SYNERGY PLASTIC SURGERY

Round Rock: 7700 Cat Hollow Dr. Ste 103 Round Rock, Texas 78681
Austin: 11200 Manchaca Rd Blg 2, Ste 201 Austin, Texas 78748
512-244-1444
www.synergyplasticsurgery.com

Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Race _____ Ethnicity _____ Language _____

Any restrictions for contacting you? ☐ No ☐ Yes E-mail _____

Age _____ Birthdate _____ SS# _____ Gender ❒ Female ❒ Male

Marital Status ☐ Single ☐ Married to: _____ ☐ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ☐ Yes ☐ No

Address _____
Street & Suite # City State Zip

How did you hear about Synergy Plastic Surgery? (Mark all that apply)

☐ Google ☐ Website ☐ Phone Book ☐ Magazine ☐ Newsletter ☐ Seminar ☐ Realself:_____

☐ Friend/Relative: _____ ☐ Doctor: _____ ☐ Other: _____

If you were referred by a specific person, may we thank them? ☐ Yes ☐ No

Emergency Contact

_____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Areas of Interest: (mark all that apply)

Facial Procedures

☐ Blepharoplasty (Eyelid Lift)
☐ Brow or Forehead Lift
☐ Earlobe Repair
☐ Facial Liposuction (Neck, Jowls)
☐ Face or Neck Lift
☐ Lip Enhancement
☐ Otoplasty (Ear Pinning)
☐ Rhinoplasty (Nose Reshaping)

Breast Procedures

☐ Breast Augmentation
☐ Breast Implant Exchange
☐ Breast Reconstruction
☐ Breast Reduction
☐ Mastopexy (Breast Lift)
☐ Male Breast Reduction

Body Procedures

☐ Abdominoplasty (Tummy Tuck)
☐ Brachioplasty (Arm Lift)
☐ Full Body Lift
☐ Liposuction (Thighs, Abdomen, Etc.)
☐ Thigh or Buttock Lift
☐ Brazillian Butt Lift (BBL)
☐ Labiaplasty

Spa Services & Other Procedures

☐ Botox
☐ Laser Hair Removal
☐ Leg Veins
☐ Lesion / Moles
☐ Skin Resurfacing (Laser, Peel, etc.)
☐ Botox/Wrinkle Fillers (injections)
☐ Lip Enchancement

I understand that office visit charges are payable on the day service is rendered and that reservation fees may take up to 48 hours to be refunded when applicable.

Signature _____ **Date** _____

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Patient Name:			
DOB:	Age:	Marital Status :	**Weight lbs**
What surgery are you considering?			**Height ft in**

General Information:	**YES**	**NO**	**Comments:**
1. HEART			
Do you have high pressure			
Heart Attack			
Chest Pain			
Irregular Heart Beat			
High Cholesterol			
Family history of heart disease			Which family members?
2. LUNGS			
A recent respiratory illness			
Sleep apnea			
Asthma			
Wear oxygen during day/night?			
Family history of lung problems			Which family members?
3. KIDNEY			
Urinary tract infections			
Kidney Stones			
4. DIGESTIVE TRACT			
Ulcers			
Reflux/Heartburn			
Hepatitis			
Pancreatitis			
5. MUSCLE/BONE			
Arthritis			
Muscle weakness			
6. NEUROLOGICAL/PSYCH			
Head injury/Stroke			
Seizures			
Depression			
Headaches			
7. BLEEDING			
Bleeding/Clotting problems			
Family history of bleeding problems?			Which family members?
8. METABOLIC			
Diabetes			
Thyroid Problems			
9. BREAST			
Personal history of breast masses/problems?			
Family history of breast cancers?			Which family members?

1. **Please list <u>ALL CURRENT MEDICATIONS</u>**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, and weight loss drugs. **Include over-the-counter medications.**

Medication Name	Dose	Frequency	How Long?

ALLERGIES:

2. Do you have any **MEDICATION ALLERGIES**? ❒ Yes ❒ No Which? _____

3. Do you have a preferred pharmacy for us to use for any prescriptions: _____

4. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?

   ❒ Yes ❒ No If yes, when and where? _____

SOCIAL HISTORY:

5. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?

   ❒ Yes ❒ No If so, how much? _____

6. Do you smoke? ❒ Yes ❒ No If so, how much? _____ For how long? _____

7. Do you use recreational drugs? ❒ Yes ❒ No

8. Are you pregnant? ❒ Yes ❒ No

9. How many pregnancies? _____ Births? _____ Breast Fed? ❒ Yes ❒ No Recently? _____

RECENT MEDICAL HISTORY:

10. Who is your personal physician, if any? _____Please list all physicians presently caring for you.

    _____

11. Have you ever been under psychiatric care? ❒ Yes ❒ No When? _____Why? _____

12. Is there anything else you think the doctor should know? _____

13. **Please list all SURGERIES AND HOSPITALIZATIONS**, including procedures done for cosmetic reasons:

SURGERIES	When?	Why?

