Meadows
SURGICAL ARTS

CLIENT INFORMATION/ HISTORY

Thank you for visiting Meadows Surgical Arts. Please complete the following form as accurately as possible to ensure safe and effective care during your visit.

Today's Date: _____ / _____ / _____

Name: _____ DOB: _____ / _____ / _____

Social Security Number: _____ - _____ - _____ Gender: Female / Male

Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Phone: _____

Email Address: _____ Subscribe to mailing list? YES / NO

Preferred Contact Method (circle one): Home Phone / Cell Phone / Email

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

How did you hear about Meadows Surgical Arts?

_____ Home Town Neighbors Magazine
_____ Southern Distinctions Magazine
_____ Billboards
_____ Website
_____ Social Media
_____ Online Advertisement
_____ Friend: _____
_____ Other: _____

INSURANCE INFORMATION

Please fill out ALL highlighted areas listed below and provide a copy of your insurance card.

PRIMARY Insurance Name: _____

Policy # / Member ID: _____ Group #: _____

Policy Holder's Name: _____ DOB: _____

Insurance Claim Address: _____

Payer ID: _____ Insurance Provider Contact Number: _____

SECONDARY Insurance Name: _____

Policy # / Member ID: _____ Group #: _____

Policy Holder's Name: _____ DOB: _____

Insurance Claim Address: _____

Payer ID: _____ Insurance Provider Contact Number: _____

Note: Patient understands that insurance does not guarantee payment, and all unpaid costs from insurance will be left to the patient's responsibility (sign here): _____

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Patient: _____ Patient DOB: _____ / _____ / _____

MEDICAL HISTORY

Please fill out ALL highlighted areas listed below.

Do you have any known allergies (i.e. latex, medications, etc.)? YES / NO

If yes, please list known allergies: _____

Have you taken Accutane in the past 3 months? YES / NO

Approximately how much water do you drink daily? _____

What medications are you currently taking, with **current dosages**? Please list all herbs, vitamins, over-the-counter medications, topicals, and prescription drugs.

_____

_____

_____

Are you currently pregnant or breastfeeding? YES / NO

Do you exercise? YES / NO

Do you smoke? YES / NO

Do you drink alcohol? YES / NO If yes, how often? _____

Please list your medical history:

_____

_____

_____

Please list your family medical history:

_____

_____

_____

Have you ever had surgery? YES / NO If yes, please list with dates:

_____

_____

_____

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Patient: _____ Patient DOB: _____ / _____ / _____

MEDICAL HISTORY (CONTINUED)

Have you ever been diagnosed with any of the following? If so, list medications taken:

Shingles	YES	NO	_____
Eczema	YES	NO	_____
Multiple Sclerosis	YES	NO	_____
Cancer	YES	NO	_____
Asthma	YES	NO	_____
Arthritis	YES	NO	_____
Abdominal Disorders	YES	NO	_____
Congestive Heart Failure	YES	NO	_____
Heart Disease	YES	NO	_____
Pacemaker	YES	NO	_____
Cardiac Arrhythmia	YES	NO	_____
Lupus	YES	NO	_____
Scleroderma	YES	NO	_____
Herpes (cold sores/fever blisters)	YES	NO	_____
Thyroid Condition	YES	NO	_____
Thrombophlebitis	YES	NO	_____
Varicose Veins	YES	NO	_____
Diabetes	YES	NO	_____
Caratoid Sinus Syndrome	YES	NO	_____
Neuro-Muscular Disease	YES	NO	_____
Seizures	YES	NO	_____
Excessive Bleeding	YES	NO	_____
Mental Disease	YES	NO	_____
Autoimmune Disorders	YES	NO	_____
Liver Disease	YES	NO	_____
Gallbladder Problem	YES	NO	_____
OTHER: _____			_____
OTHER: _____			_____

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Patient: _____ Patient DOB: _____ / _____ / _____

GYNECOLOGICAL HISTORY (If Applicable)

