PLASTIC & COSMETIC SURGERY CENTER

Dr. Robert Wilcox, M.D. **Dr. Michael Morrissey, M.D.**

PATIENT REGISTRATION

(Please circle one) Today's visit is: Cosmetic Skin Care Self Pay Private Insurance/Medicare Worker's Compensation Other

PLEASE PRINT

MR.
MRS.
MS. _____

LAST NAME FIRST NAME MIDDLE INITIAL

SOCIAL SECURITY NUMBER DATE OF BIRTH AGE DRIVER'S LICENSE NUMBER & STATE

HOME STREET ADDRESS APT. # CITY/STATE ZIP

TEMPORARY STREET ADDRESS APT. # CITY/STATE ZIP

HOME PHONE MOBILE PHONE BUSINESS PHONE

MARITAL STATUS SEX ETHNICITY NUMBER OF DEPENDENTS

EMPLOYED BY EMPLOYER'S ADDRESS OCCUPATION

SPOUSE'S NAME EMPLOYED BY EMPLOYER'S ADDRESS BUSINESS PHONE

NEAREST FRIEND OR RELATIVE FOR EMERGENCIES (Not living with patient) RELATIONSHIP TO PATIENT PHONE

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

RESPONSIBLE PARTY INFORMATION: (Primary Insurance Holder or Legal Guardian)
(IF PATIENT IS NOT RESPONSIBLE FOR THE BILL, PLEASE INDICATE WHO IS RESPONSIBLE)

NAME STREET ADDRESS CITY/STATE ZIP

HOME PHONE RELATIONSHIP TO PATIENT BUSINESS PHONE

RESPONSIBLE PARTY SOCIAL SECURITY NO. RESPONSIBLE PARTY DATE OF BIRTH

EMPLOYER EMPLOYER'S ADDRESS CITY/STATE ZIP

I understand that I am responsible for payment of all charges incurred on my behalf and/or my family regardless of insurance benefits.

DATE _____ RESPONSIBLE PARTY SIGNATURE _____

*PLEASE **COMPLETE** THIS FORM IN ITS ENTIRETY **FRONT AND BACK!***

ADDITIONAL INFORMATION:

How did you hear about our office? (Please select one of the options below):

_____ **DOCTOR** If so, Please provide **FULL** name & **Phone #** _____
_____ INTERNET If so, Which Website _____
_____ PATIENT If so, Please list **FULL** name _____
_____ PRINT AD If so, Which one? _____
_____ OTHER If so, Please list _____
_____ YELLOW PAGES
_____ FRIEND/FAMILY

Is it okay to SEND any information to the address listed on the front page?? YES or NO **(Please circle one)**

If you would like to receive our complimentary **PLASTIC SURGERY NEWSLETTER**, please provide your **EMAIL ADDRESS** below:
(Information provided will **NOT** be shared with outside agencies!)

_____

MEDICAL INSURANCE INFORMATION: For **PRIVATE INSURANCE/MEDICARE** patients **ONLY**!
(Please complete **EVEN** though the insurance cards have been copied)

PRIMARY INSURANCE:

NAME OF INSURANCE COMPANY | INSURED'S NAME (PRIMARY CARDHOLDER'S NAME) | INSURED'S DATE OF BIRTH

INSURANCE COMPANY ADDRESS | INSURANCE PHONE NUMBER

MEMBER OR SUBSCRIBER'S ID | GROUP OR POLICY NUMBER

SECONDARY INSURANCE:

NAME OF INSURANCE COMPANY | INSURED'S NAME (PRIMARY CARDHOLDER'S NAME) | INSURED'S DATE OF BIRTH

INSURANCE COMPANY ADDRESS | INSURANCE PHONE NUMBER

MEMBER OR SUBSCRIBER'S ID | GROUP OR POLICY NUMBER

I authorize the release of any medical information necessary to process this claim and request payment of insurance proceeds, including any major medical benefits, to the undersigned physicians or clinic. This will serve as my authorization for this office to obtain insurance information from Medicare regarding any claims submitted in my behalf. A copy of these signatures is as valid as the original.

