PERSONAL DATA:

Full name: _____ Name you like to be called: _____

Address: _____ City: _____

State: _____ Zip: _____

Date of birth: _____ Age: _____ Sex: _____

SS#: _____

Home Phone: _____ Work Phone: _____

Cell phone: _____

E-mail address: _____

Which phone should we contact you on? _____

May we leave messages on this phone? Y ___ N ___ May we email you? Y ___ N ____

RESPONSIBLE PARTY (for minors under 18):

Name: _____ DOB: _____ Relation to patient: _____

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

Daytime phone: _____ Evening phone: _____ Cell phone: _____

EMERGENCY CONTACT:

Name: _____ Relation to patient: _____

Work Phone:_____ Home Phone:_____

EMPLOYER INFORMATION:

Employer: _____ Occupation: _____

Employer's address: _____ Phone number: _____

REFERRAL INFORMATION:

Physician referral: _____ Patient referral: _____ Other: _____

Primary Care Physician_____

Image Plastic Surgery | Sculptors Medical Day Spa

Insurance Information & Authorization

(Please Print Legibly & Sign)

Patient's Name _____
First Middle Last

Primary Insurance Company _____

Policyholder's Information: Policy Number: SS#

Name _____ Birthdate ___/___/___

Employer _____ Relationship to Patient _____

Does this insurance required a referral? ❒ Yes ❒ No Copay Amount $_____

Secondary Insurance Company _____

Policyholder's Information: Policy Number:

Name _____ Birthdate ___/___/___

Employer _____ Relationship to Patient _____

Does this insurance required a referral? ❒ Yes ❒ No Copay Amount $_____

Is this visit due to any type of accident? ❒ No ❒ Yes: Date of Accident _____

Type of Accident ❒ Auto: State? _____ ❒ Work Related ❒ Other: _____

All Patients – Signature on File

I request that payment of authorized benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services. I understand that I am financially responsible for all fees and charges not paid by my insurance company and that they are due and payable within 45 days of service unless other arrangements have been made with the office. I further understand that should ***Image Sculptors at ADC*** have to refer my account for outside collections that I am responsible for all fees incurred by the agency or attorney/legal fees.

Beneficiary Signature _____ DOB Date _____

Medicare Patients Only – Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by ***Image Sculptors at ADC*** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of ***Image Sculptors at ADC***. I understand that diagnosis or treatment of me by Image Sculptors may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. ***Image Sculptors at ADC*** is not required to agree to the restrictions that I may request. However, if ***Image Sculptors at ADC*** agrees to a restriction that I request, the restriction is binding on ***Image Sculptors at ADC***. I release all medical records to Image Sculptors, and all records created at ***Image Sculptors at ADC*** are the property of Image Sculptors.

I have the right to revoke this consent, in writing, at any time, except to the extent that ***Image Sculptors at ADC*** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review ***Image Sculptors at ADC*** ‘s Notice of Privacy Practices prior to signing this document. The ***Image Sculptors at ADC***'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of ***Image Sculptors at ADC***. This Notice of Privacy Practices also describes my rights and the ***Image Sculptors at ADC*** 's duties with respect to my protected health information.

Image Sculptors at ADC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the ***Image Sculptors at ADC***’s website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative	Date
Print Name of Patient or Personal Representative	Description of Personal Representative's Authority

I acknowledge that Abilene Diagnostic Clinic provided me with a written copy of its Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions. These are available in our office. Please ask to read them if you are interested upon arriving to your appointment.

_____ _____
Patient Signature **Date**

_____ _____
Personal Representative Signature (if applicable) **Relationship to Patient**

Please circle every physician/provider you see in the clinic.

FAMILY PRACTICE
RAUL CALVO, MD
JOSEPH CRUMBLISS, MD
DAVID HARPER, MD
JOSEPH DIXON, MD
B.J. ESTES, MD
FLOYD HENNAN, DO
*SHANNON POLONE, PA
GARY HOLLAND, MD
JAMES PURPURA, DO
*MARILYN BOND-KINKADE, NP
*BILL KINKADE, PA
CARL TRUSLER, MD

INTERNAL MEDICINE
CLINTON CAVUOTI, MD
MARK FEHL, DO
*MIKE BUSH, NP
JOSEPH FERGUSON, MD
THOMAS HEADSTREAM, MD
*TERESA HEADSTREAM, PA
*JODY MANUEL, NP
ROBERT KLEINHAUS, MD
KRISHNA KUMAR, MD
KEITH ROBINSON, MD
* HENRY ROBINSON, PA
LYNN ROBINSON, MD

GENERAL SURGERY
STEPHEN ABERNATHY, MD
GLEN EINSPANIER, DO
RICHARD FRAZEE, MD

ENT
THOMAS COTNEY, MD

OB/GYN
ROGER CASS, MD
CHARLES THOMPSON, MD
STEPHEN WARD, MD

ORTHOPEDICS
HENRY HENDRIX, MD
*REGAN POLONE, PA

PAIN MANAGEMENT
TONY BAUMAN, MD
GARY HEATH, MD
*SHONA PRESTON, FNP

PEDIATRICS
JAY CAPRA, MD
BRENT STEADMAN, MD

PHYSICAL THERAPY
MIKE CHAUVEAUX, PT
BILL KEEBLE, PT

UROLOGY
ROBERT PELFREY, MD
LANCE PICKARD, MD

WALK-IN CLINIC
MICHAEL JENKS, MD
*TRUDY SMITH, PA

PLASTIC SURGERY
LAURA BENNETT, MD
PETER GROTHAUS, M.B. , Ch..B.

