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
www.millennium-healthcare.com
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 The patient(s) name will not be published.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 _____

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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

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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 with 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 with 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:**_____

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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.

_____
_____

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Name: _____ **Age:** _____ **Today's Date:** _____

Describe what you would like to discuss with the doctor today:

_____

_____

Have you seen other Plastic Surgeons about the same problem(s) that you bring here today? Yes No
If yes, then by which facility/ by whom?_____
_____

Job Information	
Are you a student? Yes No	**Grade:**
Are you currently working? Yes No	
Are you retired? Yes No	
Where do you work?	
Job Title:	
How long in current position?	

Current Medical Problems
(check all that apply)

High Blood Pressure	Yes No	**Cancer : Specify** _____	Yes No
Heart Problems	Yes No	**Hepatitis B Virus:**	Yes No
Heart Stents	Yes No	**Hepatitis C Virus:**	Yes No
Over/Underactive Thyroid	Yes No	**HIV:**	**Yes No**
Gastritis/Peptic Ulcer	Yes No	**Other:**	
Asthma	Yes No	**Other:**	
Diabetes Yes No / Insulin Dependent	Yes No	**Other:**	

Surgical History

No Prior Surgeries		
Surgery:	**Date:**	
Surgery:	**Date:**	
Surgery:	**Date:**	
Surgery:	**Date:**	

I am taking:	**Medication/Prescriptions**	**Dosage**	**Medication/Prescriptions**	**Dosage**
No Medications	**1.**		**4.**	
Aspirin	**2.**		**5.**	
Herbal Supplements	**3.**		**6.**	

Allergies	**Drug Name**	**Reaction**	**Drug Name**	**Reaction**
No Known Allergies	**1.**		**3.**	
Allergic to Latex	**2.**		**4**	

Review of Symptoms

In the past 6 months, have you had any of the following: (Check all that apply)

Hormonal Problems (Endocrine)
Thyroid
Other _____
No Problems

Women's Health (Gynecology)
Hysterectomy
No Problems / Not Applicable
Last Menstrual Period _____
# of Pregnancies _____
I am currently Pregnant
# of Children _____
Other

Urinary (Genitourinary)
Night awakening to urinate
No Problems
Bleeding / Discharge
Other _____

Skin (Integumentary)
Rashes
No Problems
Itching
Ulcers
Frequent Infections
Other _____
Thick scars / Keloids

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Head Head Trauma Seizures Dizziness Stroke Other _____ No Problems	**Blood (Hematologic)** Anemia Blood Clots Bleeding Problems Sickle Cell Disease Other _____ No Problems Do you take blood thinners? Yes No
Nerve (Neurologic) Loss of movement / control of limbs Tingling / "Pins and needles" Loss of feeling in limbs Loss of strength in limbs Other _____ No problems	**Heart / Circulatory (Cardiovascular)** Heart murmur Irregular heartbeat/pulse Chest pain High Blood Pressure Leg / Ankle swelling Other No problems
Breathing (Respiratory) Shortness of breath Asthma / Wheezing Chronic Cough Previous Anesthesia Problems Other _____ No problems	**Stomach (Gastrointestinal)** Reflux Vomiting Constipation Diarrhea Abdominal Pain Other _____ No Problems
Mental Health (Psychological) Depression Anxiety Other _____ No Problems	**Notes:**

Family History

Is there a family history (mother, father, brothers, sisters) of the following (Circle all that apply)

Is there a history of:	Yes	No	Relationship
Heart Disease			
Cancer			
Diabetes			
Immune System Diseases			
Other _____			

Social History

Question	Answer	Explain
Do you smoke?	Yes No	If yes, how much?
Are you exposed to smoke?	Yes No	
Do you drink alcohol?	Yes No	If yes, how much?
Do you use drugs?	Yes No	Describe:
What is your primary language?	English Spanish Other	Specify:

History Reviewed by:

Julian Gordon, MD

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To be completed by Physician or Assistant

Updated Medical History at Follow-Up Visit

Reviewed By	Date	Interim Changes in Medical History
		None **Other**
		None **Other**
		None **Other**
		None **Other**
		None **Other**

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Initial Evaluation

PATIENT INFORMATION	
Patient Name:	Date:
DOB:	Physician:

Date:	Chief Complaint:

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MILLENNIUM HEALTHCARE
The Next Great Step In The Evolution Of Modern Medicine®

GENERAL INFORMATION

Today's Date	Prefix ☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Miss	First Name	Middle Name	Last Name

Street Address (No POB)	City	State	Zip

Social Security No.	Marital Status ☐Married ☐Single ☐Divorced ☐Widowed	Date of Birth	AGE	Spouse's Name (if applicable)

Gender ☐Male ☐Female	Home Phone	Work Phone w/Ext.	Cell Phone	Pager	Other Phone

Preferred Contact Number ☐Home Phone ☐Work Phone ☐Cell Phone ☐Pager ☐Other Number

Is it okay to leave phone messages? ☐YES ☐NO	**Email Address** (By providing your email address, you agree to accept our marketing emails. We do not share emails addresses w/ other companies)

REASON FOR VISIT AND PATIENT STATUS

Reason for Today's Visit:	Patient Status: ☐ New Patient ☐Existing Patient

EMERGENCY CONTACT INFORMATION

First Name	Last Name	Relationship	Home Phone	Work/Cell Phone

WHO ARE YOU HERE TO SEE?

