PRMA Surgeon: Patient Acct

In Or d e r to serve you properly we will need the following information All information will be strictly confidential

How did you h ear about u s? ☐ Doctor:					☐ Family/Friend:			
☐ Breast Advocate App	☐ Google	☐ Facebook	☐ Twitter	☐ YouTube	☐ Nurse Navigator	☐ Other:		
Patient Last:		Patient First:			MI:		Sex: ☐ M ☐ F	
DOB:	Age:	SSN:			Driver's License#:			
Mailing Address:								
City:		State:			Zip:			
Phone#:		Cell or Alt#:						
Email Address:								
Marital Status ☐ Single ☐ Married								
Employer:		Occupation:			Work#:			
Emergency Contact:		Relationship:			Phone#:			
Preferred Language:					Ok to send newsletter? ☐ Yes ☐ No			
Race Ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic/Latino ☐ ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Other:								
Primary Ins. Co.:				Policy Holder:				
Policy/ Member#:				Group#:				
Secondary Ins. Co.:				Policy Holder:				
Policy/ Member#:				Group#:				

Primary Policy Holder (Fill out only if other than the patient)

Last Name:	First Name:	MI:
Street Address:		
City:	State:	Zip:
DOB:	SS#:	Phone#:
Employer:		Work#:
Relationship of Patient to Insured:		

Pharmacy Info (Required):	
Pharmacy Name / Store #:	Pharmacy#
Address:	

AUTHORIZATION OF PAYMENT

Payment Policy: All professional services rendered are charged to the patient. The patient is responsible for payment regardless of insurance coverage. Full payment is expected at time of each office visit unless arrangements have been made in advance. Billing information will be provided to expedite patient reimbursement from private insurance carriers.

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED UNLESS ARRANGEMENTS HAVE BEEN MADE

I hereby authorize the provider of services to release medical information concerning any examination and/or treatment for insurance purposes and direct payment for medical benefits payable to me for services rendered.

I hereby consent to and authorize the taking of photographs to be included as part of my medical record.

/ /

(Authorized Signature of Patient, Insured and/or Guardian) (Date)

(By typing your signature you agree for this to be your form of an electronic signature.)

MEDICAL HISTORY

NAME: DATE OF BIRTH:

CURRENT BRA SIZE:

DESIRED BRA SIZE:

CAFFEINE FREQUENCY: ☐ DAILY ☐ WEEKLY ☐ MONTHLY

OF PREGNACIES:

TYPE OF DELIVERIES: ☐ NATURAL ☐ CAESAREAN

HAVE YOU HAD A MAMMOGRAM BEFORE? ☐ YES ☐ NO

WHERE WAS THE MAMMOGRAM AT?

ARE YOU CURRENTLY EXPERIENCING A RECURRENCE OF BREAST CANCER? ☐ YES ☐ NO

LAST BIOPSY DATE:

HAVE YOU HAD A MRI BEFORE? ☐ YES ☐ NO

IF SO, WHERE WAS THE MRI AT?

HAVE YOU HAD BRCA (GENETIC) TESTING? ☐ YES ☐ NO

DATE OF BRCA TEST?

BRCA TYPE/RESULT

CANCER DIAGNOSIS DATE:

TYPE OF CANCER:

HAVE YOU HAD A LUMPECTOMY? ☐ YES ☐ NO

HAVE YOU HAD A MASTECTOMY? ☐ YES ☐ NO

DATE OF MASTECTOMY/LUMPECTOMY:

BREAST DIAGNOSED: ☐ RIGHT ☐ LEFT ☐ BOTH

HAVE YOU HAD CHEMOTHERAPY? ☐ YES ☐ NO

NEOADJUVANT CHEMOTHERAPY? ☐ YES ☐ NO

HAVE YOU HAD RADIATION? ☐ YES ☐ NO

NUMBER OF RADIATION TREATMENTS?

DATE OF LAST RADIATION TREATMENT?

BREAST TREATED WITH RADIATION? ☐ LEFT ☐ RIGHT ☐ BOTH

HAVE YOU HAD A TUMMY TUCK? ☐ YES ☐ NO

HEIGHT WEIGHT

MEDICAL HISTORY CONT.

NAME: _____

FAMILY PHYSICIAN _____ PHONE

OB GYN _____ PHONE

GENERAL SURGEON _____ PHONE

PLASTIC SURGEON PHONE

PREVIOUS SURGERIES:

YEAR	OPERATION	DOCTOR	CITY	COMPLICATIONS

Have you ever had a bad reaction to a general anesthetic? N ☐ Y ☐

Has anyone in your family ever had a bad reaction to anesthesia? N ☐ Y ☐

Have you ever had a bad reaction to a local anesthetic? N ☐ Y ☐

Are you allergic to tape? N ☐ Y ☐

Are you allergic to latex? N ☐ Y ☐

Do you have high blood pressure? N ☐ Y ☐

Have you ever had scarlet or rheumatic fever? N ☐ Y ☐

Do you bleed unusually easily? N ☐ Y ☐

Do you have diabetes? N ☐ Y ☐

Are you a slow or poor healer? N ☐ Y ☐

Do you form large scars or Keloids? N ☐ Y ☐

Do you have any skin disease or rash? N ☐ Y ☐

Do you have frequent infections or boils? N ☐ Y ☐

Have you taken steroid medication, cortisone) or ACTH N ☐ Y ☐

Do you have shortness of breath with walking? N ☐ Y ☐

Have you ever had significant emotional problems? N ☐ Y ☐

Have you ever been advised to see a psychiatrist or undergone psychiatric care? N ☐ Y ☐

