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

Health History and Anesthesia History

Pt Name_____Date_____

AGE_____WEIGHT_____HEIGHT_____

Reason for Visit today_____

PRIMARY CARE DOCTOR_____OTHER DOCTORS_____

ALLERGIES AND REACTIONS TO MEDICATION?_____

_____

Do you take ANY diet pills, Natural Herbs or Health food supplements?_____

PLEASE LIST ALL MEDICATIONS BELOW

NAME	REASON FOR TAKING	FREQ/DOSE

Have you taken Steroids in last year? If Yes explain_____

Previous surgeries:_____

_____

_____

Family History of Breast Cancer Yes or No, If so who _____Age Diagnosed_____

Have you ever had a mammogram yes or no, If so where _____date_____

Are you pregnant? Yes No Date LMP_____ Are you done having children? Yes No

Do you take Aspirin on regular basis? Yes No Do you use ANY Tobacco products? Yes No

Circle all that apply-Past/Current History

Lung Disease	Mitral Valve Prolapse	Asthma	Neck Problems	Fever Blisters
Liver Disease	Heart Disease	Hepatitis	Sleep Apnea	Abnormal/Excessive Bleeding
Kidney Disease	Chest Pain	HIV	Dry Eyes	Taken Accutane w/in last year
High BP	Diabetes	Seizures	Keloids	Blood Disorders
CHF	Stroke	Chronic Acid Reflux		Difficulty Opening Mouth

Other_____

Have you had any reactions, allergic or otherwise, to the medications you received in past during surgical procedures?_____

Is there a family history of allergic reactions or fevers during anesthesia? Yes No

Are any of you teeth: loose fragile capped false Do you drink Alcoholic Beverages? Yes No

Have you had any lab work or ECG within last 6 months? Yes No Where:_____

Have you had a fever, infection, productive cough, or taken antibiotics with last two weeks? Yes No

Have you ever been told that you have a difficult airway? Yes No

Any concerns regarding undergoing anesthesia? _____

Pt Signature _____

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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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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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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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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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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