Shell
PLASTIC SURGERY™, PLLC
Dan H. Shell IV, M.D.

Patient Information

Today's Date: _____

Name: _____ _____ _____
First MI Last

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Birthdate: _____/_____/_____ Age: _____ Social Security #: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ E-mail: _____

Occupation: _____ Employer: _____

Employer's Address: _____ Phone:_____

Referring Doctor: _____ How did you hear about us? _____

Emergency Contact: _____ _____
First Last

Relationship: _____ Home Phone: ( ) _____ Cell/Work ( ) _____

Complete this section only if someone other than the patient is financially responsible:

Responsible Party: _____ Relationship to Patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: ( ) _____ Birthdate: _____ Age:_____

Occupation: _____ SSN:_____

Employer: _____ Work Phone: _____

Insurance Information: Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. See our complete financial policy for details.

Insurance Name: _____ Policy Holder Name:_____

Policy#:_____ Group#:_____Policy Holder Birthdate:_____

SS#: _____

Insurance Name:_____ Policy Holder Name:_____

Policy#:_____ Group#:_____Policy Holder Birthdate:_____

SS#: _____

Dan H. Shell IV, M.D., PLLC
Patient History Sheet

Reason for today's office visit: _____

Currently are you experiencing any of the following symptoms?

Severe headaches	Y N		Shortness of breath	Y N	
Chest pain	Y N		Breast pain, discharge or masses	Y N	
Bleeding tendencies	Y N		Other illness/conditions, not listed	Y N	_____

Current Height: _____ Current Weight: _____

Please list Medications/Dosage & Frequency taking: (Include all Prescriptions, OTC Medications & Vitamins):

MEDICATION NAME	DOSAGE	FREQUENCY

Are you allergic to:

Penicillin	Y	N	Codeine	Y	N
Sulfa	Y	N	Tetanus	Y	N
"Mycin"	Y	N	Demerol	Y	N
Aspirin	Y	N	Latex Allergy:	Y	N
Tape Allergy	Y	N	Other_____		

Social History:

Do you smoke? Y N Amount _____ Drink alcohol? Y N Amount _____ Coffee, tea, or coke? Y N Exercise daily? Y N

Medical History:

HAVE YOU EVER HAD (Please Circle if Yes) Not circling is considered a "No" Answer.

Free Bleeding	Heart Trouble	Chest Pain
High Blood Pressure	Stroke	Thyroid trouble
Severe Headaches	Diabetes	Seizures
Tobacco Use	History Tobacco Use	Dizziness
Alcohol Use	Stomach Ulcer	History Alcohol Use
Fainting Spells	Anemia (Low Blood)	Blood Thinner
Blood Transfusion	Cancer	

Have you ever received a transfusion? Y N If yes, what year? _____
Have you been tested for HIV? Y N If yes, what year _____ Test results: positive negative
Do you wear: Contact lenses: Y N Eye glasses: Y N Hearing aid: Y N Dentures: Y N

FAMILY HISTORY: If Yes – Who

Seizure Disorder:	Y	N	_____	Mental Illness	Y	N	_____
Cancer :	Y	N	_____	Suicide	Y	N	_____
Tuberculosis:	Y	N	_____	Congenital Deformities	Y	N	_____
Diabetes:	Y	N	_____	Kidney Trouble	Y	N	_____
Heart Trouble	Y	N	_____	Kidney Stones	Y	N	_____
High Blood Pressure	Y	N	_____	Bladder Trouble	Y	N	_____
Stroke	Y	N	_____	Inheritable Disease	Y	N	_____

LIST ANY OPERATION(S)YOU HAVE HAD:

Operation	Date	Surgeon	Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you experienced any problems or complications with the following types of anesthesia?

Local anesthesia: YES NO If yes, please tell us what happened:_____
General anesthesia: YES NO If yes, please tell us what happened:_____
Spinal Epidural: YES NO If yes, please tell us what happened:_____

Date last seen by Primary Care Physician: _____

Primary Care Physician (Name) _____(Telephone) (_____)_____

WOMEN PATIENTS ONLY:
Are you pregnant or suspect you may be pregnant? Y N

Number of pregnancies _____ Number of children_____ Last menstrual period _____ Did you breast feed? Yes No

Release of Medical Information/Personal/Family Contacts: Shell Plastic Surgery will not discuss your personal health information with anyone except those allowed under federal and state law without your authorization. Please list the names and relationships of those you authorize us to discuss your personal health information with.

