



Plastikos Plastic & Reconstructive Surgery  
Plastikos Surgery Center  
Millennium Healthcare  
Avatar Industries  
4370 Georgetown Square  
Atlanta, GA 30338  
(770) 457-4677 (Tel.)  
(770) 457-4428 (Fax)  
[www.plastikos.com](http://www.plastikos.com)  
[www.millennium-healthcare.com](http://www.millennium-healthcare.com)  
[www.templeofhealth.ws](http://www.templeofhealth.ws)



## **NUTRITIONAL SUPPLEMENTS FOR SURGERY**

### **Vitamin/Mineral/Herbal:**

- Dermal K: Vitamin K cream to reduce bruising.
- EpiCor: Increases natural killer T cells. Take two weeks prior to surgery and four weeks after.
- Super Immune Tone: This product provides essential nutrients for proper immune function that helps you heal better after surgery.
- Immune Protectors: Vitamin, mineral and herbal supplement to protect and strengthen the immune system.
- End Fatigue Pain Formula: Herbal pain reliever.
- Joint Connection: Effective tissue repair after surgery for injured joints, carpal tunnel release, cubital tunnel release, repetitive strain injury and tenosynovitis.
- MSM: Natural pain reliever and anti-inflammatory.
- CurcuMax: Herbal anti-inflammatory that aides surgical healing.

### **Homeopathics:**

- Bone Repair: For temporary relief of symptoms associated with inflammation due to bone injury and repair.
- Surgical-Tone: Homeopathic to help strengthen immune system before and after surgery, to aid in the healing process.

### **Other products:**

Penta Water: Penta water's patent pending technology hydrates your body more efficiently and rapidly than any other water and increases your cells' energy production. Hydration is one of our body's best and most natural ways of preventing disease. To locate a health food store in your area, go to [www.hydrateforlife.com](http://www.hydrateforlife.com) and type in your zip code.



Plastikos Plastic & Reconstructive Surgery  
Plastikos Surgery Center  
Millennium Healthcare  
Avatar Industries  
4370 Georgetown Square  
Atlanta, GA 30338  
(770) 457-4677 (Tel.)  
(770) 457-4428 (Fax)



[www.plastikos.com](http://www.plastikos.com)  
[www.millennium-healthcare.com](http://www.millennium-healthcare.com)  
[www.templeofhealth.ws](http://www.templeofhealth.ws)

Discontinue use of the following medications at least 3 weeks prior to surgery and 3 weeks after!!!

4-Way Cold Tablets	Colcin	Lobac	Persantine (Dipyridamole)
Acetilsalicylic Acid	Cope	Lodine	Phed Fast
Actron	Coricidin Tablets	Lortab ASA	Phenaphen/Codeine #3
Acutrim	Coumadin (Warfarin)	MAO Inhibitors	Phen Phen
Adprin-B products	Damason-P	Magan	Piroxicam
Advil	Darvon Compound-65	Magnaprin	Quiet World Analgesic
Advil Cold & Sinus	Darvon/ASA	Salicylate	Relafen
Aleve	Daypro	Magsal	Rhinocaps
Alka-Seltzer	Deep-down Pain Rub	Marthritic	Robaxisal
Amigesic	Relief	Mefenamic Acid	Rowasa
Anacin	Dexatrim	Mentholum Deep	Roxeprin
Anaprox	Diclofenac	Heating	Saleta-D
Anexsia w/Codeine	Dicumarol	Meprobamate	Salflex
Ansaid	Diet Pills	Mesalamine	Salicylate products
Arthra-G	Dimetapp Sinus	Methocarbarnol	Salsalate
Arthriten products	Dipentum	Micrainin	Salsitab
Arthritis Foundation products	Disalcid	Midol	Scot-Tussin
Arthritis Pain Formula	Doan's	Mobidin	Sine-Aid IB
Arthritis Strength BC Powder	Dolobid	Mobigesic	Sine-Off
Arthropan	Dristan	Mobisyl Analgesic	Sinutab
ASA	Dristan Sinus	Crème	Sodium Salicylate
Asacol	Duragesic	Momentum Muscular	Sodol Compound
Ascriptin products	Easprin	Mono-Gesic	Soltice Quick Rub
Aspercreme	Ecotrin	Backache Formula	Soma Compound
Aspergum	Empirin	Motrin	St. Joseph Aspirin
Asprinox products	Entab-650	Motrin IB Sinus	St. Joseph Cold Tablets
Axotal	Enteric Coated Aspirin	Myoflex Creme	Stanback Headache Powder
Azdone	Equagesic	Nalfon	Sulfasalazine
Azulfidine products	Etodolac	Naprelan	Supac
B-A-C	Excedrin	Naprosyn	Suprax
Backache Formula	Feldene	Naproxen	Synalgos-DC
Bayer Aspirin	Fiorgen PF	Night-Time	Talwin
BC Cold and Sinus	Fiorinal	Effervescent Cold	Ticlid
BC Powder/Tablets	Flurbiprofen	Norgesic/Norgesic	Toradol
Beffex	Gelpirin	Forte	Triaminicin
Ben-Gay	Gemisyn	Norwich products	Tricosal
Bismatrol products	Genprin	Olsalazine	Trilisate
Buffaprin	Gensan	Omega-3 or Fish Oils	Tussanil DH
Buffered aspirin	Goody's Headache	Orphengesic products	Tussirex products
Bufferin	Power	Orudis	Ursinus Inlay Tablets
Buffets II	Halfprin products	Oxycodone	Vanquish Aspirin Tablets
Buffex	Heet Analgesic	P-A-C	Vira-Med Tablets
Butal/ASA/Caff	Liniment	Pabalate products	Vitamin E Tablets
Butalbital Compound	IBU	Pain Reliever Tabs	Voltaren
Cama	Ibuprofen	Pamprin	Warfarin
Carisoprodol Compound	Indomethacin products	Panalgesic	Wesprin
Cataflam	InfraRUB Analgesic	Panasal	Willow bark products
Cheracol	Cream	Pentasa	Zorprin
Choline Magnesium Trisalicylate	Isolyl Improved	Pepto-Bismol	
Choline Salicylate	Kaodene	Percodan	
Clinoril	Lanorinal		



Plastikos Plastic & Reconstructive Surgery  
Plastikos Surgery Center  
Millennium Healthcare  
Avatar Industries  
4370 Georgetown Square  
Atlanta, GA 30338  
(770) 457-4677 (Tel.)  
(770) 457-4428 (Fax)  
[www.plastikos.com](http://www.plastikos.com)  
[www.millennium-healthcare.com](http://www.millennium-healthcare.com)  
[www.templeofhealth.ws](http://www.templeofhealth.ws)



