THE MYERS INSTITUTE
OF PLASTIC & HAND SURGERY

300 Medical Center Drive, 305
Gadsden, AL 35903
256-494-8000 Phone
256-494-0081 Fax

COSMETIC CONSULTATION FORM

(Please Print)

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:	Date of Birth:
			/ /

Reason for Visit

Explain:

Please indicate which procedures you are interested in discussing with Dr. Myers:

Botulinum Toxin	Dermal Fillers	Deoxycholic Acid
❑ Botox® ❑ Dysport®	❑ Juvéderm Voluma® Xc ❑ Juvéderm® Xc ❑ Juvéderm® Ultra Xc ❑ Juvéderm Volbella® Xc ❑ Restylane® Lyft ❑ Restylane® ❑ Restylane® Defyne ❑ Restylane® Refyne ❑ Restylane® Silk	❑ Kybella®

Surgical Consultation

❑ Face/Neck Lift ❑ Forehead Lift ❑ Eyelid Surgery ❑ Lip Enlargement	❑ Breast Reduction ❑ Breast Reconstruction ❑ Breast Lift ❑ Breast Enlargement	❑ Liposuction ❑ Abdominal Tightening ❑ Body Contouring	❑ Thigh Lift ❑ Arm Lift ❑ Other

BREAST CONSULTATION PATIENTS ONLY

Current bra size:	Desired bra size:	Is one breast larger than the other? ❑ NO ❑ YES

Do you have any problems associated with large breasts? (rash, back pain, shoulder strap indentations, etc.) ❑ NO ❑ YES

If YES, please explain

Date of last mammogram: / /	Where was the last mammogram done?
Have you had breast cancer? ❑ NO ❑ YES	Have any family members had breast cancer? ❑ NO ❑ YES
Do you have pain in your breast? ❑ NO ❑ YES	Do you have drainage from your nipples? ❑ NO ❑ YES
Do you have fibrocystic breast disease? ❑ NO ❑ YES	Do you have nipple sensation? ❑ NO ❑ YES
Have you felt any lumps or masses in your breasts? ❑ NO ❑ YES	If you have children, did you breastfeed? ❑ NO ❑ YES

Have you had any surgeries or biopsies on your breast? ❑ NO ❑ YES If YES, list date and location:

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copay is due at the time of service.
I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provides is factual and correct.

Patient or Guardian Signature	Date

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REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:	Sex:	Marital status (circle one)
			❑ Male ❑ Female	Single / Mar / Div / Sep / Wid

Social Security Number:	Date of Birth:	Age:	Place of Birth:
	/ /		City: State:

Street Address:	Email Address:

City:	State:	ZIP Code:

Home Phone Number:	Cell Phone Number:	Preferred Phone: ❑ Home ❑ Cell
( )	( )	Is it ok to leave a detailed message? ❑ NO ❑ YES

Language:	Race:	Ethnic Group:	Would you like access to the patient portal to access your medical information online?
❑ English ❑ _____	❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ White	❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Yes ❑ No

EMERGENCY CONTACT INFORMATION

Name:	Relationship:	Phone:
		( )
		( )

EMPLOYMENT INFORMATION

Occupation:	Employer:	Employer Phone:
		( )

Employer Address:	Employer City:	Employer State:	Employer Zip:

PHARMACY INFORMATION

Pharmacy Name:	Pharmacy Address:	Pharmacy Phone Number:

PHYSICIAN INFORMATION

Referring Physician:

Primary Care Physician:

Reason for Visit

HEALTH INFORMATION

Please tell us if you have any problems related to the following body systems. Check "No Problems" at the top of each category if you have systems related to that body system. Check any specific problems that you have.

Constitutional
❑No Problems
- ❑ fever
- ❑ chills
- ❑ night sweats
- ❑ change in appetite
- ❑ weight gain
- ❑ weight loss
- ❑ exercise intolerance
- ❑ Other _____

Musculoskeletal
❑No Problems
- ❑ muscle aches
- ❑ muscle cramps
- ❑ joint pain
- ❑ joint swelling
- ❑ muscle weakness
- ❑ back pain
- ❑ problems walking
- ❑ foot drop
- ❑ Other _____

Eyes
❑No Problems
- ❑ dry eyes
- ❑ irritation
- ❑ pain
- ❑ visual change
- ❑ floaters
- ❑ sensitivity to light
- ❑ double vision
- ❑ discharge
- ❑ Other _____

Skin
❑No Problems
- ❑ dry skin abnormal
- ❑ moles breast
- ❑ discharge breast
- ❑ lump or pain
- ❑ wound healing problems
- ❑ excessive sweating
- ❑ itching
- ❑ rash
- ❑ change in skin color
- ❑ bleeding or ulcerated lesions
- ❑ Other _____

