Carlin Plastic Surgery * C. Brett Carlin, MD

Welcome to our office. We strive to ensure that you are seen at your appointment time, however due to the specialty of our practice, unforeseen circumstances may arise, therefore we appreciate your patience.

We ask that you notify us no less than 24 hours prior to canceling or rescheduling your appointment.

Patient's Name:____
Last First Middle Initial

Parent's / Legal Guardian's name (*If minor*):______________________________

Address:____
Street City State Zip

Home #: (___)______________ Work #: (___)______________ Cell #:(___)______________

DOB:______________________ Age:__________ Gender: ____Female ____Male

SSN:______________________________ Marital Status: S M D W Sep.
(REQUIRED)

E-Mail Address:____

Person responsible for payment:______________________ Phone #: (___)______________

Responsible party's address:____
Street City State Zip

1) It is the policy of C. Brett Carlin, MD that charges for all services rendered be paid at the time of service unless PRIOR arrangements have been made with the office. I understand that services involving an attorney, worker's compensation or any other 3rd party does not excuse me from any financial obligation to Dr. C. Brett Carlin and will be paid, in full, as requested.
2)A $250 non-refundable surgery deposit is required at the time of scheduling a cosmetic/self-pay surgery.
3) All surgeries cancelled or rescheduled within 2 weeks of the scheduled date will incur a non-refundable $1,000 cancellation fee.
4) I authorize Dr. Carlin and his designees to provide me with proper medical care by today's health standards.

Signature:______________________________________ Date:______________

I hereby give consent to C. Brett Carlin, MD to take clinical photographs relevant to my care. I understand that these may include Pre-op, Intra-op and Post-op images. I understand that if my photos are selected for educational purposes, scientific publications or medical education lectures, etc., I will be asked for my written consent prior to use.

Signature:______________________________________ Date:______________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS / FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Health Insurance Portability & Accountability Act of 1996 (HIPPA), C. Brett Carlin, M.D. and/or his staff may not discuss your condition with others, including family members, unless we obtain your written consent to do so. The law stipulates that in the event of a critical emergency and you are unable to give your authorization, these rules may be waived.

____ I **DO NOT** authorize C. Brett Carlin, M.D. or his staff to release any or all information concerning my medical care to any individual *except* in the event of a critical emergency.

____ I **DO** authorize C. Brett Carlin, M.D. and his staff to discuss / release any and all information concerning my medical care to the following individuals or in the event of being unable to reach me in a timely fashion:

________________________________ ________________________
Name Relationship to patient

____
Phone Number

________________________________ ________________________
Name Relationship to patient

____
Phone Number

________________________________ ________________________
Patient signature Date

Medical Questionnaire

Please tell us why you are here (circle all that apply):

Breast Augmentation   Breast Reduction   Breast Lift   Gynecomastia

Liposuction   Tummy Tuck   Panniculectomy   Cleft ear (torn earring hole)

Face Lift   Neck Lift   Brow Lift   Eyelid Lift   Botox   Filler(s)

Other:____________________

Please tell us who referred you:____________________

Please be specific about what and why you have concerns about the above:____________________

____

Have you consulted any other Physicians about this?   Yes   No
If so, who and when:____________________

Please list all previous operations (including cosmetic procedures):____________________

____

Were there any complications?____________________

Please list any current medical conditions:____________________

____

Please list current medications, including vitamins and over the counter medications:____________________

____

Please list any allergies to medications:____________________

____

Do you have a latex allergy?   Yes   No   Height:__________   Weight:__________

Have you ever received an injection of local anesthesia (Novocain, Lidocaine, etc.):   Yes   No
If so, did you experience any type of reaction?   Yes   No   If yes, please list reaction:__________

Do you smoke or use any tobacco products?   Yes   No   If yes, how many per day?__________

Do you bruise easily?   Yes   No   Do you bleed abnormally?   Yes   No

Signature:____________________   Date:__________

CARLIN
PLASTIC SURGERY
COSMETIC SURGERY AND AESTHETICS

Board Certified * American Board of Surgery and Plastic Surgery
(803) 926-0969 * C. Brett Carlin, MD

Welcome and thank you for choosing Carlin Plastic Surgery. We are dedicated to providing you with the best possible care. We take pride in what we have to offer our patients and strive to make your experience a pleasurable one. To learn more about Dr. Carlin, please visit **www.CarlinPlasticSurgery.com**.

Our office is available Monday through Thursday from 8:30 am – 5:00 pm. Should you have a post-surgery emergency, rest assured that Dr. Carlin may be reached via our answering service when our office has closed. Please call Jamie, our Office Manager, for surgery scheduling and related questions. Jennie handles our insurance and billing. Brenda, Dr. Carlin's assistant, is available for pre and post-operative care questions. However, the entire staff is always ready to assist you with scheduling an appointment or any other needs you may have.

Due to the nature of our specialty, occasionally it may be necessary for us to reschedule your appointment should an unforeseen and emergent surgical need arise. Each patient becomes our top priority during their appointment; thus, an unexpected delay may arise should the patient ahead of you require additional attention. We will do our best to limit your inconvenience as much as possible. We appreciate your patience and understanding.

Any disability or leave forms require prepayment of $20.00 for completion of each form and will be completed within 1 week of receipt.

We accept Visa, MasterCard, Discover, and American Express. The 3% surcharge will be applied and added to these credit card transactions. We also accept cash, check, debit, and Care Credit with no additional fees. Cosmetic services require payment in full upon each visit. There is a $250.00 **non-refundable** surgery deposit due at the time of scheduling your cosmetic surgery. All remaining cosmetic surgery charges are required to be **paid in full 2 weeks prior** to the scheduled surgery date. Any payments not received by this time will cancel your scheduled surgery and the cancellation fee will be charged. All surgeries cancelled or rescheduled within 2 weeks of the scheduled surgery date will incur a non-refundable $1,000.00 cancellation fee. All previous balances must be paid in full prior to scheduling additional, non-emergent procedures.

A solid "provider-patient" relationship is important to us, so we encourage you to contact our office should you have any questions or concerns related to this policy.

By signing below, you state that you have read this in its entirety, understand it fully, and agree to the terms listed above.

____________________________ ____________________
Signature Date

____
Print Name