## **Herb/Supplement Precautions Prior to Surgery**

### **To Avoid Problems with:**

#### **Bleeding:**

Avoid for 2 weeks prior to surgery:

- Bilberry
- Cat's Claw (Saventaro)
- Feverfew
- Garlic
- Ginger
- Ginkgo biloba
- Omega 3 Oil, i.e. fish oil supplements, flaxseed oil, hemp oil
- Red Clover
- Vitamin C in doses greater than 4 gms per day
- Vitamin E in doses greater than 400 IU per day
- Cat's Claws/Saventaro

#### **Anesthesia:**

Avoid for one (1) week prior to surgery:

- Ephedra
- Kava Kava
- Lavendar
- Lemon Balm
- Licorice
- Passion Flower
- Skull Cap
- St. John's Wort
- Valerian
- Yohimbe

#### **Other Problems:**

- Aloe – may cause low potassium levels
  - Ginseng – may cause hypertension and rapid heart rate and may decrease the effectiveness of certain anti-clotting agents.
  - Goldenseal – may worsen swelling and/or high blood pressure
  - Niacin – may increase liver function tests
  - PC-SPES – may increase the risk of blood clots
- 
- ❖ Discontinue use of Aspirin or aspirin products for 3 weeks prior to surgery.
  - ❖ Consult your surgeon if you are using pain patches or any pain management medication before you continue to take the medication.
  - ❖ This is not a complete list of medications or supplements that should be avoided before surgery.
  - ❖ If you are currently taking any medications on an occasional basis, consult your physician or anesthesiologist.
  - ❖ Any anti-inflammatory medications, medications containing aspirin, or MAO inhibitors should also be avoided.



Plastikos Plastic & Reconstructive Surgery  
Plastikos Surgery Center  
Millennium Healthcare  
Avatar Industries  
4370 Georgetown Square  
Atlanta, GA 30338  
(770) 457-4677 (Tel.)  
(770) 457-4428 (Fax)  
[www.plastikos.com](http://www.plastikos.com)  
[www.millennium-healthcare.com](http://www.millennium-healthcare.com)  
[www.templeofhealth.ws](http://www.templeofhealth.ws)



## REMOVAL OF BREAST IMPLANTS/CONSULTATION FORM

### GENERAL:

Elective surgery – Long consultation  
Realistic expectations/Full Disclosure – Key to Success

### DIAGNOSIS/CONDITION:

Implants:

- Breast implants first inserted surgically in \_\_\_\_\_(year)
- Type of current implant:
  - Silicone gel (silicone gel contained in silicone envelope)
  - Double lumen (saline in a silicone envelope surrounding gel in second silicone envelope)
  - Polyurethane covered silicone gel implant
  - Saline inflatable (saline in a silicone envelope)

If implant(s) have been changed, describe original and subsequent implant(s):

\_\_\_\_\_

Current physical complaints: \_\_\_\_\_

\_\_\_\_\_

Evaluation by other physicians regarding implants or conditions related to implants:

- Names/Dates: \_\_\_\_\_
  - Treatment/diagnosis/recommendations: \_\_\_\_\_
- Concerns other than physical complaints (if any): \_\_\_\_\_
  - Cancer (specifics): \_\_\_\_\_
  - Autoimmune Diseases (specifics): \_\_\_\_\_
  - "Leakage" / Rupture (specifics): \_\_\_\_\_
- Removal of Implants is being considered because of: \_\_\_\_\_
- Medical indications / necessity (specify): \_\_\_\_\_

\_\_\_\_\_

- Anxiety/psychological need (even though documented medical indications are not present) (specify): \_\_\_\_\_

\_\_\_\_\_

### GOALS:

- Relief of physical complaints (if present)
- Prevention of future speculative/theoretical problems (even though not presently identified nor suspected)
- Relief of anxiety and psychological concerns (if present)
- Return to pre-augmentation appearance and physical condition
- Maintain or improve the current appearance of the breast if current implants are replaced with different implants

### LIMITATIONS:

- Implants cannot be removed (or replaced) without surgery which carries risk.
- According to the FDA, the risk of removal in patients without physical/medical indication may be greater than the risk of implants remaining in place.
- Incisions may be placed in the same location or a different location than the original incisions used to insert the implants.
- Scars from incisions used for removal or replacement are expected to be similar in appearance to the original scars but some may be better or worse.
- Some internal healing from the original surgery and from the surgery to remove the implants will result in permanent internal scarring which may be felt and/or create visible irregularities of the breast. More extensive internal scarring may occur if the operation must be extended to remove scar tissue, lumps, or to remove a ruptured implant.



**Plastikos Plastic & Reconstructive Surgery**  
**Plastikos Surgery Center**  
**Millennium Healthcare**  
**Avatar Industries**  
 4370 Georgetown Square  
 Atlanta, GA 30338  
 (770) 457-4677  
[www.plastikos.com](http://www.plastikos.com)  
[www.millennium-healthcare.com](http://www.millennium-healthcare.com)



- Changes in breast occur naturally with the passage of time from such events as pregnancy, weight gain/loss, loss of skin elasticity, gravity, and other naturally occurring circumstances unrelated to the implants; the appearance of the breasts after removal of the implants may be significantly affected by these changes as well as the changes expected from the removal of the implants themselves especially when the implants are not replaced.
- Implants cannot be removed permanently without significant loss of fullness (although no breast tissue is ordinarily removed), possible distortion, wrinkling and/or appearance worse than prior to the original operation.
- Permanent implant removal may result in psychological disturbance including depression which is expected to be temporary but could be long lasting.
- Loss of interest in sexual relations by the patient and/or their sexual partner has been reported.
- Removal of scar tissue lining the cavity prolongs the operation but removes silicone in the scar capsule. Removal of scar capsule often decreases the risk of postoperative complications.
- Removal of the implants may not relieve any of the physical complaints nor psychological concerns which the patient may believe are related to the implants.
- If implants are replaced with different implants, the risk and complications related to the new implants are the same as assumed at the time of the original surgery or if the implants were being inserted for the first time.
- Internal scarring may limit or alter reconstruction or reaugmentation in the future.
- If implants are replaced, the appearance and physical character of the breast may be altered.

**ALTERNATIVES:**

- Leave everything as it is. Continue regular follow-up evaluation at least every 2 years.
- Remove implants only.
- Remove implants and the natural capsular scar tissue lining in the cavity as well as lumps or abnormal scar tissue if present.
- Remove implants with or without the capsular scar tissue and replace with different implants.