Eyes, Nose, Throat
❑No Problems
- ❑ difficulty hearing
- ❑ ear pain
- ❑ vertigo
- ❑ ringing in ears
- ❑ frequent nosebleeds
- ❑ sinus problems
- ❑ difficulty hearing
- ❑ ear pain
- ❑ vertigo
- ❑ ringing in ears
- ❑ frequent nosebleeds
- ❑ sinus problems
- ❑ neck pain/tender
- ❑ teeth problems
- ❑ Other _____

Neurologic
❑No Problems
- ❑ loss of consciousness
- ❑ slurred speech
- ❑ weakness
- ❑ numbness
- ❑ headache
- ❑ restless legs
- ❑ tingling
- ❑ tremor
- ❑ seizures
- ❑ dizziness
- ❑ memory problems
- ❑ loss of balance
- ❑ Other _____

Cardiovascular
❑No Problems
- ❑ chest pain
- ❑ arm pain w/exercise
- ❑ shortness of breath
- ❑ irregular heartbeat
- ❑ heart murmur
- ❑ lightheadedness
- ❑ ankle/leg swelling
- ❑ Other _____

Psychiatric
❑No Problems
- ❑ irritability
- ❑ depression
- ❑ anxiety
- ❑ panic attacks
- ❑ sleep problems
- ❑ paranoid thoughts
- ❑ suicidal thoughts
- ❑ hallucinations
- ❑ psychotic episode
- ❑ Other _____

Respiratory
❑No Problems
- ❑ wheezing
- ❑ shortness of breath
- ❑ rapid breathing
- ❑ problem snoring
- ❑ frequent cough
- ❑ sleep apnea
- ❑ Other _____

Endocrine
❑No Problems
- ❑ fatigue
- ❑ cold or heat intolerance
- ❑ decreased sex drive
- ❑ erection problems
- ❑ abnormal hair growth
- ❑ hair loss
- ❑ irregular periods
- ❑ abnormal menses
- ❑ Other _____

Gastrointestinal
❑No Problems
- ❑ nausea
- ❑ vomiting
- ❑ vomiting blood
- ❑ abdominal pain
- ❑ blood in stools
- ❑ loss of appetite
- ❑ diarrhea
- ❑ constipation
- ❑ heartburn
- ❑ Other _____

Blood & Lymphatic
❑No Problems
- ❑ swollen glands
- ❑ blood clots
- ❑ easy bruising
- ❑ bleeding problems
- ❑ Other _____

Genitourinary
❑No Problems
- ❑ pain w/urination
- ❑ loss of bladder control
- ❑ difficulty urinating
- ❑ frequent urination
- ❑ urge to urinate
- ❑ flank pain
- ❑ frequent infections
- ❑ Other _____

Allergy & Immune
❑No Problems
- ❑ nasal allergies
- ❑ frequent infections
- ❑ hives
- ❑ immune compromised
- ❑ Other _____

Please List Any Prior Surgeries:

Surgery:	Date:	Doctor:	Hospital:

Please list all current medications (include over-the-counter medications)**:**

Medicine:	Dose:	Frequency:	Medicine:	Dose:	Frequency:

Allergies:

Name:	Reaction:	Name:	Reaction:

Please indicate any health problems which any of your blood relatives have or had:

Health Condition / Disease:	Relative:

Are you pregnant?	❑ NO	❑ YES	**If Yes, When is your due date?** **/ /**

SOCIAL HISTORY

Do you smoke or use tobacco? ❑ NO ❑ YES	If YES, type ❑ Cigarettes ❑ Cigars ❑ Pipe ❑ Chewing or Smokeless Tobacco ❑ Other If YES, frequency of use:

Do you use other nicotine products (i.e. E-cig, Nicorette gum/lozenge, Nicotine patch, Nicotrol inhaler)? ❑ NO ❑ YES

Do you drink alcohol? ❑ NO ❑ YES	If YES, number of drinks per _____ day _____ week _____ month

Type of alcohol consumed ❑ Beer ❑ Wine ❑ Liquor ❑ Other

Do you have a history of substance abuse? ❑ NO ❑ YES	Does anyone in your household have a history of substance abuse? ❑ NO ❑ YES

❑ Amphetamines ❑ Cocaine ❑ Marijuana ❑ Methamphetamines ❑ Prescription medications / Name_____
❑ Inhalants ❑ Heroin ❑ Hallucinogens/LSD ❑ Other

Lives with: ❑ Alone ❑ Children ❑ Father ❑ Mother ❑ Parents ❑ Siblings ❑ Significant Other ❑ Spouse ❑ Other _____

Diet Type: ❑ Regular ❑ Soft ❑ Calorie Controlled ❑ Vegetarian ❑ Other _____

Are there Cultural/Spiritual practices that we should be aware of? ❑ No ❑ Yes

Please explain:

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copay is due at the time of service.
I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provides is factual and correct.

