MD AESTHETIC PLASTIC SURGERY

713.794.0368

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: ______________ Drivers License# ______________

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 M.D. Aesthetic Plastic Surgery? (Mark all that apply)

❒ TV ❒ Radio ❒ Yellow Pages ❒ Magazine ❒ Brochure ❒ Seminar ❒ Website ❒ Google

❒ 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 Dr. Mark Schusterman M.D., F.A.C.S or Dr. Patrick Hsu, M.D./M.D. Aesthetic Plastic Surgery 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 Dr. Mark Schusterman and/or Dr. Patrick Hsu, M.D., M.D. Aesthetic Plastic Surgery and myself.

Signature ____________________________ **Date** ______________

Would you like a complimentary skin evaluation while you are here today? ❒ Yes ❒ No

Name: ____ DOB: _____/_______/______

Date of Visit: _____/_____/______ Reason For Visit: ____
____

Past medical History (Please Check)

Pt denies past medical history		Bronchitis		Dizziness/Vertigo		Hay Fever/Allergies		High Blood Pressure		Sinus Problems/Infections		Tonsillitis	
Abdominal Bleeding		Cancer		Ear Infection		Headaches/Migraine		HIV/AIDS		Skin Cancer		Tuberculosis	
Arthritis		Chest Pain/tightness		Epilepsy/Seizures		Heart Disease		Hives		Skin Disease		Ulcers	
Asthma		Depression		Facial Pain		Heart Murmur		Kidney Stones		Stroke			
Breast Cancer		Diabetes		Fever Blisters		Hepatitis		Pneumonia		Thyroid Disorder			

OTHER:____

Past Surgeries

Surgery/Hospitalization	Date	Anesthesia Complications	Notes

Family History (Please Check)

Pt denies any contributing family Hx		Breast Cancer		Hearing Loss		Lung Cancer		Substance Abuse	
Abnormal Bleeding		Cleft Lip		Heart Disease		Malignant Hyperthermia		Von Willebrand	
Abnormal Clotting		Cleft Plate		Hemophilia		Other Cancer			
Anesthesia Problems		Diabetes		High Blood Pressure		Prostate Cancer			
Autoimmune Disorders		Drug Allergies		Kidney Disease		Skin Cancer			
Brain Tumors		Endocrine Disease		Liver Disease		Skin Disease			

OTHER:____

Museum District
Aesthetic Plastic Surgery

Current Medications (Please Check)

Aspirin		HCTZ		Latisse		Minocycline 100mg		Scopalmine TD patch	
Azithromycin		Hydroquinone 4%		Loratab 500mg		Norco 5/325mg		Valtrex 500mg	
Colace 100mg		Keflex 500mg		Lovenox		Phenergan 25mg		Vicodin	

OTHER:____

Allergies (Please Check)

NKA		Betadine		Hydrocodone		Neosporin		Retinol		Sulfa	
Amoxicillin		Ceclor		Iodine		PCN		Salycylic Acid		Surgical Tape	
Augmentin		Cephalosporin		Keflex		Penicillins		Seasonal Allergies		Versed	
Bactrim		Clindamycin		Latex		Phenergan		Shellfish		Vicodin	
Bandaids		Codiene		Lidocaine		Prednisone		Steroids			

Social History (Please Check)

Patient Social History

ALCOHOL / HIGH RISK FACTORS

Denies alcohol use		**Denies high risk factors**	
Admits alcohol use socially		Admits high risk factors	
Admits alcohol use daily			

ILLEGAL DRUGS / STD

Denies using illegal drugs		**Denies STD history**	
Admits using illegal drugs		Admits STD history	

Patient Smoking History (Please Check)

DENIES

Denies tobacco use	

PACKS PER DAY		LENGTH		QUIT	
<1 pack per day		For <5 years		Quit <1 year ago	
1 pack per day		For 5 -10 years		Quit 1 -5 years ago	
2 packs per day		For 10 – 15 years		Quit 5 -10 years ago	
3 packs per day		For 15 -20 years		Quit 10 -15 years	
4 packs per day		For 20 -25 years		Quit 15 – 20 years ago	
+4 packs per day		For > 25 years		Quit > 20 years ago	

Museum District
Aesthetic Plastic Surgery

Patient Ability to Heal

	Yes	No
Does your skin appear fragile, burns easily?		
Do you form thick or raised scarring from a cut or burn?		
Do you have bruising or bleeding problems?		

Female Questions

	Yes	No	N/A
Do you have regular periods?			
Are you going through menopause?			
Are pregnant or lactating?			
Are you planning on becoming pregnant?			

OBGYN Questions

	Number		Type Delivery	Yes	No	N/A
Pregnancy			Vaginal			
Children			C-Section			

Patient has experienced:	Normal	Abnormal	Notes
Recent Weight Loss			
Recent Weight Gain			
Fevers			
Chills			
Rigors			
Nausea			
Vomiting			
Diarrhea			
Chest Pain			
Shortness Of Breath			

***Office useOnly*:**

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, ____________________, authorize Dr. Mark A. Schusterman M.D., P.A. and/or Dr. Patrick Hsu M.D. or **his** representative(s), to take photographs, slides or videotapes of me or parts of my body for the following procedure(s) and for medical purposes to be used for my care, medical presentations and/or articles.

