Midland Plastic Surgery Center PA
701 N Tradewinds Blvd, Suite B
Midland, TX 79706
Office: 432-618-6772
Fax: 432-618-6775

Patient Information

Date: ____/____/____ Sex: ☐ Female ☐ Male

Patient Name: _____ Date of Birth: ____/____/____

Physical Address: _____
Street City State Zip Code

Mailing Address: _____
Street City State Zip Code

Home Phone: ( ) _____ Cell Phone: ( ) _____

Social Security Number: _____
(needed for insurance or worker's compensation billing)

Employer: _____ Work Phone: ( ) _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

If married, Spouse's name: _____

Spouse's employer: _____

Emergency Contact: _____ Relationship: _____

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

Primary Insurance Information:

Subscriber: _____

Policy Number: _____

Group Number: _____

Insured's DOB: _____

Pharmacy Name: _____

Secondary Insurance Information:

Subscriber: _____

Policy Number: _____

Group Number: _____

Insured's DOB: _____

Pharmacy Name: _____

Physician(s) Information:

Referring Physician: _____ Phone: ( ) _____

Primary Care: _____ Phone: ( ) _____

Were you seen in the emergency room? ☐ Yes ☐ No If yes, when: _____

Patient Record of Disclosures

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also providing the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to an individual's office instead of to their home.

I wish to be contacted in the following manner (Check all that apply):

- ☐ Home Phone: ( ) _____
  - ☐ Okay to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Cell Phone: ( ) _____
  - ☐ Okay to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Work Phone: ( ) _____
  - ☐ Okay to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Other: _____
- ☐ Written Communication:
  - ☐ Okay to mail to my address
  - ☐ Okay to fax to my work/office
  - ☐ Please mail all correspondence to:

    _____

    _____

You may disclose my information to the following people (family and friends only — you do not need to list other Healthcare Providers on this form):

Name: _____ Phone: ( ) _____

Name: _____ Phone: ( ) _____

_____	_____	_____
Patient Signature	**Date of Birth**	**Print Name / Date**

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Financial Policy

Patient Financial Responsibility:

We are delighted that you have entrusted your care to Dr. Cook and the staff at Midland Plastic Surgery Center (AKA MPSC). We look foward to helping you reach your healthcare goals. Our practice believes that a good physician/patient relationship is based upon understanding and open communication. To that end, the policies outlined below are intended to provide understanding of our mutual expectations regarding the financial guidelines of MPSC. We hope you will find this information helpful.

Overview of our Respective Financial Responsibilities:

- MPSC's Responsibility: To post charges and payments accurately. To prove claims and statements to the responsible party based on the best information available to us. This includes direct insurance billing and patient billing for remaining balances. To provide accurate financial counsel to patients who contact our billing department.
- Patient's Responsibility: To assure that MPSC is provided with the most current insurance information known. To provide timely payment to MPSC for all balances to be the responsibility of the patient (whether co-pay at the time of service or balances due following insurance payments applies i.e., deductibles and co-insurance). Delays in communicating changes in your insurance coverage may result in the balance being uncollectible from the insurance company and the full responsibility for payment falling on the patient.

Payment:

The total patient balance due is required to be paid at the time services are provided. For your convenience we accept cash, checks, Visa, Mastercard, Discover, and American Express.

Our office participates with a variety of insurance plans. It is your responsibility to:

- Bring your insurance card at every visit. If you do not have your insurance card, you may be asked to pay at the time of the service and sign a waiver of responsibility;
- Be prepared to pay your co-payment and or co-insurance at each visit;
- For medical care not covered, deemed medically unnecessary, or deemed cosmetic by your insurance company, payment in full is due at the time of the visit. If unable to do so, please contact our Billing Department at 432-618-6772 ext. 113.

Insurance:

You are responsible for any balance your insurance does not cover. We will file your insurance claim and allow forty-five (45) days to render payment. After forty-five (45) days, if we have not had a response from your insurance company, you will be responsible for the entire balance.

Financial Policy

We do file secondary insurance claims for your payment to our office.
If you have insurance that is considered "out of network", we will bill them as a courtesy to you, but any amounts unpaid by your plan will be your responsibility.

Medicare and Medicaid:

Medicare: Please be aware that some office visits and/or procedures are not covered by Medicare on an annual basis. Please check with your local Medicare carrier for specific benefit guidelines. We accept assignment from Medicare. For services/procedures not covered by Medicare, you will be asked to complete and sign an ABN form.

