Carolina Plastic Surgery

100 E. Wood St. Suite 100 Spartanburg, SC 29303 864-583-1222	Dr. John T. Lettieri	2755S.Hwy 14, Suite2250 Greer, SC 29650 864-583-1222

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential.

PATIENT INFORMATION

Patient's Name (Last) (Middle) (First)	Gender:	Birth Date ______/______	Marital Status: Single[ ] Married [ ] Widowed [ ] Divorced [ ]
Patient's address City State Zip		Home Phone:	Cell Phone:
E-Mail Address:		Patient's Social Security #	
Emergency Contact Person & Phone Number:		Primary Care Physician:	
Specialist Physician(s):	OBGYN Physician:	How did you hear about our office? Friend: ___________________________ Internet: Website: ___________________________	
Patient Occupation/ Employer:	Business Phone #:	Physician:_____________________ Other: ___________________________	

Spouse/ Guarantor Information

Spouse/Guarantor:	Relationship □ Spouse □ Parent	Responsible Party's Birthdate ____/____/	Responsible Party's Social Security #
Responsible Party Driver's License Number: State:		Cell Phone	Email:
Name of Employer:		Business Phone	Other Parent/Contact Informat

INSURANCE INFORMATION

Primary insurance company		Is insurance through your employer?	
Primary insurance subscriber's name	Subscriber birth date	Policy # or SSN	Group #
Secondary insurance company		Is insurance through subscriber'?	
Secondary insurance subscriber's name	Subscriber birth date	Policy & Group #:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balances. I also authorize Carolina Plastic Surgery, PA to release any information to my insurance company that is required to process my claims.

_______________________________________ _______________________

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

(Over)

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2755 South Hwy 14, Suite 2250
Greer, SC 29650

Protected Health Information Release Form:

Patient Name: ______________________________________ Date: ____________________

(1) Concerning matters of my health, I give permission for Dr. Lettieri or a member of his staff to speak with:

Name: ________________________Relationship to patient ____________Contact#: ____________

Name: __________________________Relationship to patient _____________Contact#: _____________

Name:__________ ________________ Relationship to patient ____________Contact#:______________

(2) I request that my protected health information not be disclosed to the following individuals or entities, [list individuals or entities to which information would not be disclosed]:

____

____

Name: ___________________________ Phone: _________________ (must be listed above)

Signature of patient: ___________________________________ Date: __________________

Witness: ____ Date: ___________________

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COSMETIC INTEREST QUESTIONNAIRE

Patient Name: ______________________________ Date: _________________________

Please answer the following questions so we can better address your concerns today:

What brings you to Dr. Lettieri Today? _______________________________________

As a comprehensive plastic surgery office, we offer a full service medical day spa. Some of the services provided in our spa include: Skin care, Laser treatment, Makeup products (Jane Iredale) Facials, Laser hair removal, Rosacea treatment, Adult acne, and treatment of all forms of skin aging.

Dr. Lettieri offers the latest in cosmetic and reconstructive surgical procedures. He works with our Esthetician to provide comprehensive care for our spa patients.

Are you interested in learning more about the following? (Please check all that apply).

- ❑ Gel Breast Implants
- ❑ Breast Lift
- ❑ Botox Cosmetic for fine lines & wrinkles
- ❑ Skin Rejuvenation
- ❑ Breast Reduction
- ❑ Micro-Dermabrasion
- ❑ Collagen Injectable gel for deep lines & facial folds
- ❑ Chemical Peels
- ❑ Laser Resurfacing
- ❑ Latisse increase eyelashes length, thickness and darkness
- ❑ Brown Spots/Age Spots
- ❑ Jane Iredale (Make-Up)
- ❑ Other, please specify: ____
- ❑ Liposuction
- ❑ Skin Care Products
- ❑ Skin Care
- ❑ Liver Spots/Age Spots
- ❑ Sunscreen Advice
- ❑ Breast Reconstruction
- ❑ Upper/Lower Blepharoplasty
- ❑ Hair Removal
- ❑ Laser Treatment
- ❑ Face Lift
- ❑ Tummy Tuck

The Greatest compliment you could ever pay us is to refer your family and friends.
Did a friend or family member refer you? _____YES _________NO

We would like to thank them. Is it okay for us to send them a thank you card? Y N
****We will not discuss any details of your care.****

Who referred you? ____
First and Last Name

May we email you about our special offers and events? ________YES _________ NO

Email: _____________________________________

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Financial and Contact Authorization

I hereby authorize payment for any surgical and/or medical care to go directly to Dr. John T Lettieri at Carolina Plastic Surgery. **I AGREE TO PAY ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY INSURANCE**. I understand that Carolina Plastic Surgery, PA will bill my health insurance as a onetime courtesy and that rebilling is not customary. I understand that I am responsible to follow up with my insurance company if there are any discrepancies or lack of payment for services rendered. I understand that it is my responsibility to know the coverage allowed under my insurance policy.

Patient Name: ____Date: ____________________

Patient Signature: ____________________________________ Date: _____________________

Authorization for disclosure/release of information: I authorize Carolina Plastic Surgery, PA to disclose complete information concerning medical findings and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who in Carolina Plastic Surgery's, PA determination are required to receive such information for the purpose of medical treatment., medical quality assurance, peer review and if applicable to process the insurance claim for services rendered at Carolina Plastic Surgery, PA. I further authorize any other physician and /or medical facility to release my medical information to Carolina Plastic Surgery, PA for the purpose of my medical treatment and, if applicable, to process the insurance claim for services rendered at Carolina Plastic Surgery, PA. This authorization shall remain in effect until written notice revoking this authorization is sent to Carolina Plastic Surgery, PA.

Patient Name: _____________________________________ Date of Birth: ________________________

Patient Signature: ______________________________ Date: _____________________________

Contact Authorization:

In order to provide better care for you, the practice may need to contact you or your designated representative regarding your treatment. Please fill out the form below as to how you would like to be contacted regarding appointments, treatment and/ or information pertinent to your healthcare and/or payment for your healthcare provided by Carolina Plastic Surgery, P.A.,

Please check all forms of contact that are acceptable:

- ❑ Email: __________________ ****This is our preferred method of contact****
- ❑ Home Phone:_______________
- ❑ Cell Phone________________
- ❑ Answering Machine: **YES**_____ **NO** _____
- ❑ Other: _________________________

Signature: ______________________________________ Date: __________________________

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HIPAA COMPLIANCE STATEMENT

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Carolina Plastic Surgery, P.A. is committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities. A detail copy can be obtained by asking the receptionist.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit our offices, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to: plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care.

YOUR RIGHTS

Although your chart belongs to our practice, the information contained in the chart is yours. You have the right to: inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information.

OUR RESPONSIBILITIES

We are required to: maintain the privacy of your health information; send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION IS USED

Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Bills will be sent to your insurance company. The information in the bills will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.

OTHER NOTICES

We may leave a message at your home, at your business, on your answering machine, on your voicemail, or email. We may mail you a letter or other written notices. You have the right to restrict how you receive this information. Please see the “Contact Authorization Form”. We may need to disclose your information to your family members or other people helping with your care. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have concerns or would like additional information, you may contact the practice’s Privacy Officer at (864-583-1222)

Patient Signature____ Date________________________

(Over)