



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

**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

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](http://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, and American Express. There will be a 3.5% convenience fee applied 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. 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 balance after insurance payment is received is your responsibility and is 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 and/or surgery deposits 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, Medi-Share, 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.

By signing below, you state that you have read this in its entirety, understand it fully, and agree to the terms listed above. (Once completed, a copy will be given to you. Please keep this for your records.)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name