Midland Plastic Surgery Center PA
701 N Tradewinds Blvd, Ste 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

Mailing Address: _____
Street City State Zip

Home # (_____) _____ Cell # (_____) _____

Social Security #:(Needed for any insurance or Workers' Comp billing): _____

Employer: _____ Work #: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

If married, spouse's name: _____

Spouse's employer: _____

Emergency Contact: _____ Relationship: _____

Home # (_____) _____ Cell # (_____) _____ Work # (_____) _____

Insurance Information

Primary Insurance	**Secondary Insurance**
Subscriber: _____	Subscriber: _____
Policy Number: _____	Policy Number: _____
Group Number: _____	Group Number: _____
Insured's DOB: _____	Insured's DOB: _____
Pharmacy Name: _____	Location: _____

Physician(s) Information

Referring Physician: _____ Telephone: _____

Primary Care:_____ Telephone: _____

Were you seen in the Emergency Room: _____ When: _____

MIDLAND

Patient Record of Disclosures

In general, the HIPPA privacy rule give 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 Telephone _____

- ☐ 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 Telephone _____

- ☐ 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 from):

_____ _____
Name Phone #

_____ _____
Name Phone #

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

Midland Plastic Surgery Center PA

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 forward 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. 110.

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 ne responsible for the entire balance.

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 do accept assignment from Medicare. For services/procedures not covered by Medicare you will be asked to complete and in an ABN form.

For Surgical Procedures – We will require a deposit of $500.00 which will be due ten (10) business days prior to your surgery date.

Medicaid - We do accept assignment from Medicaid.

Children of Divorced Parents:

Responsibility for payment for treatment of minor children, whose parents are divorced, rest with the patent 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 sperate 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 waiting 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 wit 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 $25.00 charge added to you account.

Surgical Fees - Midland Plastic Surgery Center provides only surgical services. Other services are necessary to complete your surgical treatment i.e., anesthesia, radiology and pathology, to name a few. 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: During the scheduling process, our Surgery Coordinator will estimate the "out-of-pocket" cost of your scheduled procedure. A deposit of one-half of the estimated cost will be collected at the time your surgery is scheduled along with a cancellation fee of $500.00*. The remaining balance must be paid ten (10) business days prior to your surgery.

*If you cancel within five to ten (5-10) business days prior to your surgery date, one-half of your deposit will be refunded. If less than five (5) business days, there will be no refund.

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 schedule.

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. 110.

Important Numbers to Know:

Appointments	432-618-6772 ext. 101
Billing Department	432-618-6772 ext. 110
Nurse	432-618-6772 ext. 103
Practice Manager	432-618-6772 ext. 108
Surgery Coordinator	432-618-6772 ext. 107

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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 were 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 _____

MIDLAND

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

I understand that part of my healthcare, the Physician originates and maintains medical records describing my health history, symptom, 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 used and disclosures 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 tat 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:

_____

_____

_____ _____

Signature of Patient or Representative Date

_____ _____

Patient Name Printed Name Date of Birth

_____ _____

Name of Representative (if applicable) Relationship

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	_____
☐ 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 _____
- [ ] Xray Therapy _____

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 Family History	
☐ Unknown - Adopted	
☐ Abnormal Clotting	
☐ Anesthesia Problems	
☐ Allergies	
☐ Anemia	
☐ Arterial Fibrillation	
☐ Arthritis Conditions	
☐ Asthma	

☐ Autoimmune Disorder	_____
☐ Breast Cancer	_____
☐ Cancer	_____
☐ Depression	_____
☐ Diabetes	_____
☐ High Blood Pressure	_____
☐ Premature Coronary Heart Disease	_____
☐ Seizure	_____
☐ Stroke	_____
☐ Thryoid Disorder	_____

Allergies (if none, please state none)

	Allergy	Reaction
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____
5	_____	_____
6	_____	_____
7	_____	_____
8	_____	_____
9	_____	_____
10	_____	_____

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 a day _____

☐ Recently Started Date: _____

☐ Ended Date: _____

Patient Ability to Heal (check appropriate box)

☐ Does your skin burn easily?

☐ Do you form thik 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**