MARK MITCHELL JONES, M.D.
Atlanta Plastic Surgery Specialists, P.C.

Welcome to Atlanta Plastic Surgery Specialists! We are very pleased to meet you and eager to show you how Dr. Mark M. Jones can help you achieve your highest vision of yourself. To help us better understand your needs; please take a few moments to complete this questionnaire.

Patient Information

Name _____ Date _____

Birth Date _____ Age _____ Gender _____

Marital Status _____ SS# _____

Address _____

City _____ State _____ Zip _____

Phone_____ Okay to contact you by phone/text? Y __ N __

Office _____ Okay to contact you by phone? Y __ N __

Email_____ Okay to contact you by email? Y __ N __

Occupation _____ Employer _____

Number of Children _____ Health Insurance Plan Name _____

Emergency Contact Information

Name _____ Relation _____ Phone _____

How did you hear about us? (Check all that apply)

__Magazine Advertisement __ Family/ Friend __ Internet Search __ Social Media

__ Referred by: _____

Let us help you…

How long has "your problem area" bothered you? __ 0-1 year __ 1-3 years __ 3+ years

How long have you been considering this change? __ 0-1 year __ 1-3 years __ 3+ years

---

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

Signed: _____ Date: _____

MARK MITCHELL JONES, M.D.
Atlanta Plastic Surgery Specialists, P.C.

Name:_____

A) **Please check <u>all</u> 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
- ☐ BBL (Brazilian Butt Lift)

Reconstructive Surgery

- ☐ Septoplasty
- ☐ Scar Revision / Moles
- ☐ Ear Reconstruction
- ☐ Ear Repair

Non-Surgical

- ☐ Botox
- ☐ Injectable Fillers
- ☐ Other: _____

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

- ☐ $5,000 or less
- ☐ $5,000-$10,000
- ☐ $10,000-$15,000
- ☐ $15,000 +

MARK MITCHELL JONES, M.D.
Atlanta Plastic Surgery Specialists, P.C.

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:_____

MARK MITCHELL JONES, M.D.
Atlanta Plastic Surgery Specialists, P.C.

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. If there are any financial matters in dispute after procedures are performed, you waive your right to privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) guidelines.

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. 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.

I agree not to file insurance if I accept the cosmetic contract for a procedure and relinquish all rights with regard to insurance coverage for the procedure paid for under cosmetic contract irrevocably. I understand that the procedure(s) I seek are elective in nature, not medically necessary, and therefore would be fraudulent and unethical to submit to any insurance company for coverage. If insurance is filed on your behalf for a procedure, any DISCOUNTED FEE(S) will become null and void. The insurance rates will be filed accordingly and any amount(s) not covered will become your full responsibility. I understand I will be fully responsible for the surgical fees for the surgery I seek.

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.

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

MARK MITCHELL JONES, M.D.
Atlanta Plastic Surgery Specialists, P.C.

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

MARK MITCHELL JONES, M.D.
Atlanta Plastic Surgery Specialists, P.C.

Consent Release

The use of photographs is essential to the planning and evaluation of cosmetic or reconstructive surgery. We will need to obtain a series of photographs before and after and perhaps during your surgical procedure.

At times it is often helpful for prospective patients to view photographs of procedures which have been performed such as you may have done during your own consultation and research. Dr. Mark Jones would like your permission to use your photographs as well. Every effort will be made to conceal your identity and your name will not be released without your expressed permission.

I authorize my plastic surgeon to use my photographs, videos and case information in the following settings: my surgeons office patient education materials; my surgeon's file of pre/post-operative patient photographs available to prospective patients for viewing in the office; magazine articles in which my surgeons participates; television programs in which my surgeon participates; my surgeons personal website; lectures and multi-media presentations given by my surgeons for the general public.

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