GENECOV PLASTIC SURGERY GROUP

Patient Information

Name_____

Address_____

City_____ State_____ Zip_____

Home(____) _____

Work(____) _____ Cell(____) _____

Email_____

Preferred Method of Contact_____

DOB_____ Sex F M Marital Status S M D W

Social Security Number_____

Student: Y N Occupation_____

Employer_____

Patient's Spouse/Guardian

Spouse/Guardian_____

Address_____

City_____ State___ Zip_____

Home(___) _____ Work(____) _____

If the Patient is a Child

Mother's Name_____

Work Phone (___) _____

Father's Name_____

Work Phone (___) _____

Child Lives With_____

In Case of Emergency (someone not living w/patient)

Name_____

Phone (___) _____ Relationship_____

Pharmacy (name & location or phone #)

_____

Reason for Consultation

_____

Whom May We Thank for Referring You?

Name_____

Address_____

City_____ State_____ Zip_____

Phone(___) _____ Relationship_____

Other: Internet_____ GOOGLE___ TV___ Staff_____

Other_____

Pediatrician or Family Doctor

Name_____

Address_____

City_____ State_____ Zip_____

Phone(___) _____

Guarantor/Responsible Party

Name_____

Relationship to Patient_____

Address_____

City_____ State_____ Zip_____

Home Phone(____) _____

Work Phone (____) _____

DOB_____ Sex F M Marital Status S M D W

Social Security Number_____

Employer_____

Carrier_____

Benefits Phone Number (___) _____

Policy #_____ Group #_____

Is this Plan a PPO___ POS___ HMO___ Indemnity_____

Are Referrals Required?___ Are we in your Network?_____

If Medicaid, which Plan_____

Primary Care Physician_____

Phone Number (___) _____

Other Guarantor Information

Name_____

Relationship to Patient_____

Address_____

City_____ State_____ Zip_____

Home Phone(____) _____

Work Phone (____) _____

DOB_____ Sex F M Marital Status S M D W

Social Security Number_____

Employer_____

Insurance Carrier_____

Benefits Phone Number (___) _____

Policy #_____ Group #_____

Is this Plan a PPO___ POS___ HMO___ Indemnity_____

Are Referrals Required?___ Are we in your Network?_____

If Medicaid, which Plan_____

Primary Care Physician_____

Phone Number (___) _____

I certify the above information is correct to the best of my knowledge. I understand that I am financially responsible for all charges whether or not covered by insurance. I also have received a *Notice of Privacy Practices* from GPSG on date signed.

Signature_____ Date_____

Update Signature_____ Date_____

Update Signature_____ Date_____

GENECOV PLASTIC SURGERY GROUP
PATIENT MEDICAL HISTORY (ADULT)

ALLERGIES:

Do you have or have you ever had any drug/food allergies? Yes❒ No❒
If yes, please list and give type of reaction:_____

HISTORY:

Have any blood relatives had:

Diabetes?	Yes❒	No❒	_____
Cancer?	Yes❒	No❒	_____
Heart Disease?	Yes❒	No❒	_____

Other_____

Are you taking medications for the following conditions?			Medication	Dosage	How Often?
Diabetes	Yes❒	No❒			
High Blood Pressure	Yes❒	No❒			
Anemia	Yes❒	No❒			
Nervousness	Yes❒	No❒			
Sleep	Yes❒	No❒			
Heart Disease	Yes❒	No❒			
Thyroid	Yes❒	No❒			
Pain Killers	Yes❒	No❒			
Birth Control	Yes❒	No❒			
Menopause	Yes❒	No❒			

Please list any other medications you are taking (including dosage & how often taken)

Do you take aspirin or aspirin products: Yes❒ No❒

PAST OPERATIONS:

Have you ever had any operations? Yes❒ No❒ (Please include cosmetic procedures)
If yes, please list below:

Year	Type of Operation/Physician
_____	_____
_____	_____
_____	_____

Have you ever experienced malignant hyperthermia? Yes❒ No❒
Have you ever been pregnant? Yes❒ No❒ Number of children_____

MAJOR ILLNESSES:	Yes	No	Date		Yes	No	Date
Heart Disease	❒	❒	_____	Convulsions	❒	❒	_____
High Blood Pressure	❒	❒	_____	Nervous Breakdown	❒	❒	_____
Angina	❒	❒	_____	Depression	❒	❒	_____
Ulcers	❒	❒	_____	Jaundice	❒	❒	_____
Colitis	❒	❒	_____	Hepatitis	❒	❒	_____
Cancer	❒	❒	_____	Glaucoma	❒	❒	_____
Diabetes	❒	❒	_____	Cataract	❒	❒	_____
Kidney Disease	❒	❒	_____	Scarlet Fever	❒	❒	_____
Thyroid – *Over / Under Active*	❒	❒	_____	Rheumatic Fever	❒	❒	_____
Arthritis	❒	❒	_____	Tuberculosis	❒	❒	_____
Blood Clots	❒	❒	_____	Deep Vein Thrombosis	❒	❒	_____
Abnormal Bleeding	❒	❒	_____	Sleep Apnea/CPAP	❒	❒	_____
HIV/AIDS	❒	❒	_____	Other_____	❒	❒	_____

ADDITIONAL INFORMATION:

Height _____Weight _____Blood Pressure_____Do you smoke? Y❒ N❒ Do you drink alcohol? Y❒ N❒
When was your most recent: Chest x-ray_____EKG_____Complete Physical_____
Please include any other medical condition, illness or handicap that you may have:

PHARMACY INFORMATION:

Name_____ Phone _____
Location _____

SIGNATURE:_____ DATE: _____

THE GENECOV PLASTIC SURGERY GROUP
FINANCIAL POLICY

We are committed to providing you with the best possible health care, and we are pleased to discuss our professional fees with you at any time. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policies. Please ask if you have any questions about our fees, your responsibility or the financial policy.