_____	_____	_____
Contact Name	Relationship	Phone #
_____	_____	_____
Contact Name	Relationship	Phone #
_____	_____	_____
Contact Name	Relationship	Phone #

Adult Patient/Guarantor:_____Date:_____

Relationship to patient: _____

Financial Policy

Shell Plastic Surgery's financial policy requires our office to collect payment for your office care at the time services are rendered. We accept cash, cashier's check, money order, personal check through TeleCheck, debit card, Mastercard, Visa, American Express and Discover. There will be a $40.00 fee charged to the patient on any returned check. We ask you to remember that the ultimate responsibility for full payment for our services rest with the adult patient or guarantor. If your account becomes delinquent and it becomes necessary for the account to be referred to an attorney or collection agency or suit, the patient or guarantor will be responsible for paying all patient charges, reasonable attorney fees, collection expenses and court costs.

The undersigned agrees that any and all services of every kind or nature provided by Shell Plastic Surgery, PLLC through any of its agents or employees (licensed or otherwise) shall be considered to constitute medical care and any action based upon the delivery of such services, or the failure to provide such services shall be governed by the provisions of document 11.-1-60, et seq. and document 15-1-36, The Mississippi Medical Malpractice Reform Act.

Patient Consent for Use of Credit cards, Debit Card, and Financing

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.
Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Shell Plastic Surgery, PLLC to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing company when they request such information to process an account and assist with payment.
I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.
I agree that this noncredit card challenge agreement is irrevocable.

Cosmetic

There is a **$100 cosmetic consultation fee**. If surgery is booked, the $100 will be applied towards Dr. Shell's surgical fee. The cost for an injectable is often determined during the consultation with Dr. Shell, depending on the number of units or syringes used. The patient is responsible for paying in full for the treatment immediately afterwards. Every patient is given an individual assessment for an injectable; therefore, the amount differs from one patient to another. If the patient comes back for an assessment and Dr. Shell and patient agree that more product is needed to achieve satisfactory results, additional charges will be incurred and required to be paid in full at that time. The treatment fees you pay for are not a guarantee of results. The practice of medicine and surgery is not an exact science. Although good results are expected, there cannot be any guarantee of warranty, expressed or implied, by anyone as to the results that may be obtained.

In office cosmetic procedure not covered by insurance are charged at the rate of **$750 per hour,** unless otherwise noted by Dr. Shell.

Cosmetic Surgery at Surgery Center or Hospital - In the interest of safe surgery, laboratory, pathology and diagnostic tests (up to date mammogram, chest x-ray and/or EKG) may be ordered and you are financially responsible for payment of these tests. Prescriptions are not provided by Shell Plastic Surgery. Additional breast implant financial assistance warranties are available and specific to implant company and product.

Dr. Dan Shell, M.D.'s surgeon's fee, the anesthesia, surgical and facility fee are for the procedure(s) as agreed upon. The fee quoted to you is an estimate and is based on the standard time needed to perform the procedure(s) properly. If the operation room time is extended for medical reasons, additional fees will be billed by the facility and anesthesiologist. Excess operating room time is the exception and not the rule. If there are any additional procedures needed, there will be additional fees. The fees are non-refundable and you are financially responsible for payment of the additional fees.

If Dr. Shell determines that a revision is necessary, requiring general anesthesia and a return trip to the operating room, you will be responsible for the facility and anesthesia fees. Consideration of reduced fees for Dr. Shell for revision surgery requires you to keep all post-operative appointments and demonstrate that post-op instructions were followed. If a revision can be done in the office procedure room, there is a fee for supplies to be determined by Dr' Shell.

Insurance Deductibles (if applicable), co-payments (if applicable), and cosmetic surgical fees must be paid 2 weeks prior to surgery. For your convenience, we accept Visa, Mastercard, American Express and Discover or, you may pay cash, a personal check (through Telecheck), or cashier's check for payment. No personal checks will be accepted within 7 days of surgery. For procedures under $5000, a $500 non-refundable scheduling and booking fee is required to reserve the surgical date. For procedures over $5000, a $1000 non-refundable scheduling and booking fee is required to reserve the surgical date. Your deposit is forfeited if you cancel less than 5 days prior to your surgery.
You will not receive any kind of coded receipt for insurance purposes, as these services are understood to be cosmetic procedures not deemed medically necessary.

