Lubbock Plastic Surgery Institute (LPSI)
Patient Registration

Date:			Acct:
PATIENT: LAST NAME	**FIRST NAME**	**MIDDLE NAME**	
MAILING ADDRESS	**CITY, STATE**	**ZIP**	
SEX / **BIRTH DATE**	**SOCIAL SECURITY NUMBER**	**AGE**	**HOME TELEPHONE**
EMPLOYER/SCHOOL NAME	**WORK/SCHOOL TELEPHONE**		
ADDITIONAL PHONE (CELL, PAGER)	**Race:** **Language:**	**Ethnicity:**	
SPOUSE LAST NAME	**FIRST NAME**	**MIDDLE NAME**	

PATIENTS RELATIONSHIP TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SPOUSE EMPLOYMENT INFORMATION

EMPLOYER	**WORK TELEPHONE**	
EMPLOYER ADDRESS	**CITY, STATE**	**ZIP**

PATIENTS STATUS: A) ☐ SINGLE ☐ MARRIED ☐ OTHER
B) ☐ EMPLOYED ☐ FULL TIME STUDENT ☐ PART TIME STUDENT

PRIVATE OR GROUP INSURANCE

ARE YOU A MEMBER OF A MANAGED CARE PLAN? (PPO, HMO, ETC?) ☐ YES ☐ NO

NAME OF PRIMARY (FIRST) INSURANCE COMPANY

POLICY NUMBER	**GROUP NUMBER**	**GROUP NAME**
INSURANCE COMPANY ADDRESS	**CITY, STATE**	**ZIP**
POLICY HOLDERS LAST NAME	**FIRST NAME**	**MIDDLE NAME**
STREET ADDRESS	**CITY, STATE**	**ZIP**
SEX / **BIRTH DATE**	**SOCIAL SECURITY NUMBER**	**AGE** / **HOME TELEPHONE**

MEDICARE SUPPLEMENTAL OR ADDITIONAL INSURANCE COMPANY

NAME OF INSURANCE COMPANY

POLICY NUMBER	**GROUP NUMBER**	**GROUP NAME**
INSURANCE COMPANY ADDRESS	**CITY, STATE**	**ZIP**
POLICY HOLDERS LAST NAME	**FIRST NAME**	**MIDDLE NAME**
STREET ADDRESS	**CITY, STATE**	**ZIP**
SEX / **BIRTH DATE**	**SOCIAL SECURITY NUMBER**	**AGE** / **HOME TELEPHONE**

HOW DID YOU HEAR ABOUT OUR OFFICE? IF A PHYSICIAN REFERRED YOU, WHOM MAY WE THANK?

NAME	**TELEPHONE**

PERSON TO CALL IN EMERGENCY (NOT LIVING WITH YOU)

NAME	**TELEPHONE**

PCP (PRIMARY CARE PHYSICIAN)

May we contact you via E-Mail? Yes or No **E-Mail:** _____

P1 Reg. Schmidt2PT

Lubbock Plastic Surgery Institute (LPSI)

AGREEMENT AS TO GOVERNING LAW AND FORUM:

The patient or patient's representative and health care provider, including employees and agents of the healthcare provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree: (1) that all health care rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any health care rendered to patient; and (2) in the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas Court in the county / district where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action or cause of action ever be brought in any other state. The choice of law and forum selection provisions of the paragraph are mandatory and are not permissive.

Patient Signature: _____ Date: _____

Wintess Signature: _____ Date: _____

10105 Quaker Avenue
Lubbock TX 79424
Phone: 806.797.6398
Fax: 806.797.6399

Consent to Treatment

Lubbock Plastic Surgery Institute (LPSI)

CONSENT TO TREATMENT:

I (the patient/parent/guardian/legal representative of the patient acting on the patient's behalf) give permission for medical treatment, including radiological and laboratory procedures to be performed by the physicians and staff of Lubbock Plastic Surgery Institute (LPSI). This consent is valid from this date forward.

