PLASTIC SURGERY CENTER OF DALLAS

DR. RACHEL WALKER, M.D.

6190 LBJ FREEWAY, SUITE 500 ▪ DALLAS, TEXAS ▪ 972-661-5077

IN OFFICE USE ONLY

PATIENT ID #:_____

PATIENT INFORMATION

Last Name: _____ First:_____ Middle_____

Date-of-Birth: _____/_____/_____ Age:_____ ☐ Male ☐ Female Social Security #: _____-_____-_____

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

Home: (_____)_____ Cell: (_____)_____ Other: (_____)_____

E-mail: _____ Would you like to receive appointment reminders? ☐ E-Mail ☐ Text

Employer: _____ Occupation: _____

Address: _____ Work # : (_____)_____

City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

Name:_____Relationship:_____

Address: _____

Home: (_____)_____ Cell:(_____)_____ Work : (_____)_____

ANY OTHER # THAT YOU MAY BE REACHED ON THE DAY OF SURGERY FOR LAST MINUTE CHANGES: (_____)_____

Marital Status: ☐ Single ☐ Married ☐ Other _____ Spouse's Name: _____
(or parent, if patient is a minor)

Spouse's Date of Birth: _____/_____/_____ Spouse's Employer: _____

Occupation: _____ Spouse's Cell # : (____)_____ Work #: (____)_____

PREFERRED PHARMACY

Name:_____ Pharmacy Phone #: (_____)_____

Address: _____
Street City State Zip

HOW DID YOU HEAR ABOUT OUR OFFICE? ☐ Web Search ☐ Sign/Drove By ☐ Real Self ☐ Social Media

☐ Personal Doctor ☐ Patient _____ ☐ Other _____

Who may we thank for your referral? _____

What procedure(s) are you here to discuss? _____

WOULD YOU LIKE INFORMATION ON ANY OF OUR OTHER SERVICES?

SURGERY
- ☐ BREAST IMPLANTS
- ☐ BREAST LIFT OR REDUCTION
- ☐ EYELIDS OR BROWLIFT
- ☐ NECK, CHIN CONTOURING
- ☐ NOSE RESHAPING
- ☐ LABIAL RESHAPING
- ☐ LIPOSUCTION, BODY CONTOURING
- ☐ TUMMY TUCK

OTHER AREAS_____

MEDICAL SPA
- ☐ BOTOX
- ☐ FILLERS
- ☐ CORRECTION OF EYELID BAGS
- ☐ LASER CORRECTION OF SKIN DISCOLORATION
- ☐ LASER HAIR REMOVAL
- ☐ LASER SKIN TIGHTENING
- ☐ LASER FOR SPIDER VEIN
- ☐ LASER WRINKLE REMOVAL
- ☐ LIP ENHANCEMENT

SKIN THERAPIES
- ☐ ACNE
- ☐ EYELASH ENHANCEMENT
- ☐ CHEMICAL PEEL
- ☐ FACIAL DISCOLORATION
- ☐ FACIAL SKIN RETEXTURIZING
- ☐ HYPERPIGMENTATION
- ☐ OTHER

_____

NAME: _____ DATE: _____/_____/_____

HISTORY & PHYSICAL

Sex: M ☐ F ☐ Age: _____ Height: _____ Weight:_____

Do You Have a Responsible Adult Available to Assist During Recovery Period Y ☐ N ☐ Relationship: _____

PERSONAL HABITS

Smoke: Y ☐ N ☐ Amount: _____pack(s) / cigarette(s) per _____ day / week
Alcohol: Y ☐ N ☐ Amount: _____ drink(s) per _____ day / week
Other: _____

ALLERGIES

Drug Allergies: Y ☐ N ☐ List drug(s) and type of reaction: _____

_____

Latex Allergy: Y ☐ N ☐ Tape Allergy: Y ☐ N ☐ Anesthesia Allergy: Y ☐ N ☐

MEDICATIONS

Please list any medications (name, dosage and frequency) that you are currently prescribed or are taking over–the–counter:

PRESCRIPTION NON – PRESCRIPTION

_____ _____

_____ _____

_____ _____

REGULAR ASPIRIN USE: Y ☐ N ☐ DOSE: _____ FREQUENCY: _____

NSA (ADVIL, MOTRIN, IBUPROFEN): Y ☐ N ☐ DOSE: _____ FREQUENCY: _____

FAMILY HISTORY

Have any blood relatives ever had the following problems:

Abnormal Bleeding: Y ☐ N ☐ Abnormal Clotting: Y ☐ N ☐ Anesthetic Problems: Y ☐ N ☐
Cancer: Y ☐ N ☐ Blood Clots in Legs: Y ☐ N ☐

Please describe questions with a "Yes" answer: _____

PERSONAL HISTORY

Have you ever been diagnosed with or experienced any of the following problems:

Abnormal Bleeding:	Y ☐ N ☐	Asthma:	Y ☐ N ☐	HIV	Y ☐ N ☐
Abnormal Clotting:	Y ☐ N ☐	Diabetes:	Y ☐ N ☐	Hypertension:	Y ☐ N ☐
Anemia:	Y ☐ N ☐	Heart Attack:	Y ☐ N ☐	Weight change in past 12 Mo.:	Y ☐ N ☐ _____ lbs. lost
Angina:	Y ☐ N ☐	Hepatitis:	Y ☐ N ☐	Other Serious Illness:	Y ☐ N ☐ _____

