MARK MITCHELL JONES, M.D., F.A.C.S.
Atlanta Plastic Surgery Specialists, P.C.
2001 PEACHTREE ROAD, NE, SUITE 630 ATLANTA, GEORGIA 30309 (404) 355-3566

Patient Registration Form

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

_____ Office Phone: _____

City: _____ State: _____ Fax Number: _____

Zip: _____ County: _____ E-mail: _____

Occupation: _____

Date of Birth: _____ Age: _____ SSN: _____

Marital Status : ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partnered

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In case of emergency, local friend or relative to be notified. (not living at the same address as patient)

Emergency Contact: _____ Relationship: _____ Phone: _____

If Patient is a Minor (Under the Age of 18):

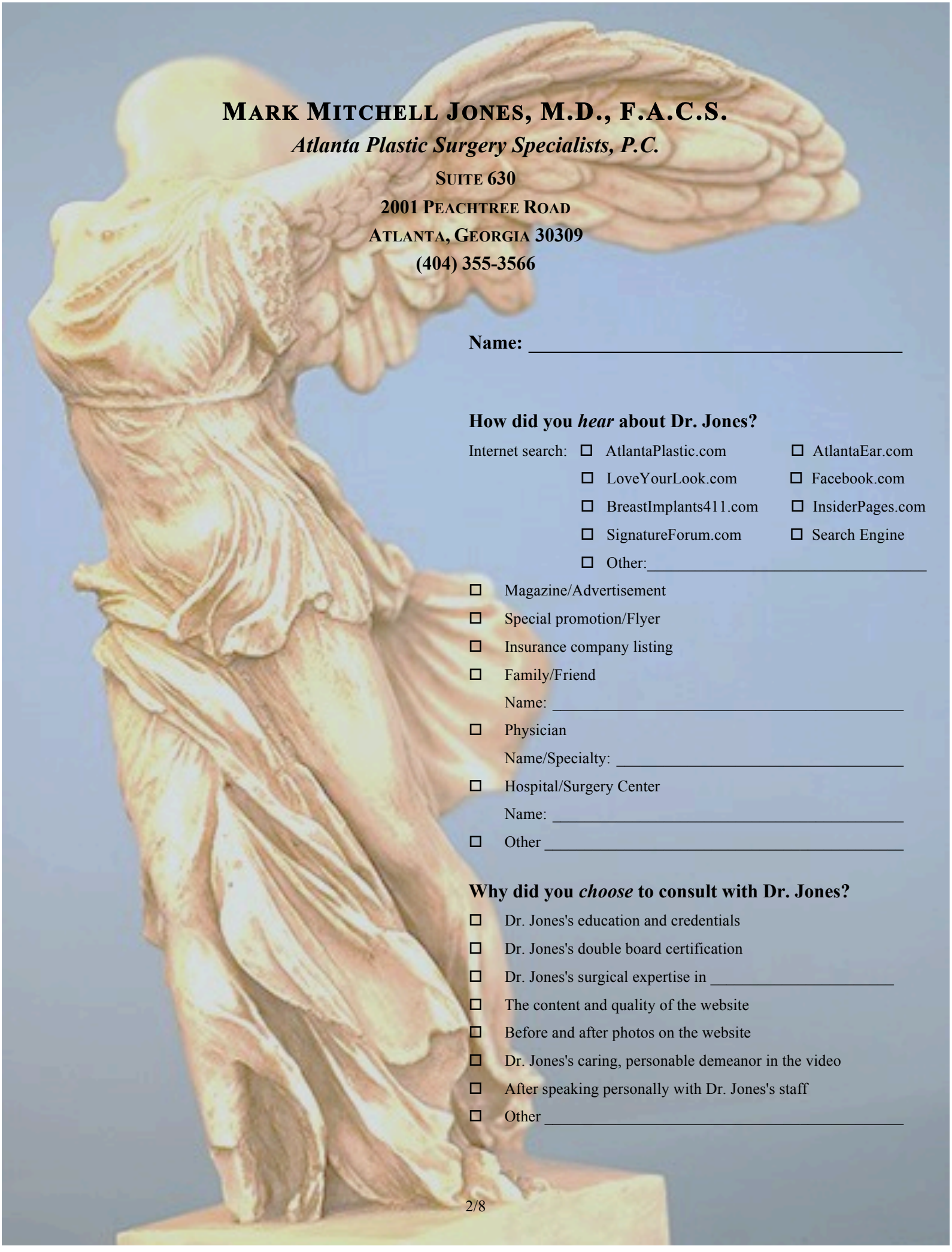
Father: _____ Mother: _____

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Subscriber Name:	Subscriber Name:
Mailing Address:	Mailing Address:
Patient's Relationship to Subscriber:	Patient's Relationship to Subscriber:
Subscriber Social Security Number:	Subscriber Social Security Number:
Subscriber's Date of Birth:	Subscriber's Date of Birth:
Subscriber's Employer:	Subscriber's Employer:
ID#	ID#
Group#	Group#

Assignment and Release: I hearby authorize my insurance and/or government benefits be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release any information, including medical records, required to obtain payment.