Dr. Robert Wilcox, M.D. **Dr. Michael Morrissey, M.D.**
5316 W. PLANO PARKWAY PLANO, TEXAS 75093 (972-620-1700)

_____ AUTHORIZED SIGNATURE

_____ DATE

HISTORY & PHYSICAL

Plano Center for Surgical Arts

Please print and complete all blanks

Patient Name: _____ Today's Date: _____ Date of Birth: _____

What brings you in today? _____

Are you here related to a work injury? _____ Occupation: _____

Age: _____ Height: _____ Weight: _____ Gender: _____

Are you currently under a physician's care? If so, please list all physicians who are currently treating you

Physician's Name:	**Specialty:**

Medical History: *Please answer the following questions*

Do you have sleep apnea, use CPAP or BiPAP?	□ Yes □ No	Do you have a history of liver disease or cirrhosis?	□ Yes □ No
Do you experience shortness of breath or chest pain when climbing two flights of stairs?	□ Yes □ No	In the past two years, have you required prolonged treatment with steroids?	□ Yes □ No
Do you have high blood pressure which requires treatment with medication?	□ Yes □ No	Do you have Diabetes which requires treatment with medication or insulin?	□ Yes □ No
Do you have a history of blood clots, stroke, carotid artery blockage or TIA's (mini strokes)?	□ Yes □ No	Do you have a history of excessive bleeding after surgical or dental procedures?	□ Yes □ No
Are you currently taking blood thinners such as Coumadin, Plavix or Aspirin?	□ Yes □ No	Do you have any implanted medical devices? Device: _____ Year: _____	□ Yes □ No
Do you have kidney issues (except kidney stones or recurrent infections) that require treatment by a kidney specialist?	□ Yes □ No	Within the last 6 months have you taken anabolic steroids or prohormones? When?_____ What Dose? _____	□ Yes □ No

Surgical History: □ Never had surgery

Type of Surgery/Procedure:	**Year**	Have you, or anyone in your immediate family ever had complications with anesthesia? □ Yes □ No
		Complication: _____

Social History:

Do you use nicotine?	□ Yes □ No	Which product?	How much per day?
Do you consume alcohol?	□ Yes □ No	How many drinks?	How often?
Do you use recreational drugs?	□ Yes □ No	Which drug?	How often?

Allergies: *Please list all allergies to medications* □ No Known Allergies

Medication:	**Reaction:**	Are you allergic to latex? □ Yes □ No Reaction: _____ Are you allergic to shellfish? □ Yes □ No Reaction: _____

Current Medications: *Please list all medications you are currently taking including prescription, over the counter and supplements*

Medication/Supplement:	**Dose:**	**Frequency:**	□ Not taking any medications

Which pharmacy do you use? _____ Pharmacy Phone Number _____

Patient Signature _____ Today's Date _____

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HISTORY & PHYSICAL

Plano Center for Surgical Arts

DETAILED HEALTH QUESTIONAIRRE

Please provide detailed information so we can take the best possible care of you!

