

American Institute for Plastic Surgery
Surgery Center of Texas

PATIENT INFORMATION

Today's Date: _____

Patient's Legal Name _____ Preferred Name _____
Last First Middle

Date of Birth: ___/___/___ Age ___ SSN: ___-___-___ Height: ___' ___" Weight: ___ lbs

Gender: Male Female MtF FtM Other
Marital Status: S/ M/ D/ W Preferred Language _____

Address: _____
Street & Apt # City State Zip

Phone Home: (____) ____ - ____ - ____ Privacy
Work: (____) ____ - ____ - ____ Privacy
Fax: (____) ____ - ____ - ____ Privacy
Cell: (____) ____ - ____ - ____ Privacy
Emergency Contact, can we discuss your care?
Name: _____ Y N
Relationship: _____
Home: (____) ____ - ____ - ____
Work: (____) ____ - ____ - ____

E-mail _____ Preferred Method of Contact _____

May we send you email correspondence? (Promotions, specials, appointments) Y N

Occupation / Employer or school: _____ / _____
 Full Time Employment Part Time Employment Retired
 Full Time Student Part Time Student Other

Tell us what procedures you are interested in? _____

Whom may we thank for referring you? Patient Physician Internet Magazine Radio Other
Name: _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT- If other than patient:

Legal Name _____ Relationship _____
Last First Middle

Date of Birth: ___/___/___ Age: ___ SSN: ___-___-___ License #/State: _____/____

Sex: Male Female Phone: H: _____ W: _____ Cell/Pager: _____

Address: _____
Street & Apt # City State Zip

PRIMARY INSURANCE COMPANY:

Insurance Company: _____ Phone #: _____

Claim Address: _____ Insured Name and date of birth _____

Insurance Plan Type: PPO HMO POS EPO Group #: _____ ID#: _____

Workers Comp Manager / Phone: _____

PRIMARY CARE PHYSICIAN _____ PH#: _____

I have a referral from my PCP I need a referral from my PCP

American Institute for Plastic Surgery / Surgery Center of Texas

HEALTH HISTORY

(All information is strictly confidential)

Name _____ Age _____ Today's Date _____

Reason For Visit _____

For Injuries: Date of Injury _____ On the job? Yes No Occupation _____

Height: ___' ___" Weight: _____ lbs. What is the most you have ever weighed: _____ lbs

PAST MEDICAL HISTORY

Please check if you have, or ever had any of the following conditions:

- | | | | | |
|--|---|---|--|--|
| <p><u>Cardiovascular</u></p> <input type="checkbox"/> Anemia
<input type="checkbox"/> Angina / chest pain
<input type="checkbox"/> Arrhythmia
<input type="checkbox"/> Congestive heart failure
<input type="checkbox"/> Heart attack
<input type="checkbox"/> Heart murmur
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> High cholesterol
<input type="checkbox"/> Heart valve disorder
<input type="checkbox"/> Pacemaker / Stent | <p><input type="checkbox"/> Rheumatic heart disease</p> <p><u>Respiratory</u></p> <input type="checkbox"/> Asthma / Bronchitis
<input type="checkbox"/> COPD / Emphysema
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Tuberculosis <p><u>Gastro-intestinal</u></p> <input type="checkbox"/> Liver disease
<input type="checkbox"/> GERD
<input type="checkbox"/> Hernia
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Peptic ulcers | <p><u>Blood</u></p> <input type="checkbox"/> Bleeding disorders
<input type="checkbox"/> Blood transfusion
<input type="checkbox"/> DVT / Blood clots / Pulmonary Embolism <p><u>Neurologic</u></p> <input type="checkbox"/> Epilepsy
<input type="checkbox"/> Migraines
<input type="checkbox"/> Paralysis
<input type="checkbox"/> Stroke/ TIA <p><u>Mental Health</u></p> <input type="checkbox"/> Alcohol/ Drug dependency | <p><input type="checkbox"/> None</p> <input type="checkbox"/> Anorexia /Bulimia
<input type="checkbox"/> Depression
<input type="checkbox"/> Psychiatric care
<input type="checkbox"/> Suicide attempt <p><u>Skin/ Skeletal</u></p> <input type="checkbox"/> Jaundice
<input type="checkbox"/> Skin disorder
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Gout
<input type="checkbox"/> Fracture <p><u>Immune/Infection</u></p> <input type="checkbox"/> AIDS / HIV
<input type="checkbox"/> Herpes / fever blister | <p><input type="checkbox"/> Immune problem
 <input type="checkbox"/> MRSA/ VRE
 <input type="checkbox"/> Venereal disease</p> <p><u>Endocrine</u></p> <input type="checkbox"/> Diabetes
<input type="checkbox"/> Thyroid disorders <p><u>Other</u></p> <input type="checkbox"/> Glaucoma
<input type="checkbox"/> Kidney disorders
<input type="checkbox"/> Impairment: Type _____
<input type="checkbox"/> Cancer: Type _____ |
|--|---|---|--|--|

Are you being treated for any other illness at this time? Yes No. If yes, please explain:

Date of Last Physical _____ Results _____

Have you ever had **SURGERY**? Yes No If yes, please list:

