Mark F. Deutsch, MD, FACS
Board certified by the American
Board of Plastic Surgery

Inspired by your Inner Beauty

PERIMETER PLASTIC SURGERY

Cosmetic and Reconstructive Surgery
www.perimeterplasticsurgery.com

We would like to take this opportunity to welcome you to Perimeter Plastic Surgery. It is our goal to assist you with all of your cosmetic and reconstructive needs. Our practice philosophy embraces the belief that every patient is entirely unique. Therefore, Dr. Deutsch tailors his approach to best suit each patient's needs. He believes that spending ample time with patients is critical to achieving the highest quality of care and makes it a priority to remain highly accessible throughout the course of every patient's aesthetic journey.

Dr. Deutsch is a double-board certified plastic and reconstructive surgeon with more than 25 years of cosmetic and reconstructive surgery experience. With specialized training from MD Anderson Cancer Center and Albert Einstein Montefiore Medical Center, Dr. Deutsch performs cutting edge surgery for breast cancer reconstruction, head and neck cancer reconstruction, and complex cosmetic cases.

During your consultation, Dr. Deutsch will review your medical history, perform a physical exam, and discuss your aesthetic desires and goals.

We look forward to guiding you through your aesthetic journey.

Warmest Regards,

Mark Deutsch, MD, FACS and the Entire Perimeter Plastic Surgery Family

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Perimeter Plastic Surgery Request for Limitations and Restrictions of Protected Health Information (PHI)

By signing this authorization, I give Perimeter Plastic Surgery permission to use and/or disclose my protected health information (PHI) to the party or parties listed below. I understand anyone who accompanies me into the exam room may be privy to information and Perimeter Plastic Surgery is not responsible for how these persons may use the PHI. If you need another person to call regarding a surgery request, date of appointment, insurance information or financial information, we cannot speak to them without your permission unless the information below is signed. Please list the name(s) of the people we may discuss your information with.

_____

Name of person(s) & relationship(s) to patient

_____

Signature of Patient or Legal Guardian Relationship to Patient

_____

Print Patient's Name Date

I wish to be contacted in the following manner; check all that apply:

Cell phone or home phone please provide #_____

__ leave a detailed message

__leave call back number only

__leave message with family

Work phone please provide #_____

__leave a callback number only

__written communication mailed to home

__email please provide_____

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Consent to Treat and Routine Procedures – Perimeter Plastic Surgery

During the course of my care and treatment, I understand various types of tests, treatments and procedures may be necessary. These procedures may be performed by a physician, nurse or other healthcare professionals. While these are routinely performed without incident, there could be a risk associated with these procedures. I understand it is not possible to list every risk for every procedure and this form only identifies the most common risks and alternatives (if any) associated with the procedures. I also understand various healthcare professionals may have differing opinions of what constitutes risk and alternative procedures. The procedures may include, but are not limited to:

1. **Needle sticks** - IV lines, IV injections, shots or injections. The possible risks include, but are not limited to, nerve damage, infection, infiltration, disfiguring scar. Alternative to needle sticks may include: rectal, nasal, oral or topical medications, all of which may be less effective, or refusal of treatment.

2. **Physical test, assessments and treatments –** vital signs, wound cleansing or dressing, range of motion checks, etc. The risks of these include, but are not limited to, infection, allergic reaction, loss of blood, paralysis or partial paralysis. Alternatives do not exist except modification of procedure or refusal of treatment.

3. **Administration of medication** - oral, rectal, topically or through the eye, nose or ear. The risks include, but are not limited to, allergic reaction, puncture, infection or perforation. Other than changing the mode of administration or refusal of treatment, no valid alternatives exist.

4. **Drawing blood, tissue samples or bodily fluid-** used for lab testing. The risks include, but are not limited to, infection, nerve damage or bleeding. Long term observation or, refusal of treatment are the only practical alternatives.

5. **Insertion of internal tubes –** drainage tubes, bladder catheterizations, etc. Associated risks are, but not limited to, infection, allergic reaction, and internal injury. Refusal of treatment or external collection devices are the possible alternatives.

