Heidi D. Williams, MD
PATIENT INFORMATION

Date:_____

Last Name:_____ Sex: Male:__ Female:__ DOB:_____ Age:___

First Name:_____ SSN:_____

Middle Name:_____ Preferred Name:_____

Address:_____City:_____ County:_____State:___Zip:_____

Email Address:_____**Send emails for special offers: Yes__ No__**

Home Phone: _____ Cell:_____Work:_____

May we leave a message about appointments and/or normal test results on the phone numbers you provided? Yes__ No__

Martial status: Married Single Separated Divorced Widowed

Ethnicity: Hispanic or Latino No Hispanic or Latino Other:_____

Primary Language: English Spanish French Other:_____ Race: Caucasian African American Asian other:_____

Student Status: Not a student Full time Part time Occupation:_____

Employment Status: Full Part N/A Employer:_____

Pharmacy name:_____Address:_____Phone:_____

Emergency contact: Name:_____ Relationship:_____Phone:_____

Referred by:_____Primary Care Physician:_____

Insurance Information:

Primary Insurance: _____Policy #:_____Group#:_____

Policy holders name:_____**Date of birth:**_____ **Relationship to patient:**_____

Secondary Insurance:_____Policy #:_____Group#:_____

Policy holders name:_____**Date of birth:**_____**Relationship to patient:**_____

MEDICARE AUTHORIZATION:
I request the payment of authorized Medicare benefits be made either to me or on my behalf to Heidi Williams, MD LLC, for any service received. I authorize Dr. Heidi Williams holder of my medical information, to release my information to the Health Care financing Administration and its agents an information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment is made and authorized release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for deductible coinsurance and non covered services.

Patient signature:_____ Date:_____

Patient name:_____

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? (Please provide the information below)

For ongoing communication regarding your healthcare and for your privacy, your privacy, you must complete this section to authorize the office of Dr. Heidi Williams to release and/or discuss your health information with the following people or organizations for the following specific dates of service. Any revocation or modification to your authorization with regard to a family member or other individual must be submitted in writing.

From date of service:_____ To date of service:_____

Name of Person	Address	Phone/Cell	Relationship
_____	_____	_____	_____
_____	_____	_____	_____

A separate Authorization to release Information Form must be completed for the releases and disclosures not listed in the section below.

To request restrictions of the use of your information, you must complete a separate Request For Restrictions Form.

I voluntarily consent to medical treatment and diagnostic procedures provided by Heidi Williams, MD, LLC and/or other personnel. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as to the result of treatment or examination.

I consent to allow Dr. Heidi Williams to use and release my protected health information for treatment, payment, and healthcare operations I have been offered a copy of Heidi Williams, MD, LLC Notice of Privacy Policies **(Health Insurance Portability and Accountability Act)**, detailing how my information may be used and disclosed as permitted under federal law.

Yes (I accepted a copy)_____ **No (I decline)**_____

I understand that my medical information including complete medical records, test results,and billing information be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and credit card payment purposes.

I allow payment to be made directly to Heidi Williams, MD for all medical or surgical benefits otherwise payable to me under terms of my insurance and agree to allow credit card payments be made directly to Heidi Williams, MD on my behalf, upon my request.

I understand that I am financially responsible for paying all co payments, co insurance, deductibles and non covered services.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep my Physician informed of changes to any of my contact information: a failure to do so may interfere with the ability to contact me concerning my healthcare.

Patient's signature:_____ Date:_____

Print Legal Guardian's Name:_____ Date:_____

Legal Guardian's signature:_____

Reviewed form :_____ **Date:**_____

HEIDI D. Williams, MD
Health History

Patient name:_____ **DOB:**_____ **Date:**_____

Reason for seeing the doctor:_____

_____

List all surgeries, and any illnesses for which your were hospitalized, with approximate dates:_____

_____

List all medications, including herbal medicine:_____

_____

Allergies and reactions to medication:_____

_____

Past Medical History:(have you ever had any of the following)

Arthritis__	Glaucoma__	Kidney Disease__	Heart Disease__
Anemia__	Asthma, lung problems__	Thyroid Disease__	Cancer__
Blood Clots__	AIDS or HIV__	Bleeding tendency__	Stroke__
Diabetes__	Hepatitis__	Mitral Valve Prolapse__	Stomach__
Anxiety/depression__	High Blood Pressure__		

Please explain any checked answers:_____

_____

Review of systems-(Please check any you have now, or have you had in the past year)

Weight change__	Swollen feet/ankles__	Seizures__
Dry eyes__	Rash or skin problems__	Joint or muscle pain__
Chronic cough__	Diarrhea/Constipation__	Unexplained lump or node__
Rapid heart beat__	Jaundice__	Easy bleeding or bruising__
Chest pain__	Depression__	Migraines, bad headaches__

