DEMOGRAPHICS AND MEDICAL INFORMATION

Name: _____ DOB: _____ Sex: F / M / T

Height: _____ Weight: _____

Email: _____ Cell #: _____ Home #: _____

Address: _____ City: _____ ST: _____ Zip: _____

How did you hear about us? _____ Primary Care Physician: _____

IN CASE OF EMERGENCY: _____ Ph#: _____ Relation: _____

Pharmacy: _____ Address: _____ No. _____

Are you pregnant? ☐YES ☐NO Breastfeeding? ☐YES ☐NO

Smoke/Vape? ☐Never smoked ☐Current heavy smoker ☐Current social smoker ☐Former heavy smoker ☐Former social smoker

Alcohol Use- Weekly? ☐1-2 ☐3-4 ☐5+ ☐ Never

List previous surgeries _____

Any complications from surgeries? ☐YES ☐NO If yes, please explain _____

Any problems anesthesia? ☐YES ☐NO If yes, please explain _____

History of infectious diseases? ☐YES ☐NO If yes, please explain _____

History of autoimmune disease? ☐YES ☐NO If yes, please explain _____

Do you have a history of antibiotic resistant infections? ☐YES ☐NO

History of Herpes Simplex/cold sores? ☐YES ☐NO

Any bleeding issues/tendencies? ☐YES ☐NO

Have you ever had a DVT? ☐YES ☐NO If yes, please explain _____

Do you take immune-suppressant medication? ☐YES ☐NO If yes, please explain _____

Do you use cardiology? ☐YES ☐NO If yes, list name/ph # _____

Use of blood thinners (e.g., Aspirin, Aleve, Motrin, Advil, Coumadin, Plavix, fish oil, vitamin E, etc.)? ☐YES ☐NO
(Please avoid blood thinners 7-10 days prior to Botox/Dysport Fillers)

Do you have a facial implant (e.g., chin or cheek)? ☐Yes ☐No If yes, please explain _____

Do you have a pacemaker, defibrillator or any other similar implants? ☐Yes ☐No

Have you had any previous aesthetic treatments? ☐Yes ☐No If yes, please explain _____

FILLER TREATMENTS- You cannot have dental work (including cleaning) 4 weeks prior and after your treatment.
☐YES, I am aware.

ALLERGIES: ☐**NO KNOWN ALLERGIES** ☐**LATEX** ☐**OTHER – LIST BELOW**

Allergy:	Adverse Reaction:	Allergy:	Adverse Reaction:

Include all prescriptions, over the counter, vitamins, supplements, and herbal or natural medications taken routinely.

Medication Name:	Dose:	Route:	Frequency:

Please answer yes or no to the following and indicate if you or any family members (specify) have been affected by condition.

	Anemia			Excessive Scarring			Mitral Valve Prolapse	
	Angina			GI Upset			Pace Maker	

	Arthritis			Headaches			Pulmonary Disorders	
	Asthma			Heart Disease			Seizures	
	Blood Clots			Heartburn			Skin Cancer	
	Breast Cancer			Hepatitis A/B/C			Stroke	
	Covid19			High Blood Pressure			Thyroid	
	Depression			HIV/AIDS			Tuberculosis	
	Diabetes			Hypertension				
	Excessive Bruising			Melanoma				

Patient Signature and Date

Financial Policy- Cosmetic

Cosmetic Services: Many procedures performed by The Williams Center and its affilates may be deemed to be cosmetic in nature. The Williams Center and its affiliates will not submit a claim or provide medical records to any insurance company for reimbursement on behalf of the patient for a cosmetic procedure. Payment for services rendered will be due at the time of visit (or 2 weeks prior to a surgical procedure).

In-Office Procedures: I understand that if I cancel with less than two weeks notice or if I no-show for my appointment, I will be charged a $250 non-refundable cancellation fee. I also understand that if I reschedule my appointment more than two times I may not be able to go back on the schedule, it is up to the manager/providers discretion.

I have read the above policy regarding my financial responsibilty to **The Williams Center** for services provided. I agree to pay **The Williams Center** at the time of my appointment (or 2 weeks prior to my surgical procedure).