I understand the practice of medicine is not an exact science and no guarantees have been made to me in regards to the outcome of these procedures. The professionals involved in my care will take into consideration my documented medical history, information received from me or others knowledgeable of my care to determine whether or not to perform any procedure(s). I agree to give accurate information and by signing this form: I consent to the procedures the healthcare professionals may deem necessary. I acknowledge I have been told of the nature and purpose of these procedures and the practical alternatives. If I have any questions, I will ask for additional information.

This consent will stay in effect until specifically revoked in writing.

Signature_____ Printed Name of Patient _____Date _____

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PRIVACY PRACTICES

The privacy of medical information is very important to us. We are committed to protecting the personal information of our patients. A medical record is prepared and maintained by our office on all patients to ensure quality care and to comply with certain legal requirements. Under the HIPAA law we are required to keep each patient's medical information private, give notice describing our legal duties, privacy practices, and patient's rights regarding their medical record, and follow terms of the privacy notice now in effect. We reserve the right to make changes to the privacy policies at any time as permitted by the law and notice is give to the patients.

USE AND DISCLOSURE OF MEDICAL INFORMATION

We will not use or disclose any private medical information for any purpose not listed without specific written authorization by the patient or legal guardian. The following is a list of how we are permitted to use medical information without the written consent of the patient.

1. **Treatment-** We may disclose information to doctors, nurses, technicians, medical students, or others who are taking care of the patient. We may also share information with other providers to assist them in the treatment of a mutual patient.
2. **Payment**-Medical information may be disclosed when requested by insurance companies for payment of claims. Limited information can be disclosed to collection agency for purposes of receiving payment from the patient.
3. **Health Care Operations**-Use and disclosure for operations includes improving quality, evaluating employee performance, training purposes and obtaining accreditation, licenses, and credentials needed to perform day to day business.
4. **Notification**-Medical information may be released to notify or help notify a family member, a personal representative, or person responsible for the patient's care about the location of the patient, general condition, or death. If the patient is present then permission will be obtained or documented. In case of an emergency, when the patient is unable to give permission, only the information that is necessary for treatment will be disclosed according to our professional judgment.
5. **Funeral Director, Coroner, Medical Examiner**-Information may be released to assist in performing their duties for a patient that has died.
6. **Court Orders, Judicial and Administrative Proceedings**-Under limited circumstances, such as court order, warrant, or grand jury subpoena, we may share medical information about a patient. We may also share limited information with law enforcement concerning a suspect, fugitive, material witness, crime victim, missing person, or inmate under lawful custody of a correctional facility.
7. **Public Health Activities**-As required by law, medical information may be disclosed when preventing or controlling a disease, injury or disability, including child abuse or neglect. Information may also be disclosed to the FDA for purposes of reporting adverse events associated with product defects or problems, and to enable product recalls. We may also, when authorized by law to do so, notify persons who may have been exposed to a communicable disease or otherwise be at risk of spreading or contracting a disease or condition.
8. **Victims of Abuse, Neglect, or Domestic Violence**-We may disclose medical information to appropriate authorities if we reasonably believe that a person is a possible victim of abuse, neglect, domestic violence, or other crimes. We may share information if it is necessary to prevent a serious threat to the health or safety of the patient or others.

Privacy Practices Acknowledgement Form/HIPAA

By signing below I acknowledge that I have received the Notice of Privacy Practices for Perimeter Plastic Surgery and I have been provided an opportunity to review it.

Patient's Name (Please Print)_____

Signature of Patient _____

Or Signature of Patient's Legal Guardian (if minor) _____

Date _____

Please contact our office with any questions or concerns at above address. A copy of this form is available for you upon request.

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Date: _____

Patient Name: _____

Our administrative fee for the following forms is $25.00 per request. Payment is due upon initial request of the form(s). Processed and completed forms can be picked up at the office or emailed to the patient only. Repeat requests require additional fee's ($25.00) per request. We accept cash or credit/debit cards. (Visa, MasterCard, Discover, or Amex) Please allow 5 business days for processing. For expedited processing, there will be an additional charge of $10.00.