**LIKELY OUTCOMES:**

- Cannot be predicated with certainty and varies from patient to patient. Examples are:
  - Significant relief of anxiety and peace of mind – positive psychological and physical response.
  - Acceptance of return to “former self” in exchange for less worry and concern.
  - Depression which is hoped to be temporary but could be prolonged – could require counseling.

**SURGICAL TECHNIQUES/ANESTHESIA/FACILITY/RECOVERY:**

Local anesthesia & sedation vs. general anesthesia	Incisions
Office OR/aesthetic surgical unit/hospital OR	Dressings/drains
Out-patient vs. hospitalization	Restrictions/return to normal activities

**TRADE OFFS:**

Discomfort (pain/sensitivity)	Discoloration/Swelling	Temporary numbness
Tightness/Relaxation	Lumps/Irregularities	Restricted activity

**RISKS/COMPLICATIONS:**

Bleeding/blood collection**	Wrinkling/Irregularity	Lymph node enlargement
Infection	Sensory changes (numbness/pain)	Calcification in tissues
Asymmetry	Changes in color of skin	Implants may be damaged during removal
Fluid collection	Indentations	Inability to remove all the silicone – may need further surgery to remove

**EVEN THOUGH THE SPECIFIC RISKS AND COMPLICATIONS CITED ABOVE OCCUR INFREQUENTLY, THEY ARE THE ONES THAT ARE PECULAR TO THE OPERATION OR OF THE GREATEST CONCERN. OTHER COMPLICATIONS AND RISKS CAN OCCUR BUT ARE EVEN MORE UNCOMMON. THE MAJOR RISKS OF SURGERY ARE COMPARABLE TO THE RISKS YOU TAKE EVERYDAY WHEN DRIVING OR RIDING AN AUTOMOBILE.**

**ANY AND ALL OF THE RISKS AND COMPLICATIONS CAN RESULT IN:**

Additional Surgery	Time Off Work
Hospitalization	Expense to You



Plastikos Plastic & Reconstructive Surgery  
Plastikos Surgery Center  
Millennium Healthcare  
Avatar Industries  
4370 Georgetown Square  
Atlanta, GA 30338  
(770) 457-4677  
[www.plastikos.com](http://www.plastikos.com)  
[www.millennium-healthcare.com](http://www.millennium-healthcare.com)



**DISPOSAL OF IMPLANTS/TISSUE:**

Unless you specifically direct otherwise, implants and any tissue removed will be sent to the Department of Pathology for evaluation. A charge for this examination will be made by Pathology. Implants are returned to you by Pathology or after surgery.

**INSURANCE MAY NOT COVER THIS PROCEDURE IF THERE ARE NO DOCUMENTED MEDICAL INDICATIONS FOR IMPLANT REMOVAL; TREATMENT OF COMPLICATIONS MAY OR MAY NOT BE COVERED BY INSURANCE.**

**NO GUARANTEE:**

The practice of medicine and surgery is not an exact science; although good results are expected, there cannot be any guarantee, nor warranty, expressed or implied, by anyone as to the results that may be obtained.

\*\*Must be off all aspirin containing products for three (3) weeks before surgery and for two (2) weeks after surgery. (Check all medications with us; Some medications such as Motrin and Advil may also affect clotting).

**IF THERE IS ANY ITEM ON THIS CONSULT SHEET THAT YOU DO NOT UNDERSTAND, MARK IT, AND CALL THE OFFICE. AN EXPLANATION OR ADDITIONAL INFORMATION WILL BE PROVIDED. SHARE THE INFORMATION WE PROVIDE YOU WITH YOUR SPOUSE OR OTHER INTERESTED FAMILY MEMBERS OR FRIENDS. I WILL BE HAPPY TO MEET WITH THEM IF YOU WISH.**

Date: \_\_\_\_\_ Surgeon: \_\_\_\_\_

Copied & Provided to patient by: \_\_\_\_\_

A copy of this Consultation was provided to me: \_\_\_\_\_  
(Patient's Signature)



Plastikos Plastic & Reconstructive Surgery  
 Plastikos Surgery Center  
 Millennium Healthcare  
 Avatar Industries  
 4370 Georgetown Square  
 Atlanta, GA 30338  
 (770) 457-4677 (Tel.)  
 (770) 457-4428 (Fax)  
[www.plastikos.com](http://www.plastikos.com)  
[www.millennium-healthcare.com](http://www.millennium-healthcare.com)  
[www.templeofhealth.ws](http://www.templeofhealth.ws)



**PHOTO RELEASE FOR PHYSICIAN**

I hereby authorize Susan Kolb, M.D., Asaf Yalif, M.D., Julian Gordon, M.D., Plastikos Plastic & Reconstructive Surgery LLC, Plastikos Surgery Center LLC, Millennium Healthcare LLC, Avatar Industries LLC, and/or Holisticare South LLC to use any and all slides/photos/video images of the following patients:

---



---

These images may be used for purposes such as, but not limited to presentations, advertisements, television appearances, websites, journals, textbooks, newspapers, magazines, pamphlets, and/or video tapes. It is understood that the purpose of this usage will be professional and in keeping with accepted medical ethics and standards.

Susan Kolb, M.D., Asaf Yalif, M.D., Julian Gordon, M.D., Plastikos Plastic & Reconstructive Surgery LLC, Plastikos Surgery Center LLC, Millennium Healthcare LLC, Avatar Industries LLC, and/or Holisticare South LLC has my permission to copyright and use, reuse, and republish images of my patient(s) as listed above. The patient(s) name will not be published. I understand that in some circumstances the photographs may make my identity recognizable.

I hereby state that I have obtained permission from the above patient(s) to allow their slides/photos/images to be used by Susan Kolb, M.D., Asaf Yalif, M.D., Julian Gordon, M.D., Plastikos Plastic & Reconstructive Surgery LLC, Plastikos Surgery Center LLC, Millennium Healthcare LLC, Avatar Industries LLC, and/or Holisticare South LLC in the manner described above, and said patient has executed a photo release form attached as Exhibit A (Photo Release).

