Welcome to the Practice

Precision Plastic Surgery, PA

Roy A. Hobbs, M.D.

2995 Reidville Road, Ste. 150, Spartanburg, SC 29301

We welcome you to our practice, and look forward to the privilege of working with you regarding your health care needs. Please feel free to ask questions and provide all information pertinent to your health requirements. Below are Practice Policies important to understand.

Scheduled Appointments
Both scheduled appointments and walk-in service are offered for the convenience of our patients, but appointments are recommended to ensure that you can be seen. Patients who are reminded of their appointment and do not keep it, will be charged $25.

Collection of Patient Amounts Due
Insurance companies require that any co-pay or co-insurance amounts be collected at the time of service. Co-pay amounts will be collected at the time of check-in to avoid a wait at check-out. If you have a deductible, full deductible is due unless determination can be made otherwise. The patient/guarantor will be responsible for any amounts not paid by your insurance company. Patients having surgery are expected to pay an estimated deposit prior to the procedure.

Prescription Refills
Please make Dr. Hobbs aware on the day of your visit of any prescriptions that need refilling. To ensure Practice personnel understand your current medical condition, the Practice generally will need to see a patient back in the office prior to calling in a prescription. Prescriptions refills are not available on the weekend.

Assignment of Payment
By signing below, I hereby authorize payment of medical benefits directly to Precision Plastic Surgery for their services and to release any information acquired in the course of my examination or treatment for insurance purposes. I understand that records may be transmitted electronically or by mail as required.

Should any financial disagreement occur in relation to services rendered by Precision Plastic Surgery, I waive my right to privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines in order to process claims/charges remaining on my personal account.

Acknowledgement of Receipt of Notice of Privacy Practices
This signed form acknowledges that you have received a copy of our practice's Notice of Privacy Practices as required by federal law. Your signature does not mean that you have read this notice yet, only that you were given a copy to read when convenient for you. The Notice is yours to keep.

Do You Want To Share Your Medical Information With Someone?
If you would like to authorize us to share your medical information with a relative or someone else, you will need to authorize us to discuss and provide that information. Indicate the name of the person and their relationship to you.

Authorized Person's Name: ________________________________ Relationship: ______________________

Print Patient Name: ____________________________________ Patient's Date of Birth: ________________

Signature of Patient, Parent, or Legal Guardian: ____

Date: ____________________________________

Precision Plastic Surgery — **Dr. Roy A. Hobbs**

2995 Reidville Road, Suite 150, Spartanburg, SC 29301 — 864-641-1491

Date:			
Patient Information (Enter "same" if identical to above)			
First Name		Gender M or F	
Middle		Home Phone	
Last Name		Cell phone	
Street Address		Social Security #	
Suite/ Apt #		Birthdate	
City/State		Marital status	
Zip		Race / Ethnicity	
EMAIL Address		Emergency Contact name	
Employer		" Relationship	
Employer Phone		Emergency Contact Phone	
Contact Preference		Alternative Contact	

Guarantor Information (Person Responsible For Bill)					
Last Name			Social Sec #		
First Name		Middle>		Birth Date	
Relationship to Pt				Gender---M or F	
Marital Status					
Street Address		Apt #		Phone-Home	
City		State/ Zip		Phone-Cell	
Email address					

Guarantor Employment Information			
Employer Name		Employer Phone	
Street Address		Suite / Apt #	
City / State/Zip		County	

Physician Information	
Other physicians you are seeing for care	

Insurance Information For Patient– Provide complete or provide copy of insurance card		
Insurance Company **# 1**	Policy #	Name of Insured:
	Group #	Their Social Security #:
	Relationship to insured	Birthday of insured:
Insurance Company **# 2**	Policy #	Name of Insured:
	Group #	Their Social Security #:
	Relationship to insured	Birthday of insured:

We hope to fill our email newsletters with product specials, updates relating to Dr. Hobbs' trips to other countries, and other interesting details. If you are interested, please provide us with your email address below. If you should change your mind later, there will be a place at the bottom of the email where you can "unsubscribe" from the email.

Email Address:

Signature Of Patient >	

PRECISION PLASTIC SURGERY **FINANCIAL POLICY**

2995 Reidville Road, Suite 150 864-641-1491
Spartanburg, SC 29301

Precision Plastic Surgery, PA. believes that in our commitment to excellence it is best to establish a patient account policy in order to avoid any misunderstandings. Our account representative will be glad to discuss your account with you at any time. Our primary responsibility is to deliver quality health care services. We wish to spend our time and energy toward that responsibility. To achieve these goals, we need your assistance and your understanding of our payment policy:

Initial Consultations - Patients are expected to pay for their co-pay at the time of check-in. We accept cash, checks, MasterCard, Visa, American Express and Discover. We also have financing available through various finance companies. Please ask our billing specialist for information on how to apply.

Planned Surgery - All insurance is verified prior to a patient having surgery. If the insurance company has approved the surgery, then we will file these services after surgery is performed. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R." as defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. A cash price for surgery is available if you have (a) a high deductible & wish to pursue a less expensive option, OR (b) if you have a “health-sharing” plan.

There will be a required "pre-payment/deposit for surgery" at the time of the patient's pre-op visit (which is usually 1 week before planned surgery). This would include 30% of the approximate surgery cost, plus any deductible not met.

