Date ______________________ Referred by ______________________

Patient Name ______________________ ______________________ __________
Last First M

Patient's Date of Birth ______________________ SSN ______________________

Male or Female Age________ Marital Status: Married Single Divorced Widowed

Mailing Address ____

____
City State Zip Code

Home Phone #__________________ Cell # __________________ Email __________________

Employment__________________ Profession__________________ Work # __________________

Parent/Spouse's Name ____

Cell # __________________ Work #__________________ Email __________________

Emergency Contact (not at same address)__________________ Phone # __________________

♦♦

Primary Insurance ____

Insured's Name__________________ DOB__________________ Policy # __________________

Secondary Insurance ____

Insured's Name__________________ DOB__________________ Policy # __________________

♦♦

Insurance and Billing

We will be happy to assist you in filing your insurance claims. We will file your primary and secondary claims free of charge. There is a $10.00 fee for filing all other claims.

Your insurance is a contract between you and your insurance company. You are financially responsible for any services or deductibles/ co-insurance not covered by your plan. If your plan requires a referral, it is your responsibility to obtain it from your primary physician.

All copays/deductibles are due at time of service. There is a $30.00 charge for all returned checks. All accounts that are over 60 days will be charged interest at the rate of 1.5% per month. If accounts are turned over to collections, the patient/guarantor will be responsible for all collection fees.

To enable your insurance company to pay directly to us please sign below.

I hereby assign my insurance company to pay benefits for professional services rendered by Kitti. K. Outlaw, M.D., P.C. and Megan Carlyle, P.A.C. to be payable to Kitti K. Outlaw M.D., P.C. I understand that I am financially responsible for any charges not covered by this assignment. I also authorize release of any medical information necessary to process all claims.

______________________________ ______________________
Patient/Insured/Guarantor Date

When Patient is a minor or incompetent to give consent:

______________________________ ______________________
(Person Authorized to Consent for Patient) Date

OUTLAW PLASTIC SURGERY

NAME:_____ DATE: _____

DESCRIBE BRIEFLY THE REASON YOU ARE SEEING US TODAY AND HOW LONG THIS HAS EXISTED:

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____

HEIGHT:_____ WEIGHT:_____ AGE: _____

LIST ALL CURRENT MEDICATIONS: _____

_____

_____

_____

_____

_____

_____

PLEASE LIST ANY SURGERIES AND APPROXIMATE DATES: _____

_____

_____

_____

PLEASE CHECK BELOW IF YOU OR YOUR FAMILY HAVE A HISTORY OF THE FOLLOWING·

	SELF	FAMILY		SELF	FAMILY
HIGH BLOOD PRESSURE			SEIZURES		
HEART DISEASE			CHRONIC LUNG DISEASE		
DIABETES			HEPATITIS		
THYROID DISORDER			BLOOD CLOTS - LUNG/LEGS		
STROKE			CANCER		
FREE BLEEDING TENDENCIES			ASTHMA		
ANEMIA			ANESTHESIA PROBLEMS		

DO YOU HAVE ANY OTHER MEDICAL CONDITIONS NOT LISTED? IF YES, PLEASE LIST:_____

_____

DO YOU TAKE ASPIRIN OR IBUPROFEN? Y_____ N_____ FREQUENCY? _____

DO YOU TAKE A BLOOD THINNER? Y_____ N_____ IF YES PLEASE LIST _____

HAVE YOU EVER RECEIVED A TRANSFUSION? Y_____ N_____

HAVE YOU BEEN TESTED FOR HIV? Y____ N____ RESULTS? _____ HEPATITIS? Y____ N____ RESULTS? _____

DO YOU SMOKE? Y_____ N_____ FOR HOW LONG? _____ HOW MUCH? _____

HAVE YOU EVER SMOKED? Y_____ N_____ WHEN DID YOU QUIT?_____

DAILY EXERCISE? Y_____ N_____ AMOUNT? _____

DO YOU TAKE DIET PILLS? Y_____ N_____ DO YOU USE ALCOHOL? Y_____ N_____ HOW OFTEN? _____

RECREATIONAL DRUGS? Y_____ N_____ IF YES, WHAT KIND? _____

FEMALES ONLY: ARE YOU PREGNANT, PLANNING A PREGNANCY OR NURSING A CHILD? Y_____ N_____

WHO IS YOUR PRIMARY PHYSICIAN? _____

_____ _____

PATIENT SIGNATURE PHYSICIAN/ PHYSICIAN ASSISTANT SIGNATURE

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 REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we **(Outlaw Plastic Surgery)** use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at Outlaw Plastic Surgery may be billed to and payment may be collected from you, and insurance company or a third party. For example, we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at Outlaw Plastic Surgery, or the hospital. For example, we may disclose medical information about you to people outside Outlaw Plastic Surgery who may be involved in your medical care, such as family members, clergy, or other persons who are in part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run Outlaw Plastic Surgery and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professionals authorize to enter information into your medical chart, any member of a volunteer group, which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGUARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at Outlaw Plastic Surgery. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Outlaw Plastic Surgery, whether made by practice personnel or by your personal doctor. The law requires us to make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected health care information include: appointment reminders; as required by law; for health- related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes, military and veterans, national security and intelligence activities, protected services for the President and others, public health risks, and workers compensation.

NOTICE OF INDIVIDUAL RIGHTS

You gave the following rights regarding medical information we maintain about you.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, Outlaw Plastic Surgery. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restriction you must make your request in writing to the Privacy Officer.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosure." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosure, you must submit your request in writing to the Privacy Officer.