- **For Surgical Procedures:** For any Medicare patients with a co-pay or deductible, we will require a booking fee of $500.00 which will be due at the time of scheduling your surgery date. This booking fee may be refundable, but is dependent on Medicare's final assessment of the patient's current balance for their co-pay and/or deductible at the time of final billing. MPSC may withhold a portion or all of the booking fee to cover the balance not paid by Medicare to account for the co-pay/deductible.

Medicaid: We accept assignment from Medicaid and no booking fee is required.

Children of Divorced Parents:
Responsibility for payment for treatment of minor children, whose parents are divorced, rest with the patient who seeks the treatment. Any court ordered responsibility judgement must be determined between the individual involved, without the inclusion of Midland Plastic Surgery Center PA.

Outside Services:
Please be advised that patients may receive separate bills for any lab tests, cultures, and biopsies, as they may be sent to outside sources for analysis. Any inquires regarding their charges should be made directly to that facility's business office.

Other Fees:

- **Medical Records Fee:** If you are wanting medical records for your personal use, there is a $25.00 charge for the first twenty (20) pages and $.50 for each page thereafter. There will need to be a Medical Release Form completed and signed. Please allow fifteen (15) days for the records to be processed.
- **Return Check Fee:** If a check does not clear the first time, our bank will automatically run the check through a second time of processing. Checks that are returned to our office will carry a $25.00 return check handling fee. It is expected that the patients will pay the amount of the returned check and the fee with cash or credit card as soon as the situation is brought to their attention.
- **No Show Appointment Fee:** If we do not receive a 24 hour notice to cancel or reschedule an appointment, there will be a $30.00 charge added to you account.

Financial Policy

- **Surgical Fees:** Midland Plastic Surgery Center provides only surgical services for any procedure performed. Other services may be necessary to complete your surgical treatment i.e., anesthesia, radiology, and pathology, among others. There is a possibility that "out of network" providers may provide all, or part, of the covered services related to your surgical care.
- **Cosmetic Procedures:** At the time of scheduling the surgery, we will collect a non-refundable $1,000 deposit. This will be applied to the total cost of the surgery, but is not refundable in the event of cancellation. The remaining balance for the procedure must be paid ten (10) business days prior to your surgery.
- **Non-Cosmetic Procedures:** During the scheduling process, our Surgery Coordinator will estimate the "out-of-pocket" cost of the scheduled procedure. This estimated cost will be collected when the surgery is scheduled.
    - For procedures that will be billed to insurance, MPSC collects a $1,000 booking fee at the time of scheduling the surgery. If the surgery is cancelled, this fee is refundable. For completed procedures, this fee is available to be refunded in part or in full after payment from the insurance company to MPSC. The amount to be refunded can vary based on factors including the patient's unmet deductible, yearly out-of-pocket expense, and co-pay amounts that insurance may deduct from their payment to MPSC.

Form Completion: If you have the following forms that will need to be completed, there is a $25.00 fee per form:

- FMLA;
- Short Term Disability;
- Long Term Disability; or
- Verification of Wellness Examination

Please note, these forms will be completed within ten (10) business days after being submitted. If you would like them in a timely manner, bring them to your Pre-Operative appointment with our Surgery Coordinator.

Thank you for taking the time to review and understand our financial policies and the reason behind them. If you have any questions or concerns about the financial aspects of your relationship with us, please feel free to contact our Billing Department at 432-618-6772 ext. 113.

Important Numbers to Know:

Appointments	432-618-6772 ext. 101
Billing Department	432-618-6772 ext. 113
Nurse	432-618-6772 ext. 106
Practice Manager	432-618-6772 ext. 108
Surgery Coordinator	432-618-6772 ext. 107

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN HAVE ACCESS TO YOUR INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact:
Privacy Officer, Laura Jacobo
Midland Plastic Surgery Center, PA
701 Tradewinds Blvd, Suite B
Midland, Texas 79706
432-618-6772 ext. 108

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

WE MAY USE AND DISCLOSE HEALTH INFORMATION

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by contacting our practice Privacy Officer.

Treatment: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment: We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party, for the treatment and services you received. For example, we may give your health plan Health Information so that they will pay for your treatment.

Notice of Privacy Practices

Effective Date: January 2016

Health Care Operations: We may use and disclose Health Information for health care operations purposes, including outside of Midland Plastic Surgery, PA. For example, we may use and disclose Health Information to make sure that all of our patients receive quality care and to operate and manage our office. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities. We may also share your information for the training of medical residents, students or trainings for their training and educational purposes as they participate in educational programs, training, internships and residency programs.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services: We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Family and Friends Involved in Your Care or Payment for Your Care: When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research: Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law: We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract with them.