For those patients having surgery, there will probably be additional laboratory, pathology, anesthesia and/or x-ray charges. **You will be billed separately for these services.**

If surgery has not been approved and/or is cosmetic, **full payment** of the surgical cost would be required at the pre-op visit prior to surgery and at least two (2) weeks before surgery.

Fees - During your initial consultation, you should receive a detailed breakdown of approximate charges. This breakdown should consist of the following charges that will constitute your billing:

1. Surgeon's fee

If your procedure is performed in the private office surgical suite, our charges will also include:

2. Facility fee (operating room and supplies)
3. Anesthesia fee

While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If it becomes necessary for your account to be referred to an outside collection agency, a **15%** collection fee will be added to your balance. If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

______________________________ ______________________________

Precision Plastic Surgery Patient

Date__________________________ Date __________________________

PRECISION PLASTIC SURGERY **864-641-1491**
2995 REIDVILLE ROAD, SUITE 150
SPARTANBURG, SC 29301

NAME:____ DOB:____________________

Do you have any current medical conditions? IF YES, Please list(see more space below)________

____NO___________

Do you have or have you ever had Hepatitis or HIV? YES__________ NO__________

Are you allergic to Iodine, shellfish, or IVP dye for kidney XRAYS? YES___________NO_______

Are you allergic to latex? YES____________NO___________

Do you take water pills? YES__________ NO__________

Do you bruise easily? YES__________ NO __________

Have you ever had problems with bleeding during surgery? YES________ NO_______

Do you take aspirin products? (Goody, Motrin, Advil, Ibuprofen, Naprosyn, BC) YES_____NO_____

Do you take any vitamins or herbs? IF YES, list __________________________________NO_____

Have you ever had surgery? IF YES, please list ___________________________________NO_____

Have you had any anesthesia related problems during or after surgery? YES________NO_______

Have you or a family member had a high fever during or immediately after surgery? YES____NO____

Do you or anyone in your family have a history of malignant hyperthermia? YES______ NO_____

Do you have a high temperature after exercising? YES__________ NO__________

Do you have problems with EYES, EARS, NOSE THROAT? YES, please list ______________________

____ NO___

Do you SMOKE, dip, or chew? IF YES, How much? How many years? ___________________NO___

PAST: Have you EVER smoked, chewed tobacco, dipped? IF YES, list ___________________NO___

Does anyone in your household smoke? YES____________ NO________

Do you have any problems with your heart? IF YES, please list_________________________________

____NO_________

Do you ever get shortness pf breath? YES, _______________NO____________

Do your ankles ever swell? YES____________NO____________

(please turn over)

NAME:____ DOB:_____________________

Do you have any problems with ulcers? YES_________NO_________

Have you ever vomited blood? YES__________NO__________

Have you ever passed blood in your stool? YES__________NO__________

Do you have diabetes? YES__________NO___________

Have you ever had gallbladder trouble? YES__________ NO__________

Have you ever had yellow jaundice? YES__________NO_________

Have you ever had any trouble with kidney stones? YES__________NO__________

Have you ever had any trouble with kidney infections? YES__________NO__________

Do you have trouble with bladder infections? YES___________NO__________

(Men) Do you have prostate trouble? YES__________NO_________

(Women)Are your periods regular? YES____ NO____ any excessive bleeding? YES____NO____

(Women)Is there a chance you could be pregnant? YES________NO________

Have you ever had blood clots in your legs? YES________ NO________

Have you ever had blood clots in your lungs? YES________NO________

Do you have a history of any anxiety disorders? YES__________ NO ________

Do you have sickle cell anemia? YES _________ NO _________

Do you have any dental problems? YES _________ NO _________

Have you recently had any dental procedures? YES__________ NO _________

Do you drink alcohol? IF YES, what type and how often? YES______ NO _________

Do you now or have you ever used street drugs? YES__________ NO _________

LIST **ANY MEDICATIONS** YOU ARE TAKING AT THIS TIME____
____
____
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Please list ANY other health concern or medical condition that HAS NOT BEEN stated in this questionnaire.
____
____

Thank you for filling out this form so we can better serve you.

PRECISION PLASTIC SURGERY

2995 Reidville Road, Suite 150, Spartanburg, SC 29301

864-641-1491

Name: ____DOB___________________

Family Medical History

Please check any of the following related to your relatives. Circle the appropriate relative.

Anemia – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

High Blood Pressure – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Congestive Heart Failure – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Dementia – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Epilepsy – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

HIV – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Myocardium Infarction (Heart Attack) – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Stroke – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Anxiety – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Back Problem – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

COPD – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Depression – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

GERD – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Headaches – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Migraines – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Tuberculosis – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Arthritis – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Breast Cancer – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Cancer – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Dermatitis – YES ___ NO ____ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Glaucoma – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Hepatitis – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

NAME ____

Pneumonia – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Thyroid Dz – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Asthma – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

CAD – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

High Cholesterol – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Diabetes – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Gout – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Hypertension – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Renal Stone – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

Ulcer (GI) – YES ___ NO ___ Please circle (Father, Mother, Sister, Brother, Son, Daughter, Spouse)

If you need more space PLEASE CONTINUE TO LIST ANY MEDICATIONS YOU ARE PRESENTLY TAKING:

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