SYNERGY PLASTIC SURGERY

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

Patient Information as of _____(enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone_____Cell Phone_____Other Phone _____

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

Contact Restrictions: _____

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? (Mark all that apply)

☼ TV News ❒ TV Ad ❒ Phone Book ☼ Magazine ❒ Newsletter ☼ Seminar ☼ Salon ❒ Web

❒ Friend/Relative: _____❒ Doctor:_____❒ Other: _____

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

Emergency Contact
(Not in your household) _____Relationship to Patient _____

Home Phone_____Work Phone_____Other Phone _____

Primary Health Insurance Company: _____

Policy #_____Group # _____Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $_____

Insured: Name _____ DOB ____/_____/____ Employer _____

Secondary Health Insurance Company: _____

Policy #_____Group # _____Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $_____

Insured: Name _____ DOB ____/_____/____ Employer _____

I understand that office visit charges are payable on the day service is rendered. I authorize Synergy Plastic Surgery, PLLC to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Synergy Plastic Surgery, PLLC and myself.

Signature _____ **Date** _____

SYNERGY PLASTIC SURGERY

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

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?

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. Are you pregnant? ❒ Yes ❒ No

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

RECENT MEDICAL HISTORY:

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

_____

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

_____

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

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

SURGERIES	When?	Why?

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

SYNERGY PLASTIC SURGERY

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

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.

Surgery Deposit:

A deposit is required to initially secure a surgery day and get on our schedule for your procedure.

For insurance surgery, this deposit will be $1,000 or the remaining balance of your insurance deductible, whichever is the larger amount.

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 this date are not allowed and are subject to a 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