Have you ever been diagnosed with Hep. A, B or C ? N ☐ Y ☐

Have you ever been diagnosed with HIV? N ☐ Y ☐

Have you ever been exposed to or diagnosed with Tuberculosis? N ☐ Y ☐

Have you ever been diagnosed with a bleeding disorder? N ☐ Y ☐

CHECK OFF if you have had problems in any of the following areas:

☐ BRAIN
☐ EYES
☐ EARS
☐ NOSE
☐ THROAT
☐ NECK
☐ CHEST
☐ LUNGS
☐ HEART
☐ STOMACH
☐ INTESTINES
☐ KIDNEY
☐ ARMS
☐ LEGS

Explain: _____

Please list any allergies to drugs or medications: _____

Please list all medications, vitamins, and/or supplements: _____

Do you smoke, vape or use Nicotine patch/gum?

N ☐ Y ☐ How much?

Do you chew tobacco?

N ☐ Y ☐ How much?

Do you drink alcohol?

N ☐ Y ☐ How often?

Do you use recreational drugs? N ☐ Y ☐

PRMA
PLASTIC SURGERY

Patient Name: _____ Medical Record No: _____

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented
8. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

/ / _____ _____

(By typing your signature you agree for this to be your form of an electronic signature.)

Patient's/parent/guardian Signature Date Time

/ / _____ _____

(By typing your signature you agree for this to be your form of an electronic signature.)

Witness signature **Date** Time

S/2015

ASSIGNMENT OF BENEFITS/ ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (employer. or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (employer or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provide, I hereby instruct and direct my benefit plan (employer or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (employer or its administrator) to make out check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid In full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Notice of Privacy Practices

In accordance with the Protected Health Information Act (PHI) our office will, without asking your express consent or authorization, use and disclose your PHI for the purposes of:

Treatment
Payment
Health Care Options
Advice of Appointments and Services
Directory/Sign-In Log
Court Orders, Subpoenas and Government Investigations
Advise Family/Friends directed by you to receive information regarding your health or to assist in the payment of your bill.

You have the right to revoke, request special limits or conditions, to receive communication by more confidential means or at alternate locations, to inspect and copy your PHI, and to amend your PHI.
Our office strives to maintain HIPAA compliance. I understand that by signing the above statement I have been notified of my rights in compliance with HIPAA regulations. I have been advised that I may request a complete copy of these rights available through the HIPAA officer at this location.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments: (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA .Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031 (b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider, and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

/ / _____

Patient
(By typing your signature you agree for this to be your form of an electronic signature.)

Date

_____

Policyholder/Insured

Date

PRMA Plastic Surgery
9635 Huebner Rd, San Antonio, TX 78240
502 Madison Oak Dr. #220, San Antonio TX 78258
210-692-1181

For all breast reconstruction patients:

All breast reconstruction procedures, whether immediate or deferred (cancer-free), are usually performed in three (3) stages. However, patients presenting for delayed reconstruction (cancer- -free) can be reprogrammed to accommodate a patient with immediate cancer.

The three (3) Stages of breast reconstruction are:
Stage 1: Mammary reconstruction
Stage 2: Phase review: Revision of the breast/abdomen and/or creation of the nipple*
Stage 3: Micro"pigmentation: nipple areola Tattoo
* Note: Depending on the type of review, the reconstruction of nipple recognition can be moved to Stage 3, which will move your micro pigmentation to a fourth stage.

The 3 stages of breast reconstruction surgery have a global period of 90 days according to the guidelines of the American Medical Association. This global period guarantees 90 days of recovery and postoperative care. It also indicates that you will not undergo additional surgery during the recovery period unless your surgeon requires it medically. All stages are billed separately to the insurance at the end of the surgery. Patients will be responsible for any applicable deductible/coinsurance at each stage of the reconstruction process. The benefits will be verified at each stage.

In addition, all insurance companies require a medical necessity letter before the revision surgery is approved. This process can take up to eig11t weeks. We cannot book a surgery date until your insurance company has approved the surgery.

Insurance policies will typically deem the first post-reconstruction revision surgery as medically necessary. Any additional revision surgery (beyond the first) will be reviewed on a case-by-case basis to determine medical necessity. If necessary, a cosmetic fee quote will be provided.

If you have any questions about these policies, please feel free to contact your individual insurance company, our surgery scheduler or the billing department.

I have read and understood the above information.

Patient Signature: / /

(By typing your signature you agree for this to be your form of an electronic signature.)