I grant this consent as a voluntary contribution and release any claim for payment in connection with distribution or publication of the photographs. I certify that I have read the above authorization and release and fully understand its terms.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name printed or typed \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Witness \_\_\_\_\_



Plastikos Plastic & Reconstructive Surgery  
 Plastikos Surgery Center  
 Millennium Healthcare  
 Avatar Industries  
 4370 Georgetown Square  
 Atlanta, GA 30338  
 (770) 457-4677 (Tel.)  
 (770) 457-4428 (Fax)  
[www.plastikos.com](http://www.plastikos.com)  
[www.millennium-healthcare.com](http://www.millennium-healthcare.com)  
[www.templeofhealth.ws](http://www.templeofhealth.ws)



## INITIAL EVALUATION - EXPLANT

### PATIENT INFORMATION

Patient Name:		Date:	
DOB:		Physician:	

Date:	Chief Complaint: _____  Date of Implant: _____ Augment or Reconstruction: _____ Incision: _____ Sub-mammary or Sub-pectoral? _____ <b>IMPLANT:</b> <ul style="list-style-type: none"> <li>• Type: _____</li> <li>• Size: _____</li> <li>• Manuf: _____</li> <li>• Complications: _____</li> <li>• Additional Surgery? Date/Type/Complications _____</li> </ul> Symptoms: <ul style="list-style-type: none"> <li>• Date Onset: _____</li> <li>• Change in Shape?: _____</li> <li>• Mastodynia?: _____</li> <li>• Candidiasis?: _____</li> <li>• Progressive?: _____</li> <li>• Fatigue?: _____</li> </ul> Mammogram: Date/Result: _____ <ul style="list-style-type: none"> <li>• U/S: Date/Result: _____</li> <li>• MRI: Date/Result: _____</li> </ul> ROS: _____  PMHx: _____
-------	---





Plastikos Plastic & Reconstructive Surgery  
Plastikos Surgery Center  
Millennium Healthcare  
Avatar Industries  
4370 Georgetown Square  
Atlanta, GA 30338  
(770) 457-4677 (Tel.)  
(770) 457-4428 (Fax)  
[www.plastikos.com](http://www.plastikos.com)  
[www.millennium-healthcare.com](http://www.millennium-healthcare.com)  
[www.templeofhealth.ws](http://www.templeofhealth.ws)



## BREAST EXPLANT QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please complete the following information. This information may be provided to your insurance company and/or legal counsel, or to the manufacturer of your breast implants. This information may help expedite approval for removal and possible replacement of your current breast implants.

1. Have you been implanted with one or more breast implants prior to June 1, 1993 (whether or not later removed)? Y / N
2. Have you received or requested to receive the settlement notice of breast implant claims? Y / N
3. Do you have counsel? Y / N (If so, please complete information below):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

### **SURGICAL HISTORY:**

Please provide a history of your surgeries involving breast implants. If you do not know the details of the surgeries, please leave them blank. (If you have had more than one surgery, please attach this information to this form).

#### **A. GENERAL INFORMATION**

Date of Implant surgery: \_\_\_\_\_

Type of Anesthesia: General or Local w/ sedation ( Circle One)

Name of Surgeon: \_\_\_\_\_

Surgeon's Address: \_\_\_\_\_

Surgeon's Office #: \_\_\_\_\_

Surgeon's Fax #: \_\_\_\_\_

#### **HOSPITAL (OR SURGICAL FACILITY)**

Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_

#### **B. TYPE OF IMPLANT AND SURGICAL TECHNIQUES**

Manufacturer: \_\_\_\_\_

Lot#: Left: \_\_\_\_\_ Right: \_\_\_\_\_

Catalog #: Left: \_\_\_\_\_ Right: \_\_\_\_\_

**Type (Please check one):**

- Silicone Gel; Smooth                       Saline Filled; Smooth
- Silicone Gel; Textured                       Saline Filled; Textured
- Silicone Gel; Low Bleed                       Combination (Double-Lumen)
- Natural Y; (Meme)                      (Polyurethane Coated)

**Placement of Implant (Please check one):**

- Above Muscles                       Below the muscle

**Incision Used:**

- Around the nipple-areolar area
- On the lower portion of breast
- In the Axilla or armpit

Reason for Surgery:

---

---

Were the implants ruptured?

- Yes                       No                       Don't Know

**C. COMPLICATIONS NOTED AFTER THIS SURGERY (please check all that apply):**

- Capsular Contracture (Firmness/local tightening/possible displacement or shifting up of implant)?
  - Right Side                       Left Side
- Pain or discomfort lasting more than two months?
  - Right Side                       Left Side
- Thinning of tissues, displacement of implant down towards abdomen?
  - Right Side                       Left Side
- No Complication
- Other Complications (please list in detail): \_\_\_\_\_

---

**D. OPERATION REPORT FROM THIS SURGERY:**

- \_\_\_\_\_ Available (please send us a copy)
- \_\_\_\_\_ Sent for
- \_\_\_\_\_ Not available
- \_\_\_\_\_ Will send for (& provide Dr. Kolb with a copy)

Have you noticed any generalized symptoms since the placement of your breast implants (please circle one)? Y / N  
If Yes, please fill out the *Medical Signs / Symptoms Questionnaire*, and please provide the following information of any Medical Doctors (including Rheumatologist) who you have seen for these symptoms:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Have you had a mammogram, breast ultrasound, breast MRI since the placement of your implants? Y / N

If **NO**, please SKIP this question, if **YES**, please complete the following information:

Type of test: \_\_\_\_\_

Date: \_\_\_\_\_

Location where test was performed: \_\_\_\_\_

Phone #: \_\_\_\_\_

Written report available? Y / N (please provide a copy)

Written report sent? Y / N

Will send for written report? Y / N (please provide Dr. Kolb a copy)

**DIAGNOSTIC TESTS:**

Type of Test: \_\_\_\_\_

Date: \_\_\_\_\_

Location where test was performed: \_\_\_\_\_

Phone #: \_\_\_\_\_

Written report available? Y / N (please provide a copy)

Written report sent? Y / N

Will send for written report? Y / N (please provide Dr. Kolb a copy)

Do you have a family history of breast cancer?

Yes If Yes, what relationship: \_\_\_\_\_

No

Do you suspect that one or both of your implants have ruptured or are leaking?

Yes  No  Don't Know

If YES, please check all that apply (and circle appropriate side):

Sudden change in shape or size (Left / Right)

Sudden softening (Left / Right)

History of chest wall trauma (Left / Right)

Noted on Mammogram (Left / Right)

History of closed capsulectomy (Left / Right)

**EXPLANTATION INFORMATION:**

Do you desire removal of your implants?