Please explain any checked answers:_____

_____

FOR WOMEN ONLY:
Breast lump_____Last mammogram/_____ Last menstrual period began_____

Family history: (has any blood relatives ever had the following and indicate the family member)
Breast cancer_____ Other cancer_____ Kidney disease_____ Mental illness_____
Skin cancer_____ Heart disease_____ Diabetes_____ High blood pressure_____

Social History: Do you smoke?_____ If so, how many packs/day_____
Do you consume alcohol?_____If so, how many drinks/week___Any illicit drug use?_____

What type of work do you do?_____ Are you married_ single_ Divorced_ Separate_ Other_
Number of children and ages_____

The above information is accurate to the best of my knowledge

Patient_____Date_____Reviewed by_____

FINANCIAL POLICIES FOR HEIDI WILLIAMS PLASTIC AND RECONSTRUCTION SURGERY

Patient name:_____**Date:**_____

Appointment Cancellation Rescheduling Policy

Dr. Heidi Williams and Mt. Pleasant Medi Spa are dedicated to setting aside appropriate time to meet all of your needs and answer all of your questions. We ask in return that you provide the office with at least 24 hours of "courtesy notice" in the event that you need to cancel or reschedule your appointment.

Our office staff tries to give a courtesy appointment reminder phone call, but ultimately the responsibility is the patients to keep track of appointment dates and times. A $50.00 "no show fee" will be charged if you fail to keep your appointment. We thank you for understanding.

In the event that your scheduled surgery needs to be cancelled, we require a two week notice. Surgeries cancelled within two weeks of the scheduled surgery date will be charged a 20percent cancellation fee.

Photo Consent

I understand that photographs are an important component in the process of plastic surgery. They are taken to allow the patient, physician and insurance companies to identify asymmetries abnormalities and are of concern. They are also used to assist the patient in appreciating pre and post operation results.

I, grant permission for the use of any photograph or other imaging record created in my case, for examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc. Pictures will not be viewed outside of this practice.

Patient printed name:_____

Patient signature:_____Date:_____

Patient name:_____**Date:**_____
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It is the goal and commitment of our practice to provide you with the highest level of care available, for years to come. In this spirit, we believe it is possible to avoid miscommunications by having clear expectations and therefore have outlined the following policies regarding your patient account.

Please initial each line and sign

__PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE.
We accept cash, checks, credit and debt cards. (There is a $25.00 charge for all returned checks)

__COSMETIC SERVICES WILL NOT BE SUBMITTED FOR INSURANCE PAYMENT
However, if prior to surgery, Dr. Williams agrees to bill any portion to your insurance company, you will be reimbursed only the amount you paid for that portion of the procedure minus any deductibles, copays or coinsurance.

__IF YOU HAVE INSURANCE, WE ARE HAPPY TO SUBMIT CLAIMS TO MOST CARRIERS
Payment for deductibles and out of pocket expenses are estimated and due at the time of service
1-We can only **ESTIMATE** what your insurance will cover. Therefore, the account holder is responsible for out of pocket expenses at the time of services AND all unpaid balances after insurance has either paid their portion, or determined otherwise. Preauthorization will be obtained from your insurance company prior to your surgery but unfortunately this does not guarantee payment.
2-Any balance remaining after insurance is complete will be due within 30 days. Likewise, if any insurance co. pays more than estimated, we will refund the excess paid by you or apply it to a current balance due on your account. You may also leave it on your account for future use. Any overpayments by the insurance co will be refunded back to them.
3-The patient is responsible to inform our office of any changes regarding their insurance provider or job status that might affect coverage or claim filing.
4-Signature below will be used as Signature on file claim submissions, credit and debt card payment and via phone

__NON-COVERED SERVICES
It is the responsibility of the patient to determine if Dr Williams is a contracted/credentialed provider with insurance co.
1-Not covered by my insurance plan
2-In the event that my Primary care physician did not provide a referral/authorization for services
3-If my condition is deemed pre existing by my insurance carrier
4-Services not considered medically necessary

___ ALL BOTOX, FILLER, AND MEDI SPA SERVICES ARE DUE UPON RECEIPT AND ARE NEVER BILLED LATER

___OUTSTANDING BALANCES ARE DUE WITHIN 30 DAYS OF THE STATEMENT DATE

__TO AVOID BILLING FEES AND MONTHLY FINANCE CHARGES....
Please call office promptly so we can facilitate a resolution to any/all concerns

In the event that I fail to make my payment in full(in a timely manner) or if I fail to make a resonable paymentarrangement and my account is past due. I shall be liable for and I agree to pay, all collection agency fees (not to exceed 33.3%) attorney's fees and court costs.

I have read and understand all current policies for the Practice of Heidi Williams, Plastic and Reconstructive Surgery and I will keep all staff members of any insurance change, financial change, marital status and person I want you to share my person information.

Patient signature:_____**Date:**_____

Wittnessed;_____**Date:**_____