Form(s) requested:

_____FMLA Form

_____Short Term Disability

_____RTW (Return to Work)

Please choose the one of the following:

Pick Up: _____

Email To Patient: _____

If paying by Credit Card:

CC#_____EXP_____

CVS Code_____ Billing Zip Code_____

Name on Card and Billing Street Address: _____

_____

Patient's Signature: _____

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FINANCIAL POLICY

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance, co-payments and surgical deductibles for participating insurance companies. Perimeter Plastic Surgery accepts credit cards, cash, CareCredit, & Alphaeon. There is a $35.00 fee for NSF. Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments & surgeries. Payment plans can be arranged if requested.

INSURANCE

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within 90 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or your insurance carrier. All Medicare patients are required to fill out an ABN for all surgical procedures & office visits. Patients who are enrolled in a managed care insurance plan (i.e., HMO),must receive a referral from their primary care physician prior to coming to our office. Retroactive referrals are not allowed.
If you are an insurance based patient and need to cancel your surgery, you may reschedule once with no penalty. Any subsequent rescheduling will be a $50.00 fee.

COSMETIC CONSULTS

If your consultation is strictly cosmetic in nature, there is a $100 charge, which will be deducted from your surgery cost. If during your consultation it becomes an insurance case, it is no longer cosmetic and your copay will be due. To reserve your desired date and time for cosmetic surgery, there is a **non-refundable** $1,500.00 deposit required. If you are a cosmetic patient and need to reschedule your surgery there is a $250.00 fee. If you are a cosmetic patient and for any reason other than the death of an immediate family member or lack of medical clearance by another MD, you decide to cancel your surgery, there is a minimum 20% penalty in your refund. Please see your cosmetic contract for complete details.

REFUNDS

Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances unless a written request for refund is received.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. In order to provide excellent care to all of our patients, we require a 48 hour notification if you need to cancel or reschedule; otherwise a $100.00 fee will be incurred for both insurance and cosmetic patients. Excessive abuse of scheduled appointments may result in discharge from the practice.

FORMS

All Medical Records by Georgia state law Section 2: code section: 31-33-3 states that we can charge a reasonable fee for medical records; our fees are: $0.97 per page for the first 20 pages of the patient's records which are copied, $0.83 per page for pages 21 through 100 and postage & handling charges.
Completion of Physician Statements, FMLA, AFLAC, Disability, etc. to be filled out by the staff or doctor will be charged a fee of $25.00.

I have read and understand the Perimeter Plastic Surgery Financial Policy. I agree to assign insurance benefits to the Perimeter Plastic Surgery Practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency for costs of collections.

Signature of Guarantor/ authorized representative_____
Printed Name_____Date_____

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PATIENT PHOTOGRAPH RELEASE FORM

PATIENT'S NAME_____

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 Perimeter Plastic Surgery staff. I hereby give my consent for Perimeter Plastic Surgery, LLC to use the photographs under one of the following circumstances:

Please initial ONE of the following:

ALL MEDIA

_____Photographs taken of me or parts of my body as well as details regarding medical services I have received at Perimeter Plastic Surgery, L.L.C. may be used in any print or broadcast media, including but not necessarily limited to newspapers, pamphlets, educational films, our internet site and television, in order to inform the public about plastic surgery methods. Further, I release and discharge Perimeter Plastic Surgery, L.L.C., the facility used and the American Society of Plastic Surgery, 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 a party.

WEBSITE ONLY

_____Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Perimeter Plastic Surgery, L.L.C. may be used on our internet website in order to inform the public about plastic surgery methods. Further I release and discharge Perimeter Plastic Surgery, L.L.C., and employees of Perimeter Plastic Surgery, L.L.C., any facility used and the American Society of Plastic Surgery, 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.

PHOTO ALBUM ONLY

_____ Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Perimeter Plastic Surgery, L.L.C. may be used in the photo album in order to inform the public about plastic surgery methods. Further I release and discharge Perimeter Plastic Surgery, L.L.C., and employees of Perimeter Plastic Surgery, L.L.C., any facility used and the American Society of Plastic Surgery, 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 in the photo album. 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 Perimeter Plastic Surgery, L.L.C. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Perimeter Plastic Surgery, L.L.C.