- Yes                       No                       Don't Know

Do you desire removal of the scar capsule around your breast implants? (This is advisable for patients who are not being reimplanted and who have a diagnosis of connective tissue disease such as Lupus or Scleroderma, patient with polyurethane coated implants, or patients with silicone implants or textured implants)

- Yes                       No                       Don't Know

Do you desire replacement of your present implants with saline filled breast implants? (You should be aware that the covering of this implant is a silicone envelope into which saline or salt water is placed)

- Yes                       No                       Don't Know



Plastikos Plastic & Reconstructive Surgery  
 Plastikos Surgery Center  
 Millennium Healthcare  
 Avatar Industries  
 4370 Georgetown Square  
 Atlanta, GA 30338  
 (770) 457-4677 (Tel.)  
 (770) 457-4428 (Fax)  
[www.plastikos.com](http://www.plastikos.com)  
[www.millennium-healthcare.com](http://www.millennium-healthcare.com)  
[www.templeofhealth.ws](http://www.templeofhealth.ws)



## BREAST EXPLANT MEDICAL SIGNS / SYMPTOMS QUESTIONNAIRE

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

CATEGORY A	DATE OF ONSET OF SYMPTOMS	DOCTOR SEEN FOR THIS CONDITION
Sudden color changes of the hands		
Sudden temperature changes of the hand		
Ulceration of the hands or fingertips		
Swelling of the joints lasting greater than 6 weeks		
Tenderness of the joints lasting greater than 6 weeks		
Dry eyes or impaired tear production		
Dry mouth for long periods of time		
Abnormalities of tear glands, salivary glands or parotid glands		
CATEGORY B	DATE OF ONSET OF SYMPTOMS	DOCTOR SEEN FOR THIS CONDITION
Myalgias (tenderness of the muscles)		
Rashes over face (flat or raised)		
Scaly rashes raised from the skin		
Diffuse spider-like spots on the skin		
Skin thickening of face, extremities, neck, elbow and knee		
Other types of skin rashes		
Restrictive lung disease		
Obstructive lung disease		
Chest x-ray reflecting lung changes		
Abnormal pulmonary function tests (if you are a non-smoker)		
Abnormal arterial blood gas studies (if you are a non-smoker)		
Pleuritis (inflammation and/or abnormal fluid in the sac around the lungs)		
Pericarditis (inflammation and/or abnormal fluid in the sac around the heart)		
Changes of the heart seen on EKG or echocardiogram		
Cognitive dysfunction		
Memory loss		
Difficulty concentrating		
Abnormal MRI, PET or SPECT scan of the brain		
Abnormal neuropsychological testing		
Loss of sensation to pinprick, vibration, touch or position		
Tingling, loss of sensation or burning pain in the extremities		
Muscle weakness in extremities		
Weakness of ankles, hands or foot drop		
Partial loss of feeling in extremities		
Abnormal electromyelogram (EMG) or muscle biopsy		
Abnormal blood antibodies (AMA, antiODNA, anti-Sm, IgG, IgA, IgM, ESR, etc.)		
False positive test for syphilis		
Patient Signature: _____		Date: _____
CATEGORY C	DATE OF ONSET	DOCTOR SEEN FOR



Plastikos Plastic & Reconstructive Surgery  
 Plastikos Surgery Center  
 Millennium Healthcare  
 Avatar Industries  
 4370 Georgetown Square  
 Atlanta, GA 30338  
 (770) 457-4677  
[www.plastikos.com](http://www.plastikos.com)  
[www.millennium-healthcare.com](http://www.millennium-healthcare.com)  
[www.templeofhealth.ws](http://www.templeofhealth.ws)



	OF SYMPTOMS	THIS CONDITION
Pain in the joints		
Swelling of the joints		
Fluid in the joints		
Pain in the muscles		
Chronic fatigue greater than 6 months		
Enlargement of the lymph glands		
Sensitivity to the sun		
Difficulty swallowing		
Loss of large amounts of hair (other than after pregnancy)		
Sustained balance disturbance		
Easy bruisability or bleeding disorder		
Chronic urinary tract infections or bladder irritability		
Abnormalities of the esophagus or gastrointestinal tract		
Malabsorption syndrome		
Diverticulitis		
Colitis or bowel irritability		
Persistent low grade fever or night sweats		
Ulcers of the mucous membranes (inside mouth, throat, esophagus)		
Burning pain in the chest		
Burning pain in the breast (s), arm (s) or axilla (armpits)		
Disfigurement of breast after breast implant insertion		
Granulomas, siliconomas, or lumps after breast implant insertion		
Breast infections after breast implant insertion		
CATERGORY D (other signs and symptoms)	DATE OF ONSENT OF SYMPTOMS	DOCTOR SEEN FOR THIS CONDITION
Renal (kidney) disease		
Seizures		
Psychosis not caused by drugs		
Blood disorder		
Tremors		
Mood swings		
Anxieties		
Neurosis		
Restlessness		
Shortness of breath		
Depression		
Chronic fatigue		
Headaches		
CATERGORY E (questionnaire for diagnosis of SLE)	DATE OF ONSENT OF SYMPTOMS	DOCTOR SEEN FOR THIS CONDITION
Have you had arthritis or rheumatism for more than 3 months?		
Do you fingers become pale, numb or uncomfortable in cold?		
Have you ever had mouth sore for more than 2 weeks?		
Have you ever had low blood counts, WBC, Anemia or low platelet count?		
Have you ever had a rash on your cheek for more than one month?		
Does your skin break out when you are in the sun (not sunburn)?		
Has it ever been painful to take a deep breath?		
Have you ever had protein in your urine?		
Have you ever had rapid hair loss?		
Have you had a seizure, convulsion or fit?		

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Plastikos Plastic & Reconstructive Surgery  
 Plastikos Surgery Center  
 Millennium Healthcare  
 Avatar Industries  
 4370 Georgetown Square  
 Atlanta, GA 30338  
 (770) 457-4677  
[www.plastikos.com](http://www.plastikos.com)  
[www.millennium-healthcare.com](http://www.millennium-healthcare.com)  
[www.templeofhealth.ws](http://www.templeofhealth.ws)



## RHEUMATOLOGIC / NEUROLOGIC DIAGNOSIS

Has any physician ever told you that you had one of the following disease conditions? If so, please list the date that the diagnosis was made and the doctor you saw for this problem.

DIAGNOSIS	DATE OF DIAGNOSIS	DOCTOR SEEN FOR THIS CONDITION
Systemic Sclerosis		
Scleroderma		
Systemic lupus Erythematosus (lupus or SLE)		
Rheumatoid Arthritis		
Myositis		
Atypical Neurological Disease Syndrome		
Polyneuropathy		
Polymyositis		
Dermatomyositis		
Multiple Sclerosis		
Multiple Sclerosis-like syndrome		
ALS-like Syndrome (Lou Gehrig's Disease)		
Disease of the Neuromuscular Junction		
Raynaud's Phenomenon		
Raynaud's Disease		

## DEGREE OF DISABILITY AS A RESULT OF IMPLANTS

- A. Does your breast implant related illness symptoms interfere with work? If yes, please describe with as much detail as possible.
- B. Does your breast implant related illness interfere with your family life? If yes, please describe with as much detail as possible.
- C. Does your breast implant related illness interfere with any of activities you engage in or engaged in prior to illness? If yes, please describe with as much detail as possible.
- D. Has your breast implant related illness interfered with your sex life, reproductive decision, etc? If yes, please describe with as much detail as possible.

