

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: _____

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 ?

(Mark all that apply)

TV News TV Ad Phone Book Magazine Newsletter Seminar Salon Web

Friend/Relative: _____ Doctor: _____ Other: _____

If you were referred by a specific person, may we thank them? Yes No

Emergency Contact

_____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Areas of Interest: (mark all that apply)

Facial Procedures

- Blepharoplasty (Eyelid Lift)
- Botox
- Brow or Forehead Lift
- Earlobe Repair
- Facial Liposuction (Neck, Jowls)
- Face or Neck Lift
- Lip Enhancement
- Otoplasty (Ear Pinning)
- Rhinoplasty (Nose Reshaping)
- Skin Resurfacing (Laser, Peel, Etc.)
- Wrinkle Fillers (Injections)

Breast Procedures

- Breast Augmentation
- Breast Reconstruction
- Breast Reduction
- Mastopexy (Breast Lift)
- Nipple Reduction or Inversion
- Body Procedures**
- Abdominoplasty (Tummy Tuck)
- Brachioplasty (Arm Lift)
- Full Body Lift
- Liposuction (Thighs, Abdomen, Etc.)
- Thigh or Buttock Lift

Other Procedures

- Skin Care
- Endermologie
- Telangectasia (spider veins)
- Laser Hair Removal
- Laser Tattoo Removal
- Leg Veins
- Lesions / Moles

I understand that office visit charges are payable on the day service is rendered.

Signature _____ Date _____

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

Health Information as of _____ (enter today's date)
 (Please Print Legibly & Fill In or Correct All Fields)

Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Name: _____ Reason for Visit: _____

Age: _____ Height: _____ Feet _____ Inches Weight: _____ Lbs.

Current Physician(s): _____

List all Surgeries (Hospitalization and the Date of Occurrence):

List any Serious Illnesses and/or Accidents:

Do you have or have you had any of the following: (circle for each, give date occurred if Yes)

Aids / HIV	No	Yes	Epilepsy / Seizures	No	Yes	Kidney Problems	No	Yes
Arthritis	No	Yes	Facial Pain	No	Yes	Pneumonia	No	Yes
Asthma	No	Yes	Fever Blisters	No	Yes	Sinus Problems / Infections	No	Yes
Bronchitis	No	Yes	Goiter / Thyroid	No	Yes	Stroke	No	Yes
Cancer	No	Yes	Hay Fever / Allergies	No	Yes	Tonsillitis	No	Yes
Depression	No	Yes	Headaches / Migraine	No	Yes	Tuberculosis	No	Yes
Diabetics	No	Yes	Heart Trouble	No	Yes	Ulcers	No	Yes
Dizziness / Vertigo	No	Yes	Hepatitis	No	Yes			
Ear Infection	No	Yes	High Blood Pressure	No	Yes			

Do you smoke? No Yes If yes, how much? _____ Pack(s)/day How long? _____ Years

Do you drink alcohol? No Yes If yes, how much? _____ How often? _____

Do you use recreational drugs? No Yes If yes, describe: _____

Do you have bleeding or bruising problems? No Yes If yes, describe: _____

Do you have problems with scarring? No Yes If yes, describe: _____

Do you have any history of problems with anesthesia? No Yes If yes, describe: _____

List the name of all medications you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency.

List ALL drug and/or latex allergies.

The above information is accurate and complete to the best of my knowledge.

Signature _____ Date _____

ETHRIDGE PLASTIC SURGERY

Patient:

Procedure Date:

PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, , authorize Ethridge Plastic Surgery, , and/or their 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. Richard Ethridge M.D and/or Ethridge Plastic Surgery 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 dermatology methods. I understand that such uses may also include marketing on behalf of Dr. Richard Ethridge M.D. , for which Dr. Richard Ethridge M.D. may be receive direct or indirect remuneration.
2. I will not be identified by name in any of the media described above; however, I also 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 **Mona Pyle Office Manager at 1622 8th Avenue Suite 130 Fort Worth, TX 76104**, A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization. If I do not revoke this authorization, it shall expire on the in 7 years. If I fail to specify an expiration date, event, or condition, this authorization will expire in **03/2017**, except to the extent action has been taken thereon.
4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Richard Ethridge M.D and/or Ethridge Plastic Surgery.

