TRILLIUM
Plastic Surgery

WELCOME TO OUR PRACTICE!

Patient Name: ______________________________ Today's Date: ____________________

Reason for your visit today: ____

Are there any other areas of interest or concern that you'd like to discuss with the provider today? Please check all that apply.

☐ Loss of Volume in Cheeks	☐ Excess Skin/Fat on Stomach	☐ Uneven Skin Color/Tone
☐ Weak Chin	☐ Breast Augmentation/Lift	☐ Acne/Oily Skin
☐ Bags Under the Eyes/Tear Troughs	☐ Buttock Aug/Brazilian Butt Lift	☐ Uneven Skin Texture/Pore Size
☐ Droopy Eyelids	☐ Mommy Makeover	☐ Facial Fine Lines/Wrinkles
☐ Flat/Droopy Eyebrows	☐ Tummy Tuck	☐ Lip Lines/Thin Lips
☐ Double Chin	☐ Excess Fat/Liposuction	☐ Thin or Light Eyelashes
☐ Saggy Neck/Neck Bands	☐ Nose Surgery/Rhinoplasty	☐ Other: ______________

My main goal in seeking treatment is to (choose only one):

☐ Look Less Sad	☐ Look Less Angry	☐ Look Less Tired	☐ Look Less Saggy
☐ Look Younger	☐ Look Slimmer	☐ Look More Attractive	☐ Look More Masculine/Feminine

How did you hear about our practice?

☐ Patient Referral: ____________________ ☐ Staff Member: ______________________

☐ Friend: __________________________ ☐ Publication: ________________________

☐ Physician Referral: __________________ ☐ Other: ____________________________

☐ Google ☐ RealSelf ☐ Yelp ☐ Facebook ☐ Instagram ☐ Practice Website

☐ What search terms did you use to find us?: ______________________________________

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NEW PATIENT INFORMATION

Full Name: ______________________________ Today's Date: ______________

DOB: ____________________ SSN: ____________________ Gender: M F

Home Phone:______________ Cell Phone: ______________ Mobile Provider: ______________

Address: ____

City: ____________________ State: ____________________ Zip: ______________

Email Address: ____

Emergency Contact: ______________ Relationship: ______________ Phone: ______________

Employer: ______________________________Phone: ______________

Pharmacy Name & Address: ______________________ Pharmacy Phone Number: ______________

Primary Care Physician Name & Phone Number: ______________________________

Are you a member of Brilliant Distinctions? ☐ No ☐ Yes, password: ______________________

Patient Medical History

Height: ________ ft ________ in Weight: __________ lbs.

Please list any current MEDICAL CONDITIONS: ______________________________

____

Please list any ALLERGIES (medication & non-medication): ______________________

______________________ ____ I am allergic to Latex ____ I am allergic to adhesive tape

Please list all MEDICATIONS which you are currently taking (including over-the-counter medications, vitamins, and supplements):

____

______________________ ☐ Aspirin ☐ Ibuprofen/Motrin ☐ Blood thinners (Coumadin, etc)

List any previous SURGERIES (please include the date): ______________________

____

FAMILY HISTORY:	PERSONAL HISTORY:	
☐ Asthma	☐ Required unusually large amount of local anesthesia for a procedure (medical/dental)	☐ Currently pregnant and/or breastfeeding
☐ Blood/Bleeding Disorders	☐ Reaction to local anesthetic (i.e. Novacain, etc.)	☐ Has sought psychiatric care
☐ Cancer	☐ Family/personal history of anesthesia complications	☐ Bruises easily
☐ Diabetes	☐ Required blood transfusion for surgery	☐ Forms large scars or keloids
☐ Epilepsy	☐ Religion prohibits blood transfusions	☐ Sleep apnea
☐ Heart Disease	☐ Bleeds unusually easily (from cuts, surgery, etc.)	☐ Diabetes
☐ High Blood Pressure	☐ Family/personal history of DVT (blood clots)	☐ HIV/AIDS
☐ Kidney Disease	☐ Had Scarlett or Rheumatic Fever	☐ Hepatitis
☐ Lung Disease	☐ Shortness of breath with walking	☐ Smokes/Uses Tobacco
☐ Mental Illness	☐ Skin Diseases (hives, eczema, rash, etc.)	☐ Drinks Alcohol
☐ Tuberculosis	☐ Has taken steroid medications, cortisone, or ACTH	☐ Exercises regularly
☐ Thyroid Problems		

By signing below, I attest that the health history as noted above is complete and accurate. All prescribed medicines and over the counter supplements and vitamins are listed. I understand that omissions or misrepresentations may affect my personal health, safety, and/or the outcome of any of my procedures.

______________________________ ______________________________

Signature *Date*

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CONSENT TO RECEIVE CONFIDENTIAL INFORMATION

Please identify how we may contact you (select all the apply):

I prefer to be contacted via: ☐ Cell Phone ☐ Home Phone ☐ Other (please list): ____________________

Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any

May we leave a voice mail message: ☐ YES ☐ NO

May we leave a message with another person: ☐YES ☐ NO

May we send you information via US Mail: ☐ YES ☐ NO

May we send you information via email: ☐ YES ☐ NO

May we send you information via text message (SMS): ☐ YES ☐ NO

Don't worry – we don't like SPAM, either, which is why we won't send you any!