Patient Signature:

Date:



**Plastikos Plastic & Reconstructive Surgery**  
**Plastikos Surgery Center**  
**Millennium Healthcare**  
**Avatar Industries**  
4370 Georgetown Square  
Atlanta, GA 30338  
(770) 457-4677 (Tel.)  
(770) 457-4428 (Fax)  
[www.plastikos.com](http://www.plastikos.com)  
[www.millennium-healthcare.com](http://www.millennium-healthcare.com)  
[www.templeofhealth.ws](http://www.templeofhealth.ws)



## **DISCLOSURE OF OWNERSHIP**

To My Patients:

In order to comply with prevailing Federal regulations, I am required to inform you that I am either the owner or have an equity (financial) interest in the following businesses:

Avatar Industries, LLC  
Millennium Healthcare, LLC  
Plastikos Plastic and Reconstructive Surgery, LLC  
Plastikos Surgery Center, LLC

These businesses provide a range of medical, therapy and related services, all of which I routinely use in the course of treating my patients. I established these companies so that my patients would receive convenient, timely and high quality medical care as it is my express desire that all of my patients regain maximum functionality in the shortest possible time.

Please know that you are under no obligation to use the services of the companies referenced above. If you wish, I will be happy to direct you to other high quality professionals or business that I know are capable of providing similar services.

Dr. Susan Kolb

### **RECEIVED BY:**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date





Plastikos Plastic & Reconstructive Surgery  
Plastikos Surgery Center  
Millennium Healthcare  
Avatar Industries  
4370 Georgetown Square  
Atlanta, GA 30338  
(770) 457-4677  
[www.plastikos.com](http://www.plastikos.com)  
[www.millennium-healthcare.com](http://www.millennium-healthcare.com)  
[www.templeofhealth.ws](http://www.templeofhealth.ws)



## **A STATEMENT OF FINANCIAL POLICIES FOR OUR PATIENTS**

Welcome to the practice of Plastikos Plastic and Reconstructive Surgery, Plastikos Surgery Center, Millennium Healthcare and Avatar Industries. We hope to make your visit as pleasant as possible. Aside from the emotional and physical impact of any illness or injury, there is all too often a degree of financial impact as well. We would like to ease your potential financial burden as much as possible. Your review of our financial policies will assist in avoiding any future misunderstandings. We strive to provide high quality, affordable plastic surgery and integrative medical care.

### **Office Visit Payment:**

Our staff will assist you in filing insurance. Deductible and co-payments are collected on the day of your office visit. If eligibility of insurance cannot be verified or if insurance information is not given, we ask for payment in full. Individuals without insurance are expected to pay, in full, on the day of their visit.

### **Insurance For Surgery:**

We will provide you with an estimated surgical cost analysis if you are having elective surgery. This consists of a listing of the planned procedures and fees. You may use this information to check with your insurance company prior to surgery to determine if they will cover the proposed procedures. We ask that patients scheduled for elective surgery pay their prepay two weeks in advance, if using a personal check. If paying by money order, certified check or credit card, then the prepay will be collected 1 week in advance. Insurance payments, which are authorized to be paid directly to us, will be credited to your account as those payments are received. **\*Please note:** Although we will help you gain maximum reimbursement from your insurance company, realize that payment for services rendered is your personal responsibility and our charges are in no way influenced by what your insurance company pays. The amount an insurance company reimburses for a particular procedure will vary with the company and the type and quality of each patient's individual or group policy.

### **Cosmetic Surgery:**

Most insurance do not cover cosmetic procedures. Payment for all cosmetic surgery must be made in advance. We ask that payments be made two weeks in advance for personal checks. If paying by money order, certified check or credit card, then the prepay will be collected 1 week prior. A deposit is required at the time of scheduling.

### **Liability Claims:**

If you are insured in a liability claim, such as an automobile accident, you or a legal guardian are responsible for all medical charges. You will be required to sign a lien agreement and a payment plan. While involved with a lien, monthly payments towards the balance are required. If you change legal counsel and do not notify us of the change, any balance due on your account becomes due and payable immediately.

### **Worker's Compensation:**

To receive full benefits, we must have employer verification and/or the adjustor's authority to treat. We will provide your employer will all medical and financial details. Without this information, you will be treated as a non-worker's compensation case, meaning you will be responsible for the bill.

### **Medicare:**

We are a participating practice (Plastikos Plastic & Reconstructive Surgery and Millennium Healthcare) and will file all Medicare paperwork. When provided with secondary information, our office will also file those claims. For services that are non-covered by Medicare, you will be required to sign an Advance Beneficiary Agreement.

### **Past Due Accounts:**

In the event you may have any financial concerns, please contact our Central Business Office at (678) 514-2108. Our staff is committed to assisting you with any questions or concerns you may have regarding your account.

### **Returned Check Fee:**

There will be a \$35.00 fee assessed to your account anytime a check is returned from the bank.

### **Finance Charges:**

Monthly interest in the amount of 1.5% may be charged to any account with a balance greater than sixty days. We are all too aware of the current nationwide crisis in health care financing. Quality, personalized medical and surgical care is sometimes a necessary expense. Despite the pressures to pass along increased costs to the patient, we work hard on your behalf to contain fees and other charges. We are here to serve you for your medical care needs. If we have done well, please tell your family, your friends, and your referring physician. If not, please tell us!

**I have read and understand the above statement and I agree with its content. By my signature below, I attest that I am not falsely representing myself.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Plastikos Plastic & Reconstructive Surgery  
Plastikos Surgery Center  
Millennium Healthcare  
Avatar Industries  
4370 Georgetown Square  
Atlanta, GA 30338  
(770) 457-4677 (Tel.)  
(770) 457-4428 (Fax)  
[www.plastikos.com](http://www.plastikos.com)  
[www.millennium-healthcare.com](http://www.millennium-healthcare.com)  
[www.templeofhealth.ws](http://www.templeofhealth.ws)



## PATIENT ACKNOWLEDGEMENT AND CONSENT

I have been given a copy of PPRS/PSC/MHC/Avatar Notice of Privacy Practices. I consent to the uses and disclosure of my health information as outlined in the Notice.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Printed Name of Representative

Please describe the Representative's authority to act on behalf of the Patient (**initial one**).

