TEXAS FACIAL AESTHETICS

(469) 362-6975

Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Sex: ❒ Male ❒ Female

Preferred method of contact: ❒ Home phone ❒ Cell phone ❒ Email Race _____

Email Address _____ Date of Birth _____

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

Patient's Employer _____ Occupation _____

Work Phone # _____ Is it okay to call you at work? ❒ Yes ❒ No

Responsible Party (if different from patient) _____ Relationship to patient _____

Address _____

Home Phone _____ Cell Phone _____ Other Phone _____

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Cell Phone _____ Other Phone _____

Insurance Information

Primary Carrier _____ Subscriber Name _____ Subscriber DOB _____

Address _____ Phone # _____

Policy # _____ Group # _____

Secondary Carrier _____ Subscriber Name _____ Subscriber DOB _____

Address _____ Phone # _____

Policy # _____ Group # _____

How did you hear about our office?

❒ txfaces.com ❒ Facebook ❒ Instagram ❒ Twitter ❒ Frisco Style Magazine

❒ realself.com ❒ Word of Mouth ❒ Search Engine ❒ 24 Hour Fitness ❒ YouTube

❒ Friend/Family: _____ ❒ Other: _____

Assignment of Benefits:
I hereby assign medical and/or surgical benefits, to include major medical benefits, to which I am entitled including Medicare, private insurance and other health plans to: Texas Facial Aesthetics, PLLC.

This 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 necessary information to secure payment.

Payment Policy:
I understand that all charges for injectable neuromodulators, dermal fillers, laser treatments, spa services and other minor cosmetic procedures are payable by cash or credit card at the time services are rendered.

Signature of Patient or Authorized Person _____ Date _____

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Patient's Name _____ **Today's Date** _____

Date of Birth _____ **Height** _____ **Weight** _____

Which of the following procedures interest you? (Please check all that apply)

❒ Facelift	❒ Rhinoplasty (nose)	❒ Otoplasty (Ears)	❒ Laser Vein Treatment	❒ Microneedling	❒ Botox
❒ Necklift	❒ Hair Transplant	❒ Earlobe Repair	❒ Laser Skin Resurfacing	❒ Facials	❒ Filler
❒ Eyelid Surgery	❒ Cheek Implants	❒ Neck Liposuction	❒ Laser Hair Removal	❒ Treatment of Brown Spots	
❒ Browlift	❒ Chin Implant	❒ Scar Revision	❒ Dermaplaning	❒ Other: _____	
❒ PRP	❒ Lip Enhancement	❒ Chemical Peels	❒ Microdermabrasion	_____	

DO YOU NOW OR HAVE YOU EVER HAD…… (You must circle an answer for each individual item)

Cardiovascular			**Eyes, Ears, Nose, Throat**		
Chest Pain	Yes	No	Visual Disturbances	Yes	No
Palpitation or Irregular Pulse	Yes	No	Wear Contacts or Glasses	Yes	No
Heart Murmur	Yes	No	Glaucoma or Eye Problems	Yes	No
Pacemaker or Defibrillator	Yes	No	Dentures, Bridges, Capped Teeth or Crowns	Yes	No
Blood Pressure Abnormalities	Yes	No	Loose Teeth	Yes	No
Heart Failure	Yes	No	**Gastrointestinal**		
Abnormal EKG	Yes	No	Kidney or Renal Disease	Yes	No
Respiratory			Esophageal Varices	Yes	No
Shortness of Breath	Yes	No	Frequent Indigestion	Yes	No
Asthma	Yes	No	Ulcers or Gastritis	Yes	No
Bronchitis	Yes	No	Cirrhosis of the Liver	Yes	No
Pneumonia	Yes	No	Colitis	Yes	No
Coughing or Spitting up Blood	Yes	No	Tarry or Bloody Bowel Movements	Yes	No
Chronic Cough	Yes	No	Vomiting Blood	Yes	No
Emphysema	Yes	No	Gallstones or Gallbladder Trouble	Yes	No
Allergy/Immunology			**Endocrine**		
Hay Fever / Seasonal Allergies	Yes	No	Goiter or Thyroid Disorders	Yes	No
Postive blood test for: HIV, AIDS, Hepatitis	Yes	No	Diabetes	Yes	No
Cold sores	Yes	No	**Musculoskeletal**		
Psychiatric			Arthritis	Yes	No
Insomnia	Yes	No	Fracture of Neck or Spine	Yes	No
Anxiety/Depression	Yes	No	**Hematologic**		
Alcoholism or Drug Dependency	Yes	No	Abnormal Bleeding after tooth extraction	Yes	No
Psychiatric Hospitalization or Care	Yes	No	Bleeding Tendency or Disorder	Yes	No
Nervous Breakdown / Panic Attack	Yes	No	Blood Transfusion	Yes	No
Neurologic			**Integumentary**		
Palsy or paralysis	Yes	No	Skin Disorders	Yes	No
Seizures, Convulsions, Black outs	Yes	No	Rashes	Yes	No
Stroke	Yes	No	Abscesses	Yes	No
ALS	Yes	No	Piercing other than the ears	Yes	No
Multiple Sclerosis	Yes	No	**Immune System**		
			Lupus	Yes	No
			Rheumatoid Arthritis	Yes	No
			Myasthenia Gravis	Yes	No

