Welcome To Our Office

Carolina Plastic Surgery, PA

The Vein Center

DATE_____

100 E. Wood Street, Suite 100
Spartanburg, SC 29303
864-583-1222

735 Sixth Ave., West, Suite C
Hendersonville, NC 28739
828-696-3000

Village at Pelham
2755 S. Highway 14, Suite 2250
Greer, SC 29650
864-208-2354

Please check one:

_____John T. Lettieri, M.D. _____Julia U. Park, M.D.

Patient Information

Last Name: _____First Name: _____Middle Initial:_____

Address: _____City/State: _____Zip _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Marital Status: _____

Email : _____

Age: _____SSN: _____ Birthdate: _____/_____/_____ Sex: M F Race_____

Primary Care Doctor: _____ Referrered By:_____(Internet / Magazine)_____

Employer: _____Work Phone: ( ) _____Ext. _____

Occupation: _____

Emergency Contact: _____Relationship: _____Phone: ( )_____

Cell Phone: _____

Student: Full Time Part Time Permanent Address: _____

Spouse/Guarantor Information:

Spouse/Guarantor Name: _____DOB: _____/_____/_____SSN:_____

Employer: _____Phone ( ) _____Ext. _____

Occupation: _____

Other Parent Name: _____DOB _____/_____/_____SSN: _____

Employer: _____Phone ( ) _____Ext. _____

Occupation: _____

Primary Insurance Carrier:

Insurance Company: _____

Policy No. _____Group No. _____

Insured's Name: _____

DOB:_____/_____/_____ Insured's SSN:_____

Secondary Insurance Carrier:

Insurance Company:_____

Policy No. _____Group No. _____

Insured's Name: _____

DOB:_____/_____/_____Insured's SSN: _____

OVER

Worker's Comp Information:

Is it work related? _____ Date of Injury/Accident: _____/_____/_____ Auto Accident?_____

Insurance Information/Auto/Workers Comp. _____Claim # _____

Have you consulted an attorney regarding your condition and/or accident? _____

If so, attorney Name and Address:_____

AUTHORIZATIONS and ASSIGNMENT:

I authorize the release of any medical information neccessary to process the insurance claim form for services rendered by Carolina Plastic Surgery. I hereby authorize payment to go directly to Carolina Plastic Surgery for any medical or surgical benefits that they may be entitled to under my medical and surgical plans. I understand that I am responsible for any balance due for professional services in excess of the benefits provided by my policy.

Witness: _____Signature: _____

Date: _____/_____/_____

MEDICARE ASSIGNMENT:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who may be responsible for paying for my treatment. (Section 112B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding information.) Regulations pertaining to Medicare assignment of benefits also apply.

Witness: _____Signature: _____

Date: _____/_____/_____

AUTHORIZATION FOR DISCLOSURE/RELEASE OF INFORMATION:

I authorize Carolina Plastic Surgery to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Carolina Plastic Surgery's determination, are required to receive such information for the purpose of *medical treatment, medical quality assurance, peer review, and if applicable to process the insurance claim for services rendered at Carolina Plastic Surgery.* I further authorize any other physician and/or medical facility to release my medical information to Carolina Plastic Surgery for the purpose of my medical treatment and if applicable to process the insurance claim for services rendered at Carolina Plastic Surgery. This authorization shall remain in effect until written notice revoking this authorization is sent to Carolina Plastic Surgery.

Witness: _____Signature: _____

Date: _____/_____/_____

Carolina Plastic Surgery, PA

CONTACT AUTHORIZATION

In order to provide better care for you, the practice may need to contact you or your designated representative regarding your treatment. Please fill out the form below as to how you would like to be contacted regarding appointments, treatment and/or information pertinent to your healthcare and/or payment for your healthcare provided by Carolina Plastic Surgery, P.A., as well as who is authorized to receive this information.

Please check all forms of contact that are acceptable:

_____Email_____This is our preferred method of contact.

_____Regular Mail

_____Home Telephone #_____ Work Telephone #_____

_____Cell Phone #_____May we text you to remind you of your appointment?___Yes ___No

Answering Machine _____yes _____no Voice Mail _____yes _____no

_____Home Fax Machine # _____

_____Other _____

Disclosure of your health information or its use for any purpose other than those listed in our "Notice of Privacy Practices" acknowledgement requires your specific written authorization. If you change your mind after authorizing a use or disclosure, you may submit a written revocation of the authorization. Also, you have the right to request restrictions on the use and disclosure disclosure of your health information.

Persons Authorized to Receive Information:
Health information CPS collects or receives about you may be disclosed to the following persons:

_____
Name of person/relation

_____
Name of person/relation

I would like the following restrictions regarding the use and disclosure of my health information:

_____

_____

_____

_____

_____ _____ _____
Name of Patient/Representative (print) Signature of Patient/Representative Date

_____
Relationship to Patient

DEPOSIT AND CANCELLATION POLICY FOR COSMETIC SURGERY
CAROLINA PLASTIC SURGERY
John T. Lettieri, M.D.