- ( ) The representative is the parent of the patient, who is a minor.
- ( ) The representative is the guardian of the patient, who has been adjudicated incompetent.
- ( ) The representative is acting under a Durable Power of Attorney for Health Care for the patient, and has presented a copy of this document to PPRS/PSC/MHC personnel.
- ( ) I authorize/give my consent to the person(s) below to discuss my PHI. I understand that I may revoke this authorization at any time by giving written notice to PPRS/PSC/MHC:

1. \_\_\_\_\_ (Name) \_\_\_\_\_ (Relationship)

2. \_\_\_\_\_ (Name) \_\_\_\_\_ (Relationship)

3. \_\_\_\_\_ (Name) \_\_\_\_\_ (Relationship)

### FOR OFFICE USE ONLY

If acknowledgement of receipt of the Notice of Privacy is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgment and reason you could not obtain it.



**Plastikos Plastic & Reconstructive Surgery**  
**Plastikos Surgery Center**  
**Millennium Healthcare**  
**Avatar Industries**  
 4370 Georgetown Square  
 Atlanta, GA 30338  
 (770) 457-4677 (Tel.)  
 (770) 457-4428 (Fax)  
[www.plastikos.com](http://www.plastikos.com)  
[www.millennium-healthcare.com](http://www.millennium-healthcare.com)  
[www.templeofhealth.ws](http://www.templeofhealth.ws)



Patient Name:	Date:
---------------	-------

Height:	Weight:
---------	---------

YES	NO	GENERAL INFORMATION
		Do you smoke? If yes, how much:
		Do you drink alcohol? If yes, please estimate your consumption: Daily: _____ Weekly: _____ Occasionally: _____ None: _____
		Are you allergic to any pills, drugs or medicines? If yes, please list:
		Please list ALL medications you are taking, including birth control pills, diuretics (water pills), blood pressure or heart medications, tranquilizers, hormones, steroid medications, cortisone, blood thinners, aspirin, bufferin, etc.
		Have you ever had a reaction to general anesthetic (being put to sleep)?
		Do you have high blood pressure? If yes, please list any medications you are taking for it.
		Do you form heavy scars?
		Do you have frequent infections or boils?
		Have you ever had any excessive bleeding problems?
		Have you taken a course of steroids (prednisone, cortisone) in the last year?
		Do you or a member of your immediate family have a history of blood clots or pulmonary embolism?
		Do you have a history of RSD or regional nerve pain?
		Have you ever had any significant emotional problems?
		Have you ever been advised to have, or have you had, psychiatric treatment?
		Have you seen other plastic surgeons about the SAME problem(s) that brings you here today?
		If INJURY is the reason for your visit, please answer the following. Date and Time of INJURY: <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Pedestrian <input type="checkbox"/> Animal Bite <input type="checkbox"/> Work Related <input type="checkbox"/> Other Give Detail:
		Have you ever been pregnant? If yes, how many times? _____ How many children do you have? _____
		Are you pregnant now?

Have you had any serious illnesses or injuries related to the following areas? If yes, please explain.							
YES	NO	Area	Explanation	YES	NO	Area	Explanation
		Brain				Urinary	
		Eyes				Kidney	
		Ears				Bleeding Problems	
		Nose				Reproduction	
		Breast				Nervous/ Nerves	
		Lungs				Extremities	
		Heart				Endocrine (Diabetes)	
		Intestine				Jaundice	
		Abdomen				Other	

Previous Surgical History – Please List ALL Surgeries		
Operations/Procedures	Year	Complications
Serious Injuries?	Year	History – Type of Injury

Patient Signature:	If not patient, your relationship:
--------------------	------------------------------------



**Plastikos Plastic & Reconstructive Surgery**  
**Plastikos Surgery Center**  
**Millennium Healthcare**  
**Avatar Industries**  
4370 Georgetown Square  
Atlanta, GA 30338  
(770) 457-4677  
[www.plastikos.com](http://www.plastikos.com)  
[www.millennium-healthcare.com](http://www.millennium-healthcare.com)  
[www.templeofhealth.ws](http://www.templeofhealth.ws)

**GENERAL INFORMATION**

Today's Date	Prefix <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Miss	First Name	Middle Name	Last Name	
Street Address (No POB)			City	State	Zip
Social Security No.	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Date of Birth	AGE	Spouse's Name (if applicable)	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone	Work Phone w/Ext.	Cell Phone	Pager	Other Phone
Preferred Contact Number <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Pager <input type="checkbox"/> Other Number					
Is it okay to leave phone messages? <input type="checkbox"/> YES <input type="checkbox"/> NO			Email Address (We do not share emails addresses w/ other companies)		

**REASON FOR VISIT AND PATIENT STATUS**

Reason for Today's Visit:	Patient Status: <input type="checkbox"/> New Patient <input type="checkbox"/> Existing Patient
---------------------------	---

**EMERGENCY CONTACT INFORMATION**

First Name	Last Name	Relationship	Home Phone	Work/Cell Phone
------------	-----------	--------------	------------	-----------------

**WHO ARE YOU HERE TO SEE?**

<input type="checkbox"/> Clofine, Richard (DO) <input type="checkbox"/> Dhanani, Nadya (BHMS) <input type="checkbox"/> Gordon, Julian (MD)	<input type="checkbox"/> Gould, Brad (MD) <input type="checkbox"/> Greenberg, Mike (DC) <input type="checkbox"/> Kolb, Susan (MD, FACS)	<input type="checkbox"/> Lawson, Carolyn <input type="checkbox"/> Nair, Satish <input type="checkbox"/> Stockton, Cindy (LE)	<input type="checkbox"/> Yalif, Asaf (MD) <input type="checkbox"/> Other: _____
--	---	--	--

**EMPLOYMENT**

Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time Student <input type="checkbox"/> Part Time Student <input type="checkbox"/> Retired <input type="checkbox"/> Other			
Occupation	Company Name	Manager's Name	
Employer Street Address (NO POB)	City	State	Zip

**ADDITIONAL PERSONAL INFORMATION**

Ethnicity <input type="checkbox"/> African-American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other _____	
Date of Current Illness/Accident	Were You Injured on the Job? <input type="checkbox"/> Yes <input type="checkbox"/> No

**PRIMARY CARE PHYSICIAN**

Primary Care Physician Name	Primary Care Physician's City & State
-----------------------------	---------------------------------------

**WERE YOU REFERRED BY ONE OF THE FOLLOWING?**

<input type="checkbox"/> Patient <input type="checkbox"/> Physician <input type="checkbox"/> Primary Care Physician <input type="checkbox"/> Attorney <input type="checkbox"/> Other _____ <i>If so, please complete the information below so we can thank them.</i>			
Company or Practice Name	First, Middle Last Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address (NO POB)	City	State	Zip
Phone Number:	Fax Number:		

**PRIMARY INSURANCE COMPANY INFORMATION**

Name of Insurance Company		Contact Name (if applicable)	
Claims Address	City	State	Zip
Customer Service Number	Effective Date	Co-Pay	
Insurance Plan Name	Plan Type (HMO, PPO, POS, etc)	Patient's Policy Number	Group OR FECA No.