Are you allergic to LATEX? ❒ Yes ❒ No

Do you have any medication allergies? ❒ Yes ❒ No Which? _____

Social History

How often do you exercise? ❒ None ❒ Less than 3 times per week ❒ More than 3 times per week

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

Do you drink alcohol? ❒ Yes ❒ No If so, how many per day/week? _____

Do you use drugs? ❒ Yes ❒ No If yes, what kind? _____ How often? _____

Females only

Are you currently pregnant or nursing? ❒ No ❒ Pregnant ❒ Nursing

Skin History:

Sun Exposure: ❒ Daily ❒ Occasionally ❒ Rarely Skin Cancer _____ Acne _____

Have you ever used Accutane treatment for your skin? ❒ Yes ❒ No If yes, when? _____

Other skin problems? _____

Please list all COSMETIC surgeries and the SURGEONS who performed them.

PROCEDURE NAME OF SURGEON DATE

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

Please list all NON-COSMETIC surgeries and date performed. (This includes colonoscopies, wisdom teeth, etc.)

_____

_____

_____

Please list any other hospitalizations and reason for treatment.

_____

_____

Any ANESTHESIA problems in the past? ❒ Yes ❒ No If yes, please explain: _____

Family history of problems with anesthesia? ❒ Yes ❒ No If yes, please explain: _____

Any problems with blood clotting? ❒ Yes ❒ No If yes, please explain: _____

Family history of bleeding problems? ❒ Yes ❒ No If yes, please explain: _____

Please list when you had the following:

Physical Exam _____ EKG _____

Blood Work _____ Chest X-Ray _____

Primary Care Physician: _____ Phone # _____

Please list any additional physicians presently caring for you

_____

_____

Please list medications that you are currently taking: (Include Vitamins, Herbal Supplements & Over the Counter Medications)

DRUG NAME	DOSAGE	FREQUENCY	START DATE

Pharmacy: _____

ADDITIONAL INFORMATION:

_____

_____

_____

Patient Signature: _____ **Date:** _____

TEXAS FACIAL AESTHETICS

PHONE CONSENT

Patient Name (print): _____

Texas Facial Aesthetics takes patient privacy very seriously. Our policy requires staff to obtain authorization from the patient to leave detailed messages for the patient. This policy is to protect the patient and to also protect the employees of Texas Facial Aesthetics from violating a patient's confidentiality.

By completing the consent below, you hereby authorize the staff to call and leave their name, the provider's name, and additional information on an answering machine or voicemail system. Unless notified in writing, this consent will remain in effect permanently.

A message may be sent to the following (please write in number):

1. Home voicemail: _____

2. Cell phone voicemail: _____

3. Work voicemail: _____

I do NOT consent to <u>any</u> messages being left. ☐

EMAIL CONSENT

Texas Facial Aesthetics can use email to contact you with your permission. This information will be sent in an encrypted fashion from our email system for privacy reasons. *Please keep in mind that communications via email over the internet are not totally secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.* You may notify us in writing at any point to change your contact preferences. By providing your email address below, we may also occasionally send you information about our practice, including information regarding promotions and special events. You may unsubscribe or opt out of these emails at any time by notifying us in writing or unsubscribing from any email communications you receive. Your information will never be sold or given out to anyone outside of our practice.

I consent to being contacted by email ☐

Email Address: _____

Patient Signature: _____ Date: _____

Matthew A. Richardson, M.D.

Jordan A. Cain, M.D.

TEXAS FACIAL AESTHETICS

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.

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical conditions being treated.

Health care operations: Your health information may be used as necessary to support the day to day activities and management of our medical and surgical companies. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Release of Information to Family/Friends: With prior written authorization, our surgery center and surgical practice may release your health information to a friend or a family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to a pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information. Likewise, if a spouse is scheduling appointments for their family member, some medical information may be released, etc.