Cardiovascular					
High blood pressure	□ Yes □ No	Coronary artery disease	□ Yes □ No	Irregular heart beat	□ Yes □ No
Low blood pressure	□ Yes □ No	History of heart attack	□ Yes □ No	Pacemaker/Defibrillator	□ Yes □ No
Chest pain	□ Yes □ No	Congestive heart failure	□ Yes □ No	Abnormal EKG	□ Yes □ No
Sickle cell disease	□ Yes □ No	Prolonged bleeding	□ Yes □ No	History of blood clots	□ Yes □ No
If you answered YES to any of the above questions, please provide details: _____					
Respiratory					
Difficulty breathing	□ Yes □ No	Asthma	□ Yes □ No	Nasal allergies	□ Yes □ No
Chronic cough	□ Yes □ No	COPD/emphysema	□ Yes □ No	Sleep apnea	□ Yes □ No
Shortness of breath	□ Yes □ No	Nose bleeds	□ Yes □ No	Nasal obstruction	□ Yes □ No
Digestive					
Heartburn / Reflux	□ Yes □ No	Weight loss surgery	□ Yes □ No	Liver disease	□ Yes □ No
Obesity	□ Yes □ No	Eating Disorder	□ Yes □ No	Ulcers	□ Yes □ No
Urinary					
Frequent UTI	□ Yes □ No	Kidney Disease	□ Yes □ No	Dialysis – When?	□ Yes □ No
Endocrine					
Diabetes	□ Yes □ No	Hyperthyroid	□ Yes □ No	Hypothyroid	□ Yes □ No
Neuro					
Epilepsy	□ Yes □ No	History of seizures	□ Yes □ No	Fainting /dizziness	□ Yes □ No
Migraines	□ Yes □ No	History of stroke	□ Yes □ No	Nerve pain	□ Yes □ No
If you answered YES to any of the above questions, please provide details: _____					
Sensory					
Blurry vision	□ Yes □ No	Dry eyes	□ Yes □ No	Previous eye surgery	□ Yes □ No
Contacts / Glasses	□ Yes □ No	Hearing loss	□ Yes □ No	Hearing aids	□ Yes □ No
Musculoskeletal					
Arthritis	□ Yes □ No	Rheumatoid arthritis	□ Yes □ No	Fibromyalgia	□ Yes □ No
Back/neck pain	□ Yes □ No	TMJ	□ Yes □ No	Are you a body builder?	□ Yes □ No
Are you currently taking prescription pain medication?	□ Yes □ No	Which medication are you taking?			
Psychiatric					
Anxiety	□ Yes □ No	Depression	□ Yes □ No	Suicidal thoughts or actions	□ Yes □ No
Claustrophobia	□ Yes □ No	Bipolar disorder	□ Yes □ No	Body dysmorphic syndrome	□ Yes □ No
If you have a history of suicidal thoughts or actions, when did this occur?					
Cancer					
History of cancer	□ Yes □ No	What type and area?			
Radiation therapy	□ Yes □ No	Chemotherapy	□ Yes □ No	Still on treatments?	□ Yes □ No
Abnormal mammogram	□ Yes □ No	Breast pain	□ Yes □ No	Family history of breast cancer	□ Yes □ No
Female Reproductive					
Could you be pregnant?	□ Yes □ No	When was your last menstrual period?			
Hysterectomy	□ Yes □ No	Menopause	□ Yes □ No	How many years?	
Infectious Disease					
HIV	□ Yes □ No	Hepatitis B	□ Yes □ No	Hepatitis C	□ Yes □ No	History of tuberculosis	□ Yes □ No

Do you have any other health related issues other than those listed above? If YES, please explain: _____

_____

Patient Signature _____ Today's Date _____

I HAVE REVIEWED THIS H&P WITH THE PATIENT _____

SIGNATURE OF CLINIC INTERVIEWER/CLINIC PRE-OPERATIVE STAFF — DATE/ TIME

Physician Signature _____ Date _____ Time _____

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Plastic & Cosmetic Surgery Center of Texas

Robert D. Wilcox, M.D

5316 West Plano Parkway - Plano, Texas 75093

Authorization to Contact

You may be contacted by *Plastic & Cosmetic Surgery Center of Texas* to remind you of any appointments, healthcare treatments options, or other health services that may be of interest to you. When addressing our calls we will announce ourselves as to which doctor you are established with.

Home Tel. (_____) _____
May we contact you at home? **Yes** **No** OK to leave Voice mail? **Yes** **No**

Work Tel. (_____) _____
May we contact you at work? **Yes** **No** OK to leave Voice mail? **Yes** **No**

Cell Tel. (_____) _____
May we contact you via cell ph. **Yes** **No** OK to leave Voice Mail? **Yes** **No**

E-Mail address _____
May we contact you via e-mail? **Yes** **No**

What is your preferred method for us to contact you? _____
May we leave a detailed message? **Yes** **No**

Is there anyone we can leave a message with? **Yes** **No**
If Yes please list first and last names:

_____ _____

Would you like to authorize an individual as your personal representative? This person would have the authority to schedule, confirm, change appointments and receive information regarding your medical condition. If so please list first and last name:

_____ _____

If you would like to receive our monthly newsletter please make sure we have your email address

Patient Name: _____ Date:_____

Print Name: _____

HIPAA Notice of Privacy Practices

PLASTIC & COSMETIC SURGERY CENTER OF TEXAS
5316 West Plano Parkway
Plano, Texas 75093
(972) 620-1700

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. We may also call the telephone number you provide us to confirm any or all upcoming appointments.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information to be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. WE may used or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements or Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature:_____ Date:_____

Plastic & Cosmetic Surgery Center of Texas
Robert D. Wilcox, MD
5316 West Plano Parkway
Plano, Texas 75093

Billing Policies and Procedures

Thank you for choosing our doctor and Plastic & Cosmetic Surgery Center of Texas. We value our patients, and our goal is to provide a quality experience. We believe this should include how we handle the billing process for our services. We would like to take time to explain our office policies in order to avoid any greater out of pocket expense.