This is for appointment reminders and our monthly newsletter (which you can opt-out of at any time).

Please list any person(s) that you consent to receive any confidential information regarding your medical care:

Name: ____ Relationship: ______________________

Name: ____ Relationship: ______________________

Communication by Text Message & Email Privacy Notice

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Dr. Jason Hall and associates, there is a reasonable chance that a third party may be able to intercept those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

I consent to allow Dr. Jason Hall and associates to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Appointment Reminders
- Health Related Information
- Marketing offers

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that message & data rates may apply. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

______________________________ ______________________________
Signature *Date*

FINANCIAL POLICIES

Please carefully read the following items and sign below:

"Third-Party Free" Insurance Policy

Our office holds no contracts with any government or private health care plan, however you may still use your out-of-network healthcare insurance benefits for your services. You will be presented with a detailed quote for your services prior to treatment. Payment of these charges is due in full at the time of service (for surgical procedures, payment is due at least 3 weeks prior). We do not obtain pre-authorization for "minor" office procedures such as biopsies, injections, or removal of warts, moles, or other skin lesions. Jason J. Hall, MD, PLLC is not a participating provider with any federal healthcare plan (Medicare, Medicaid, TennCare).

If you participate in one of these plans, you must sign our "Medicare Opt-Out Private Contract" prior to treatment.

Cosmetic Procedures and Treatments Payment Method Policy

All cosmetic procedures performed at Trillium Plastic Surgery are not covered by insurance carriers. Payment in full is expected at the time of service. For your convenience, we accept cash, check, most major credit cards, Care Credit, and Apple Pay.

Cosmetic Surgery Payment Policy

A non-refundable deposit of $500.00 is required to schedule a surgical procedure. A 5% reduction in the professional fee may be granted if a procedure is scheduled within one business day of the initial consult for the scheduled procedure. The remaining balance is due 21 days before the scheduled date of surgery. Any payment for cosmetic surgical procedures that occurs less than three weeks from the surgical date must be in the form of cash, credit, debit, or third-party payment plan (Care Credit). Unfortunately, personal checks are not an accepted form of payment.

Third-Party Financing

Patients wishing to finance any payments may do so through Care Credit or Alphaeon Credit. Trillium Plastic Surgery does not offer in-house financing options. Any transactions processed through third-party financing must meet a minimum balance of $2000.00 (Surgical patients may use third-party financing for their $500.00 non-refundable surgical deposit). Per the requirements of these companies, the authorized cardholder must be present at the time of processing with a valid photo ID, and their signature will be required for all transactions processed through Care Credit.

Employer Family Medical Leave Act (FMLA) Forms

FMLA paperwork is for "serious medical conditions" only, and does not apply to procedures performed for cosmetic reasons. If you or your child are having a reconstructive procedure, we will be happy to fill out FMLA paperwork for your employer. Please note that we will not release any information to unauthorized third-parties, so you will need to supply us with the paperwork yourself. A service charge of $50 is required to have this paperwork completed.

Treatment Packages

In the event that you wish to discontinue treatment or services are not rendered within one year of the purchase on a pre-paid discounted package, the services previously rendered will revert back to regular price.

Product Purchases

All sales on skincare products, cosmetic makeup, or other cosmetic devices are final. Many of these products may be sampled in the office prior to purchase. Returns may be made for unused, unopened product only.

Cancellations and Missed Appointments

We request that you give at least 24 hours' notice if you are unable to keep your scheduled appointment. If an appointment is missed without at least 24 hours' notice, your consultation fee will be forfeited and you will be charged for a second consultation should you reschedule. For cosmetic surgical procedures, we request that a 21-day notice be given to us to cancel or reschedule a procedure. Failure to do this will result in the forfeiture of any and all payment(s) previously made toward the procedure.

Returned Checks

There will be a $25.00 service fee charged to your account if your check is returned by your bank for any reason. Upon notification from our office of your returned check, payment of the entire balance is due immediately.

Financial Policy Regarding Revision

I may desire future surgical procedures to further enhance my results. I understand that post-operative changes may occur in any patient who has undergone a cosmetic surgical procedure, but may be particularly likely to occur in patients who have had liposuction, breast surgery, or body contouring. These changes may occur over time with aging or weight fluctuation. I understand that if these changes occur I may have the option to undergo secondary surgical procedures to further improve those areas if agreed upon in consultation with my surgeon. These secondary procedures might involve liposuction, re-excision of skin due to soft tissue laxity, scar revision, capsulectomy, implant exchange, or other technique. In some cases, these are considered "secondary procedures" and not "touch ups" or "revisions". Other procedures, including but not limited to, laser treatments and fat grafting normally require additional treatments before full enhancement occurs. These procedures are excluded from this policy since additional treatments will be required and therefore full price will be charged. In the event a touch up or revision is determined to be necessary by Dr. Hall, our practice's policy regarding revisions is as follows: 1) Touch up surgery must be performed within ONE YEAR of the original procedure; 2) Any patient undergoing liposuction, body contouring or breast procedures must be at or below their preoperative weight; 3) Full payment is required for any type of implant, medical device or garment; 4) Touch ups under local anesthesia will be charged a $350 per hour facility fee. Touch ups requiring sedation will be charged a $350 per hour facility fee and a $600 per hour anesthesia fee.