When you ask us to schedule surgery for you, we must do several things, long before the day of your surgery:

1. Reserve the operating room.
2. Order and pay for any surgical supplies or implants that are needed for your surgery.
3. Secure the necessary specialized surgical nurses and surgical technicians that will be needed, and/or provide coverage to free them up from their other responsibilities.
4. Arrange anesthesia coverage for your case. We must guarantee that we will pay them for this time, whether or not you have surgery.
5. Prepare the required equipment and sterilize the necessary instruments.
6. We must turn down every other patient who wants surgery on the day and time we have reserved for you.

Because of these financial and time commitments we must make, we ask that you be definite about your desire for surgery and be certain that you have the funds available before asking us to schedule your surgery. The following is:

Cancellation policy:

- If it becomes necessary for you to cancel your surgery within 7 days of surgery, a cancellation fee of $1000.00 will be charged (in addition to your non-refundable deposit).
- If it becomes necessary for you to cancel your surgery two weekdays (Monday-Friday) or less before your surgery, a cancellation fee of 50% of the total price of the surgical procedure will be charged.
- **If cancellation is requested within 24 hours, you will lose the entire amount paid for surgery.**
- If you are a smoker and have failed to stop smoking prior to surgery, Dr. Lettieri reserves the right to cancel your procedure and the above cancellation policy will apply.
- If you are financing your surgery: Do not request us to reserve a surgery date for you unless you are certain that you want to have surgery. When you ask us to reserve a surgery date for you the entire amount of the surgical fee will be processed through your financing company. If you later cancel your surgery date we will refund the finance company or credit card and your deposit will be deducted from this refund.
- CHANGE OF SURGERY DATE: If you request to change your surgery date, we ask that it is more than 3 weeks before the date we have reserved for you, and we will try to accommodate your request. *If you call us less then 3 weeks before your surgery date, there will be an additional rescheduling fee of $500.00 that must be paid before we can reschedule your surgery.
- Deposit policy: A non refundable deposit is required to schedule surgery. If your surgery is under $5000.00 the deposit is $500.00. If it is over $5000.00 the deposit will be $1000.00. The deposit will be credited to your surgical fees.
- If we are filing Insurance:$100.00 deposit is required to hold your surgery date and will be applied to any remaining balance due at pre-op. Any balance not covered by your insurance is due at your pre-op visit. _____(initial)

_____ _____

Witness Signature

_____ _____

Date Patient Name Printed

Carolina Plastic Surgery, PA
COSMETIC INTEREST QUESTIONNAIRE

WHAT BRINGS YOU TO DR. LETTIERI TODAY? **DATE** _____

_____

_____

HOW DID YOU HEAR ABOUT HIM?

☐ Friend or family member ☐ Physician or other healthcare provider ☐ Ad or article
☐ Internet (Web site) or Search Engine (i.e., drlettieri.com, google, yahoo, bing, loveyourlook.com, etc.)
(Please Describe)

_____

☐ Seminar or other event (date & location) _____ ☐ Other: _____

BREAST SURGERY

☐ ***Breast Augmentation*** ☐ ***Breast Lift*** ☐ ***Breast Reduction*** ☐ ***Breast Reconstruction***

BODY CONTOURING

☐ ***Liposuction*** ☐ ***Tummy Tuck*** ☐ ***Armlift*** ☐ ***Thighlift*** ☐ ***Buttock Enhancement***

FACE REJUVENATION

☐ ***Facelift*** ☐ ***Browlift*** ☐ ***Laser Eyelift*** ☐ ***Necklift***

WHAT ARE YOUR AREAS OF CONCERN?

(Please check all that apply)

☐ Frown lines between the brows
☐ Lines around nose and mouth
☐ Sagging skin
☐ Fine lines and wrinkles
☐ Rough skin texture
☐ Facial hair

ARE YOU INTERESTED IN LEARNING MORE ABOUT THE FOLLOWING?

(Please check all that apply)

☐ Cohesive Gel Breast Implants
☐ BOTOX Cosmetic for fine lines & wrinkles
☐ JUVEDERM™ injectable gel for deep lines & facial folds
☐ LATISSE increases eyelash length, thickness, and darkness
☐ Anti-Aging
☐ Skincare
☐ Skin care products
☐ Hair removal
☐ Chemical Peels
☐ Skin rejuvenation
☐ Microdermabrasion
☐ Laser skin treatments
☐ Brown spots/age spots
☐ Facials and eye treatments

Other:

_____

YOUR INFORMATION:

Your Name

_____

Address

_____

Telephone _____ Email _____

May we email you about our special offers or events? Yes_____ No_____

www.drlettieri.com