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 and 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 20 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.

We look forward to helping you achieve your desired aesthetic goals.

Warmest Regards,

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

(P) 404-255-0886
(F) 404-255-2726
www.perimeterplasticsurgery.com

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

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.

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

LAST NAME *FIRST NAME* *MIDDLE INITIAL*

_____

_____

STREET ADDRESS *CITY* *STATE* *ZIP CODE*

_____-_____-_____ _____-_____-_____ _____-_____-_____

HOME PHONE *CELL PHONE* *WORK PHONE*

_____

PRIMARY CARE PHYSICIAN *NAME AND ADDRESS*

_____

REFERRING PHYSICIAN NAME AND ADDRESS (IF NOT PCP)

_____/_____/_____ *F/M* *S___M____D____W____O____* ____/____/_____

DATE OF BIRTH *SEX* *MARITAL STATUS* *SOCIAL SECURITY #*

_____

EMPLOYER NAME

_____

INSURANCE NUMBER *POLICY NUMBER* *GROUP*

_____

NAME OF POLICY HOLDER (IF NOT PATIENT)

_____

POLICY HOLDER'S ADDRESS (IF NOT THE SAME AS PATIENT)

_____-_____-_____ _____/_____/_____

POLICY HOLDER'S SS# *POLICY HOLDER'S DOB*

_____@_____

PATIENT'S EMAIL ADDRESS

HOW DID YOU HEAR ABOUT OUR OFFICE?

_____

I accept responsibility as Guarantor for the above named patient. I authorize release of any medical information necessary to process claims for services rendered. I assign, transfer and set over to PERIMETER PLASTIC SURGERY, LLC 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. I accept responsibility for any balances unpaid by my insurance company.

SIGNATURE_____

DATE_____

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

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_____

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

PATIENT NAME: _____ Height: _____ Weight: _____

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 Leukemia Blood Clots/DVT's Bleeding Tendencies	○ Migraines
○ Arthritis or Rheumatic Disorders	○ Diabetes	○ Hepatitis	○ Mental Illness
○ 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	○ Tuberculosis	○ Thyroid Disease
○ Cancer Type:____	○ Hepatitis	○ Heart Attack	○ 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? Y or N How many packs per day? _____

Did you smoke in the past? Y or N When did you quit? _____

How many caffeinated beverages do you consume per day? _____ Alcoholic beverages per day? _____

Please list any medication(s) you are taking along with their dosages: (attach additional sheet if necessary)

Are you taking any of the following medications? Please circle:

Ibuprofen products or 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

Are you allergic to any medications, latex products, adhesives or betadine? Please list:
_____

<u>WOMEN ONLY</u>: Date of last mammogram: _____ Results: _____

How many biological children do you have? _____ Could you be pregnant? Y or N

_____ _____/_____/_____
SIGNATURE OF PATIENT OR RESPONSIBLE PERSON DATE

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

PERIMETER PLASTIC SURGERY, LLC

FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy. A copy of these policies will be provided to you by the receptionist, once signed if requested.

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 and personal checks (in-state only). There is a $35.00 service charge for returned checks.
Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments. In case of extreme emergency's a payment plan 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 by your insurance carrier. All Medicare patients are required to fill out an ABN for all surgical procedures.
Patients who are enrolled in a managed care insurance plan (i.e., HMO), you must receive a referral from your primary care physician prior to being seen in our office. Retroactive referrals are not guaranteed and your appointment may be cancelled.
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.

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. If you are a cosmetic patient and for any reason, other than a death of an immediate family member or lack of medical clearance by another MD, you decide to cancel your surgery there is a minimum 15% penalty in your refund. Please see your cosmetic contract for complete details.

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 request a 48 hour notification if you need to cancel or reschedule; otherwise a $100.00 fee will be incurred. 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 apical 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 also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured or authorized representative_____

Date:_____

980 Johnson Ferry Rd. Suite 510, Atlanta, GA 30342 • 1233 Hwy 54 West Suite 210, Fayetteville, GA 30214
info@perimeterplasticsurgery.com • (404) 255-0886 • fax (404) 255-2726
Member, American Society of Plastic Surgeons