



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 The patient(s) name will not be published.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 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.

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: _____

Are you right-handed, left-handed, or both? Right Left Both

Problem Hand: Right Left Both

Describe current hand/arm problem:

What tests have you had done related to this problem?

	Date: _____	Facility/ By Whom
<input type="checkbox"/> EMG/Nerve Conduction Study	_____	_____
<input type="checkbox"/> X-Rays	_____	_____
<input type="checkbox"/> MRI	_____	_____
<input type="checkbox"/> Bone Scan	_____	_____
<input type="checkbox"/> CAT Scan	_____	_____
<input type="checkbox"/> Tomogram	_____	_____
<input type="checkbox"/> Other	_____	_____

Describe any previous hand/arm/shoulder injury or surgery: NONE

Left Right Both

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? _____

Describe tasks at work and/or school: _____



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Is this a work-related injury? Yes No Don't know

Date of injury: _____

Is there a lawyer involved in this case? Yes No

Current Medical Problems *(check all that apply):*

- | | | |
|---|---|---|
| <input type="checkbox"/> No Current Medical Problems | <input type="checkbox"/> Gastritis/Peptic Ulcer | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Heart Problems (Angina/Attack) | <input type="checkbox"/> Gout | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> Diabetes (Insulin Dep. Y/ N) | <input type="checkbox"/> Heart Stents | <input type="checkbox"/> Cancer (Specify) _____ |
| <input type="checkbox"/> Over/Underactive Thyroid | | |

Surgical History:

- No Prior Surgeries

Past Surgeries	Date

Current Medications (List on the table below↓)

Medication	Dosage	Medication	Dosage

Allergies:



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Review of Symptoms

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

<p>Hormonal Problems (Endocrine)</p> <p><input type="checkbox"/>Thyroid Problems</p> <p><input type="checkbox"/>Diabetes</p> <p> Insulin dependent: Yes No</p> <p><input type="checkbox"/>Other _____</p> <p><input type="checkbox"/>No Problems</p>	<p>Women's Health (Gynecology)</p> <p><input type="checkbox"/>Hysterectomy</p> <p><input type="checkbox"/>Last menstrual period</p> <p># of Pregnancies _____</p> <p># of Children _____</p> <p><input type="checkbox"/>Other _____</p> <p><input type="checkbox"/> No problems</p>
<p>Urinary (Genitourinary)</p> <p><input type="checkbox"/>Night awakening to urinate</p> <p><input type="checkbox"/>Bleeding / Discharge</p> <p><input type="checkbox"/>Other _____</p> <p><input type="checkbox"/>No Problems</p>	<p>Skin (Integumentary)</p> <p><input type="checkbox"/>Rashes</p> <p><input type="checkbox"/>Itching</p> <p><input type="checkbox"/>Ulcers</p> <p><input type="checkbox"/>Other _____</p> <p><input type="checkbox"/>No Problem</p>
<p>Head</p> <p><input type="checkbox"/>Head Trauma</p> <p><input type="checkbox"/>Seizures</p> <p><input type="checkbox"/>Dizziness</p> <p><input type="checkbox"/>Stroke</p> <p><input type="checkbox"/>Other _____</p> <p><input type="checkbox"/>No Problems</p>	<p>Blood (Hematologic)</p> <p><input type="checkbox"/>Anemia</p> <p><input type="checkbox"/>Bleeding Problems</p> <p><input type="checkbox"/>Sickle Cell Disease</p> <p><input type="checkbox"/>Other _____</p> <p><input type="checkbox"/>No Problem</p> <p>Do you take blood thinners? Yes No</p>
<p>Nerve (Neurologic)</p> <p><input type="checkbox"/>Loss of movement / control of limbs</p> <p><input type="checkbox"/>Tingling / "Pins and needles"</p> <p><input type="checkbox"/>Loss of feeling in limbs</p> <p><input type="checkbox"/>Loss of strength in limbs</p> <p><input type="checkbox"/>Other _____</p> <p><input type="checkbox"/>No Problems</p>	<p>Heart / Circulatory (Cardiovascular)</p> <p><input type="checkbox"/>Heart murmur</p> <p><input type="checkbox"/>Irregular heartbeat / pulse</p> <p><input type="checkbox"/>Chest pain</p> <p><input type="checkbox"/>High blood pressure</p> <p><input type="checkbox"/>Leg / Ankle Swelling</p> <p><input type="checkbox"/>Other _____</p> <p><input type="checkbox"/>No Problems</p>
<p>Breathing (Respiratory)</p> <p><input type="checkbox"/>Shortness of breath</p> <p><input type="checkbox"/>Asthma / Wheezing</p> <p><input type="checkbox"/>Chronic Cough</p> <p><input type="checkbox"/>Previous Anesthesia Problems</p> <p><input type="checkbox"/>Other _____</p> <p><input type="checkbox"/>No Problems</p>	<p>Stomach (Gastrointestinal)</p> <p><input type="checkbox"/>Reflux</p> <p><input type="checkbox"/>Vomiting</p> <p><input type="checkbox"/>Constipation</p> <p><input type="checkbox"/>Diarrhea</p> <p><input type="checkbox"/>Abdominal Pain</p> <p><input type="checkbox"/>Other _____</p> <p><input type="checkbox"/>No Problem</p>
<p>Mental Health (Psychologic)</p> <p><input type="checkbox"/>Depression / Anxiety</p> <p><input type="checkbox"/>Other _____</p> <p><input type="checkbox"/>No Problems</p>	<p>NOTES :</p>



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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
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EMERGENCY CONTACT INFORMATION

First Name	Last Name	Relationship	Home Phone	Work/Cell Phone
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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: _____ <small>*This provider does not diagnose and/or treat diseases. For all diseases and/or treatments, please see one of our Licensed Medical Doctors.</small>
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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

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
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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
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I, _____, hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examinations, testing, credentialing, and/or certifying purposes by the American Board of Plastic Surgery, Inc.

(Patient Signature)

(Witness Signature)

(Date)