TEXOMA

Plastic Surgery

Phillip J. Stephan, M.D., F.A.C.S.

Patient Information

Date: _____

Referred by: _____

Pharmacy: _____

Primary Dr: _____

Patient's Legal Name: _____

Preferred Name: _____ Guardian (if minor) _____

Address _____

City _____ State _____ Zip _____

Email _____ Home Phone _____

Work Phone _____ Cell Phone _____

Date of Birth: _____ Sex: _____

SS#: _____ Preferred Language: _____

Marital Status (circle one)

Single Married Separated Divorced Widowed

Employment (if minor, responsible parties)

Employer _____

Position _____ May we call you at work? _____

Address _____

In case of Emergency

Name _____

Relationship _____ Phone _____

Name _____

Relationship _____ Phone _____

I understand that I am financially responsible for all charges. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. We accept cash, checks, money order and credit cards Visa, MasterCard and Discover.

_____ _____

Signature Date

2200 Keil Blvd. • Wichita Falls TX 76309 • 940-264-2600 • FAX 940-264-2601
drphilstephan.com

Initial/ Yearly

*NAME*_____, *DOB*_____, *Today's Date*_____

PATIENT HISTORY & PHYSICAL (Initial/Yearly)

Welcome to **Texoma Plastic Surgery**. This form is a permanent part of your medical record. Please complete this questionnaire as carefully and completely as possible. Complete all sections **except the box marked "HPI".** Thank you.

What is/are the reason(s) for your visit? (Please limit to the three most concerning lesions):

1.

2.

3.

Referred by: _____

HPI **(Patients—leave this section blank—continue with "Allergies"):**

General Info			
Location			
Duration			
Severity Mild/mod/sev.			
Timing Constant/ intermittent			
-Mod factors Makes better/worse -Treatments attempted			
Associated symptoms			
When occurs Symptoms			

***Medication Allergies:** (rash, hives, shortness of breath):*
1.
2.
3.

***Medication Intolerances**: (upset stomach, headache, diarrhea):*
1.
2.
3.

Please CIRCLE any cosmetic concerns:

Reducing wrinkles	Microdermabrasion
Botox	Leg/facial vein laser
Collagen	Chemical peels
Laser	Glycolic acid
Hair removal laser	

MEDICATIONS		
Name	*Strength*	*How often*
1.		
2.		
3.		
4.		
5.		
6.		

HERBS/DIETARY SUPPLIMENTS List below:
1.
2.
3.
4.
5.

Vaccinations Up to Date (yes or no)	
Flu	
Pneumonia	
Shingles	

Initial/ Yearly

*NAME*_____, *DOB*_____, *Today's Date*_____

PAST MEDICAL HISTORY—Please circle <u>ALL</u> dermatologic or medical conditions that you have had or currently have:

Skin Cancer (BCC/SCC/MM)
Actinic Keratoses -pre skin cancer
Acne
Warts
Blistering Sunburns
Hay Fever/Allergies
Shingles
Psoriasis/eczema
Flaking or itching scalp
Anxiety/Depression
Seizures/fainting
Stroke/TIA
Irregular heart rate
Coronary artery disease
Heart murmur
Pacemaker/defibrillator
High blood pressure
High cholesterol
Asthma/COPD
Lung disease/TB
Thyroid disease
Diabetes
Acid reflux
Renal disease
Hepatitis
Liver disease
Blood disorder
HIV/AIDS
Arthritis
Gout
Lupus/sarcoidosis
Any type of cancer
Exposure to toxins or radiation
Dentures, Partials, lose teeth
Other:_____

LIST ANY SURGERIES AND YEAR:

_____

_____

_____

_____

FAMILY HISTORY: **<u>(Heart or Lung problems, Cancer; include melanoma, reaction to anesthesia)</u>**

	Medical problems/cause of death if applicable
Mother	
Father	
Sibling	
Sibling	

- **Do you smoke?_____Do you drink alcohol (if so how much/often)?_____**
- **Do you use sunscreen?___ SPF_____ History of tanning bed use?_____**
- **History of increased sun exposure:_____**
- **Adverse Reaction to Anesthesia?_____Family member with reaction to anesthesia?_____**

<u>FULL</u> REVIEW OF SYSTEMS:

Y/N Fevers/Chills/Night Sweats
Y/N Unintentional Wt loss
Y/N Problems healing/Scarring/Bleeding
Y/N Rash/Seasonal Allergies
Y/N Immuosuppression
Y/N Anxiety/Depression
Y/N Headache/Seizure disorder
Y/N Abdomen pain
Y/N Blood in stools or urine
Y/N Joint aches/Muscles weakness
Y/N Neck stiffness
Y/N Cough/Shortness of Breath/Wheezing
Y/N Chest Pain
Y/N Thyroid problems/Diabetes
Y/N Sore throat
Y/N Blurry Vision

Alerts:
Y/N Allergy to Lidocaine
Y/N Rapid heartbeat with epinephrine
Y/N Allergy to topical antibiotics
Y/N Pace maker/Defibrillator
Y/N/NA Pregnant or planning/Nursing

If YES, is your primary care provider aware?_____

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Insurance Information

(Please note: This information is for the POLICY HOLDER, not for the patient)

Primary Insurance_____

Policy # _____ Group #_____

ISURED'S Name (***NOT Same as Patient***): _____

INSURED's S.S. #____-____-____ Male_____ Female____

INSURED's DOB _____ Relation to Patient _____

(Please note: This information is for the POLICY HOLDER, not for the patient)

Secondary Insurance _____

Policy # _____ Group # _____

ISURED'S Name (***NOT Same as Patient***): _____

INSURED's S.S. #____-____-____ Male____ Female____

INSURED's DOB _____ Relation to Patient _____

****

Assignment of Benefits: I hereby assign all medical and/or surgical benefits for private insurance to: Texoma Plastic Surgery. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure the payment.