Your insurance company can be helpful for filling prescriptions

Primary Insurance Company: _____

Secondary Insurance Company (if any): _____

Policy Number: Group Number:

Insurance Phone contact:

Insured name (if other than yourself): _____

DOB: ____/____/_____

Employer: _____

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Signature:_____ Date: _____

FREQUENTLY ASKED QUESTIONS REGARDING HIPAA

In a constantly changing healthcare environment, SYNERGY PLASTIC SURGERY is committed to educating their patients about healthcare issues that affect them. As a result, they have provided general information about the Health Insurance Portability and Accountability Act (HIPAA) of 1996 for your review. SYNERGY PLASTIC SURGERY is complying with HIPAA regulations and will be happy to answer any additional questions you might have.

WHAT IS THE PRIVACY RULE?

The Privacy Rule is part of the HIPAA regulation of 1996. The Privacy Rule establishes a federal requirement that Doctors, hospitals or other healthcare providers and health plans obtain a patient's written consent before using or disclosing a patient's personal information to carry out treatment, payment or healthcare operations.

WHAT IS PROTECTED HEALTH INFORMATION (PHI)?

Protected Health Information (PHI) means any personal health information as defined by law, including demographic information collected by healthcare provider or other entity that could potentially identify the individual. PHI includes all medical records and other individually identifiable health information held or disclosed by SYNERGY PLASTIC SURGERY regardless of how it is communicated (e.g. electronically, written verbally).

WHAT IS TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS (TPO)?

TPO refers to the treatment, payment or healthcare operations of SYNERGY PLASTIC SURGERY. In other words, SYNERGY PLASTIC SURGERY can use or disclose PHI for performing any activity that it deems necessary to provide quality patient care; ensure that the physician is paid for services; and , operate the business. Some examples of these activities are use of PHI by the physician and clinical staff to treat a patient; use of PHI by the clerical staff to verify insurance information for billing purposes or obtain referrals; and, use of PHI by administrative staff for strategic planning and internal management activities.

WHY DO I HAVE TO SIGN A CONSENT FORM?

In order to use or disclose your PHI, SYNERGY PLASTIC SURGERY is required to obtain a signed consent form from you to directly treat you or carry out healthcare payment and business related activities. SYNERGY PLASTIC SURGERY is not required to obtain your prior consent in an emergency, when SYNERGY PLASTIC SURGERY is required by law to treat you, or when there are substantial communication barriers. SYNERGY PLASTIC SURGERY reserves the right to refuse to treat you if you do not sign the consent form.

WHAT IS THE DIFFERENCE BETWEEN THE CONSENT AND AUTHORIZATION FORMS?

In order to use or disclose your PHI for specific purposes, other than direct treatment, payment, or healthcare operations, SYNERGY PLASTIC SURGERY is required to obtain a signed authorization form from you. For example, if you request Synergy Plastic Surgery to disclose PHI to a third party, you must sign an authorization form. This authorization form is more detailed than a consent form and has a specific expiration date.

PATIENT RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

SYNERGY PLASTIC SURGERY has provided information regarding the Notice of Privacy Practices. This notice describes the practice's commitment to privacy, my rights to privacy, and how SYNERGY PLASTIC SURGERY may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

By signing this form, I am acknowledging that I have reviewed the Notice of Privacy Practices which explains how my medical and personal information will be used and disclosed. I understand that I am entitled to receive a copy of this document, upon request.

_____

Patient Name (Printed)

_____

Signature of Patient/Personal Representative Date

_____

Relationship to Patient

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Fee Policy Acknowledgement:

We look forward to planning your surgery with you! In order to assure smooth and timely scheduling and pre-operative planning we have the following policies you need to be aware of.

Deposit:

A deposit is required to initially secure a surgery day. *Full payment will be needed to lock the actual surgery date and time. This is due 21 business days before your surgery happens.* If you are unable to fully pay for surgery at that time your surgery date will be given to another patient and your deposit will be applied as a cancellation fee. This cancellation fee is nonrefundable and the deposit value is fully forfeited.

Full Payment & Surgery Lock Date:

Full payment for your surgery is required 21 business days before the operation. There are multiple ways to cover this payment (check, debit, money order, bank check, credit card, care credit). Actual cash is not accepted.

Failure to pay for your surgery date at this time will result in loss of the surgery date reservation and forfeiture of your initial deposit.

Cancellations of surgery dates within the lock period will result in a forfeiture of 50% of the collected surgeon fees and 100% of the facility and anesthesia fees. Cancellation or no show with less than 48 hours notice will result in forteiture of 100% of all fees collected including surgeon fee, facility, anesthesia, and implant if applicable. Return of any remaining funds will require signing a legal release of claim. This late cancellation fee is not refundable.

Date Changes:

If possible we try to accommodate surgery date changes. These are allowed until 21 business days before your scheduled surgery date. *There is a $500.00 fee to change your day.* Changes after the lock date are not allowed and are subject to the late cancellation fee.

I understand completely the above policy and timeline for the scheduling of my surgery and possible fees for cancellations or date changes.

_____ _____ _____

Signature Print Name Date