Patient Information Form - Appointment Date:

Patient Name: _____ Preferred Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Carrier: _____

DOB / Age: _____ Race: _____ Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino

SSN: _____ Gender: _____ Email Address: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

Who is your dermatologist? _____

Pharmacy Name: _____

Address: _____ City: _____ State: _____ Zip: _____

How did you hear about our clinic?

☐ Social Media ☐ Patient Referral: _____
☐ Magazine ☐ Friend: _____
☐ Google ☐ Dr. Referral: _____
☐ Other: _____

What is the nature of your visit? _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Insurance

Name: _____ Policy #: _____ Group ID: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance

Name: _____ Policy #: _____ Group ID: _____

Address: _____ City: _____ State: _____ Zip: _____

Assignment and Release

I, _____, insurance coverage and assign directly all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured / Guardian Date

Section I: Surgery and Anesthesia History

1. Have you ever had surgery? ☐ No ☐ Yes, please describe:

_____

_____

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

_____

_____

Section II: Specific Medical History

1. Are you pregnant? ☐ No ☐ Yes Height: _____ Weight: _____

Have you or do you still have:	No	Yes	Description
2. Asthma	☐	☐	
3. Emphysema	☐	☐	
4. High Blood Pressure	☐	☐	
5. Heart Trouble	☐	☐	
6. Hepatitis or Liver Trouble	☐	☐	
7. Kidney Trouble	☐	☐	
8. Diabetes	☐	☐	
9. Epilepsy or Seizures	☐	☐	
10. Stroke	☐	☐	
11. Problem Scarring	☐	☐	
12. Have you been advised to or had psychiatric care?	☐	☐	
13. History of MRSA?	☐	☐	

14. Others Not Listed: _____

Section III: Social History

1. Do you smoke? ☐ No ☐ Yes, how much? _____
2. Do you drink? ☐ No ☐ Yes, how much? _____
3. Do you have children? ☐ No ☐ Yes, how many? _____

Section IV: Family History

	Have any blood relatives had any of the following?	No	Yes	Description
1.	Cancer	☐	☐	
2.	Bleeding Tendency	☐	☐	
3.	Leukemia	☐	☐	
4.	Heart Disease	☐	☐	
5.	High Blood Pressure	☐	☐	
6.	Repeated Infections	☐	☐	
7.	Chronic Lung Disease	☐	☐	
8.	Tuberculosis	☐	☐	
9.	Asthma	☐	☐	
10.	Severe Allergies	☐	☐	
11.	Kidney Disease	☐	☐	
12.	Arthritis	☐	☐	
13.	Mental Illness	☐	☐	
14.	Convulsions or Fits	☐	☐	
15.	Migraine Headaches	☐	☐	
16.	Diabetes	☐	☐	
17.	Gout	☐	☐	
18.	Thyroid Trouble	☐	☐	
19.	Obesity	☐	☐	

Section V: Medications

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list:

_____

Section VI: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

_____

_____

Are you allergic to Latex? ☐ No ☐ Yes, please list:
Are you allergic to Iodine? ☐ No ☐ Yes, please list:
Are you allergic to Eggs/ Egg Products? ☐ No ☐ Yes, please list:

I have read ALL SECTIONS of this questionnaire & disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

Consent to Communicate

Patient Name:

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email			☐	-
☐ Email Appointment Reminders				
☐ Email Medical Information				
☐ Email Office Specials				
☐ Send Regular Mail			☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Message - if so, please list carrier (e.g., AT&T):			☐	-
☐ Text Appointment Reminders				
☐ Text Office Specials				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

Advance Directive

Patient Name: _____

In the event that you are unable to communicate your desires for medical care, have you established an Advance Directive?

If so, would you have a copy forwarded to this office for your permanent record?

☐ Yes, I have an advance Directive

☐ No, I do not have an Advance Directive.

Signature: _____ Date: _____

HIPAA Information and Consent Form

Patient Name:

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the
patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

Office Policies

Dear Patient:

In an effort to provide the best possible experience for our patients, we have established office policies that we ask our patients to review prior to the first visit

Please read and acknowledge the following:

☐ Office Visit co-pays are expected at the time of service per contractual obligation with the insurance companies.

☐ There will be a $100 fee for cosmetic consultations collected at the time of service. This fee will be applied to the surgery, should you proceed with scheduling. (**We require a card to be left on file at the time of scheduling your appointment through our secure payment system.**)

☐ We accept most major credit or debit cards, cash, money orders or cashier's checks. NO personal checks, please.

☐ There will be a $25 charge for returned checks.

☐ Because we know that everyone's time is valuable, we ask that you inform the receptionist of any and all concerns you would like for Dr. McLaughlin to address when scheduling your appointment. This will allow sufficient time for your consultation and prevent any unnecessary wait time for our other patients.

☐ In order to communicate effectively with our nurse and Dr. McLaughlin, we ask that you refrain from using your cellular phones during your consultation time.

☐ Please inform our office if you might be running late to your scheduled appointment time. Patients who are more than 15 minutes late are subject to being rescheduled to help maintain the office schedule.

☐ **Cancellation Policy:**

I understand that if I do not give 24 hours' notice to cancel an appointment I will be billed for the full session.

I understand that if I need to reschedule and do not do so more than 24 hours prior to the schedule appointment I will be billed for the full session amount.

I understand that if I do not call or show up for my scheduled appointment, I will be billed for the full session amount. Please note, this includes spa appointments where the fee is $50. **(We will charge the card left on file at the time of scheduling the appointment. By completing this form, you authorize your card to be charged at the time of cancellation.)**

Thank you,
West Magnolia Plastic Surgery & The Retreat Medical Spa

Signature: _____ Date: _____

CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

Patient Name:

Purpose: This form is intended to obtain your permission to participate in a telemedicine consultation.

Introduction: Telemedicine is the use of video conferencing to enable healthcare providers at a different location to provide health care treatment to you and/or consult with you and your health care provider about your health care options and decisions. Telemedicine consultations are not the same as direct patient/healthcare provider visits, as you will not be in the same location as the consulting provider. Telemedicine allows Vermillion-Parke Community Health Center to provide services to you that may otherwise require you to travel long distances. Your participating in any telemedicine consultation is completely voluntary.

Process: By signing this form, you are acknowledging that you understand the following:
● Details of your medical history, including but not limited to, images, x-rays and tests may be shared electronically and discussed with the consulting provider.
● A physical examination may take place.
● Non-medical personnel may be present to assist in operating video conferencing equipment. You will be informed of any non-medical personnel present during the video conference.
● Video, audio, and/or photo recordings may be taken during the procedure to aid in documenting the progress of your treatment.
● The responsibility of the consulting provider regarding your health care will terminate upon conclusion of the teleconference.
● Your provider as well as the consulting provider may keep a record of the consultation.

Possible Risks: By signing this form, you are acknowledging that you understand the following:
● Despite our best efforts to protect the privacy of patient information, security protocol could fail causing a breach of privacy of personal medical information.
● Information provided by telemedicine to the consulting provider may be insufficient to allow for treatment and general medical care decision to be made.
● Delays in medical evaluation and treatment may occur due to failures of the electronic equipment.

Consent: By signing this form, you are consenting to participate in a telemedicine consultation. You are acknowledging that you have read and understand the provisions in this form. If you are unable to read, you are acknowledging that your health care provider has read this form to you. You are acknowledging that your health care provider has explained to you how telemedicine video conferencing works.

I hereby consent to participation in a telemedicine consultation.

Signature: _____ Date: _____