What is the reason you are coming in today?:_____
Due to an injury? Y N On the job injury? Y N Auto accident? Y N Date of injury/accident: _____

PAST MEDICAL HISTORY: (Have you ever had any of the following medical conditions?)

High blood pressure	Y	N	Stomach ulcer or gastritis	Y	N
Heart attack or congestive heart failure	Y	N	Hepatitis or other liver disorder	Y	N
Heart murmur or heart valve disorder	Y	N	Kidney disease or failure	Y	N
Asthma, bronchitis or COPD	Y	N	History of blood clots in the veins of your legs	Y	N
Sleep apnea, or use CPAP	Y	N	Stroke or paralysis	Y	N
Anemia or any other blood disorder	Y	N	Diabetes or thyroid disorder	Y	N
Transfusion of blood or blood products	Y	N	Autoimmune disease	Y	N
Glaucoma or other eye disorder	Y	N	Arthritis or degenerative joint disease	Y	N
Seizure disorder	Y	N	Cancer (What type? _____)	Y	N
Depression, anxiety or any psychiatric disorder?	Y	N			

Any other medical problems (Be specific): _____

PAST SURGICAL HISTORY: (List all previous operations by date and any associated problems with the surgery or anesthetic)

SURGERY	*DATE*	*PROBLEMS WITH SURGERY OR ANESTHETIC*

ALLERGIES: (Reaction to any medication, drug or anesthetic)

MEDICATION	*REACTION*

MEDICATIONS: (**All** prescription and over-the-counter medications)

MEDICATION	*DOSE / FREQUENCY*

SOCIAL HISTORY:

Marital status: *S M D W* Number of children: ____ Children at home: ____ Hobbies: _____

Do you use tobacco/Nicotine products (gum, patches, etc.) ***Never In the past Occasionally Regularly***

Amount/day: _____ Number of years: _____ If yes, explain: _____

Do you drink alcohol? ***Never In the past Occasionally Regularly*** Amount/day: _____ Number of years: _____

FAMILY HISTORY: (Any history of the following conditions in a blood relative? Which family members?)

High blood pressure	Y	N _____	Heart disease	Y	N _____
Diabetes	Y	N _____	Stroke	Y	N _____
Cancer (type)	Y	N _____	Bleeding disorder	Y	N _____

REVIEW OF SYSTEMS: (Have you recently experienced or do you currently experience any of the following symptoms?)

Recent weight loss or easy fatigability	Y	N	Pain or burning when you urinate	Y	N
Fever, chills or night sweats	Y	N	Pain in your extremities or major joints	Y	N
Change in vision or temporary loss of vision	Y	N	Slow wound healing or excessive scaring	Y	N
Excessive tearing or excessively dry eyes	Y	N	Change in size or color of a mole or other growth	Y	N
Irregular heart rate or palpitations	Y	N	New lumps or discomfort in your breast	Y	N
Tightness, pressure or pain in your chest	Y	N	Dizziness, light-headedness or faintness	Y	N
Swelling of your feet or ankles	Y	N	Weakness in any extremity	Y	N
A recent cold, flu or pneumonia	Y	N	Any unusual stress in your life at this time	Y	N
Wheezing or shortness of breath	Y	N	Any chance that you may be pregnant	Y	N
Heartburn or reflux	Y	N	Excessive or prolonged bleeding when cut	Y	N
Frequent loose stools or constipation	Y	N	Any known deficiency of your immune system	Y	N
Blood in your stool or urine	Y	N	Allergy or reaction to Latex	Y	N

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

Please initial beside each paragraph. Where appropriate please **circle** the desired response

1._____ I consent to the taking of photographs by Image Sculptors or staff designee of me or parts of my body in connection with the plastic surgery procedures(s) to be performed by Image Sculptors. I understand my photograph will be taken prior to each and every treatment and saved for evaluation throughout the treatment process. (required)

2._____ I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc. (required)

3._____ I understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty years from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Image Sculptors. (required)

4._____ I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because all parties acting under Image Sculptors license and authority are not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA and may be redisclosed by parties acting under Image Sculptors license and authority. (required)

5._____ I release and discharge Image Sculptors, and all parties acting under his/her license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs. (required)

6._____ I (do/do not) grant permission of the use of any of my medical records including illustrations, photographs or other imagine records created in my case, ***for use in teaching purposes***, **so long as my identity is kept confidential, by removing all identifying features**. Teaching purposes include, but are not limited to: teaching seminars, medical publications and medical presentations.

7._____ I (do/do not) grant permission of the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in advertising, so long as every attempt is made to keep my identity confidential.

I grant this consent as a voluntary contribution and certify that I have read the above Authorization and Release and fully understand its terms.

Patient X_____ Date _____

WITNESS/PHYSICIAN: _____

I have read the above Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

Parent/Guardian _____ *Date* _____