Relationship to Patient: ☐ Self ☐ Child ☐ Dependent ☐ Other _____

Printed Name	Signature	Date
Printed Name of Witness	Signature of Witness	Relationship of Signer

FINANCIAL AGREEMENT:

The person signing below agrees, whether he/she signs as patient or representative of the patient, that in consideration of services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the Center at the regular rate and term of the Center. Should the account be referred to an attorney for collection, the person signing below shall pay reasonable attorney's fees and collection expenses.

"I assign payment for the unpaid charges for certain medical treatment furnished by the physicians and staff of Lubbock Plastic Surgery Institute (LPSI) and by attending physicians for whom the Center is authorized to bill. I understand that I am responsible for any health insurance deductibles and coinsurance at the time of services rendered.

Printed Name	Signature	Date

ASSIGNMENT OF BENEFITS:

In consideration of services rendered, I hereby assign to Lubbock Plastic Surgery Institute (LPSI) and/or any physician who has treated me, all rights, title, and interest in any payment due me for services described herein as provided in the policy or policies of insurance. I agree to pay the charges of the Center and/or attending physician which is greater that the amount paid by the insurance company or companies.

Printed Name		

MEDICARE AND/OR MEDICAID CERTIFICATION: (If applicable)

The person signing below certifies that he/she has read this document and is the patient, or is duly authorized by the patient as the patient's representative to execute the above and accepts its terms.

"I certify that the information given by me in applying for payment under Title XVII and/or Title XIX of the Social Security Administration is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or it's intermediaries/carriers any information needed for this or related Medicare claim I request payment of authorized benefits be made on my behalf."

Relationship to Patient: ☐ Self ☐ Child ☐ Dependent ☐ Other _____

Printed Name	Signature	Date
Printed Name of Witness	Signature of Witness	Relationship of Signer

LUBBOCK PLASTIC SURGERY INSTITUTE (LPSI)

10105 Quaker Ave. • Lubbock, TX 79424 • 806.797.6398 • TOLL FREE 866.797.6398 • FAX 806.797.6399

AUTHORIZATION FOR TAKING OF PATIENT PHOTOGRAPH

Name _____

Address _____
(street address, city, state and zip code)

I consent to the taking of photographs by Lubbock Plastic Surgery Institute (LPSI) or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Lubbock Plastic Surgery Institute (LPSI).

I understand that such photographs shall become the property of Lubbock Plastic Surgery Institute (LPSI) and my medical records.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Lubbock Plastic Surgery Institute (LPSI).

I understand that I have the right to inspect and copy the information that I authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any affect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPPA"). I further understand that, because ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer by protected by HIPPA.

I certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____
Signature Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of _____ _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

_____ _____
Signature Date

_____ _____

Lubbock Plastic Surgery Institute (LPSI)

Consent for Use and Disclsure of Protected Health Information For Treatment, Payment, or Healthcare Operations

I understand that part of my healthcare, the Physician originates and maintains medical records describing my health history, symptoms, examination and test results, diagnosis, treatment, financial and demographic information, and any plans for future care or treatment. The Physician also originates and maintains billing records. I understand and consent to this information being used or disclosed for the following purposes:

- Planning my care and treatment;
- Communications between my Physician and healthcare professionals that act under the direction of my Physician and participating in my diagnosis, evaluation, or treatment;
- Collection of fees for medical services;
- Determining liability for payment and obtaining reimbursement;
- Conducting healthcare operations, including the evaluation of healthcare services, appropriateness and quality of healthcare treatment, and the qualifications of healthcare practitioners.

I have been provided with a copy of the Physician's *Notice of Privacy Practices* that provides information about how the Physician uses and discloses Protected Health Information about me. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent; and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. The Physician is not required to agree to the requested restrictions, but is bound to any restrictions agreed to.