ETHRIDGE PLASTIC SURGERY

Patient: _____

Procedure Date: _____

5. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.
6. A copy of this Authorization is 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. Richard Ethridge M.D. and/or Ethridge Plastic Surgery 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.

If I have questions about the use or disclosure of my photographs, slides, or videotapes, I can contact **Mona Pyle Office Manager** at Ethridge Plastic Surgery 817-921-5566.

Patient is a minor years of age, and we, the undersigned, are the parents or legal guardian of them and do hereby have legal authority to consent and do consent for them.

Signature _____

Date _____

Witness _____

**NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM**

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

Date

Signature

Patient Initials: _____

Patient Name: _____

Procedure Date: _____

CONSENT FOR PROCEDURE or TREATMENT

1. I hereby authorize Dr. _____ and such assistants as may be selected to perform procedure(s) or treatment(s).
2. I recognize that during the course of medical treatment, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above physician and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time the procedure is begun.
3. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
4. I consent to the photographing or televising of the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures.
5. I consent to the disposal of any tissue, medical devices or body parts which may be removed.
6. I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical-device registration if applicable.
7. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
 - a. THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN
 - b. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
 - c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

SIGN A OR B

A. I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-7). I HAVE BEEN ASKED IF I WANT A MORE DETAILED EXPLANATION, BUT I AM SATISFIED WITH THE EXPLANATION, AND DO NOT WANT MORE INFORMATION.

Patient or Person Authorized to Sign for Patient

Date _____ Witness _____

B. I CONSENT TO THE TREATMENT OR PROCEDURE AND ABOVE LISTED ITEMS (1-7). I REQUESTED AND RECEIVED, IN SUBSTANTIAL DETAIL, FURTHER EXPLANATION OF THE PROCEDURE OR TREATMENT, OTHER ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT AND INFORMATION ABOUT THE MATERIAL RISKS OF THE PROCEDURE OR TREATMENT.

Patient or Person Authorized to Sign for Patient

Date _____ Witness _____

Patient Initials: _____

FINANCIAL POLICY

Thank you for choosing my practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

Please initial each of the following numbered items:

1. ____ If we participate with your managed care plan or you have a commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans. You will be responsible at the time of service for the payment of:

- Annual Deductible
- Co-payments
- Charges for non-covered or cosmetic services

In the event that we are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

2. ____ In the event your account balance is not paid within 120 days from date of the original statement, please be aware that your account could be referred to an outside collection agency. In addition, you may be subject to a service fee equal to 3% of your total balance owed.

3. ____ We are Medicare participating providers, therefore we will bill Medicare directly. You will be responsible at the time of service for payment of:

- The annual deductibles
- Co-payments
- Charges for non-covered or cosmetic services

You will be asked to sign a Waiver of Liability Form in the event that a service is provided, which we know is not covered by Medicare.

4. ____ If you have no health insurance, payment is expected in full at the time of service.

5. ____ In the event we receive a returned check due to insufficient funds, a fee of \$35.00 will be charged to your account and payment is due upon receipt of your statement.

6. ____ If you purchase skin-care products or supplies from our office, please understand that these products/supplies are a nonrefundable item. In the event that the product is defective, we will gladly replace the item(s).

7. ____ We request that you give 48 hours notice if you are unable to keep your appointment. Failure to give 48 hours notice will result in a \$35.00 missed appointment fee. This fee is not covered by your insurance plan

8. ____ Cosmetic consultation appointments require a credit card or debit card on file to hold your appointment. Your card will not be charged unless you No Show your appointment or hesitate to contact us within 48hrs that you need to cancel your appointment and is nonrefundable in the amount of \$100 if the appointment is missed. For your convenience we accept cash, check, MasterCard, Visa, American Express, Discover, and Care Credit.

If you have any questions, please do not hesitate to ask us. We are here to assist you any way possible.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Patient/Guardian Signature

Date

Patient Initials: _____