How old were you when you had your first period? _____
How frequently do your periods come? Every _____ days.
How long do your periods last? _____ days.
When did your last period start? _____
Do you experience cramping with your periods? YES / NO
If yes, when during your cycles do you have pain (circle all that apply)? BEFORE / DURING / AFTER
How would you describe the cramps? MILD / MODERATE / SEVERE
Do you often take pain medication for the cramps? YES / NO
If yes, specify: _____
Do you bleed or spot between periods? YES / NO
If yes, please describe: _____
Have you ever had an abnormal Pap smear result? YES / NO
If yes, what therapy was required? _____
Have you ever had any infections involving any part of the reproductive tract (includes vagina, cervix, uterus, ovaries)? YES / NO
If yes, which one(s) of the following: Chlamydia / Trichomonas / Gonorrhea / Herpes / Genital Warts
What treatment did you receive? _____
What type of contraception do you use presently (if applicable)?
_____ Contraceptive Pills
_____ Condoms
_____ IUD / Foam / Sponge
_____ Other: _____
Do you have any family members who have or who have had one of the following gynecological problems?
Endometriosis / Uterine Fibroids / Breast Cancer / Ovarian Cancer / Uterine Cancer / Cervical Cancer
If yes, please specify: _____

I certify that the above medical history information is complete and accurate.

Patient/Guardian Signature	Date
Medical Staff / Technician's Signature	Date

I understand and agree to allow Meadows Surgical Arts to take photos/video of my treatment and/or treated areas to be used for the purpose of monitoring my progress, education, and/or advertising.

I understand that my identity will remain anonymous and no images will be taken without my knowledge.

Patient/Guardian Signature	Date

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CLIENT INFORMATION/ HISTORY

Patient: _____ Patient DOB: _____ / _____ / _____

COSMETIC HISTORY INFORMATION

(If appointment is not cosmetic, this section may be left blank)

Have you had sun exposure or been in a tanning bed in the past 4 weeks? YES / NO
Do you use tanning beds? YES / NO
Are you using any chemical tanning solutions? YES / NO
Do you regularly use sunscreen? YES / NO
Have you waxed or used depilatories, bleaches, or other chemical processes? YES / NO
Do you currently have any open sores or lesions? YES / NO
Do you have a history of acne breakouts? YES / NO
    If yes, how frequent are your breakouts? Frequent / Occasional / Rare
    Do you experience cystic acne breakouts? YES / NO
Do you have any scarring as a result of acne? YES / NO
Have you recently had a microdermabrasion treatment? YES / NO
Have you recently had any chemical peels? YES / NO
Have you ever had laser skin resurfacing? YES / NO
Have you ever had gold therapy? YES / NO
Do you have Rosacea? YES / NO
Have you had Botox or Collagen injections in the past 6 months? YES / NO
    If yes, and within the last three months, please give approximate dates: _____
What type of skin care products are you using? _____
_____

I certify that the above cosmetic medical history information is complete and accurate.

Patient/Guardian Signature	Date
Medical Staff / Technician's Signature	Date

I hereby allow Meadows Surgical Arts to release my medical health records in case of emergency to the following people:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Patient/Guardian Signature	Date
Medical Staff / Technician's Signature	Date

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CONSENT FOR
USE AND DISCLOSURE OF
HEALTH CARE INFORMATION ("CONSENT")

Patient: _____ Patient DOB: _____

"I" and "Patient" shall be understood to mean _____.
Print Patient Name

I understand that Patient's personal health information is private and confidential. I understand that Meadows Surgical Arts works very hard to protect Patient's personal health information.

I understand that Meadows Surgical Arts may use and disclose Patient's personal health information to help provide health care to Patient, to handle billing and payment, and to take care of other health care operations.

Meadows Surgical Arts has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting Patient's privacy. I understand that I have the right to read the "Notice of Privacy Practices" before signing this Consent.

Meadows Surgical Arts may update this "Notice of Privacy Practices". If I ask, Meadows Surgical Arts will provide to me the most current "Notice of Privacy Practices".

Under the terms of this Consent, I can ask Meadows Surgical Arts to limit how Patient's personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that Meadows Surgical Arts does not have to agree to my request. If Meadows Surgical Arts does agree to my request, I understand that Meadows Surgical Arts would follow the agreed limits.

I give permission to Meadows Surgical Arts to contact me by email, phone, and leave messages on my answering machine or voicemail. These phone calls and/or messages may be in regard to my appointments, status of health of financial standing, but are not limited to these topics.