Patient Name: _____

_____

Patient Signature and Date

THE WILLIAMS CENTER

Notice of Privacy Practices

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment/services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you.

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend the Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current notice in our office in a visible location at all times. You may request a copy of our most current notice at any time.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Tanya Waters
Director of Operations
1072 Troy-Schenectady Road
Latham, New York 12110

I, _____ , have received a copy of The Williams Center notice of Privacy Practices.

_____ _____
Signature of Patient Date

_____
Date of Birth

Please list who we are able to share your information with:

_____ Relationship _____

_____ Relationship _____

THE WILLIAMS CENTER

Insurance Only – Financial Policy

Insurance Services: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each vist. If you are insured by a plan we participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your coverage. It is the patient's responsibilty to inform the doctor's office if there is a change in health insurance information.

- **Medicare:** We are a participating Medicare provider. As a participating Medicare provider, we will submit your claim to Medicare, as well as your secondary insurance if provided. However; that does not mean that all services are covered. A separate Medicare waiver will be obtained. Covered benefits are subject to Medicare's annual deductible and coinsurance, which is usually 20% of the allowed amount. You are responsible for these amounts due after processing.
- **Secondary Insurance:** Your medical claim will be forwarded to your secondary insurance (if provided) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.
- **Copayments, Coinsurance and Deductibles:** All copayments, coinsurance and deductibles must be paid at the time of service. This is required by our contract with your insurance plan.
- **Self Pay:** Payment in full is due at the time of service if you do not have health insurance. Cosmetic payments are payable 2 weeks prior to your procedure.
- **Non-Covered Services: Please be aware that some of the services you receive may not be covered by insurance. We make our best offorts to obtain authorization from insurance prior to providing services, however there is no guarantee of payment made by your plan. You are responsible for payment of these services.**
- **Referrals/Authorizations:** When applicable, we are required to follow the guidelines of your managed care plan which may require a referral from your primary care physician prior to seeking speciality care. You are financially responsible for the services received, unless your referral is presented at the time of this visit. Payment in full is expected upon completion of your visit. If a referral is presented to our office within 48 hrs of this visit, credit will be given. You will have the option to reschedule your appointment.
- **Claim Submission:** We will submit your claims and assist you in any way we resonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibilty to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.
- **Patient Billing:** You will be sent up to four notices for amounts deemed to be your responsibilty. After the fourth and last notice, your account may be forced to collections. Please let the billing office know if you have any difficulties resolving your bill. Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, check or credit card. An additional $30.00 will be added to your statement if the check is returned for insufficient funds. In the event that your insurance company issues payment directly to you, thoses funds, along with the explanation of benefits, must be sent to our office to reduce your financial responsibilty.

I have read the above policy regarding my financial responsibilty to **The Williams Center** for services provided. I agree to pay **The Williams Center** any balance unpaid by my insurance carrier for myself or the below named person.

Assignment of Benefits: I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **The Williams Center** all insurance benefits, payable for services rendered. I understand that I am responsible for payment of deductibles, coinsurance, copayments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of the signature on all insurance submissions.

Medicare Authorization

I request that payment of authorized Medicare Benefit be made on behalf of Dr. Edwin Williams III M.D., F.A.C.S. for any services furnished to myself by the above physician. I authorize any holder of medical information about myself to release to Health Care Administration and its agent any information needed to determine these benefits payable for related services. I understand my signature requests payment and authorizes' release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted forms, my signature authorized releasing of the information to the determination of Medicare carrier as the full charge. The patient is responsible the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Name: _____

_____

Patient Signature and Date

Contact Consent Form

By providing your email and phone number, you authorize The Williams Center & its affiliates to send you information for but not limited to: Appointment Reminders, medical/scheduling information, paperwork, our upcoming events, specials, monthly newsletter, etc. via email, text messages and voicemails.

Patient Signature _____

Date _____

THE WILLIAMS CENTER

Computerized Imaging Consent

In an attempt to determine if my expectations are realistic during my initial consultation with the Provider, I will be imaged on the United/Vectra 3D Digital System Computer Imager and/or FotoFinder. The system software is utilized to view and/or alter the features the Provider will address with regard to the type of surgical or non-surgical procedure I may be interested in or is recommended during my consultation.