**GUARANTOR/POLICY HOLDER INFORMATION**

Please complete the information below if you are not the primary insurance policy holder.

Policy Holder's First Name	Policy Holder's Middle Name	Policy Holder's Last Name	
Policy Holder's Street Address (NO PO Box)	City	State	Zip
Policy Holder's Employer	Policy Holder's Date of Birth	Policy Holder's Social Security No.	
Policy Holder's Phone Number	Relationship to Policy Holder	Policy Holder's Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	

**ATTORNEY INFORMATION**

You may be asked to sign an attorney/patient lien.

Attorney Name	Attorney Phone	Attorney Fax	
Attorney Address	City	State	Zip

Do you need auto/medical insurance filed also? Yes No**INSURANCE DISCLAIMER**

Any insurance benefits our office discusses with you are based on verbal conversations with your insurance carrier(s). We do not guarantee the accuracy of this information, nor do we determine eligibility, medical necessity, or the existence of a pre-existing condition. Please contact your Insurance carrier(s) for more information.

**FINANCIAL AGREEMENT**

- All information is accurate to the best of my knowledge.
- I authorize the release of all medical records necessary to insure payment to Plastikos Plastic & Reconstructive Surgery, Millennium Healthcare, Holisticare South or their representative(s).
- I assign all benefits payable to Plastikos Plastic & Reconstructive Surgery, Millennium Healthcare or Holisticare South and agree to give fifteen days written notice should I decide to void that agreement.
- All accounts are due and payable on the date of service unless prior arrangements have been made. There will be a \$28.00 fee assessed for returned check fees.
- As a courtesy, my insurance may be filed. Regardless of coverage, all accounts are due and payable within 60 days.
- If Plastikos Plastic & Reconstructive Surgery agrees to accept an attorney lien, I understand that regular monthly payments are due from date of service until the case is settled. I also understand Payment in full is due within 30 days of the date of settlement.
- Plastikos Plastic & Reconstructive Surgery, Millennium Healthcare and Holisticare South reserve the right to modify this agreement with ten days written notification.
- Interest in the amount of 1.5% monthly may be charged to any account with a balance greater than 60 days.
- I authorize the Physicians to use images of me for identification purposed and/or images captured during the course of treatment for educational/instructional purposes.
- In the event that my account is delinquent, I understand and agree that I will be responsible for attorney fees (15%), court costs, or any related fees. In addition, I understand and agree that should my account be turned over to a collection agency that I will be responsible for any collection fees (30%).

Signature of Patient or Guarantor	Today's Date
-----------------------------------	--------------

**INTERNAL USE ONLY**

<input type="checkbox"/> Driver's Lic Copy	<input type="checkbox"/> Insurance Copy	<input type="checkbox"/> Photo Taken	<input type="checkbox"/> Auto Insurance (if applicable)	Your Initials
--	---	--------------------------------------	---	---------------



Plastikos Plastic & Reconstructive Surgery  
 Plastikos Surgery Center  
 Millennium Healthcare  
 Avatar Industries

4370 Georgetown Square  
 Atlanta, GA 30338  
 (770) 457-4677 (Tel.)  
 (770) 457-4428 (Fax)

[www.plastikos.com](http://www.plastikos.com)  
[www.millennium-healthcare.com](http://www.millennium-healthcare.com)  
[www.templeofhealth.ws](http://www.templeofhealth.ws)



## BIOTOXICITY SYMPTOM QUESTIONNAIRE

Rate each of the following symptoms based upon your typical health profile:

POINT SCALE	
0	Never or almost never have the symptoms
1	Occasionally has it, effect is not severe
2	Occasionally has it, effect is severe
3	Frequently has it, effect is not severe
4	Frequently has it, effect is severe

Add up the numbers to arrive at a total for each section below, and then add the totals for each section to arrive at the grand total. If any individual section total is 10 or more, or the grand total is 50 or more, you may benefit from a detoxification program.

### DIGESTIVE

- Nausea or vomiting
- Diarrhea
- Constipation
- Bloating feeling
- Belching, passing gas
- Heartburn
- TOTAL**

### ENERGY/ACTIVITY

- Fatigue, sluggishness
- Apathy, sluggishness
- Hyperactivity
- Restlessness
- TOTAL**

### JOINT/MUSCLES

- Pain or aches in joints
- Arthritis
- Stiff, limited movement
- Pain, aches in muscles
- Weakness or tiredness
- TOTAL**

### EMOTIONS

- Mood Swings
- Anxiety, fear, nervous
- Anger, irritability
- Depression
- TOTAL**

### HEAD

- Headaches
- Faintness
- Dizziness
- Insomnia
- TOTAL**

### NOSE

- Stuffy nose
- Sinus problems
- Hay fever
- Sneezing attacks
- Excessive mucus
- TOTAL**

### EYES

- Watery, itchy eyes
- Swollen, reddened or sticky eyelids
- Dark circles under eyes
- Blurred/tunnel vision
- TOTAL**

### MIND

- Poor memory
- Confusion
- Poor concentration
- Poor coordination
- Difficulty making decision
- Stuttering, stammering
- Slurred speech
- Learning disabilities
- TOTAL**

### HEART

- Skipped heartbeats
- Rapid heartbeats
- Chest pain
- TOTAL**

### LUNGS

- Chest congestions
- Asthma, bronchitis
- Shortness of breath
- Difficulty breathing
- TOTAL**

### MOUTH/THROAT

- Chronic coughing
- Gagging, need to clear throat
- Sore throat, horse
- Swollen or discolored tongue, gums, lips
- Canker sores
- TOTAL**

### WEIGHT

- Binge eating/drinking
- Craving certain foods
- Excessive weight gain
- Compulsive eating
- Water retention
- Underweight
- TOTAL**

### EARS

- Itchy ears
- Earaches, ear infection
- Drainage from ear
- Ringing in ears, hearing loss
- TOTAL**

### SKIN

- Acne
- Hives, rashes, dry skin
- Hair loss
- Excessive sweating
- TOTAL**

### OTHER

- Frequent illness
- Frequent/urgent urination
- Genital itch, discharge
- TOTAL**

**Grant Total:** \_\_\_\_\_