I may cancel this consent in writing at any time by doing one of the following:

1. Signing and dating a form that Meadows Surgical Arts can give me called "Revocation of Consent for Use and Disclosure of Health Care Information"; or
2. Writing, signing, and dating a letter to Meadows Surgical Arts. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of Patient's personal health information for treatment, payment, and health operations.

If I revoke this Consent, Meadows Surgical Arts is not obligated to provide any further health care services to Patient.

My signature below indicates that I have been given the opportunity to review a current copy of Meadows Surgical Arts' "Notice of Privacy Practices". My signature means that I agree to allow Meadows Surgical Arts to use and disclose Patient's personal health information to carry out treatment, payment, and health care operations.

_____ _____
Signature Date

If Patient is a minor, relationship to Patient: _____

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STATEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES

Patient: _____ Patient DOB: _____

In order to provide a better understanding of the rights and responsibilities that exist between you, the patient, and Meadows Surgical Arts, and to encourage a meaningful participation by you in your health care, we encourage you to be aware of your rights and responsibilities.

PATIENT RIGHTS

1. No patient shall be denied surgical services on the basis of race, creed, color, national origin, religion, sex, age, or handicap.
2. Every person who is or has been a patient is entitled to have information from his/her medical record explained to him/her by the appropriate person and to authorize the release of information from his/her medical record to an appropriate individual, organization, or institution.
3. Every patient is entitled to privacy during the provision of treatment or care.
4. Every patient is entitled to confidentiality of all records and communications pertaining to his/her care.
5. Every patient is entitled to receive, from the appropriate person within the facility, information about his/her illness, course of treatment, and prospects for recovery in terms that the patient can understand.
6. Every patient is entitled to refuse treatment to the extent provided by law and to be informed of the consequences of their refusal. When a refusal of treatment prevents the facility or its staff from providing appropriate care according to its ethical and professional standards, the relationship with the patient may be terminated upon reasonable notice.
7. Every patient is entitled to feel safe and secure while in the facility. If, at any time, a patient feels that their safety has been compromised in any way, it should be reported to the Circulating Nurse.
8. Every patient is entitled to information about Meadows Surgical Arts' policies and procedures for the initiation, review, and resolution of patient complaints.
9. Every patient is entitled to examine and receive an explanation of his/her bill regardless of source of payment.
10. Every patient is entitled to receive information concerning his/her continuing health needs and alternatives for meeting those needs, and to be involved in his/her discharge planning.
11. Every patient is entitled to know who is responsible for and who is providing his/her direct care.
12. Every patient is entitled to information about facility policies and procedures affecting patient care and conduct.
13. Patient can change providers at any time.
14. Patient can refuse participation in research.

PATIENT RESPONSIBILITIES

Every patient is responsible for:

1. Following facility policies and procedures affecting patient care and conduct;
2. Providing a complete and accurate medical history;
3. Providing documentation with regard to advance directives and/or healthcare surrogates (if unfamiliar with the above, please ask a Front Office Representative and they will be happy to assist you);
4. Making it known whether he/she clearly comprehends a contemplated course of action and the things he/she is expected to do;
5. Following the treatment plan and expectations;
6. Being considerate of the rights of other patients and facility personnel and property.
7. Providing Meadows Surgical Arts with accurate and timely information concerning his/her sources of payment and ability to meet financial obligations; and
8. Actively participating in their healthcare decision-making.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Meadows
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AGREEMENT AS TO RESOLUTION OF CONCERNS

Patient: _____ Patient DOB: _____

PLEASE READ CAREFULLY

"I" and "Patient/Guardian" shall be understood to mean _____.
Print Patient Name

"Physician" shall be understood to mean Dr. Lionel Meadows and Meadows Surgical Arts.

I understand that I am entering into a contractual relationship with the Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by my Physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board-certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Board of Cosmetic Surgery or the American Board of Obstetrics and Gynecology.

I agree the expert will be obligated to adhere to the guidelines or code of conduct defined by the American Board of Cosmetic Surgery or the American Board of Obstetrics and Gynecology.

I agree to require any attorney I hire and any physician hired by me on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Patient/Guardian and Physician agree that a conclusion by the specialty society affording the due process to an expert will be treated as supporting or refuting evidence of a meritless or frivolous claim.

Patient/Guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses, and other dependents.

Patient/Guardian and Physician agree that these provisions apply to any claim for medical malpractice, whether based on a theory of contract, negligence, battery, or any other theory of recovery.