Notice of Privacy Practices

Effective Date: January 2016

Organ and Tissue Donation: If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation: We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes: We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Notice of Privacy Practices

Effective Date: January 2016

Coroners, Medical Examiners and Funeral Directors: We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors, as necessary for their duties.

National Security and Intelligence Activities: We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information, as necessary, if we determine that it is in your best interest based on our professional judgment.

Disaster Relief: We may disclose your Health Information to disaster relief organizations that seek your Health Information to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Health Information will be made only with your written authorization:

1. Uses and disclosures of Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Health Information

Other uses and disclosures of Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Health Information under the authorization. However, disclosures that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Notice of Privacy Practices

Effective Date: January 2016

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Review and Copy: You have a right to review and request copies of your Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the Privacy Officer. We may charge you a reasonable fee to copy and/or mail the requested Health Information as permitted by law. If we are able, we will provide an electronic copy to you within 15 days of your written request and receipt of appropriate fee.

Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured Health Information, as required under state and federal laws.

Right to Amend: If you feel that the Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the Privacy Officer.

Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Privacy Officer.

Right to Request Restrictions: You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the Privacy Officer. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments: If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Notice of Privacy Practices

Effective Date: January 2016

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.
Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site www.midlandplasticsurgery.com. To obtain a paper copy of this notice contact the Privacy Officer.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Privacy Officer. All complaints must be made in writing. Your care will not be affected in any way for filing a complaint.

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Patient Acknowledgement of Financial Polices

In signing below, I agree that I was informed and have received a copy of the "Financial Policy" that was effective January 2016.

Patient's Name (please print) _____ **Date of Birth** _____

Patient Signature _____ **Date** _____

Patient Acknowledgement of the Notice of Privacy Practices

In signing below, I agree that I was informed and have received a copy of the "Notice of Privacy Practices" that were effective January 2016.

Patient's Name (please print) _____ **Date of Birth** _____

Patient Signature _____ **Date** _____

Consent for Use and Disclosure of Protected Health Information For Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, the Physician originates and maintains medical records describing my health history, symptoms, examinations and test results, diagnosis, treatment, financial and demographic information, and any plans for future care or treatment. The Physician also originates and maintains bills records. I understand and consent to this information being used or disclosed for the following purposes:

- Planning my care and treatment;
- Communication between my Physician and healthcare professional that act under the direction of my Physician and participating in my diagnosis, evaluation, or treatment;
- Collection of fees for medical services;
- Determining liability for payment and obtaining reimbursement;
- Conducting healthcare operations, including the evaluation of healthcare services, appropriateness and quality of healthcare treatment, and the qualifications of healthcare practitioners.

I have been provided with a copy of the *Physician's Notice of Privacy Practices* that provides information about how the Physician uses and discloses Protected Health Information (PHI) about me. I understand that I have the following rights and privileges:

- The right to review the notice prior is signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. The Physician is not required to agree to the requested restrictions, but is bound to any restrictions agreed to.

I understand that as provided in the *Physician's Notice of Privacy Practices*, the terms of the Notice may change. If they do, I may obtain a revised copy from the Privacy Officer by calling 432-618-6772 ext. 108.

I understand that I may revoke this consent in writing, except to the extent that the Physician has already acted in reliance thereon. I also understand that by refusing to sign or by revoking this consent, the Physician may refuse to treat me. I wish to restrict the use or disclosure of my health information as follows:

_____

_____

I understand that my confidential information may be released to the following individuals:

_____

_____

Consent for Use and Disclosure of Protected Health Information For Treatment, Payment, or Healthcare Operations

Patient's Name (please print)	**Date of Birth**
Patient Signature	**Date**
Representative Name (if applicable)	**Relationship**

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Medical History Form

Patient Name: _____ Date of Birth: _____

Reason for visit: _____

Patient Past History (please check the appropriate box)	**Details**
☐ No Pertinent Past Medical History	_____
☐ Abnormal Clotting	_____
☐ Allergies	_____
☐ Anemia	_____
☐ Arterial Fibrillation	_____
☐ Arthritis Conditions	_____
☐ Asthma	_____
☐ Bleeding Disorder	_____
☐ BPH	_____
☐ Breast Cancer	_____
☐ Cancer	_____
☐ Cardiac Arrest	_____
☐ Celiac Disease	_____
☐ Chest Pain/Tightness	_____
☐ Depression	_____
☐ Diabetes	_____
☐ Eczema	_____