In addition, I authorize the use of these images, without compensation to me, for the following specific purposes: (Please **initial** in the boxes marked Yes or No for each item)

Yes	No	Medium
		In the office **photo album** for prospective patients.
		In office **seminars** for prospective patients.
		On our **website** for prospective patients.
		In print **advertisements**.
		On **television**.

Additional Comments:

I understand that:

1. Such photographs, slides or videotapes may be published by Dr. Mark Schusterman and/or Dr. Patrick Hsu in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that such uses may also include marketing on behalf of Dr. Schusterman, for which Dr. Schusterman may be receive direct or indirect remuneration.

2. I will not be identified by name in any of the media described above; however, I understand that in some circumstances the photographs, slides or videotapes may display features that identify me.

3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to the office of **M.D. Aesthetic Plastic Surgery** at 1200 Binz, Suite 1200 Houston, TX 77004.

4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Mark Schusterman and/or Dr. Patrick Hsu.

5. The information disclosed under this Authorization, or some portion thereof, is protected by
   Texas state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

6. Any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by applicable federal and/or state confidentiality rules.

7. A copy of this Authorization is as valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

I release and discharge Dr. Mark Schusterman and/or Dr. Patrick Hsu from all liability, including liability for negligence that in any way arises out of:

any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization; and

any claim that I may have or may have had relating to such use and disclosure of those photographs, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public education and I certify that I have read this Authorization and Release carefully and fully understand its terms.

Signature ______________________________ Date ______________

Witness ______________________________

If I have questions about the use or disclosure of my photographs, slides, or videotapes, I can contact the office at **713-794-0368**

To maintain a timely schedule and provide patients with the best service possible, we have implemented policies to lessen the occurrence of patients who are late for appointments or who do not show up for scheduled appointments.

NO SHOW POLICY FOR APPOINTMENTS: We will charge New patients $95 and Established patients $50 (each occurrence), if you do not come for your scheduled appointment or cancel your appointment with less than 24 hours notice.

LATE POLICY FOR APPOINTMENTS: Since we allot a certain amount of time for each appointment, if you arrive late for your appointment one of two things will occur: 1) your appointment will end as scheduled, thereby limiting the time available to accomplish the services scheduled for your appointment, or 2) we will work you into our schedule that day to the extent possible in order to accomplish the services for which you are scheduled, possibly pushing your appointment to the end of the day.

I have read, understand and authorize Museum District Aesthetic Plastic Surgery to keep my signature on file for NO SHOW credit card charges. By signing below, I agree that I am aware of and understand the above noted policies.

Signature: ____Date:___________________

MD Aesthetic Plastic Surgery

Consent of Privacy Practices for Purposes of Protected Heath Information For Treatment, Payment, and/or Healthcare Operations

I, ________________________________, hereby give my consent for MD Aesthetic Plastic Surgery to use and disclose protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations by MD Aesthetic Plastic Surgery. I understand that diagnosis or treatment of me by MD Aesthetic Plastic Surgery may be conditional upon my consent as evidenced by my signature on this document. The release of Protected Health Information with regard to my medical treatment may be sent by fax, telephone, mail or email to other physicians, healthcare facilities or insurance companies.

I understand I have the right to request a restriction as to how my Protected Health Information is used or disclosed to carry out treatment, payment or healthcare operations of this practice. My treating physician is not required to agree to the restrictions that I, the patient, may request if the restriction falls within the exceptions to confidentially by law. However, if MD Aesthetic Plastic Surgery agrees to a restriction that I request, the restriction is binding on MD Aesthetic Plastic Surgery and my treating physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that MD Aesthetic Plastic Surgery, or it's physicians has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my demographic information, collected from me and created or received by my physician, another health care provider, a health insurance plan, my employer or a health care clearinghouse. This relates to my past, present or future physical or mental health or condition that may identify me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to preview and request a copy of MD Aesthetic Plastic Surgery Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information that will occur in my treatment, payment of my bills or in the performance of health care operations of MD Aesthetic Plastic Surgery. The Notice of Privacy Practices for MD Aesthetic Plastic Surgery is posted in the waiting room area and on MD Aesthetic Plastic Surgery, website at www.alwaysyouthful.com. This Notice of Privacy Practices also describes my rights and MD Aesthetic Plastic Surgery duties with respect to my Protected Health Information.

A. You have the right to request and be provided with a description of the procedures for exercising, the following with respect to your Protected Health Information:
   (i) Inspecting and copying;
   (ii) Amending or correcting; and
   a. An accounting of the disclosures of such information by MD Aesthetic Plastic Surgery

MD Aesthetic Plastic Surgery may change its policies and procedures relating to Protected Health Information at anytime. Should the Protected Health Information policies change, a revised Notice will be available at MD Aesthetic Plastic Surgery and posted on the website, www.alwaysyouthful.com. If you believe that there has been a violation of your Privacy Rights, a complaint may be filed with MD Aesthetic Plastic Surgery, by contacting the Practice Manager, address: 1200 Binz St., Suite 1200, Houston, TX 77004, or at 713-794-0368. Further, a complaint may be filed with the U.S. Department of Health and Human Services.

☐ I have read and received a copy of the Notice of Privacy Practices.

☐ I have read and refuse to accept a copy of the Notice of Privacy Practices.

Printed Name: ____

Signature: ____

Date: ____________________________________