☐ Clofine, Richard (DO) ☐ *Dhanani, Nadya (BHMS) ☐ Gordon, Julian (MD)	☐ Gould, Brad (MD) ☐ Greenberg, Mike (DC) ☐ Kolb, Susan (MD, FACS)	☐ Lawson, Carolyn ☐ Nair, Satish ☐ Stockton, Cindy (LE)	☐ Yalif, Asaf (MD) ☐ Other:_____ *This provider does not diagnose and/or treat diseases. For all diseases and/or treatments, please see one of our Licensed Medical Doctors.

EMPLOYMENT

Employment Status ☐Full Time ☐Part Time ☐Full Time Student ☐Part Time Student ☐Retired ☐Other

Occupation	Company Name	Manager's Name

Employer Street Address (NO POB)	City	State	Zip

ADDITIONAL PERSONAL INFORMATION

Ethnicity ☐African-American ☐Asian ☐Caucasian ☐Hispanic ☐Native American ☐Other_____

Date of Current Illness/Accident	Were You Injured on the Job? ☐Yes ☐No

PRIMARY CARE PHYSICIAN

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

WERE YOU REFERRED BY ONE OF THE FOLLOWING?

☐ **Patient** ☐ **Physician** ☐ **Primary Care Physician** ☐ **Attorney** ☐ **Other**_____

If so, please complete the information below so we can thank them.

Company or Practice Name	First, Middle Last Name	Gender ☐Male ☐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** ☐Male ☐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

1. All information is accurate to the best of my knowledge.
2. 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).
3. 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.
4. 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.
5. As a courtesy, my insurance may be filed. Regardless of coverage, all accounts are due and payable within 60 days.
6. 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.
7. Plastikos Plastic & Reconstructive Surgery, Millennium Healthcare and Holisticare South reserve the right to modify this agreement with ten days written notification.
8. Interest in the amount of 1.5% monthly may be charged to any account with a balance greater than 60 days.
9. 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.
10. 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

☐Driver's Lic Copy	☐Insurance Copy	☐Photo Taken	☐ Auto Insurance (if applicable)	Your Initials

Plastikos Plastic & Reconstructive Surgery

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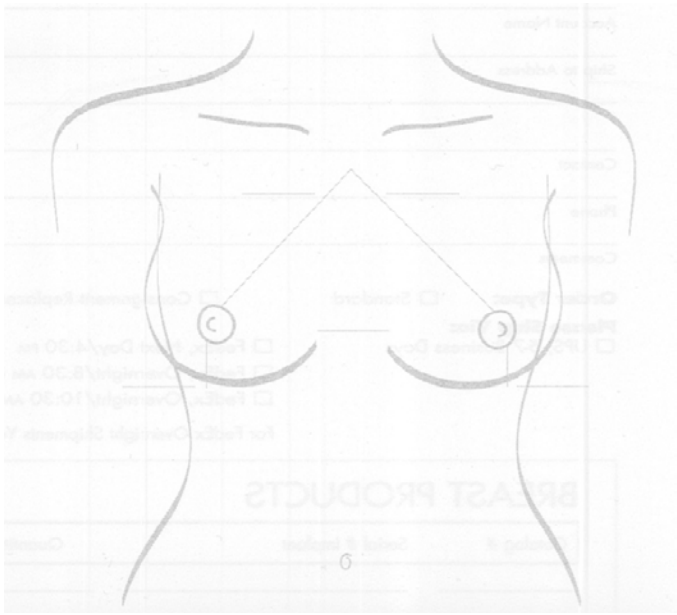
Patient: _____ DOB:_____

Date:_____

Breast Implant Surgery Preoperative Planning

Dr. Gordon

BREAST PARAMETERS		
	Right Breast	**Left Breast**
Base Width	_____ cm	_____ cm
Nipple Inflammatory Fold Distance	_____ cm	_____ cm
Intermammary Disease	_____ cm	_____ cm
Nipple to Midline Distance	_____ cm	_____ cm
Areolar Diameter	_____ cm	_____ cm



Patient Evaluation	**Specific Limitations Discussed**
Breast Masses □ None □ Size & Location_____	Some Residual Asymmetries Inevitable □
Larger Breast □ Right □ Left Est. Vol. Diff. _____cc	Sensory Loss, Partial or Complete on Breast □
Nipple Level Discrepancy _____cm	Palpable or Visible Edges of Implant □
IMP Level Discrepancy _____cm	No Guarantee of Cup Size □
HT: WT: Current Breast Size:	Warranty □
Envelope Characteristics	Other □
Envelope Compliance: □ Normal □ Loose □ Tight	
Tissue Coverage: □ Adequate □ Compromised	**Notes**
Superior Tissue Pinch Test: Right _____cm Left _____cm	
Other _____	
Incision Approach □ IM □ PA □ AX	
Pocket □ Subpectoral □ Subglandular □ Other	

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Video/Pre-Op Photos/Post-Op Photos
Patient Attestation Form
Dr. Julian Gordon

Patient Name: _____ Date: _____

Patient Initials

_____ Patient has seen the ASPS' patient information DVD on Breast Reduction

_____ Patient has seen the ASPS' patient information DVD on Breast Augmentation

_____ [1]Patient has seen Pre-Operative Photos and Post-Operative photos of previous patients.

_____ Patient has "tried on" multiple breast implant sizes and has chosen the implant she desires.

_____
Patient Signature

_____
Physician Signature

_____
Date

[1] *The same "before" and "after" results may not occur for all patients.*