

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: _____ SSN: _____
(REQUIRED)

Gender: ___ Female ___ Male Preferred Pronoun(s): _____

Marital Status: S M D W Sep.

E-Mail Address: _____

Person responsible for payment: _____ Phone #: (____) _____

Responsible party's address: _____
Street City State Zip

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- 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 if my photos are selected for any other use, I will be asked for my written consent prior to.

Signature: _____ **Date:** _____

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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)
Brachioplasty 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(ex: cardiac, depression, anxiety, etc):

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

Please list any allergies and the reaction (ex: medications/adhesive/dye(s)etc.):

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 have any religious, spiritual or personal contradictions to not accepting blood in the case of an emergency? Yes No

Do you have a latex allergy? Yes No Do you bruise easily? Yes No

Do you bleed abnormally? Yes No

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

Height: Weight:

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