Date: _____

PRMA
PLASTIC SURGERY

Patient Photograph Consent and Release

This consent document has been prepared to request your permission to take photographs and to use these images for a purpose as defined within this document. It is important that you read this information carefully and completely. After reviewing, please indicate which consent you agree to by placing your initials where indicated and sign and date the consent at the bottom of this form.

By signing below, I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after each surgery. The photographs will be taken by a member of the PRMA clinical staff. I hereby give my consent for PRMA use the photographs for the below initialed circumstances:

_____ **1. ALL MEDIA**
INITIALS
Photographs taken of me or parts of my body as well as details regarding medical services that I have received at PRMA can be used in any print or broadcast media, including, but not limited to newspapers, pamphlets, office photo albums, educational films, internet, and television in order to inform the public about surgical procedures and methods. Further, I release and discharge PRMA and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication. I further release all rights if any I may have in said photographs and details, including any claim for payment in connection with any such use or publication. I give my consent as a voluntary contribution to public education. My consent is given on the condition that I am not identified by name at any time during any use or publication of these materials by any party.

_____ **2. MEDICAL CARE ONLY**
INITIALS
Photographs taken of me or parts of my body can be used solely for the purpose of medical care with PRMA and to request authorization for surgical procedures with my insurance company. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at PRMA. I also hereby grant permission for the use of any of my medical records including illustrations, photographs, or other imaging records created in my case, for the use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery.

Date: _____

Patient Printed Name: _____

Patient Signature: / _____ /
(By typing your signature you agree for this to be your form of an electronic signature.)
Witness:_____

Plastic Reconstructive & Microsurgical Associates

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Plastic Reconstructive & Microsurgical Associates's Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We will abide by the terms of this notice.

Uses and Disclosures
Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated. NOTE: If you pay out-of-pocket in full for the care or service provided, you have the right to ask us to restrict the disclosure of that information to your health plan.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of Plastic Reconstructive & Microsurgical Associates. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Individuals involved in your care or payment for your care: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research: When a research and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures that require your authorization: Disclosure of your health information or its use for any purpose other than those allowed or required by law requires your specific written authorization. Examples of these would be psychotherapy notes, marketing or fundraising activitiies. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information
Appointment reminders and testing results: Your health information will be used by our staff to send you appointment reminders. We may also contact you to provide results from exams or tests and to provide information that descibes or recommends treaments for your care.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples are billing or copying services, etc. We may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights
You have certain rights under the federal privacy standards. These include:

- **The right to receive a printed copy of this notice**

- **The right to inspect and copy your protected health information**
  This means that you may inspect, and obtain a copy of you complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper and electronic copies as established by professional, state or federal guidelines.

- **The right to request restrictions on the use and disclosure of your protected health information**
  This means you may ask us in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it , except in emergency circumstance when the information is needed for your treatment. In certain cases, we may deny your request for restriction. You have the right to request in writing, that we restict communication to your health plan regarding a specific treatment or service that you or someone on your behalf, has paid in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

- **The right to receive request and alternative means of confidential communications concerning your medical condition and treatment**
  This means that you have the right to ask us to contact you about medical matters using an alternative method and to a alternative destination (i.e., cell phone number or alternative address, etc.) designated by you. You must inform us in writing, using the form provided by our practice. We will follow all reasonable requests.

- **The right to amend or submit corrections to your protected health information**
  This means that if you believe that the information in your health record is incorrect or that information is missing, you have the right to request that we correct the records. Your request must be in writing and include the reason you are requesting the change. In certain cases we may deny your request.

- **The right to receive an accounting of how and to whom your protected health information has been disclosed to entities or persons for reasons other than treatment, payment or healthcare operations**

- **The right to receive notification following a breach of unsecured protected health information**

Right to Revise Privacy Practices As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting The Privacy Officer at the address below. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Contact Person
If you would like to submit a comment, concern or complaint about our privacy practices, you can do so by sending a letter or contacting the Privacy Officer with your concerns to:

Privacy Officer
Plastic Reconstructive & Microsurgical Associates
9635 Huebner Road
San Antonio, Texas, 78240
210-692-1181

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

Revised Effective Date : June 30, 2013

Plastic Reconstructive & Microsurgical Associates

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have reviewed Plastic Reconstructive
Patient Name
& Microsurgical Associates Notice of Privacy Practice, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

/ _____ / _____

Signature of Patient
(By typing your signature you agree for this to be your form of an electronic signature.)

Date

Please Indicate the parties you are allowing to have access to your medical records.

Name Relationship

Name _____ Relationship

Name Relationship

****

Plastic Reconstructive & Microsurgical Associates was unable to obtain acknowledgement because:

- ☐ Emergency Patient
- ☐ Sedated
- ☐ PatientRefused
- ☐ Reason_____
- ☐ Patient Non-Responsive
- ☐ Patient Confused/Disoriented
- -
- Other

_____ _____

Staff Signature Date

When you have finished the paperwork, please attach to an encrypted/secure email along with
your insurance cards & drivers license and send to
FrontDesk@PRMAPlasticSurgery.com.
If you need help with sending a secure email, please contact our front office at
210-692-1181 and select option 0.