It is emphasized that the image the Provider will create using the United/Vectra 3D Digital System Computer Imager and/or FotoFinder is an ideal goal that the Provider believes is achievable with the surgical or non-surgical procedure that will be proposed during my consultation. However, because of the unpredictability of healing and biology, the desired goal is in no way promised as an outcome of surgery or procedure.

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.

These photos/images are for your medical chart only, unless otherwise specified and agreed upon in a separate signed document.

Patient _____ Date _____

Witness _____ Date _____

Patient Code of Conduct

At The Williams Center, we are committed to providing a high-quality and level of medical care to our patients in a safe and respectful environment. In order to do so we ask that all patients please follow our practice's Code of Conduct either in person at the office or via telephone conversations as well.

- *Treat all staff and providers with courtesy and respect at all times*
- *Refrain from the use of profanity or inappropriate language*
- *Verbal threats, abuse, harassment will not be tolerated*
- *We ask that you be on time for your appointments or procedures (or you will be asked to be rescheduled)*
- *We ask that you respect the privacy of other patients*

No alcohol, illegal drugs or weapons are permitted on the premises

- *Any patient suspected of being under the influence of any substance(s) will be asked to be rescheduled for safety reasons*

I understand that my failure to follow the above code of conduct may result in dismissal from all lines of the business, removal from the premises and/or notification of law enforcement, if necessary, at the discretion of The Williams Center.

_____

Patient Signature and Date

THE WILLIAMS CENTER

Williams Center Cosmetic Cancellation Policy

Payment:

- At the time of booking your surgical procedure including in- office procedures, we require a 20% Deposit.
- Final Payment: This includes Surgeon's Fee, OR and Anesthesia Fees
- Final payment is due in FULL 4 weeks prior to date of surgery
- If you book with less than 4 weeks, payment is due in FULL within the week that you book.

Cancellation Policy:

- If you cancel at 6 weeks or greater for your scheduled surgery date- you will receive a FULL refund (Deposit and/or full payment). (*if you pre-book your procedure once you come in for your consultation, you have until the end of that same week to be able to cancel and receive your deposit back.
- If you cancel less than 6 weeks notice your deposit and/or FULL Payment are non-refundable.

Rescheduling Policy:

- If you reschedule before the 6 weeks- there is no penalty.
- If you reschedule less than 6 weeks notice regardless of the reason- you would be subject to a 10% rescheduling fee of the surgeon's fee, and you MUST pay in FULL before we can reschedule you.
- If you reschedule more than once, it would be up to surgeon and at management's discretion if we can continue to accommodate your needs and you may be subject to additional fee(s).

Medical Clearances:

- Please note that if you are not compliant for completing your medical clearance including but not limited to seeing any specialists within the appropriate timeframe given during your Pre-operative Testing call and your procedure gets cancelled, we will keep your full deposit.

Other:

- Please note that the cost of the surgeon's fee is valid for 6 months from the date of your quote.

- Operating Room and Anesthesia Fees are subject to change and may vary depending on your surgery.

- All Insurance-related expenses are the responsibility of the patient, i.e. including co-pays, deductibles, denials of coverage.

- Monies that are kept are NON-TRANSFERABLE to any other procedures or any of the other Williams Center businesses.

Please understand that having surgery with us is a major commitment, not only to yourself but also to the entire team here at The Williams Center. There are many aspects that go into making your experience with us safe, seamless, and successful;these resources are booked well in advance including a full anesthesia team, clinical support and specific OR time.

Patient Signature: _____ **Date:** _____

THE
WILLIAMS
CENTER

Pre- Surgical Questionnaire

If you decide to book surgery with us, regardless of whether it is cosmetic or insurance some of the surgical procedures require anesthesia and clearance from a doctor/specialist.

Please complete the information below- this will help ensure that our office we get the information in a timely manner.

◯ I have my own Primary Care Doctor who I will see for my preop clearance appointment. PCP Name: _____

◯ I DO NOT want to use my Primary Care Physician for my preop clearance- I understand that I can go to Central Med.

Please list any specialists that you may see (Including but not limited to: Cardiologist, Endocrinologist, Oncologist, Hematologist)

_____

_____

_____

_____

_____

_____ _____

Patient Signature Date