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Have you, or a family member ever had a problem with anesthesia? Yes No. If yes, please explain:

Have you been diagnosed with a sleep disorder/sleep apnea? Yes No

Do you use a C-Pap Machine for your sleep disorder? Yes No

Do you have any **DRUG ALLERGIES**? Yes No. If yes, please note name of drug and reaction:

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FAMILY HISTORY (Only list blood related relatives.) None

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer/ type	
<input type="checkbox"/> Other			

LIST ALL MEDICATIONS YOU ARE TAKING WITH NAME AND DOSAGE: No Meds

	<input type="checkbox"/> Weight control	<input type="checkbox"/> Estrogen/ hormones
	<input type="checkbox"/> Accutane (past year)	<input type="checkbox"/> Chemotherapy
	<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Antidepressants
	<input type="checkbox"/> Aspirin/ NSAID's	<input type="checkbox"/> Steroids
	<input type="checkbox"/> Blood thinners	<input type="checkbox"/> Vitamins/ supplements
	<input type="checkbox"/> Birth control	<input type="checkbox"/> Herbal/ homeopathics

Are you taking or have you ever taken recreational drugs? Yes No What type _____
Please give more details _____

Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Quit? _____	How much? _____	# per day
Do you drink?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Socially	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Moderately

ADDITIONAL HEALTH HISTORY (Female Gender or FtM please complete)

Pregnancies: _____ Live births: _____ Miscarriages: _____ Abortions: _____

Date of Last Menstrual Period: _____ Are you pregnant? Yes No

Date of Last Mammogram: _____ Results: _____

Breast Cancer Yes No History of Breast Biopsy Yes No Current Bra Size: _____ (female gender only)

REVIEW OF SYSTEMS Please circle the following symptoms you have had recently: No Symptoms

- General: Fatigue. Fever. Chills. Sweats. Sleep disturbance. Recent weight gain or loss.
- Eyes, Ears, Nose, & Throat: Blindness. Blurred vision. Cataracts. Contact lenses. Double vision. Dry eyes. Eye irritation. Eye pain. Excessive tearing. Red eyes. Sensitivity to light. Visual changes. Ear discharge. Difficulty breathing through nose. Dizziness. Hearing loss. Ringing in the ears. Chronic nasal congestion. Nose bleeds. Loss of sense of smell. Past nasal injury. Sinus problems. Ulcer/sore. Capped teeth. Loose teeth. Tooth pain. Dental problems. Dentures. Difficulty swallowing. Hoarseness. Snoring.
- Cardiovascular: Chest pain. Congestive heart failure. Irregular / rapid heartbeat. Heart attack. Low blood pressure. Mitral valve prolapse/ need for antibiotics for dental procedures. Foot swelling. Palpitations/ Skipped beats. Poor circulation. Rheumatic fever. Varicose veins.
- Respiratory: Bronchitis. Bloody cough. Shortness of breath. Pneumonia. Recent cough. Wheezing. Tuberculosis.
- Gastrointestinal: Bloating. Blood in vomit / stools. Changes in appetite. Change in bowel habits. Chron's colitis. Constipation. Diarrhea. Hemorrhoids/ rectal bleeds. Gastritis/ reflux. Hepatitis/ jaundice. Irritable bowel syndrome. Nausea/ vomiting. Peptic ulcers. Ulcerative colitis.
- Genitourinary: Urinary infections. Urinating: Blood/ Difficulty/ Frequent/ Pain/ incontinent. STD. Yeast infections.
- Musculoskeletal: Arthritis. Difficulty walking. Extremity pain. Injuries. Joint pain. Leg cramps. Lupus Erythematosus, Rheumatoid arthritis. Unusual muscle weakness. Swelling.
- Neurologic: Dizziness/ fainting. Numbness. Migraines/ headaches. Seizures/ epilepsy. Sensory loss. Stroke. Weakness/ loss of balance.
- Psychiatric: Alcoholism. Anxiety. Depression. Drug abuse. Financial trouble. Marital problems. Schizophrenia.
- Heme/ Immunologic: Bleeding gums. Blood clot/ clotting disorder. Blood transfusion. Easy bruising. HIV complications. MRSA / VRE infections. Sickle Cell Anemia. Swollen lymph nodes.
- Endocrine/ Hormonal: Adrenal disorders. Labile blood glucose levels. Neuropathy. Steroid use. Thyroid symptoms.
- Skin Disease: Acne. Burn injury. Difficulty healing wounds. Excessive or unsatisfactory scarring. Itching/ Hives. Mole changing in appearance. Skin Cancer. Unexplained rash/ inflammation.
- Breasts: Abnormal Mammogram. Bloody discharge. Benign lump/ tumor. Cancer. Clear discharge. Milky discharge. Fibrocystic breasts. Pain. Reduction. Saline breast implants. Silicone breast implants.