Consent for Irrevocable Non-Assignment
I hereby understand and consent for Dr. Shell to provide care for me, as explained to me in additional informed consent documents. I understand the procedure(s) | seek are cosmetic in nature, not medically necessary, and therefore would be fraudulent and unethical for Dr. shell to submit a fee to any insurance company for coverage I have been explained to and shown the financial costs of having Dr. Shell provide surgical care for me and accept these terms I further understand that Dr. Shell will not accept insurance for this/these procedure(s). My consent to have Dr. Shell provide care and not accept assignment from any insurance company, managed care provider Or Other coverage source is irrevocable and final. I understand, and I will be fully responsible for the surgical fees for the surgery I seek.

Adult Patient/Guarantor: _____ Date: _____

Insurance

It is the policy of this office to collect the patient's deductible and out of pocket expenses 2 weeks prior to surgery if they have not been met for the calendar year before surgical procedures are performed. For procedures covered by your insurance, we will submit a claim to your insurance company, and once the company has paid all it will pay on the claim, the adult patient (18 years of age or older), or guarantor is responsible for any remaining balance.

We participate in numerous insurance programs to accommodate our patients. While we are pleased to be able to provide this service, it is extremely difficult for us to keep track of all the individual requirements of the plans. Each plan has different policies regarding how often services may be rendered and, even more importantly, where those services may be performed. We ask you to inform us if your coverage has any special requirements, such as lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges.
We have found that many insurance plans provide payment at levels significantly lower than our fees. We take great care in setting our charges well within the acceptable norms for similar services in this area. Insurance companies no longer abide by these norms, rather they establish their own reimbursement schedules.

It is our desire that you receive the maximum benefit possible from your health insurance In order to achieve this we need your assistance in providing us complete and accurate personal and insurance information on the attached form.

Insurance Authorization and Assignment: I hereby authorize Dan Shell IV, M.D., PLLC to release information requested by my insurance company or workmen's compensation carrier. I also authorize Dan H. Shell IV, M.D., PLLC to release information to any hospital or physician to which I may be referred by this office. In addition I authorize Dan H. Shell IV, M.D., PLLC to request and obtain my medical records from my

insurance company, workmen's comp carrier, hospitals, and/or physicians who have treated me. I hereby authorize assignment and payment directly to Dan H. shell Iv, M.D., PLLC from major medical benefits or legal settlements and/or judgments due me I hereby agree to pay any and all charges that exceed or that are not covered by insurance. I understand I will be responsible for any fees attached to this account in order to recover any uncollected balances.

Adult Patient/Guarantor: _____ Date: _____

Medicare-Medicaid Certification: I authorize any holder or medical information about me to release to the Social Security Administration or its intermediaries or carries 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 Dan H. Shell IV, M.D., PLLC for services rendered me by its physician(s).

Adult Patient/Guarantor: _____ Date: _____

Cancellation

As a courtesy to our patients, we have a waiting list for appointment availability. As a policy, we ask that you contact our office at least **48 hours** prior to your scheduled appointment if you need to cancel or reschedule so that we may offer the appointment to another patient. If you fail to cancel within 48 hours or do not show, there will be a fee incurred of $50 for a missed business opportunity which will be charged to your credit card that you submitted at the time your appointment was booked, we appreciate our patients and would like to thank you for your consideration of our policies.
I understand that I am financially responsible for all services rendered, regardless of the availability of any insurance coverage(s). I have read and understand this explanation of the financial policy of Dan H. Shell IV, M.D. and agree to accept responsibility as described.

Adult Patient/Guarantor: _____ Date: _____

HIPAA-Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge the receipt of Shell Plastic Surgery's Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the notice by calling (662) 236-6465 or by requesting one at the following office:

Dan H. Shell, IV, M.D.
2680 West Oxford Loop
Oxford, MS 38655

Adult Patient/Guarantor: _____ Date: _____

Print Patient Name: _____

Photo Release(for American Board of Plastic Surgerv. Inc, ONLY):

I consent to the taking of photographs by Dr. Dan H. Shell IV or his designee of me of parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Dan H. Shell IV.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the healthcare services presently receive, or will receive, from Dr. Dan H. Shell, IV.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so, it won't have any effect on any actions taken prior to my revocation.

I understand that the information disclosed, or some portion I, hereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ('HIPAA).

I hereby grant permission for the use of any of my medical records including illustrations, photographs, or other imaging records created in my case, for use in examination. testing. credentialing. and/or certifying purposes by the American Board of Plastic Surgery, Inc.

I certify that I have read the above Authorization and Release and fully understand its term.

Adult Patient/Guarantor: _____ **Date:** _____