If you have any questions regarding our financial policies, please do not hesitate to ask us.
By signing below, I signify that I understand and agree to the financial policies as listed above.

______________________ Signature

______________________ Date

CONSULTATION INFORMATION

Please **initial** next to the statement that is appropriate to your financial plans regarding your treatment with us.

_____ I am a Cosmetic patient, therefore I do not plan on filing through my insurance company for any portion of my payment (i.e.: cosmetic treatments, procedures, and surgeries).

Please be aware that our office does not file directly with any third party insurance carriers, including Medicare and TennCare.

If you participate in MEDICARE, TENNCARE, or any other federal healthcare plan, these parties offer NO out-of-network benefit. You must bring this to the attention of our office staff prior to treatment, and you will be asked to sign our "Medicare Private Contract." This contract states that you understand that by submitting yourself to our office as a patient, you opt-out of any Medicare-coverage for services rendered by our office. Full details are outlined in the contract; all questions can be directed to the staff of Trillium Plastic Surgery.

PRIVACY NOTICE

HIPAA Statement (Use and Disclosure of Health Information)

I understand that as a part of my healthcare, Jason J. Hall, MD originates and maintains health records describing my health history, symptoms, examination, and test results, diagnosis, treatment and any plans for future care or treatment. I have been provided with a Notice of Information Privacy Practices that provides a more complete description of information, uses, and disclosures. I understand that I have the right to review the Notice prior to signing this consent. In the event of a disputed payment, I waive the privacy protection provided by HIPAA in order for Jason J. Hall, MD to provide all information necessary to adequately and completely dispute the claim. I understand that Jason J. Hall, MD reserves the right to change the Notice of Information Privacy Practices, and should information practices change, I will be notified upon my next visit to Jason J. Hall, MD.

______________________________ *Signature* ______________________________ *Date*

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

ARTICLE 1. Agreement to Arbitrate: The parties to this agreement are Physician and Patient. It is understood that any dispute related to claims of medical malpractice, claims which would otherwise be brought under the Tennessee Healthcare Liability Act, codified at Tenn. Code Ann. § 29-26-101, et seq., or any other claims asserting that medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompletely rendered, whether based in tort or contract, will be determined by submission to arbitration and not by a lawsuit or resort to court process, except as state law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration.

ARTICLE 2. All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment of services provided by the Physician including any spouse or heirs of the Patient and any children, siblings, representatives, successors, and assigns. The parties further intend that this agreement is to survive the lives or existence of the parties hereto.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the Physician and the Physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the Physician to collect any fee from the Patient shall not waive the right to compel arbitration of any healthcare liability claim. However, following the assertion of any claim against the Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

ARTICLE 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select one arbitrator (party arbitrator) within thirty days of the demand and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. At least one arbitrator selected must be board-certified by the American Board of Plastic Surgery. In the event neither party selects an arbitrator from the American Board of Plastic Surgery, the neutral arbitrator selected shall be board-certified by the American Board of Plastic Surgery. Each party to the arbitration shall pay such party's pro-rata share of the expenses and fees of the neutral arbitrator, as well as the fees of the arbitrator of their selection, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit.

Each party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The final hearing for arbitration shall be set within 180 days from the date the final arbitrator is selected, subject to the availability of the arbitrators. Extension of this deadline may only be granted to the parties to this agreement upon written motion and a showing of extraordinary circumstances.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

Except as may otherwise be provided above, the parties agree that arbitration under this agreement shall be conducted pursuant to the procedures set forth in the Uniform Arbitration Act, Tenn. Code Ann. §29-5-301 et seq.

ARTICLE 4: Voluntary Agreement: It is understood by the Patient that the services provided by Physician are elective in nature. The Patient understands that he or she is not required to use the undersigned Physician and that there are numerous other physicians in the immediate area who are qualified to provide the same service.

ARTICLE 5: General Provisions: All claims based upon the same incident transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if: (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable state statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

ARTICLE 6: Revocation: This agreement may be revoked by written notice delivered to the Physician within 30 days of signature and if not revoked will govern all medical services received by the Patient.

ARTICLE 7: Retroactive Effect: If Patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), Patient should initial below.

Effective as of the date of first medical services.

____
Patient's initials

If any provision of this Physician-Patient Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Trillium Plastic Surgery, Representative

____
Patient Date

By: ______________________________
Physician or Duly Authorized Representative Date

____
Print Name

____
Patient's Agent or Representative Date

Translated by (if applicable):

____
Signature Date

____
Print Name

____
Print Name

____
Relationship to Patient