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

X

Signature of Patient, Parent, Guardian or Personal Representative Date Time

Name of Patient, Parent, Guardian or Personal Representative Date Time

Reviewed by (Clinic Personnel, if applicable) Date Time

Reviewed by (PreOp Personnel) Date Time

American Institute for Plastic Surgery
Surgery Center of Texas

****ALL PATIENTS – please complete sections at the bottom of the page****

INSURANCE PATIENTS – please complete the following:

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and instruct my insurance carrier to make payment directly to American Institute for Plastic Surgery (AIPS) and/or Surgery Center of Texas for charges incurred. I further assign all rights to payment due for medical and/or surgical services under listed policies to AIPS Surgery Center of Texas, Anesthesia, Pathology and Radiology providers. I understand that any payment made on my behalf is not refundable to me. **PLEASE INITIAL** _____

FINANCIAL RESPONSIBILITY: I understand that AIPS/Surgery Center of Texas/Anesthesia/Pathology and Radiology providers as a courtesy will file with my insurance carrier. I understand that all co-pays and deductibles are due when services are rendered. I further understand that although these providers will file with my insurance, I am ultimately responsible for all charges incurred. **PLEASE INITIAL** _____

COSMETIC PATIENTS – please complete the following:

CONSENT FOR IRREVOCABLE NON-ASSIGNMENT: I understand the procedure(s) I seek are cosmetic, not medically necessary and it would be fraudulent and unethical for AIPS and/or Surgery Center of Texas to submit a charge to any insurance company for payment. Therefore, I understand that AIPS and/or Surgery Center of Texas will not accept insurance for my procedure(s). My consent to have AIPS and/or Surgery Center of Texas provide care and not accept assignment from any insurance company, managed care provider or other coverage source is irrevocable and final. I understand I will be fully responsible for surgical fees for the surgery I seek. **PLEASE INITIAL** _____

ALL PATIENTS - Please complete the following sections:

INFORMED CONSENT-PATIENT COMPUTER IMAGING: In the course of consultation, I may have been shown brochures or photographs of actual patients on a computer screen. I understand that those pictures and any alterations of these pictures are solely for the purpose of illustration. Furthermore, I understand that the outcome of any type of surgical procedure is related to my individual characteristics and health. I understand that because of the differences in how living tissues react to surgery, there may be no relationship between the electronic images created and my actual final surgical result. Use of computer imaging system offers an opportunity for me to discuss my desires and allows for improved communication with the medical staff. **PLEASE INITIAL:** _____

RELEASE OF PHOTOGRAPHIC IMAGES: I hereby grant permission for the use of any illustrations, photographs, or imaging records, created in my case, for use in scientific and professional journals, the AIPS website, or other medical or patient education material and presentations at any time during or after treatment, with complete confidentiality of my identity. **PLEASE INITIAL:** _____

CONSENT/RESTRICTION OF THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS: I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans of future care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the healthcare professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, a means by which a third party payer can verify that services billed were actually provided, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals. I wish to have the following restrictions to use or disclosure of my health information. None Other _____

SIGNATURE OF PATIENT or GUARDIAN:

Patient, if minor (Parent or guardian signature)

Date

Time



AMERICAN INSTITUTE FOR PLASTIC SURGERY

Dear Patient,

You are being provided this letter of acknowledgement because you have requested that your services be deemed as “self-pay” and you will *not* be submitting the claim to an insurance carrier. You have requested that this service be deemed as self-pay because (initial one):

____ I have no health insurance.

____ I have health insurance but have been informed we do not file out-of-network benefits.

____ I have health insurance, but have chosen to self-pay, and understand that codes cannot be provided for insurance filing, and a claim cannot be submitted.

We want you to know what to expect so that you can make an informed decision. In order to accomplish this, by signing below you agree to the following:

- I understand and acknowledge the procedures I seek will be considered cosmetic and it would be fraudulent and unethical for AIPS and/or Surgery Center of Texas to submit a charge to any insurance company for payment after services have been rendered.
- I understand that AIPS and/or Surgery Center of Texas will not accept insurance for any procedures such as: liposuction, facial feminization, breast augmentation, abdominal tightening, any MedSpa treatments, and extra skin removal.
- I understand that AIPS and/or Surgery Center of Texas have my consent to not accept assignment from any insurance company, managed care provider or other coverage source.
- I understand that the self-pay amount is considered a “bundled” fee and will cover professional, facility, anesthesia, lab and pathology services.

By my signature below, I acknowledge and agree to waive my insurance for any and all medical services at American Institute of Plastic Surgery and Surgery Center of Texas. I understand I will be seen on a Self-Pay basis and will be 100% responsible for any associated charges pertaining to these services.

I confirm that I am the patient, or the patient’s duly authorized representative and agree that by accepting the self-pay agreement that I will not file my insurance after services have been rendered.

Patient or Representative Signature _____ Date _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Interpreter Signature _____ Date _____

**American Institute for Plastic Surgery
6020 W. Plano Parkway
Plano, TX 75093**

COVID-19 RISK INFORMED CONSENT

I, _____, understand that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary. I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that the doctors and staff at American Institute for Plastic Surgery and Surgery Center of Texas are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for all providers and all the staff at American Institute for Plastic Surgery and Surgery Center of Texas to proceed with the same.

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.

I have been given the option to defer my treatment/procedure/surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery.

Patients Signature: _____

Date: _____

Witness Signature:  _____

Date: _____