All patients must complete our Patient Information Form and inform our office of any changes in address or insurance. In order for us to treat and care for our patients, we must have complete and correct information.

Payment for services rendered is ***due at the time of service***. We accept cash, check, Mastercard, Visa, Discover, and American Express. There will be a $25.00 service charge for any returned checks.

We expect TOTAL PAYMENT two weeks prior to all aesthetic procedures unless you have been pre-approved with one of our financial plans.

The charges on your account with our office will reflect ***our*** doctor's fees only, *unless otherwise noted*. Any hospital, x-ray, laboratory, anesthesia, pathology, etc will be billed by the provider performing the service.

Insurance Policy:
We will gladly answer questions regarding your insurance. If the proposed services are medically necessary, we will attempt authorization from your insurance company. You must realize, however, that:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- Not all services are a covered benefit in your contract. Some insurance companies arbitrarily select certain services they will not cover and these are a patient responsibility.
- If your insurance coverage is through a plan that we are ***not*** contracted with, regardless of your carrier's rate of reimbursement, you will be responsible for the **FULL** balance of your account. This includes any amount over "reasonable and customary".

We must emphasize that as a medical care provider, the relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. It is understood that temporary financial problems may affect timely payment of your account. If such problems arise, you are encouraged to contact us promptly for assistance in the management of your account.

"I hereby assign, transfer and set over to Genecov Plastic Surgery Group, P.A. all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with my current insurance company." _____ **Initials**

As part of your treatment, we require both before and after treatment photographs for which the fees are included in our charges.

If at any time after your initial surgery you feel that you need a revision surgery, facility and anesthesia fees will be applicable. Surgeons' fees are at the discretion of your surgeon.

"I authorize David G. Genecov, M.D., Carlos Raul Barcelo, M.D. and personnel of their choosing to photograph me prior to, during and following any surgery. I understand these photographs will be a part of my medical records and are vital to my quality of care and post surgical result."

Signature:_____ Date: _____

GENECOV
PLASTIC SURGERY GROUP

Photography Release

I, _____, do hereby grant the Genecov Plastic Surgery Group (**David Genecov, M.D**; **Carlos Raul Barcelo, M.D.)** its successors and assigns, the right to use photographs of me in which I have participated in for surgery on behalf of the Genecov Plastic Surgery Group.

I authorize the usage of these photographs for: (please check one or all that apply)

- ❑ Medical purposes related to case
- ❑ Scientific purposes, including seminars and medical articles
- ❑ Before-and-after photo album for cosmetic patients to view in the office
- ❑ Newsletter to be sent out to cosmetic patients
- ❑ Before-and-after sheet to be sent out to cosmetic patients
- ❑ Proprietary web site featuring cosmetic surgery information
- ❑ I WISH THAT MY PHOTOS BE USED FOR NO PURPOSE OTHER THAN MY MEDICAL FILE _____ initial

I understand that my name and/or identity will not be disclosed at any time.

I hereby release and discharge the Genecov Plastic Surgery Group from any and all claims and demands arising out of or in connection with the use of the photographs, including any and all claims for libel.

This authorization and release shall also ensure to the benefit of the legal representatives, licensees and assigns of the Genecov Plastic Surgery Group as well as the person(s) for whom he took the photographs.

I have read and fully understand the contents thereof.

_____
Witness / Office Staff Member

_____
Patient signature

_____
Patient full name (printed)

_____
Date

Patient Authorization for Personal Representative

Please print all information, then sign and date form at bottom.

Type of Authorization: Personal Representative

Patient Name: (please print)_____

Purpose of request: I authorize Genecov Plastic Surgery Group to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, they may exercise my right to inspect, copy and correct my protected health information. They may also consent or authorize the use or disclosure of my protected health information:

_____

Name of Personal Representative

_____

Address

_____

City, State, Zip

_____

Phone

Description of information to be disclosed: I authorize Genecov Plastic Surgery Group to disclose all of my protected health information to my designated personal representative.

Expirations or termination of authorization: This authorization will remain in effect until terminated by you, your personal representative or another individual(s) at legal entity authorized to do so by court order or law.

Right to revoke or terminate: As stated in out Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

Genecov Plastic Surgery Group
ATTN: Privacy Manager
11970 N. Central Expressway, Suite 270
Dallas, TX 75243

Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer by the responsibility of the Genecov Plastic Surgery Group.

_____ _____

Patient Signature Date