I understand that as proved in the *Notice of Privacy Practices*, the terms of the *Notice* may change. If they do, I may obtain a revised copy from the privacy officer by calling (806) 797-6398.

I understand that I may revoke this consent in writing, except to the extent that the Physician has already taken action in reliance thereon. I also understand that by refusing to sign or revoking this consent, the Physician may refuse to treat me. I wish to restrict the use or disclosure of my health information as follows:

_____

_____

I understand that my confidential information may be released to the following individuals:

_____

_____

_____ _____

Signature of Patient or Representative | Date

_____ _____

Patient Name | Patient Identification Number (SSN)

_____ _____

Name of Representative (if applicable) | Relationship

Lubbock Plastic Surgery Institute (LPSI)

PATIENT FINANCIAL RESPONSIBILITY

We are committed to providing you with the best possible surgical and medical care; if yo have special needs; we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. The total patient balance due is required to be paid at the time services are provided. For your convenience, we accept cash, checks, Visa, MasterCard, Discover, and American Express.

2. Our office participates with a variety of insurance plans. It is your responsibility to:

   - Bring your insurance card at every visit
   - Be prepared to pay your co-payment and or co-insurance at each visit. Payment can be made by cash, check or credit card.
   - For medical care not covered, deemed medically unnecessary, or deemed cosmetic by your insurance company, payment in full is due at the time of the visit.

3. If you have insurance that we do not participate in, our office is happy to file the claim upon request; however, payment in full is required at the time of service. A deposit will be required for all surgeries.

4. If the total patient balance due cannot be paid in full, arrangements must be made prior to services being rendered. Failure to make arrangement with Lubbock Plastic Surgery Institute (LPSI) will result in the immediate collection turnover or payment in full.

5. Referrals: It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have the referral, your visit may be rescheduled or you will be financially responsible for all services rendered.

6. If the patient is a minor (18 years or younger), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at time of service, bringing the necessary referrals and insurance card.

7. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department.

8. If you fail to make payment in full for the services that are rendered to you, your outstanding balance will be sent to a collections agency. If you consistently refuse to pay for services rendered, Lubbock Plastic Surgery Institute (LPSI) may choose to cease providing services to you.

Our practice firmly believes that a good physician patient relationship is based upon understanding and good communications. Questions about financial arrangements should be asked prior to services provided.

Patient Signature _____ Date _____

Lubbock Plastic Surgery Institute (LPSI)

New Patient Information Form

Patient _____ Chart#: _____ Age: _____

Date: _____ Referring Physician _____

Reason for today's visit? _____

Any medication allergies? _____

If so, list reactions to these? _____

Latex Allergy : ❑ Yes ❑ No Reaction: _____

Current medications:

_____ _____

_____ _____

_____ _____

_____ _____

Use of aspirin? ❑ Yes ❑ No Use of herbs/vitamins ❑ Yes ❑ No

Use of anti-inflammatories? ❑ Yes ❑ No

History

Past medical problems

_____ _____

_____ _____

_____ _____

_____ _____

Pertinent Social History

Use of alcohol? ❑ Yes ❑ No How often? _____

Use of tobacco? ❑ Yes ❑ No How often? _____

Previous Surgeries	Date	Performing Surgeon

- CONSTITUTIONAL SYMPTOMS
  - Good general healthy lately ..... No Yes
  - Recent weight change ..... No Yes
  - Fever ..... No Yes
  - Fatigue ..... No Yes
  - Headaches ..... No Yes

- EYES
  - Eye disease or injury ..... No Yes
  - Wear glasses / contact lens ..... No Yes
  - Blurred or double vision ..... No Yes
  - Glaucoma ..... No Yes

- EARS / NOSE / MOUTH / THROAT
  - Hearing loss or ringing ..... No Yes
  - Earaches or drainage ..... No Yes
  - Chronic sinus problems or rhinitis ..... No Yes
  - Nose bleeds ..... No Yes
  - Mouth sores ..... No Yes
  - Bleeding gums ..... No Yes
  - Bad breath or bad taste ..... No Yes
  - Sore throat or voice change ..... No Yes
  - Swollen glands in neck ..... No Yes