Changes to this Notice. We reserve the right to change this notice. We will post a copy of the current notice in Outlaw Plastic Surgery's office waiting room.

Complaints. If you believe your privacy rights have been violated you may file a complaint with Outlaw Plastic Surgery or with the Secretary of the Department of Health and Human Services. To file a complaint with Outlaw Plastic Surgery contact the Privacy Officer at (251) 414-1333. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide permission to us or disclose medical information about you, you may revoke that permission, in writing, at any time. If you have any questions about this notice or would like to receive a more detailed explanation please contact our Privacy Officer.

Name the people and/or organizations **(family members or significant others)** that you are authorizing to use and/or disclose the protected health information described above.

_____

_____

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Patient or Patient's Personal Representative Date

OUTLAW PLASTIC SURGERY

KITTI K. OUTLAW, M.D., P.C.
MEGAN E. CARLYLE, PA-C

3715 Dauphin Street
Suite 6A
Mobile, Alabama 36608
251.414.1333

PLASTIC SURGERY
COSMETIC & RECONSTRUCTIVE
WWW.OUTLAWPLASTICSURGERY.COM

DIPLOMATE
AMERICAN BOARD OF PLASTIC SURGERY
AMERICAN BOARD OF SURGERY

APPOINTMENT / PROCEDURE CANCELLATION POLICY

We are committed to providing all of our patients with the finest surgical care, and we appreciate the opportunity to serve you.

Dr. Outlaw and Megan Carlyle, PA-C reserve a significant amount of time for your office visit or procedure, and our staff invests a great deal of time in scheduling and registering you for your appointment. Furthermore, it jeopardizes our ability to ensure that you receive the medical care you need in a timely manner.

We realize that some patients may have an unavoidable need to change an appointment. However, we are requesting that when possible, you cancel your office visit or procedure in good time. The following provides our Appointment Cancellation Policy:

- An office visit No-Show will result in an administrative fee of $150 charged directly to you and not your insurance.
- A procedure No-Show will result in an administrative fee of $200 charged directly to you and not your insurance. Your next appointment will not be rescheduled until this fee is paid.
- If more than two appointments are cancelled without a 24 hour notification or No-Show, we will be unable to rescheduled any office visits or procedures for you.

We hope that you understand the need for this policy. Once again, thank you for allowing us to participate in your medical care.

Patient / Responsible Party Signature _____ Date _____

OUTLAW PLASTIC SURGERY

KITTI K. OUTLAW, M.D., P.C.

Dr. Outlaw received his medical degree from the University of South Alabama in 1992; he completed his General Surgery training at Louisiana State University/Charity Hospital and his Plastic Surgery training at the Medical College of Georgia. He is certified by the American Board of Surgery and the American Board of Plastic Surgery. He has been in practice in Mobile since 2000.

MEGAN CARLYLE, PA-C.

Ms. Carlyle received her Bachelor of Science in Biology from Mississippi College in 2000 and her Masters of Health Science in Physician Assistant Studies from the University of South Alabama in 2003. She is certified by the National Commission on Certification of Physician Assistants. She has been in practice in Mobile since 2004.

PLEASE READ AND INITIAL THE FOLLOWING:

_____ 1. I recognize that during the course of operation and medical treatment or anesthesia, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above physician and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time the procedure is begun.

_____ 2. Should complications occur, additional surgery or other treatments may be necessary. Even though risks and complications occur infrequently; other complications and risks can occur but are even more uncommon. The practice of medicine and surgery is not an exact science. Although good results are expected, there is no guarantee or warranty expressed or implied on the results that may be obtained.

_____ 3. I consent to the disposal of any tissue, medical devices or body parts, which may be removed and sent as specimen for pathologic evaluation.

_____ 4. I consent to the photographing of the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided the pictures do not reveal my identity.

_____ 5. For purposes of advancing medical education, I consent to the admittance of observers to the operating room.

_____ 6. I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical device registration, if applicable.

_____ 7. Cosmetic surgery is payable in full two weeks before surgery. All cosmetic consultations are $150.00 and due at the time of service. Follow up visits are included in your surgical fee for one year.

_____ 8. Depending on your particular health insurance plan, your surgery may be considered a covered benefit. Please review your health insurance subscriber-information pamphlet, call your insurance company, and discuss this further with our office. Many insurance plans exclude coverage for secondary or revisionary surgery. Most health insurance companies exclude coverage for cosmetic procedures or any complications that might occur from surgery.

_____ 9. The cost of surgery involves several charges for the services provided. The total can include fees charged by your doctor, anesthesia, pathology, and hospital charges, depending on your surgery performed. Depending on whether the cost of surgery is covered by an insurance plan, you will be responsible for necessary co-payments, deductibles, and charges not covered. Additional costs may occur should complications develop from the surgery. Secondary surgery or hospital day-surgery charges involved with revisionary surgery would also be your responsibility.

DISCLAIMER

_____ Informed-consent documents are used to communicate information about the proposed surgical treatment of disease or condition along with disclosure of risks and alternative forms of treatment(s). The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances.

However, informed consent documents should not be considered all inclusive in defining other methods of care and risks encountered. Your surgeon may provide you with additional or different information, which is based on all the facts in your particular case and the state of medical knowledge.

Informed-consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

It is important that you read the above information carefully with full understanding and have all of your questions answered.

Signature: _____ **Date:** _____

Office use only: _____ **(Signature)**