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

Insurance information is not needed for cosmetic services. Please complete all insurance information. **If any spaces are left blank, we will not be able to file your insurance.** Please allow us to copy your insurance cards as well as your Driver's License or State I.D.

Primary Insurance:_____ Is this a Cobra Policy? Y / N
Name of Policy holder:_____ Employer:_____
Their DOB (*required*)_____ Their SSN (required)_____
Your relationship to the Policy holder: Self Spouse Child Legal guardian

Secondary Insurance:_____ Is this a Cobra Policy? Y / N
Name of Policy holder:_____ Employer:_____
Their DOB (*required*)_____ Their SSN (required)_____
Your relationship to the Policy holder: Self Spouse Child Legal guardian

It is the patient's responsibility to obtain any pre-authorization(s) from the referring physician, as necessary, per your insurance plan. Rescheduling your appointment(s) may be required if not obtained in advance.

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1) I authorize payment for medical benefits to C. Brett Carlin, MD for any services furnished to me. I agree that I will be financially responsible for any amount not covered by my insurance. I also authorize you to release any of my healthcare information to my Insurance Company if needed. I understand that any denials will be my sole responsibility to investigate and appeal. I permit a copy of this authorization to be used in place of the original.
2) 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.
3) All surgeries cancelled within 2 weeks of the scheduled date will incur a $250 ~non-refundable~ 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. I also understand that my photos will be submitted to my Insurance Company, as required, in an effort to obtain pre-authorization for services.

Signature:_____ Date:_____

Carlin Plastic Surgery * C. Brett Carlin, MD

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:

Name	Relationship to patient
Name	Relationship to patient
Name	Relationship to patient
Patient signature	Date

Carlin Plastic Surgery * C. Brett Carlin, MD

Medical Questionnaire

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

Breast Augmentation Breast Reduction Breast Lift Breast Reconstruction

Liposuction Tummy Tuck Panniculectomy Protruding Ears Cleft ear (torn earring hole)

Face Lift Neck Lift Brow Lift Eyelid Lift Scar Revision Lacerations

Gynecomastia Botox Filler(s) Lesion/Mole/Cyst Moh's Closure

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:_____

_____

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:_____

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

****** Please Keep This Copy for Your Records******

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 Friday 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 Kathy, our Office Manager, for surgery scheduling and related questions. Brenda handles our insurance and billing. Jamie, 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, cash, check and Care Credit. Cosmetic services require payment in full upon each visit. We will file your insurance for any **non-cosmetic** services, however all co-pays are required to be paid when services are rendered. Please understand that your insurance plan is a contract **between you and your insurance company**. We are not an involved party to that contract. We recommend that you familiarize yourself with your benefits and the responsibilities of your plan as you are ultimately responsible for all balances. Any "after insurance" balances are requested to be paid in full within 6 months. Should your visit involve an attorney or worker's compensation, payment in full is due **prior** to services being rendered. We can supply them with an estimate of charges upon their request. All cosmetic surgery charges, deposits, or "after insurance" estimates 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. All surgeries cancelled within 2 weeks of the scheduled surgery date will incur a $250.00 ~non-refundable~ cancellation fee. All previous balances must be paid in full prior to scheduling additional, non-emergent procedures. We DO NOT file insurance claims to TriCare, Champus, Aetna, or Medicaid.

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.