Medical History Form

Patient Past History (please check the appropriate box)	**Details**
☐ GERD	_____
☐ GI Disorder	_____
☐ Heart Disease	_____
☐ Heart Murmur	_____
☐ Hepatitis	_____
☐ High Blood Pressure	_____
☐ Hives	_____
☐ Kidney Stones	_____
☐ Menopause	_____
☐ Migraines/Headaches	_____
☐ Other	_____
☐ Pulmonary Embolism/Blood Clot in Legs	_____
☐ Seizure	_____
☐ Skin Cancer	_____
☐ Skin Disease	_____
☐ Stroke	_____
☐ Thryoid Disorder	_____
☐ Tuberculosis	_____
☐ Ulcers	_____
☐ Urinary Tract Infection	_____
☐ X-Ray Therapy	_____

Medical History Form

Patient Past Surgeries/Hospitalizations (if none, please state none)

	Surgery /Hospitalization	Date	Anesthesia Complications (Yes/No)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Family History	Afflicted Family Member
☐ No Pertinent Past Medical History	
☐ Unknown -Adopted	
☐ Abnormal Clotting	
☐ Anesthesia Problems	
☐ Allergies	
☐ Anemia	
☐ Arterial Fibrillation	
☐ Arthritis Conditions	
☐ Asthma	
☐ Autoimmune Disorder	
☐ Breast Cancer	

Medical History Form

Family History	Afflicted Family Member
☐ Cancer	_____
☐ Depression	_____
☐ Diabetes	_____
☐ High Blood Pressure	_____
☐ Premature Coronary Heart Disease	_____
☐ Seizure	_____
☐ Stroke	_____
☐ Thryoid Disorder	_____

Allergies (if none, please state none)	Reaction
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

Medical History Form

Current Medications (if none, please state none)

	Medication	Dosage	Prescribed By
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Patient Social History

Alcohol

- ☐ Denies alcohol use
- ☐ Admits alcohol use socially
- ☐ Admits alcohol use daily
- ☐ Admits to history of alcoholism

Illegal Drugs

- ☐ Denies using illegal drugs
- ☐ Admits to using illegal drugs
- ☐ Admits to history of drug abuse

Smoking Status

- ☐ Active How many packs per day: _____
- ☐ Recently Started Date: _____
- ☐ Ended Date: _____

Medical History Form

Patient Ability to Heal (check appropriate box)

- [ ] Does your skin burn easily?
- [ ] Do you form thick or raised scarring from a cut or burn?
- [ ] Do you wax or use depilatories on your face?
- [ ] Do you ever get cold sores?

For Female Patients:

- [ ] Do you have regular periods?
- [ ] Are you going through menopause?
- [ ] Are you pregnant?
- [ ] During pregnancy, did you ever get hyperpigmentation or masking?

Height/Weight/BMI

Height (in): _____

Weight (lbs): _____

All information provided above is accurate and complete to the best of my knowledge.

_____ _____

Patient Signature **Date**

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Authorization to Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____

Address: _____
Street City State Zip Code

Purpose of Request: Continuation of Care Personal Legal Insurance
(please circle)

I authorize release to: _____ Phone: ( ) _____

Name/Facility: _____ Fax Number: ( ) _____

Address: _____
Street City State Zip Code

Date of Service Range From: _____ To: _____

- ☐ Billing Records
- ☐ Clinic/Progress Notes
- ☐ Complete (All records, notes, meds, flowsheets, etc.)
- ☐ Discharge Summary
- ☐ Emergency Room Report or Operative Notes
- ☐ History and Physical
- ☐ Lab Results
- ☐ Radiology Reports
- ☐ Other: _____

_____

1. Requests will be processed within 15 business days of receipt.
2. I authorize the release of my medical record, including photographs.
3. This authorization is voluntary, and the disclosure is made at my request.
4. If the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
5. Multiple requests are authorized if the purpose of the request remains the same.
6. I have a right to revoke this authorization at any time and if I revoke this authorization, I must do so in writing and present the written revocation to the department that I have authorized to release the information. Any revocation will not apply to information that has already been released in response to this authorization.
7. I need not sign this form to ensure health care treatment. I request this authorization to expire on _____ or 180 days from the date signed below and covers only treatment for the dates specified above. I am also aware fees, outlined below, for copy services may apply.

NOTE: Fees/charges will comply with all laws and regulations applicable to the release of information. Standard copying fees are as follows: $25.00 for the first 20 pages of the medial records and $.50 for each additional page thereafter. Additionally, an initial set of radiological films/CD-ROM can be provided at no cost to a patient for physician or facility referral. However, a fee of $5.00 per sheet of film and $7.00 per CD-ROM will be charged for additional copies.

IMPORTANT WARNING: The documents accompanying this message are intended for the use of the person or entity to which this message is addressed. These documents may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law. If you are the employee or agent responsible to deliver this information to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED.

_____ _____

Patient Signature **Date**