Signed: _____ Date: _____



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SUITE 630

2001 PEACHTREE ROAD

ATLANTA, GEORGIA 30309

(404) 355-3566

Name: _____

How did you *hear* about Dr. Jones?

Internet search:
- ☐ AtlantaPlastic.com
- ☐ AtlantaEar.com
- ☐ LoveYourLook.com
- ☐ Facebook.com
- ☐ BreastImplants411.com
- ☐ InsiderPages.com
- ☐ SignatureForum.com
- ☐ Search Engine
- ☐ Other:_____

☐ Magazine/Advertisement

☐ Special promotion/Flyer

☐ Insurance company listing

☐ Family/Friend

Name: _____

☐ Physician

Name/Specialty: _____

☐ Hospital/Surgery Center

Name: _____

☐ Other _____

Why did you *choose* to consult with Dr. Jones?

☐ Dr. Jones's education and credentials

☐ Dr. Jones's double board certification

☐ Dr. Jones's surgical expertise in _____

☐ The content and quality of the website

☐ Before and after photos on the website

☐ Dr. Jones's caring, personable demeanor in the video

☐ After speaking personally with Dr. Jones's staff

☐ Other _____

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Name: _____

A) Please check all procedures that interest you:

Face

- ☐ Face Lift
- ☐ Neck Lift
- ☐ Eyelid Lift
- ☐ Rhinoplasty
- ☐ Cheek/Chin Enhancement
- ☐ Otoplasty
- ☐ Brow/Forehead Lift

Breast

- ☐ Breast Augmentation
- ☐ Breast Lift
- ☐ Breast Reduction
- ☐ Male Breast Reduction

Body

- ☐ Tummy Tuck
- ☐ Liposuction
- ☐ Body Contouring

Reconstructive Surgery

- ☐ Septoplasty
- ☐ Scar Revision
- ☐ Ear Reconstruction
- ☐ Congenital Deformities

Non-Surgical

- ☐ Botox
- ☐ Injectable Fillers
- ☐ Microdermabrasion
- ☐ Facial Peels

Spa Treatments & Skin Care

- ☐ Facials
- ☐ Medical-grade Skin Care Products

- ☐ Other: _____

B) Please help us accommodate your budgetary needs by selecting a range below:

- ☐ $5,000 or less
- ☐ $5,000-$7,500
- ☐ $7,500-$10,000
- ☐ $10,000-$12,500
- ☐ $12,500-$15,000
- ☐ $15,000-$17,500
- ☐ $17,500+
- ☐ Other: _____

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Patient Medical History Today's Date:_____

Patient name:_____ Age:_____ Date of birth:_____

Height:_____ Weight: _____ Sex: ☐ Male ☐ Female

Primary Care Physician: _____ Phone: _____

Why are you here to see Dr. Jones? _____

Previous Surgeries: (Please use back of the Form if Necessary)

Operation	Year	Physician	Type of Anesthesia

Previous Non-Surgical Hospital Admissions:

Problem	Year	Physician	Complications

Past Injury or Car Accidents:

Type of Accident	Date	Type of Injuries	Outcome

Weekly consumption: Alcoholic beverages:_____ Tobacco: _____ Coffee/Tea/Cola:_____

Have you or a family member ever had any of the following (Please indicate person):

Tuberculosis:_____ Cancer (kind): _____ Cataracts:_____

Heart disease: _____ High blood pressure:_____ Glaucoma:_____

Lung disease: _____ Kidney disease:_____ Diabetes: _____

Are you ALLERGIC to any medications? _____ If yes, please list:_____

Do you take aspirin or any aspirin-containing products? Please list: _____

Date of last physical exam:_____ Name of examining physician: _____

Are you currently under the care of a physician? _____ For what condition? _____

List all current prescriptions and non-prescription medications: _____

Recent lab tests, x-rays, Pneumonia Vaccination: _____

Have you ever had problems with excessive bleeding or do you bruise easily? _____

Explain:_____

(Women) Have you had a Mammogram/(Men) Colorectal Screening within the last two years?_____ Date:_____

Have you ever been tested for AIDS or Hepatitis? Yes☐ No ☐yes, date of test:_____ Result: Positive ☐ Negative ☐

Women Only: Number of Pregnancies: _____ Number of Children:_____ Are you pregnant now?_____