- CARDIOVASCULAR
  - Heart trouble ..... No Yes
  - Chest pains or angina pectoris ..... No Yes
  - Palpitation ..... No Yes
  - Shortness of breath with walking or lying flat ... No Yes
  - Swelling of feet, ankles or hands ..... No Yes

- RESPIRATOR
  - Chronic or frequent coughs ..... No Yes
  - Spitting up blood ..... No Yes
  - Shortness of breath ..... No Yes
  - Asthma or wheezing ..... No Yes

- GASTROINTESTINAL
  - Loss of appetite ..... No Yes
  - Change in bowel movements ..... No Yes
  - Nausea or vomiting ..... No Yes
  - Frequent diarrhea ..... No Yes
  - Painful bowel movements or constipation ... No Yes
  - Rectal bleeding or blood in stool ..... No Yes
  - Abdominal pain or heartburn ..... No Yes
  - Peptic ulcer (stomach or ..... No Yes

- GENITOURINARY
  - Frequent urination ..... No Yes
  - Burning or painful urination ..... No Yes
  - Blood in urine ..... No Yes
  - Change in force of strain when urinating ..... No Yes
  - Incontinence or dribbling ..... No Yes
  - Kidney stones ..... No Yes
  - Sexual difficulty ..... No Yes
  - Male - testicle pain ..... No Yes
  - Female - pain with periods ..... No Yes
  - Female - irregular periods ..... No Yes
  - Female - vaginal discharge ..... No Yes
  - Female - # pregnancies ____ # miscarriages ____ No Yes
  - Female - date of last pap smear _____ No Yes

- MUSCULOSKELETAL
  - Joint pain ..... No Yes
  - Joint stiffness or swelling ..... No Yes
  - Weakness of muscles or joints ..... No Yes
  - Muscle pain or cramps ..... No Yes
  - Back pain ..... No Yes
  - Cold extremities ..... No Yes
  - Difficulty in walking ..... No Yes

- INTEGUMENTARY (skin, breast)
  - Rash or itching ..... No Yes
  - Change in skin color ..... No Yes
  - Change in hair or nails ..... No Yes
  - Varicose veins ..... No Yes
  - Breast pain ..... No Yes
  - Breast lump ..... No Yes
  - Breast discharge ..... No Yes

- NEUROLOGICAL
  - Frequent or recurring headaches ..... No Yes
  - Light headed or dizzy ..... No Yes
  - Convulsion or seizures ..... No Yes
  - Numbness or tingling sensations ..... No Yes
  - Tremors ..... No Yes
  - Paralysis ..... No Yes
  - Stroke ..... No Yes
  - Head injury ..... No Yes

- PSYCHIATRIC
  - Memory loss or confusion ..... No Yes
  - Nervousness ..... No Yes
  - Depression ..... No Yes
  - Insomnia ..... No Yes

- ENDOCRINE
  - Glandular or hormone problem ..... No Yes
  - Thyroid disease ..... No Yes
  - Diabetes ..... No Yes
  - Excessive thirst or urination ..... No Yes
  - Heat or cold intolerance ..... No Yes
  - Skin becoming dryer ..... No Yes
  - Change in hat or glove size ..... No Yes

- HEMATOLOGIC / LYMPHATIC
  - Slow to heal after cuts ..... No Yes
  - Bleeding or bruising tendency ..... No Yes
  - Anemia ..... No Yes
  - Phlebitis ..... No Yes
  - past transfusion ..... No Yes
  - Enlarged glands ..... No Yes

- FAMILY HISTORY
  - Cancer ..... No Yes
  - If Yes, what type _____
  - Malignant Hyperthermia ..... No Yes
  - Major health Problems ..... No Yes
  - List: _____
    _____
    _____
    _____