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HIPAA Disclosure Form

Last Name:	First Name:	Middle Name:	Date of Birth:

Privacy & Confidentially Notice Acknowledgement
(Reference Federal Register 45 C.F.R. §164.506)

I understand that protected health information may be used and disclosed to perform treatment, payment and/or health care operations. I acknowledge I've been given the opportunity to read, review, and obtain a complete copy of The Myers Institute of Plastic and Hand Surgery Notice with a complete description of such uses and understand I had a right to review the privacy notice before signing below. I understand I have a right to request this office to restrict how my information is used, but this office may not agree with the requested restrictions. I have a right to revoke this authorization and consent, in writing, at any time.
This office reserves the right to amend the privacy policy, whether required by law or otherwise, and a revised notice may be obtained by calling our office or physically coming to our office.

Designated Party Authorization for Release of Medical Information (Optional)

Some patients prefer that other individuals, especially family members, be allowed access to their medical information. In order to comply with strict legal standards, a written release is required to allow another person access to your medical records.
This release grants permission to individual(s) listed below to: Make or confirm appointments, have access to x-ray and laboratory findings, pick up sample medications, be made aware of your diagnosis, prognosis, and treatment plans, and serve as your emergency contact. This permission applies to telephone and answering machine messages as well as other means of communication and will be in effect unless I notify this office of any changes or revocations.

Name:	Relationship:	Phone Number:
		( )
		( )
		( )

I further release my medical information to the following physicians, clinics, and/or hospitals:

Name:	Relationship:	Phone Number:
		( )
		( )
		( )

This authorization for release of medical information is valid until revoked by written notice or replaced with an updated authorization.

Signature: _____ Date: _____

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HIPAA Release of Information

AUTHORIZATION FORM

I, _____hereby authorize **Myers Institute, PC** and its affiliates, its employees and
(Patient Name)
agents to release to my personal health information maintained by _____
(Leave Blank)
(e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) **except** the following information about me: _____
for the purpose of helping me to resolve claims and health benefit coverage issues. I also authorize **Myers Institute, PC** to obtain my medication history from my pharmacy, health plans, and other health care providers. By signing this consent form I am giving permission to disclose information about my medications that have been filled at my pharmacy or covered by any insurance plan. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid from the date of my/my representative's signature below and shall expire in one year.

I understand that I have a right to revoke this authorization by providing written notice to **Myers Institute, PC**. However, this authorization may not be revoked if **Myers Institute, PC,** its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Patient Name: _____
(Print Name)

Patient Signature: _____ **Date:** _____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: _____
(Print Name)

Signature of Legal Representative: _____**Date:** _____

Name of Witness: _____
(Print Name)

Signature of Witness: _____ **Date:** _____

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Patient Photograph Release Form

Patient's Name_____ Date of Birth_____

Photograph Consent and Release
I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the members of **The Myers Institute of Plastic and Hand Surgery** medical staff. I hereby give my consent for The **Myers Institute, PC** to use the photographs under one of the following circumstances.

Please initial one of the following:

_____ **Internet:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at **The Myers Institute, PC** can be used on the company's website in order to inform the public about plastic surgery methods. Further, I release and discharge **The Myers Institute, PC**, any employees and the American Society of Plastic Surgeons; and all
parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name or any other identifying marks at any time during any use or publication of these materials by any party.

_____ **All Media:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at **The Myers Institute, PC** can be used in any print or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet, and television, in order to inform the public about plastic surgery methods. Further, I release and discharge **The Myers Institute, PC**, and the American Society of Plastic Surgeons; and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

_____ **Medical Care Only:** Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with **The Myers Institute, PC.** The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at **The Myers Institute, PC.**

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other photo consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

Signature (Patient or Parent/Guardian if Patient is under 18) Date Signed

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PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
Co-payments are due at time of service.
If my plan requires a referral, I must obtain it prior to my visit.
In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to (Dr. Robert Myers OR The Myers Institute of Plastic and Hand Surgery) on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize (Dr. Robert Myers OR The Myers Institute of Plastic and Hand Surgery) to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in (Dr. Robert Myers OR The Myers Institute of Plastic and Hand Surgery). I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

In consideration of services rendered or to be rendered, the undersigned agrees to pay all costs of collection and/or reasonable attorney fees, should the account be turned over to enforce collection of said charges. The undersigned hereby waives all claims or rights of exemption allowed by the constitution of the state of Alabama or any other state of the United States.

_____

Signature of Patient, Authorized Representative or Responsible Party Date

_____

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient