MM LIFT™
Next Generation Facial Contouring

Board Certified Facial Plastic & Reconstructive Surgeon
Mike Majmundar, MD

Our goal at MM Lift is to provide complete, compassionate, and high-quality care that is centered around you. Please help us meet this goal by providing as much of the following information as possible.

First Name _____ MI _____ Last Name _____

Marital Status S ___ M ___ D ___ Other ___ Sex Male ___ Female ___ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

E-Mail Address _____

Primary Care Physician _____ Phone _____

Patient Employer _____

Job Title _____ Work Phone _____

Emergency Contact

Person to contact _____ Relationship to patient _____

Home phone _____ Work Phone _____

Cell phone _____ Other _____

Primary Insurance

Insured's name _____ Relationship to patient _____

Insured's address _____

Insured's home phone _____ Date of Birth _____

Insurance Carrier _____ Insured SS# _____

Policy# _____ Group # _____ Effective Date _____

Employer of policy holder _____

Alpharetta/Roswell Location: 1360 Upper Hembree Rd., Ste 201-B, Roswell, GA 30076, Office: 770.475.3146, Fax: 770.664.4431
Cumming Location: 1400 Northside Forsyth Dr., Ste 320, Cumming, GA 30041, Office: 770.475.3146, Fax: 770.886.0733
Atlanta Location: 5730 Glenridge Drive, Suite 220, Atlanta, GA 30328, Office: 770.475.3146

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CURRENT SYMPTOMS

Are you currently experiencing any of the following:

- ☐ Fatigue
- ☐ Active Acne
- ☐ Snoring
- ☐ Unexplained Weight Loss
- ☐ Facial Numbness
- ☐ Easy Bruising
- ☐ Fever / Chills
- ☐ Skin Rash
- ☐ Cold Sores / Fever Blisters
- ☐ Blurry / Double Vision
- ☐ Dry Eyes
- ☐ Apnea

PAST MEDICAL HISTORY INFORMATION

Medical Illnesses	Yes	No
Diabetes	☐	☐
High Blood Pressure	☐	☐
Blocked Arteries	☐	☐
Heart Attack	☐	☐
Stroke	☐	☐
HIV	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
Emphysema	☐	☐
Chronic Bronchitis	☐	☐
Heartburn	☐	☐
Bleeding Disorder	☐	☐
Dry Eyes	☐	☐
Cancer, Type	☐	☐
Radiation or Chemotherapy	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Psychiatric illness	☐	☐
Fever Blisters / Cold Sores	☐	☐
Other	☐	☐
Muscle disorder (e.g., Myasthenia Gravis)	☐	☐
Hayfever	☐	☐
Asthma	☐	☐
Known Environmental allergies	☐	☐

Surgery (Cosmetic and Non-cosmetic)

Injuries/Hospitalizations (accidents, fractures, lacerations)

Medications

Aspirin? Y ☐ N ☐

Herbal Supplements

Social History

Do you smoke? _____

Have you smoked in the past? ☐ When? _____

Tanning Bed Use _____

Alcohol Use _____

Allergies

Medical Allergies _____

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COSMETIC PROFILE

How did you hear about our practice?

☐ **Patient** Who? We would love to thank them _____

☐ **Friend** Who? We would love to thank them _____

☐ **Magazine** Which Magazine? _____ ☐ **Newspaper** Which Newspaper? _____

☐ **Internet** Which website? _____ ☐ **Our website**

☐ **Physician referral** Who? We would love to thank them _____

E-mail address if not noted above _____

What would you like to discuss with Dr. Majmundar today?

_____

_____

When do you plan to have your procedure? _____

_____

Have you seen another physician about these concerns? Y ☐ N ☐

When did you first consider plastic surgery? _____

Have you ever seen a psychiatrist? Why? _____

What are your concerns (choose all that apply)?

Eye ☐

Nose ☐

Neck ☐

Lip ☐

Total Face ☐

Please list all cosmetic procedures (including last Botox injection and last filler injection), the person who performed them, and when they were performed.

_____

_____

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SKIN CARE PROFILE

Please complete for a Complimentary Skin Care Evaluation or any scheduled skin care treatment. We believe in having good, natural looking skin for life. As such, we offer **complimentary** skin care consultations to determine the best skin care options available for you. Just ask for a Complimentary Skin Care Evaluation when you schedule your appointment.

Are you currently having any of the following skin treatments?

☐ Peels ☐ Tanning bed use ☐ Lasers ☐ Facials

☐ Waxing ☐ Dermabrasion

Have you seen a Dermatologist in the past year? ☐ If so, please list Dermatologist's name, and reason for visit:

_____

History of Skin Cancer? Where? _____

What skin care products are you currently using? _____

What is your genetic/ethnic background? _____

Are you on birth control or hormone therapy? _____

Are you pregnant or breastfeeding? _____

Please check if you are presently using or have used in the past:

☐ Tazarotene (Tazorac) ☐ Tretinoin (Retin-A, Renova, Avita) ☐ Hydroquinine ☐ Accutane

What Skin Conditions do you want to improve?

☐ Acne and/or breakouts ☐ Rosacea ☐ Facial Scarring ☐ Uneven Tone

☐ Hyperpigmentation / brown spots / melasma ☐ Uneven Texture ☐ Hypopigmentation ☐ Dehydration

☐ Enlarged Pores ☐ Oily ☐ Fine Lines & Wrinkles ☐ Sun Damaged

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge.

I understand that some skin conditions may require more than one treatment and home care products to achieve the result desired. Results cannot be guaranteed due to individual skin type(s) and condition(s). I understand that the treatment may involve risks from both known and unknown causes, and I freely assume these risks. Possible risks, though rare, can include mild swelling, mild redness, pigmentary changes, and mild discomfort.

Patient Signature _____ Date _____

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MM LIFT FINANCIAL POLICY

1. All insurance **Co-Payments** are due at the time of service.
2. A **NO-SHOW fee** of $50.00 may be assessed for each appointment missed. Notify us at least 24 hours in advance to cancel or reschedule your appointment to avoid the penalty.
3. Payment is due at time of service for all in-office cosmetic procedures.
4. Any dishonored check will result in a **$35 return check** charge.
5. It is your responsibility to confirm our physicians participate in your insurance plan. If you see a physician that is not on your plan, you are responsible for all charges in full.
6. All medical records requests must be in writing and received 72 hours prior to the date needed. All medical records request need to be in writing. There is a $25 search and find fee as well as a per page charge for coping your records in accordance to Georgia State law.
7. We charge an administrative fee to cover the coast of certain administrative tasks such as completion of FMLA, disability, school forms as well as patient requested reports such as claims, statements, payment histories, and copies of medical record.
8. If your balance becomes 60 days delinquent after insurance payments, your account may be sent to a collection agency. You are responsible for all collection fees incurred.
9. **Cosmetic Surgery Quote** After you and Dr. Majmundar have finalized your surgical plan, we will provide you with a quote for your surgery. The quote is an estimate and will include your initial consultation, a pre-operative visit with Dr. Majmundar, digital photographs, a visit with Dr. Majmundar the morning of surgery to answer any questions, the procedure, all immediate post-operative visits, and all related follow-up visits for one year. We will also provide you with an estimate of the facility and anesthesia fee with your quote. **All quotes are valid for 90 days**.
10. **Non-Refundable Deposits** We collect a **non-refundable deposit of $500** or half of the procedure quote, whichever is less, to schedule and hold your desired date of surgery. A non-refundable deposit of $500 is also collected for any laser, skin tightening, of in-office liposuction procedure at the time of scheduling. You may schedule your procedure as soon as the day of your initial consultation.
11. Full payment for cosmetic surgery is due at our office at your preoperative appointment prior to surgery. If the procedure is performed at our surgery center, the facility and anesthesia fees will be collected at the same visit. If the procedure is scheduled at another facility, that facility will contact you directly for the appropriate facility and anesthesia fees prior to your procedure.
12. **Payment Options** Cosmetic procedures are an excellent investment in your medical and psychological well-being. To make your healthcare investment cost-effective, we provide the following payment options.
    i) Cash or certified check. ii) All major credit cards - VISA, MasterCard, Discover, American Express. iii) **CareCredit** gives you convenient low monthly payment options so you can get the procedure you want now. This involves a simple one page application and immediate approval online. There are no up-front costs, no prepayment penalties and no annual fees.
13. **Cancellation/ Refund Policy** If your scheduled surgery is re-scheduled within 7 days of your surgery date, you will be charged a $250 rescheduling fee. If your scheduled surgery is cancelled, at any time, for any reason, you will be refunded all monies less the $500 non-refundable deposit and a $50 administrative fee for refund processing. Cancelling any laser, skin tightening, of in-office liposuction procedure within 48 hours of your scheduled date, will forfeit your $500 deposit. There are no refunds on skin care products, Latisse, oxygenetix, of Neotensil products. Exchanges for these products are permitted. We understand that a situation may arise that could force you to reschedule of cancel on short notice, but please understand that this also effects your surgeon's schedule, staffing, and other patients as well.
14. **Additional charges** Required lab work or additional operative time will be billed separately to you by the lab, surgery center, or hospital. We recommend that the patient be covered by health insurance at the time of the cosmetic surgery in the rare instance that a post- operative complication develops. All charges related to additional procedures for revisions or complications are the full responsibility of the patient.

Patient Signature _____ Date _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We have made every effort to obtain written acknowledgement from this patient but it could not be obtained because:

A. Patient refused to sign
B. Due to emergency situation it was not possible to obtain an acknowledgement
C. We were not able to communicate with the patient

Other _____

_____

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

CONSENT FOR PHOTOGRAPHY

I authorize Dr. Majmundar and associates to photograph myself or patient and agree that the prints may be used for purposes indicated below. I understand that my name will not be used or disclosed in connection with the image.

☐ My photographs may be used for one-on-one consultations with other patients.

☐ My photographs may be used for the practice website and marketing or promotional materials.

☐ I would like to make myself available to speak to other patients over the phone regarding my procedure.

By signing this, I release Dr. Majmundar and staff of MM Lift from all claims that may result from the taking and use of these photographs for the above named purpose(s).

☐ Yes ☐ No

Patient Signature _____ Date _____ Time _____

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