Please describe questions with a "Yes" answer: _____

_____

Have you ever received a blood transfusion? Y ☐ N ☐ If yes, in what year? _____
Have you been tested for HIV? Y ☐ N ☐ If yes, in what year? _____ Test results: ☐ Positive ☐ Negative
Do you wear: Contact Lenses: Y ☐ N ☐ List all previous surgeries and any complications:
Dentures: Y ☐ N ☐ _____
Crowns/Veneers/Caps/Bondings: Y ☐ N ☐ _____

PRIMARY CARE PHYSICIAN

Physician Name: _____ Date Last Seen : ____/____/_____
Address: Phone: : ( )

FEMALE PATIENTS ONLY

Last Menstrual Period: _____/_____/_____

# of Pregnancies: _____ # of Children: _____ Have you had a tubal ligation or hysterectomy? Y ☐ N ☐
If so, when? _____

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FINANCIAL ARRANGEMENTS AND OFFICE POLICIES

We are committed to providing you with the best possible care. The following is a statement of our financial policies which we request that you read and acknowledge prior to any treatment.

SCHEDULING AND CANCELLATION POLICY

Full payment for cosmetic procedures is due two weeks prior to surgery or at time of scheduling. To reserve a surgical date, a deposit of $2,060.00 is required (or $2000 by check or cash). We accept payment by cash, cashier's check, Care Credit or Alphaeon financing, and major credit cards.

After your surgery is scheduled, there will be a separate pre-operative appointment to thoroughly review the details of your surgery, obtain prescriptions, sign consent forms and complete all arrangements. Your balance is due in FULL at your pre-op appointment. If surgery is cancelled at any time following your pre-operative appointment, there will be an administrative fee of $500.00 deducted from your refund, in addition to any expenses we have incurred such as lab fees, shipping charges, financial transaction fees, etc. If surgery is cancelled within five working days of your procedure, 50% of your quoted fee will be refunded. Failure to show up for your scheduled surgery will result in forfeiture of 100% of your fees.

We very much understand that personal emergencies may come up unexpectedly, requiring that your surgery be rescheduled. These will be addressed individually but we may allow the above penalties to be applied towards rescheduled surgery one time. Multiple cancellations resulting in unfilled time are very costly to us. Therefore, if rescheduling is requested a second time there will be a 15% surcharge penalty which must be prepaid. All fees will be 100% forfeited in the event of a third cancellation. Forfeited funds will not be applied to future procedures. When using a finance company such as Care Credit, after your loan has been funded, any refunds will be based on their rules and policies in addition to those described above.

In the event of a dispute over payments or refunds with a credit card company or any other financial entity, we may have to disclose certain medical information to aid in resolution. For this reason, we require a HIPPA waiver for the use of credit. With your signature you hereby agree to waive your right to privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) guidelines only so that we may disclose whatever medical information is necessary to aid in the resolution of any such dispute.

_____ _____
Patient Signature Date

REVISIONS OR COMPLICATIONS

If there are necessary revisions to surgery, there will be no surgeon's fee. However, you would be responsible for anesthesia and operating room charges. This revision policy is confined to the 6 week period following your surgery unless other arrangements are made in advance of 6 weeks time. This policy does not apply to laser treatments or liposuction. (Please discuss these with the doctor.)

_____ _____
Patient Signature Date

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SHORT TERM DISABILITY, HEALTH INSURANCE & FMLA PAPERWORK POLICY

If you are filing FMLA paperwork and/or Short Term Disability with your employer, please complete all paperwork prior to your pre-operative visit and bring it with you to your pre-op appointment. We are not staffed to complete these lengthy documents or forms and have not factored into our fees the time necessary to complete them. Forms which you have completed will be given to Dr. Walker to sign and will be returned to you on the day of surgery.

The Plastic Surgery Center of Dallas is a non-insurance facility, specializing only in elective aesthetic surgery. Filing health insurance claims requires insurance coding software and up to date code books that we do not have at this facility. We do not have insurance or billing staff and we do not complete and/or file any insurance paperwork. We will give you any information we have and/or records however, so that you may file for insurance benefits on your own behalf. For any exceptions to this policy, such as forms, physician letters or other communication with your insurance company, you would be billed as an additional service.

I fully understand the Plastic Surgery Center of Dallas' policy as described above.

_____ _____
Patient signature Date

PHOTOGRAPHY

Medical photography is essential for legal documentation of your pre-operative condition and for planning of cosmetic surgery as well as medical education.

I consent to photography of appropriate portions of my face or body in preparation for surgery and for postoperative follow up.

_____ _____
Patient signature Date

I consent to the use of my photos for patient education or other educational or promotional purposes, providing that my identity is not revealed.

_____ _____
Patient signature Date

MEDICAL PHOTOS

By signing this consent, I understand the photos taken before & after my surgery are for the purpose of chart documentation and are a part of my legal medical record. I fully understand photos will NOT be released, copied, emailed, or mailed to me. I acknowledge that I am responsible for taking my own before & after photos, if I so choose.

_____ _____
Patient signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____ _____

Print Name of Patient Signature of Patient

IF PATIENT IS A MINOR:

_____ _____

Signature of patient Representative (Required if patient is a minor) Relationship of Patient Representative to Patient

Please note that Sate and Federal Law provides additional protections for minors and restricts the release of certain patient information to anyone other than the minor patient.

SECURE PHONE OPTION: Is there a phone number where a message containing personal health information could be left in the event you are not available when we call?

□ **YES** □ **NO** If 'Yes', what is the number? (_____)_____

Please list any person(s) you would like to authorize to have access to your billing, appointments, or health information*, such as your spouse, caretaker, or other family member:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____

With the exculsion of information that is protected under State and Federal Law.