Disclosure Required by Law: Our surgery center and surgical practice will use and disclose your health information when we are required to do so by federal, state, or local law,

Lawsuits and Similar Proceedings: Our surgery center and surgical practice may use and disclose your health information in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your health information in response to a discovery request, subpoena. or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain and order protecting the information the party has requested.

Deceased Patients: Our practice may release your information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death, if necessary; we also may release information in order for funeral directors to perform their jobs.

Organ and Tissue Donation: Our practice may release your health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation, but only if you are an organ donor.

Research: Our surgery center and surgical practice may use and disclose your health information for research purposes in certain limited circumstances; we will obtain your written authorization to use your health information for research purposes except when a Governing Board or Privacy Board has determined that the waiver of your authorization satisfies the following:

- The use or disclosure involves no more than a minimal risk to your privacy based on the following:
  - An adequate plan to protect the identifiers from improper use and disclosures
  - An adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifier or such retention is required by law)
  - Adequate written assurances that the private health information will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use and disclosure would otherwise be permitted.
- The research could not practicably be conducted without the waiver;
- The research could not practicably be conducted without access to and use of your health information.

Serious Threats to Health or Safety: Our surgery center or surgical practice may use and disclose your health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public, under these circumstances, we will only make disclosures to a person or organization able to prevent the threat.

Military: Our surgery center or surgical practice may disclose your health information if you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities.

Inmates: Our surgery center or surgical practice may disclose your health information to correctional institution or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary for the institution to provide health care service to you, for safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals.

Worker's Compensation: Our surgery center or surgical practice may release your health information for worker's compensation and similar programs.

CONTINUED ON OTHER SIDE

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before your notified us of your decision.

Appointment reminders: Your health information may be used by our staff to send you appointment reminders.

Information and treatment: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest We may also send you information describing other health-related goods and service that we believe may interest you.

Individual Rights: You have certain right under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive and accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Our Duties:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy polices and practices. These changes in our policies and practices may be required by changes in federal and state laws regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information: As permitted by federal regulation, we require that request to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting any of our offices locations.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by contacting:

Texas Facial Aesthetics, PLLC
6371 Preston Rd, Suite 100
Frisco, TX 75034
(469) 362-6975

By signing below, I hereby acknowledge reviewing these policies and procedures regarding my health care privacy and that I have been offered a copy of this information.

_____ _____

SIGNATURE OF PATIENT DATE

_____

PRINTED PATIENT NAME

TEXAS FACIAL AESTHETICS

STATEMENT OF PATIENT RIGHTS AND RESPONSIBILTIES

Patient rights will be exercised without regard to sex, race, cultural, economic, educational or religious background and will include:

1. Considerate and respectful care. The right to reasonable responses to any reasonable request made for service.

2. Knowledge of the name, of the physician with primary responsibility for coordinating the care and non-physicians who will see the patient, continuity of care, to be informed in advance of the time and allocation of their appointment. The right to receive information about their illness, course of treatment and prospects for recovery in terms that the patient can understand.

3. The right to receive as much information about any post-treatment or procedures the patient may need in order to be given a form of consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medical significant risk involved in this treatment, alternate course of treatment or non-treatment, the risk involved in each and to know the name of the person who will carry out the procedure or treatment.

4. The right to participate actively in decisions regarding their medical care to the extent provided by the law. This includes the right to refuse treatment and to leave the Surgery Center even against the advice of the physicians.

5. The right to full consideration of privacy concerning their medical care program, case discussion, consultation, examination and treatment. The patient has the right to be advised as to the reason for the presence of any individual.

6. The right to confidential treatment of all communications and records pertaining to the care and their stay in the Surgery Center. AU patient rights apply to the person who may be designated as such by the patient, in writing, having legal and medical responsibility. A Release of Authorization shall be obtained before the medical records can be made available to anyone not directly concerned with care.

7. The right to be advised if their Surgery Center personal physician proposes to engage in or perform human experimentation affecting care or treatment. The patient has the right to elect not to participate in such research projects.

8. The right to examine and receive an explanation of their bill regardless of the source of payment.

9. The right to file a grievance with the Surgery Center and upon request, to obtain information that reflects the Policy of the Surgery Center on what will happen if such a grievance is filed. Patient complaints are forwarded to the Medical Director for an appropriate response.

10. All Surgery Center personnel shall observe these patient rights.

11. Patients shall be responsible for reading, understanding and signing of the Rights of Privacy Act.

12. Patients shall be responsible for any and all financial obligations for services rendered by this facility and physician services.

13. Patients shall be responsible for reading the materials and paperwork given to them at the time of their visit and/or procedure. Our physicians, medical staff and office are available at all times during business hours, to answer any and all questions that may arise.

Patient Name: _____ Date: _____

Patient Signature: _____