Patient/Guardian acknowledges that he/she has been given ample opportunity to read this agreement and ask questions about it.

Patient/Guardian Signature	Date
Witness Signature	Date
Physician Signature	Date

Meadows
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FINANCIAL AGREEMENT

Patient: _____ Patient DOB: _____

Dear Patient:

Thank you for choosing Meadows Surgical Arts for your medical needs. We are committed to providing you and your family with the best possible care. The following is our Financial Policy, which will help you (the "Responsible Party") to understand our payment and billing procedures.

Payment for service is due at the time service is provided. All charges are your responsibility. We accept cash, money orders, debit cards, Mastercard, Visa, American Express, and outside funding services such as Care Credit, Lending USA, and United Financial (outside funding services are subject to change).

As a courtesy to you, we will submit insurance claims on your behalf. However, your insurance policy is a contract between you, your employer, and your insurance provider. We are not a party to that contract. You are responsible for knowing your insurance benefits. Our relationship is with you, not the insurance provider. We will not become involved with disputes between you and your insurance provider regarding deductibles, co-payments, covered charges, and their determination of "usual and customary" charges, all of which are determined by the policy your employer chooses to provide for you. We submit insurance claims with the understanding that whatever your insurance provider does not pay, the balance is then your responsibility to pay within 30 days of your first billing statement. YOUR DEDUCTIBLE AND CO-PAY WILL BE COLLECTED AT THE TIME OF SERVICE.

Please have all insurance cards available for photocopying at all times. Any change in insurance, personal address, phone numbers, or emergency contact should be reported immediately.

If your insurance provider's policy is to send payment checks directly to the insured member (who may or may not be the Responsible Party) instead of the healthcare provider, you will be responsible for payment in full at the time of service. Your insurance provider will reimburse you directly.

Remember that insurance pre-authorizations do not guarantee payment. If your insurance provider does not pay in full within 60 days, we ask that you contact them, as the charges will then be transferred to you. We require you to pay the balance due, even though your insurance provider may eventually process your claim. A refund will then be mailed to you. After 60 days, interest due on past due balances will accrue at a monthly rate of 1.5% monthly. There will be a $30 fee for all returned check items. Should your account become delinquent and have to be referred to a collection agency, an attorney, or the Magistrate's Court, you will be financially responsible for the costs of collections and/or legal fees.

At Meadows Surgical Arts, your safety is always our number one priority. The operating room fees in your surgery proposal are our best estimate of the time it will take to achieve your cosmetic goals. In order to avoid additional billing on any surgery involving liposuction, we estimate the operating room time based on your Body Mass Index ("BMI") at the time of your consultation. Your BMI will fluctuate with any changes in weight. If your BMI has increased by two or more points on the day of surgery, we may reschedule certain procedures, or you will be charged an additional $800 per point to cover the additional anesthesia and operating room fees associated with additional procedure time.

Sincerely,

Dr. Lionel Meadows

Patient Signature

Date

Meadows
SURGICAL ARTS

**CANCELLATION/
NO SHOW POLICY
FOR APPOINTMENTS**

Patient: _____ Patient DOB: _____

Meadows Surgical Arts understands that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel your appointment, you may be preventing another patient from getting the treatment he/she may need. Similarly, the situation may arise where another patient fails to cancel their appointment, and we are not able to schedule and appointment for *you* because we have a full schedule.

WEIGHT LOSS ASSESSMENTS, GYNECOLOGY VISITS, AND OFFICE VISITS
If you do not cancel your appointment 24 hours prior to your scheduled appointment time, you will be charged a **$25 No-Show Fee**.

SPA SERVICES
If you do not cancel your appointment 24 hours prior to your scheduled appointment time, you will be charged a **$50 No-Show Fee**.

INJECTABLE SERVICES
If you do not cancel your appointment 24 hours prior to your scheduled appointment time, you will be charged a **$50 No-Show Fee** and a **$75 Injection Fee**.

* If you receive a No-Show Fee, that *must* be paid before you can schedule another appointment.*

INJECTION FEE POLICY
If you do not use a full syringe of a filler at the time of your appointment, and do not come back within two (2) weeks to receive the rest of that syringe, there will be a **$75 Injection Fee** for that visit.

Patient/Guardian Signature	Date
Witness Signature	Date