkansas

Center for Plastic Surgery

D. Heath Stacey, MD | J. Alex Kelamis, MD

Patient Name: ______________________________

Financial Agreement:

• Payment is due at the time of service; unless arrangements have been made previously. Please be aware there is a $30 returned check fee. If your check is returned payments will need to be made by credit card or cash for all services.

• Medicaid patients: I understand that any non-covered service rendered will be my responsibility in full. I am aware that I will be balanced billed for these services should I elect to proceed with the proposed treatment plan.

• Please be advised this is only an estimate. Should additional services be needed, you will be informed prior, during, or after surgery.

• As a courtesy, we will gladly bill your insurance carrier on your behalf. However, you are ultimately responsible for payment on your account.

______ ***Initial*** • It is the responsibility of the patient to know their insurance coverage. Please use this treatment plan as a reference when contacting your insurance. If your insurance carrier denies any part of your claim, you will be responsible for your balance in full.

• We will provide you with an estimated prepay before surgery. Please remember that this is an estimate only and that you may still owe a balance after the claim is filed.

• For cosmetic procedures, a $500 **non-refundable** scheduling fee is required to schedule the surgery. The remaining balance is due 3 weeks before your surgery date. If you schedule your cosmetic procedure less than 3 weeks before the procedure date, the entire balance is due in full at the time of the surgery.

• For procedure revisions, there will likely be a supply fee required, the amount of which will be discussed at the time of the revision procedure.

• You understand payment is expected prior to service being rendered. The remaining balance is due in full within 61 days of service rendered regardless of insurance status.

• If no payment is received on account after 62 days, your account will be turned over to collections. At that time you will be responsible for a collection fee, which will be equal to 42.875% of your remaining balance.

I understand and agree to the above treatment plan and financial arrangements. My signature below does not obligate me to surgery.

______________________________ Patient or Responsible Party's Signature

______________ Date

______________________________ Witness' Signature

______________ Date

Authorization to Release Personal Protected Health Information to an Individual

Patient Full Name: ______________________________

Patient Date of Birth: ______________________________

☐ I do not authorize the release of any medical information to any individual except for treatment, payment and health care operations as specified in Northwest Arkansas Center for Plastic Surgery Notice of Privacy Practices.

☐ I hereby authorize the release and disclosure of my medical information to the following individuals. My authorization extends to all protected health information for general information purposes. The information that may be discussed includes but is not limited to: statements of charges or payments, records of all visits, records of visits for any and all dates, copies of records or reports provided to hospitals, laboratories, clinics or other physicians, progress notes, discharge summaries, history and physical examination reports, and consultation reports. I understand this authorization does not expire unless otherwise noted below.

(Please list the name of the individuals with whom we may discuss your protected health information.)

Name	Relationship to Patient

This authorization is given freely with the understanding that: 1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. 2. A photocopy of fax of this authorization is as valid as this original. 3. I may revoke this authorization at any time, except where information has already been released. The revocation must be in writing. 4. Northwest Arkansas Center for Plastic Surgery, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. 5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization. 6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

Patient's Printed Name	Date
Patient's Signature (or guardian, if a minor)	Expiration Date
Patient's Personal Representative	Date
Patient's Personal Representative's Authority to Act	Witness