Social History: Religious preference: _____ Hobbies: _____

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Our Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE FOR OFFICE VISITS

We accept cash, checks, or VISA/MasterCard/American Express/Discover

Regarding Insurance
We may or may not accept assignment of insurance benefits on your particular insurance. We cannot bill your insurance company unless you give us your correct information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits, we require that you pre-pay the deductible and co-pays or provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 45 days, the balance will automatically be transferred to your credit card or billed by statement. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Regarding Insurance Plans where we are a participating provider. All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Regarding Cosmetic Surgery
For financial purposes, cosmetic surgery is any procedure that insurance will not cover. Neither Dr. Jones nor the nurse will discuss financial matters or concerns, rather, the office staff will discuss the fee estimate for cosmetic surgery with you. The total fees will be broken into two categories, the surgical fee and the hospital fee. The hospital fee will include charges for the facility and anesthesia. The hospital fee is separate and independent from Dr. Jones fees. The hospital fee is always the responsibility of the patient, whether at the time of the initial surgery or any revisional surgery. The surgical fee will be paid in full to Dr. Jones at the date of your scheduled pre-op visit. Payment can be in the form of a credit card, cash or cashier's check. The hospital fee will be paid in full at the date of your scheduled surgery, to the hospital. If either of these amounts are not paid prior to the surgery, the surgery date will be re-scheduled.

Adult Patients
Adult patients are responsible for full payment at time of service.

Minor Patients
The adult accompanying a minor and the parent (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at time of service.

Missed Appointments
Unless canceled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy.

I have read the Financial Policy. I understand and agree to this financial policy:

X _____ Date:_____
Signature of Patient or Responsible Party

X _____ Date:_____
Signature of Co-Responsible Party

X _____ Date:_____
Witness

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Release of Information and Assignment of Benefits

I authorize DR. MARK MITCHELL JONES to release my medical information to my insurance company in order to process my insurance claim.

X _____
Signature

I authorize my insurance company to send my insurance payments directly to DR. MARK MITCHELL JONES for services rendered in his office.

X _____
Signature

ANY REMAINING BALANCE AFTER NINETY (90) DAYS WILL BE CHARGED A MONTHLY SERVICE CHARGE AND MONTHLY INTEREST UP TO THE MAXIMUM INTEREST RATE ALLOWED BY LAW.

X _____ X _____
Signature Witness

A photocopy of this assignment shall be considered legal and valid.

Please charge all fees or outstanding balances to my credit card:

☐ VISA ☐ MasterCard ☐ AmEx ☐ Discover

Card Number: _____ Expiration Date: _____

X _____
Signature

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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Atlanta Plastic Surgery Specialists, PC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Atlanta Plastic Surgery Specialists, PC's Notice of Privacy Practices for a more complete description of such users and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Atlanta Plastic Surgery Specialists, PC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Office Manager, 2001 Peachtree Road NE, Suite 630, Atlanta, GA 30309.

With my consent, Atlanta Plastic Surgery Specialists, PC may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Atlanta Plastic Surgery Specialists, PC may mail and/or e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Atlanta Plastic Surgery Specialists, PC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Atlanta Plastic Surgery Specialists, PC's use and disclosure of my PHI to carry out TPO. I am also giving my consent to ASCS to use photographs for teaching purposes.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Atlanta Plastic Surgery Specialists, PC may decline to provide treatment to me.

X _____ Date:_____
Signature of Patient or Responsible Party

X _____ Date:_____
Signature of Co-Responsible Party

X _____ Date:_____
Witness

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Consent Release

I, _____, hereby consent to the following:
Patient Name

☐ Patients of Dr. Mark Mitchell Jones contacting me at home or at work regarding the same or a similar surgery performed on me.

Phone Number(s) Home: _____ Work: _____

☐ Having the office of Dr. Mark Mitchell Jones contact me so that I can then call the patient interested in the same or a similar surgery performed on me at my convenience.

☐ Speaking with a patient of Dr. Mark Mitchell Jones about my surgery, regardless of the type of surgery the patient is having.

☐ Having photographs of myself shown to other patients, and to be used for medical and non-medical publications.

☐ Having before and after photographs of myself shown on the Internet or the website, for the illustration of surgery results.

☐ Having before and after photographs of myself posted on the Internet, for the illustration of the surgery case facts to counter any online misrepresentation of such facts in a damaging manner towards Dr. Mark Mitchell Jones.

I hereby release Atlanta Plastic Surgery Specialists, P.C. and its agents from any and all claims and demands arising out of or in conjunction with my photographs. Furthermore, I understand that no compensation will be granted for my permission for photographic use.

X _____ Date: _____
Patient or Guardian Signature

X _____ Date: _____
Witness