Payment Options:
We accept Visa, MasterCard, Discover, American Express, personal checks and cash. We also accept online payments if the amount is $500 or less. If a major procedure is to be done in less than two weeks, we cannot accept personal checks.

Returned Checks:
There will be a $25 charge for any returned checks. Any future treatments may be withheld until NSF checks have been cleared with our billing office.

Forms and Letters:
There is a $25 charge for forms and letter in regard to disability, insurance, FMLA, etc. Payment is to be made prior to forms being completed.

Collections:
We reserve the right to send all accounts with balances over 90 days old to an outside collection agency. You will be responsible not only for the account balance but also for the collection agency's fee.

Cosmetic Procedures:
Payments must be received in full before any procedure is performed. We accept financing through Care Credit.

Accident Cases:
Accident cases are considered self-pay. We do not become involved in litigation of the settlement of these cases. You will be given a receipt for any payment made to pursue your claim in these situations.

Medicare:
Medicare will be billed as well as any supplemental insurance carrier. You will be responsible for any charges not covered by Medicare and your supplemental insurance policy.

No Insurance:
Payment in full is expected at each visit. Should you require prolonged treatment, a monthly payment plan can be arranged. At the conclusion of your treatment, all services are to be paid in full within 60 days.

Insurance Coverage:

It is your responsibility to obtain appropriate referrals, authorizations and confirming that your insurance policy is current prior to each visit. As a service, we will bill your insurance carrier (for non-cosmetic procedures only). All co-payments are collected on the same day of services. All deductibles and co-insurance balances will be billed to you.

Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims by your insurer. Rejections of all or a portion of your bill by your insurance company does not relieve you of the financial obligation that you have incurred.

Estimates of Patient Responsibility:
We give our patients an estimate for procedures (which includes deductibles, co-insurance or co-pay) of what their responsibility will be in accordance with their insurance company. We do ask that this portion be paid prior to a procedure being performed. Please keep in mind that this is an estimate. The actual cost to you may be higher or lower, and you will be billed or refunded after your insurance has paid. Also, added procedures may be performed if the doctor deems necessary. This may cause your financial responsibility to increase.

If you have been given a cosmetic quote for a procedure prior to filing insurance, please be aware that the cosmetic quote is a reduced rate for our services. This filing amount to the insurance company may differ, and your financial obligation will be based on this filing amount.

Lab, Pathology and Anesthesia:
A procedure being filed with your insurance may require separate charges for lab, pathology and/or anesthesia services. Your insurance information will be forwarded so that these charges can be filed with your insurance company. You may receive separate bills from these providers.

Out of Network Provisions:
Please be advised that Plastic & Cosmetic Surgery Center of Texas (ASC) may not be an in-network facility with your insurance carrier.

We understand that billing and payment for healthcare services can be confusing and complicated. We are here to assist you. In certain circumstances, payment plans can be arranged with prior approval. If you have questions regarding fees or insurance, please feel free to contact us at 972-620-1700 ext 105 or 118.

I certify that I have read and understand the above financial policy.

_____ _____

(Signed by patient or responsible party) Date

_____

(Printed Name)

Robert D. Wilcox, M.D.

PLASTIC & COSMETIC
SURGERY CENTER OF TEXAS

J. Michael Morrissey, M.D.

972-620-1700

Wish List

- Do you have any concerns with the appearance of your skin? Yes / No

Please Describe: _____

- Do you have any concerns with aging skin and fine lines? Yes / No

Please Describe: _____

- Do you have any concerns regarding weight gain or weight loss? Yes / No

Please Describe: _____

- Do you have any concerns regarding hormone levels (testosterone / estrogen) Yes / No

Please Describe: _____

- Do you have any concerns with large pores or skin texture? Yes / No

Please Describe: _____

- Do you have any concerns with spider veins? Yes / No

Please Describe: _____

- Do you have any concerns with scaring / post-surgery scaring? Yes / No

Please Describe: _____

- Do you have any concerns with skin discoloration (sun damage, age spots)? Yes / No

Please Describe: _____

- Do you have any concerns with facial hollowness? Yes / No

Please Describe: _____

- Do you have any concerns with excess skin or fat under your chin / lower neck? Yes / No

Please Describe: _____

_____ _____

Patient Name Date

_____

Patient Signature