

PATIENT INFORMATION

Date: _____

Mr. Mrs. Ms. Dr. Miss First Name: _____

Middle Name: _____ Last Name: _____ D.O.B.: _____

SSN: _____ Sex: Male Female Race: _____

Mailing Address: _____ Zip: _____

City: _____ State: _____

Home #: (____) _____ Work #: (____) _____

Cell #: (____) _____ Fax #: (____) _____

Pager #: _____ Email: _____

Responsible Party Name: _____ Relationship: _____

SS#: _____ DOB: _____

Marital Status: Married Single Other

Who Referred you: _____

Type of Accident: Auto Work Other None Date of Injury: _____

Spouse: _____ DOB: _____ SS#: _____

EMPLOYER INFORMATION

Employer: _____

Employer Street: _____ Employer Zip: _____

Employer City: _____ Employer State: _____

Occupation: _____ Employer Phone #: _____

SECONDARY ADDRESS

Secondary address: _____

Street: _____ Zip: _____

City: _____ State: _____

Comments: _____

CLOSEST RELATIVE IN CASE OF EMERGENCY (OTHER THAN SPOUSE)

Last Name: _____ First: _____
Middle Initial: _____ Relationship: _____
Phone: _____ Street: _____
Zip: _____ City: _____ State: _____

INSURANCE INFORMATION

Name of Primary Insurance Company _____
Subscriber's Last Name: _____ First Name: _____
Middle Initial: _____ Insured's DOB: _____
Insured's ID: _____ Group/Policy: _____
Relationship to Insured: _____ Insured's Sex: _____
Insured's Street: _____
Zip: _____ City: _____ State: _____
Insured's Phone #: _____ Insured's Employer: _____
Co-payment: \$ _____ Deductible: \$ _____ Met ? _____
Coverage from date: _____ Coverage to date: _____

SECONDARY CARRIER INFORMATION

Name of Secondary Insurance Company _____
Subscriber's Last Name: _____ First Name: _____
Middle Initial: _____ Insured's DOB: _____
Insured's ID: _____ Group/Policy: _____
Relationship to Insured: _____ Insured's Sex: _____
Insured's Street: _____
Zip: _____ City: _____ State: _____
Insured's Phone #: _____ Insured's Employer: _____
Co-payment: \$ _____ Deductible: \$ _____
Coverage from date: _____ Coverage to date: _____
Responsible Party Name: _____
Social Security #: _____ Relationship: _____

High Plains Plastic & Reconstructive Surgery, P.A.

Patient Medical Information

Date: _____

Name: _____ Age: _____ Sex: _____

Occupation (or prior to retirement): _____ Right Handed ___ Left Handed ___

Referring Physician: _____ Primary Physician: _____

Describe below problems you wish to discuss with the doctor.

1. _____
2. _____
3. _____
4. _____

Past Medical History: Check below any problems you have or you have had in the past.

CARDIOVASCULAR

- ___ High blood pressure
- ___ Palpitations, irregular heart beat
- ___ Mitral valve prolapse
- ___ Heart murmur
- ___ Congestive heart failure
- ___ Heart attack _____ year
- ___ Angina _____ Date of Last
- ___ Difficulty walking up two flights of stairs
- ___ Other heart disease
- ___ CAB: Angioplasty
- ___ Implanted Device (pacemaker, ICD)
- ___ Physician who implanted device
- ___ Brand Model of Device
- ___ Swollen Feet or Ankles
- ___ Chest pain with Exertion

GASTROINTESTINAL

- ___ Ulcer
- ___ Hiatal Hernia
- ___ Frequent heartburn
- ___ Hepatitis/liver disease
- ___ Other gastrointestinal disease

OTHER

- ___ Night sweats
- ___ Skin Rash
- ___ Weight gain/loss
- ___ Tend to be cold or hot