Date_____ **Witness**_____

Patient or Guardian Signature_____

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PATIENT NAME_____ **Height**_____ **Weight** _____**Date**_____

Do you have or have you ever had the following (Please check and give dates of occurrences):

○ AIDS or HIV	○ Congenital Heart Disease ○ Rheumatic Heart Disease	○ Blood Disorders Anemia Blood Clots/DVT's Bleeding Tendencies	○ Migraines
○ Arthritis or Auto Immune Disorders	○ Diabetes	○ Hepatitis	○ Mental Illness Depression
○ Asthma	○ Epilepsy or Seizures	○ High Blood Pressure	○ Visual Problems ○ Hearing Problems
○ Back Problems	○ Gastrointestinal Disease Colitis Crohn's disease IBS	○ Stroke	○ Gastric Reflux ○ Stomach Ulcers
○ COPD: Chronic bronchitis or emphysema	○ Kidney Disease or Stones ○ Liver Disease	○ Tuberculosis ○ Lung Disease	○ Thyroid Disease
○ Cancer Type:_____	○ MRSA	○ Heart Attack ○ Heart Disease	○ Skin Disorders

Do you know of any blood relatives who have or have had any of the above? Please explain:

_____

Do you have any other serious illness (es) not listed above? Please explain:

_____

Please list any operations you have had along with the date of the procedure:

_____

Have you or a family member ever had a complication from anesthesia? Y or N Please explain:

_____

Do you smoke or Vape? Y or N Packs per day_____Did you smoke or Vape in past? Y or N Date Quit_____
How many caffeinated beverages do you consume per day? _____Alcoholic beverages per day? _____

List all medications you are taking, both prescription and non-prescription: (attach additional sheet if necessary)

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Are you taking any of the following medications? Please circle:
Ibuprofen Aspirin Herbal medications or Teas Diet Medications Blood Thinners Vitamins Birth Control Pills

Do you have any medical or religious reasons for denying a blood transfusion? Y or N
Allergies to any medications including Penicillin, food, latex products, adhesives or betadine? Y or N (Please circle)
If you are allergic to Penicillin, can you take Keflex? Y or N
If you are allergic to Codeine or pain medications, what do you use for pain management?_____

_____

<u>WOMEN ONLY</u>: Date of last mammogram_____ Results_____ Current Bra Size_____
Number of pregnancies _____Number of live births _____Are you pregnant now? Y or N

_____ _____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PERSON PRINTED NAME OF PATIENT OR RESPONSIBLE PERSON DATE

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PATIENT INFORMATION

LAST NAME_____FIRST NAME_____M.I._____DOB_____

ADDRESS_____

CITY_____STATE_____ZIP_____SS #_____

GENDER (circle) M F T MARITAL STATUS (circle) S M D W EMAIL_____

CELL #_____HOME #_____WORK #_____

OCCUPATION_____EMPLOYER_____REFERRING DOC_____

PRIMARY DOC_____HOW DID YOU HEAR ABOUT US?_____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

NAME_____DOB_____SS #_____GENDER (circle) M F T

ADDRESS_____

BEST CONTACT #_____OCCUPATION_____

EMPLOYER_____RELATIONSHIP TO PATIENT_____

EMERGENCY CONTACT INFORMATION

NAME_____PHONE #_____RELATIONSHIP_____

INSURANCE INFORMATION

PRIMARY INS_____POLICY HOLDER NAME (if not patient)_____DOB_____

MEMBER ID_____GROUP #_____RELATIONSHIP TO PATIENT_____

2NDARY INS_____POLICY HOLDER NAME (if not patient)_____DOB_____

MEMBER ID_____GROUP #_____RELATIONSHIP TO PATIENT_____

I accept responsibility as Guarantor for the above named patient. I authorize release of any medical information necessary to process for services rendered. I assign and transfer to Perimeter Plastic Surgery, LLC & Dr. Mark Deutsch all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize payment of these benefits to Perimeter Plastic Surgery, LLC & Dr. Mark Deutsch. I accept full responsibility for any balances unpaid by my insurance company The insurance company shall pay without equivocation all benefits directly to the physician due to them as a result of my claim. A photocopy of the authorization will be as valid as the original.

Signature of Responsible Party Printed Name Date