Signed: _____ Date: _____

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TEXOMA PLASTIC SURGERY

2200 KELL BLVD.

WICHITA FALLS, TEXAS 76309

I understand that my estimate of insurance benefits is not a guarantee of payment by my insurance company. I understand that the estimate reflects benefits available, deductibles, coinsurance that apply and is subject to my eligibility on the date of service.

I further understand that any unpaid balance due to Texoma Plastic Surgery remaining is my financial responsibility.

Patient/Responsible party signature:

_____

Date: _____

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Plastic Surgery

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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 GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the internet. At Texoma Plastic Surgery, privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this to provide service to you, to process your claims and to bring you health that might be of interest to you.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important, like name, address and insurance information.

How/Way information is shared

We limit who receives information and what type of information is shared.

_____ _____

Signature Date

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Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Texoma Plastic Surgery creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made I reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must agree to any restriction on the use and disclosure of my Protected Health Information that I request in writing, and, when I request in writing, agree to terminate any restrictions on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_____ _____

(PATIENT'S NAME PRINTED) DATE

_____ _____

(PATIENT'S SIGNATURE OR GUARDIAN IF A MINOR) Social Security

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TEXOMA
Plastic Surgery
Phillip J. Stephan, M.D., F.A.C.S.

Photographic Authorization and Release

By my signature below, I authorize Dr. Phillip J. Stephan, and his employees or agents to photograph me and/or make electronic recording of me (hereafter referred to as photographic or electronic reproductions) in connection with the plastic surgery procedure(s) he has performed or may perform. This consent includes the taking of photographic or electronic reproductions of any part of my body.

I authorize the use of any such photographic or electronic reproductions of me for purposes of my treatment and quality assurance review. 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. To the extent that I am not identifiable from such photographic or electronic reproductions, they may be used for following purpose, including but not limited to dissemination to physicians, health professionals as deemed necessary by Dr Phillip Stephan, MD.

I understand that I may refuse to consent to the taking of any photographic or electronic reproductions that are not intrinsic to operation or procedure without prejudice to my care.

Neither I, nor any member of my family, will be identified by name in any form of publication. Wherever possible, the photos will be cropped so as to show only the pertinent information, but not personally identifying information. I understand that in some circumstances, the photographs may portray features that will make my identity recognizable.

I have entered into this agreement in order to assist scientific treatment, education, public relations, and/or charitable goals and hereby waive any right for compensation for these uses. I and my successors and assignees herby hold Dr. Phillip J. Stephan, his employees, and any other person participating in my care and their successors and assignees harmless from against any claim for injury or compensations resulting from the activities authorized by this consent.

Signature	Witness Signature	Date
Printed Name	Printed Witness Name	Time

By my signature below, I authorize permission for use of photographs on the internet and/or website.

Signature	Witness	Date

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TEXOMA
PLASTIC SURGERY PA
PHILLIP J. STEPHAN, M.D., F.A.C.S.
AESTHETIC AND RECONSTRUCTIVE
PLASTIC SURGERY

CONFIDENTIALITY CONSENT FORM

Please list the family member and/or persons, if any, whom we may inform about your medical conditions and your diagnosis. If anyone calls regarding your medical conditions and are not listed on this form, WE CANNOT GIVE THEM ANY INFORMATION...It is the law!

1. _____ #_____
2. _____ #_____
3. _____ #_____
4. _____ #_____
5. _____ #_____
6. _____ #_____

Patient Signature:_____ Date:_____

Patient/Guardian Signature:_____ Date:_____

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TEXOMA
PLASTIC SURGERY PA

Phillip J. Stephan, M.D., F.A.C.S.
Vicki E. Jackson, FNPC

We value you as a patient and want to provide high-quality care and services. To do so, we need to set boundaries and expectations that will foster an effective provider–patient relationship.

This is a contract that outlines the behaviors we will expect from you. In return, we will make every effort to accommodate you and your needs. Please review the contract carefully. If you have any questions, feel free to call 940-264-2600.

This agreement is between _____(patient name or parent/guardian if under 18years old) and Texoma Plastic Surgery, PA. In an effort to better care for you the following expectations are required to maintain an effective provider–patient relationship.

Expectations:

1. Show up to scheduled appointments on time. If appointment needs to be rescheduled or cancelled they must be done at least 24hours in advance to avoid the $25 no show/reschedule fee.

2. Take medications and follow any other skin care regimens as discussed during appointments.

3. Maintain current contact information on file at Texoma Plastic Surgery, PA. If under 18 years old, ONE primary contact will be designated for discussion of lab work, medication refills etc. This helps ensure information is being communicated accurately.

I have read and understand the above-listed expectations. I also understand that failure to meet these expectations may result in termination of the relationship between me and this provider/organization.

I have had the opportunity to receive a copy of the practice's "Patient Rights and Responsibilities" policy.

I understand if I fail to reschedule or cancel my appointment within 24 hours of my appointment time or I no show my appointment, I will be responsible to pay a $25 fee prior to rescheduling another appointment.

Patient/Family/POA signature: _____ Date:_____

Provider signature/number: _____ Date:_____

Witness signature: _____ Date:_____