RESPIRATORY

- ___ Cough/Cold last two weeks
- ___ Asthma/wheezing
- ___ Emphysema/bronchitis
- ___ Sleep Apnea
- ___ Persistent cough
- ___ Shortness of breath
- ___ Cough up blood
- ___ Other lung disease

ENDOCRINE

- ___ Thyroid disease
- ___ Diabetes - dx _____
- ___ Steroid medications in past yr
- ___ TB
- ___ Other endocrine disease

NEUROLOGIC

- ___ Polio
- ___ Convulsions, epilepsy
- ___ Stroke, paralysis
- ___ Muscle weakness
- ___ Mental disorder
- ___ Any spinal cord abnormality
- ___ Other neurologic disease

KIDNEY

- ___ Kidney failure
- ___ Blood in Urine
- ___ Burning on Urination
- ___ Other Kidney disease

BLOOD

- ___ Bleeding disorder
- ___ Sickle cell
- ___ Hemophilia
- ___ Other blood disease
- ___ Previous Transfusion ___yr.

OTHER cont.

- ___ Rheumatic Fever
- ___ Arthritis
- ___ Neck/LRom
- ___ Difficulty opening mouth/TMJ
- ___ Loose/Chipped teeth
- ___ Missing teeth
- ___ Wear dentures or bridge?
- ___ Capped teeth?
- ___ Are you pregnant?
- ___ Cancer
- ___ Glaucoma
- ___ Any other Illness
- ___ Recent change in bruising
- ___ Have you or a family member had a bad reaction to anesthesia?

PATIENT MEDICAL INFORMATION continued...

Date: _____ **Patient Name:** _____

<u>Alcohol</u>	<u>Smoking</u>	<u>Education</u> (show years completed)	<u>Misc.</u>
___ Never	___ Never	___ Yrs of Grade School	Aching Muscles Y / N
___ Beers/wk	___ Quit	___ Yrs of High School	Aching Joints Y / N
___ Wine/wk (glasses)	___ #packs/day	___ Yrs of College	Leg Cramps Y / N
___ Liquor/wk (shots)	___ Cigar	___ Other	Other _____
___ Past History Abuse	___ Chew		
___ DWI			

Coffee (cups/day) _____ Tea (glasses/day) _____ Caffeinated Soda (cans/day) _____

Please List Any Other Past Medical Problems or Injuries **Year**

Past Surgeries

List Current Medications **mg** **#pills AM** **Noon** **PM** **Bedtime**

Please List any Drug Allergies

Has anyone in your family ever had the following:

<u>Condition</u>	<u>Relationship</u>
<u>Seizures</u>	_____
<u>Diabetes</u>	_____
<u>Hypertension</u>	_____
<u>Muscle/Nerve Disease</u>	_____
<u>Other</u>	_____

Patient Signature for Medical History: _____ **Date:** _____

I HEREBY AUTHORIZE AND REQUEST THAT HIGH PLAINS PLASTIC AND RECONSTRUCTIVE SURGERY (HPPRS) BILL ME OR MY INSURANCE CARRIER FOR PAYMENT OF SERVICES RENDERED. I HEREBY ASSIGN TO (HPPRS) MY RIGHTS AND INTEREST TO ANY PAYMENT MADE BY SUCH PAYORS IN PAYMENT OF THESE SERVICES. (HPPRS) MAY RELEASE ALL OR ANY PART OF MY PATIENT RECORD TO ANY PERSON OR ENTITY WHICH MAY BE LIABLE FOR ALL OR ANY PART OF (HPPRS) CHARGES, INCLUDING BUT NOT LIMITED TO INSURANCE COMPANIES, WORKER'S COMPENSATION CARRIERS, MEDICARE, MEDICAID OR OTHER WELFARE FUNDS. I UNDERSTAND THAT I AM RESPONSIBLE FOR THESE CHARGES, INCLUDING ANY HEALTH INSURANCE DEDUCTIBLE OR COPAYMENT.

THE UNDERSIGNED CERTIFIES THAT I HAVE READ THIS RELEASE, I AM THE PATIENT OR PATIENT'S RESPONSIBLE PARTY, AND I AGREE TO THESE TERMS.

SIGNED _____ **DATE** _____

High Plains Plastic And Reconstructive Surgery, P. A.
CONSENT FOR TREATMENT AND FINANCIAL POLICY

All patients must read and sign this form prior to receiving services.

The patient, or his or her representative, hereby acknowledges that patient's need for consultation or treatment because he or she is 1) suffers from a condition requiring diagnosis and medical/surgical treatment or 2) seeks cosmetic or reconstructive services. The undersigned request and voluntarily consent to the patient's receipt of these services. The undersigned has full legal authority to sign this consent on behalf of the patient.

I (we) authorize the Facility to release information acquired in the course of the examination and treatment of the above name, to physician and to physician's billing services, insurance companies (or their agents) for reimbursement purposes, and/or other institutions or organizations performing special tests or providing special equipment or transportation, and/or to local, state, or federal agencies in accordance with applicable laws.

The physicians and other pertinent independent licensed practitioners (e.g. nurse practitioners, etc.) and/or independent contracted services (e.g. hand therapists, etc.) practicing at the facility are licensed and qualified to practice in the state of Texas.

❖ It is your responsibility to provide us with your most current insurance information.

- If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
- I must emphasize that, as a medical provider, my relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, and your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **Your are financially responsible for services not covered by your insurance company.**
- Before receiving services, you must verify that we are participating providers for your insurance company. In the event we are not a participating provider with your insurance company, we will file the initial claim as a courtesy.
- We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- Co-payments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.

❖ It is your responsibility to provide us with your most current billing information.

- You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.
- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You can call **(806) 242-2001**.
- **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts may be referred to a professional collection agency for further collection activity. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
- If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency. You will be responsible for all collection costs incurred, including attorney's fees and court cost if applicable.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add \$25.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.
- We may charge you a "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

Full payment is due at the time of service. We accept cash, checks, and credit cards. I have read and understand this Consent for Treatment and Financial Policy.

Signature of Responsible Party

Date

Patient Name: _____

Patient's Date of Birth: _____



High Plains Plastic And Reconstructive Surgery, P. A.
3501 Sony Road, Suite 1001
Amarillo, Texas 79119
P: 806-242-2001 F: 806-242-2006

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand HPPRS, P.A. reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

Patient's Printed Name

Date of Birth

Patient or Legal Representative Signature

Date

Relationship to Patient

Witness

Date

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for HPPRS, P. A. to share my protected health information with:

Name

Relationship

Name

Relationship

Name

Relationship

PHOTOGRAPHIC RELEASE AND CONSENT
FOR

(NAME)

I authorize the use of my photographs and case information in the office for my surgeon's file of pre- and postoperative patient photographs available for my personal viewing upon request.

I also authorize the use of my photographs to be sent to Insurance for predetermination and/or pre-certification.

I hereby grant permission for the use of any record, illustration, photograph or other imaging record created in my case, for use in examination, testing, credentialing and/or certifying purposes by the American Board of Plastic Surgery, Inc.

Date: _____ Date: _____

Patient Signature

Witness Signature

Print Name

Print Name



High Plains Plastic And Reconstructive Surgery, P. A.
3501 Soncy Road, Suite 1001
Amarillo, Texas 79119
P: 806-242-2001 F: 806-242-2006

ACKNOWLEDGEMENT OF RECEIPTS OF NOTICE OF PRIVACY PRACTICES

****You have the right to refuse to sign this Acknowledgement****

I, _____, have been given the opportunity to read a Copy of this office's Notice of Privacy Practices. I also understand, that I have the right to Request a copy of the Notice of Privacy Practices for my records.

Patient or Guardian if minor

Date

Please Print Name

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to the following:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

Other: _____

Practice Representative

Date