LOU PLASTIC SURGERY **(713) 932-7290**

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: ________________

Pharmacy : ________________________ Pharmacy Telephone #: ________________________________

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 Dr. Lou? Yellow Pages (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
(Not in your household) ____________________________ 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

Insurance Information & Authorization

(Please Print Legibly & Sign)

Patient's Name ____
First Middle Last

Primary Insurance Company ______________________________________

Policyholder's Information:

Name ______________________________ Birthdate ___/___/___

Employer ______________________ Relationship to Patient ______________

Subscriber ID # ______________________ Group # ______________

Does this insurance require a referral? ❒ Yes ❒ No Copay Amount $ ________

Secondary Insurance Company ______________________________________

Policyholder's Information:

Name ______________________________ Birthdate ___/___/___

Employer ______________________ Relationship to Patient ______________

Subscriber ID # ______________________ Group # ______________

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 Insurance 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.

Beneficiary Signature ______________________________ 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 ______________

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** ____________________

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: _________

INFORMED CONSENT – MEDICAL RECORDS RELEASE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/PROTECTED HEALTH INFORMATION

This document must be signed by the patient or person authorized by law.

Name:____

Address: ____

City: _______ State: _______ Zip Code:

Date of Birth: Social Security Number:

Other identifying information if applicable (other names): ____________________________________

Transmission by facsimile or electronic means authorized to expedite transfer of records.

I, ____________________________,hereby authorize Dr. Derek Lou to release the records identified on Exhibit A to this Authorization for Release of Protected Health Information. I agree to be responsible for all photocopying charges associated with the reproduction of such records.

This Authorization for Release of Protected Health Information applies only to the release of the records identified on Exhibit A. Such records should be released to [ ] ____for the following purpose(s): ____ ____.

I understand that providing my authorization is voluntary. I need not sign this Authorization for Release of Protected Health Information to continue to receive healthcare treatment from Dr. Derek Lou. I understand that I may revoke this authorization, in writing, at any time except to the extent that disclosure was made prior to the time I revoked this authorization. I further understand that I may inspect and receive copies of the information to be disclosed.

I understand that the health records and information disclosed, or some portion thereof, may be protected by the Federal Health Insurance Portability and Accountability Act ("HIPAA"). I further understand that it is possible that the information described above may be re-disclosed by the recipient and may no longer be protected by HIPAA. I further understand that my records may be protected under state law and, if so, cannot be disclosed without my written consent unless otherwise provided for in the law and/or regulations.

This Authorization for Release of Protected Health Information shall expire one (1) year from the date below. **My signature below acknowledges that I have read, understand, and authorize the release of the information described on Exhibit A.**

______________________________________ Date:__________________________________
[Name]

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INFORMED CONSENT – MEDICAL RECORDS RELEASE

EXHIBIT A

DESCRIPTION OF HEALTH INFORMATION SUBJECT TO AUTHORIZATION

By placing a check-mark in the spaces below, I authorize the release of the following records pertaining to services from ____________________________ to _______________________________ [insert dates]:

___ Complete medical record (all information)

___ All hospital/institution records (includes nursing records/progress notes)

___ Transcribed hospital/institution records (includes surgical reports, history/physical exam, consultation reports, discharge summary reports)

___ Laboratory reports

___ Pathology reports

___ Diagnostic imaging reports

___ EKG/cardiac reports

___ Physical/occupational therapy reports

___ Billing statements

___ Physician office/clinical records

___ Implant information (including operative report)

___ Photographs

Release of the following information may be governed by additional laws. I understand and agree that this information will be disclosed only if I place my **initials** in the applicable space next to the type of information:

___ HIV/AIDS information

___ Mental health information

___ Genetic testing information

___ Drug/alcohol diagnosis, treatment, or referral information

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Financial Policy

We the staff at Lou Plastic Surgery thank you for choosing us as your healthcare provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family.

We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact our Office Manager and Patient Care Coordinator, Erica Musto at (713) 932-7290.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in writing in advance by our staff.

_______(Initials) We make payments as convenient as possible by accepting cash, money orders, cashiers or personal checks, Care Credit and all major credit cards. Personal checks are not an acceptable payment for surgery deposits however, all other forms of payment listed above will be accepted. A $50.00 nonsufficient funds fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Interest
_______(Initials) Interest of 5% will incur per month if a balance remains unpaid after 60 days.

Insurance
_______(Initials) We require all insurance patients to provide valid credit card information at the time of booking their appointment. If the patient needs to reschedule or chooses to cancel the appointment a 48 hour notice must be given. If the patient does not give 48 hour notice and does not come in for the scheduled appointment a $50.00 no show fee will be charged for the missed appointment. This will be charged directly to the patient, not the insurance carrier.

_______(Initials) Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

_______(Initials) It is the patients responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information.

_______(Initials) It is the patients responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, **<u>we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier.</u>**

_______(Initials) Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing and appeal if these limitations are imposed. You as the guarantor, are responsible for all out-of-network fees. If we are not contracted with your carrier we will not negotiate reduced fees with your carrier.

Cosmetic Consultations
_______(Initials) All patients scheduling for a Cosmetic Consultation must provide valid credit card information at the time of booking the appointment. A nonrefundable $50.00 consultation fee will be charged to the credit card provided at the time of scheduling the appointment. If the patient chooses to schedule surgery, the $50.00 will be applied to the total cost of surgery otherwise the $50.00 is forfeited. If the patient needs to reschedule or chooses to cancel the appointment a 48 hour notice must be given. If the patient does not give 48 hour notice and does not come in for the scheduled appointment a $50.00 no show fee will be charged for the missed appointment.

Miscellaneous Forms, Additional Information, and Authorizations
_______(Initials) We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for school, sports or extracurricular activities there will be an administrative fee, not to exceed $35.00, for the additional information.

Missed, Cancelled and Rescheduled Appointments
_______(Initials) We require a notice of cancellations and/or rescheduling 48 hours in advance. This is intended to increase physician and staff productivity, to improve timely access to all patients and to reduce and/or eliminate empty slots in the appointment schedule. If you fail to keep your appointments without notifying us in advance: a missed and/or rescheduling appointment fee will apply. These fees are typically $50.00 but not to exceed 100% of the cost of your scheduled appointment. A new payment is expected to schedule another visit. Repeatedly missed and/or rescheduled appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients. Rescheduling a surgery will be subject to additional fees as stated on the Surgery Proposal provided to the patient and signed by the patient.

Medical Records Fees
_______(Initials) Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files, and or summaries.

_______(Initials) We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

Timeliness of Appointments
_______(Initials) We try to see everyone in a timely manner but if we are taking too long, let our Patient Relations Coordinator at the front desk know so that we can best serve your needs and reschedule you if necessary.

After-Hour Phone Call Charges to Patients/ Patient Agents
_______(Initials) After-hours calls to the physician and our nurses are handled by an answering service that charges a base monthly rate as well as a per call charge which is time-based. We can no longer bear or justify this expense. The rationale is that after regular business hours calls to us must be emergencies. If it is a medical emergency, it cannot be handled by phone and should require a visit to an emergency facility.

_______(Initials) Calls for non-urgent prescription refills will be taken during regular business hours or will require a fee if the physician is contacted after hours. We are discouraging abusive and intrusive behavior, but always stand ready to serve legitimate, justifiable after-hours patient needs.

_______(Initials) So on a discretionary basis, we will charge $25.00-$75.00 per call, depending on professional time spent handling the issue. **This will be billed directly to the patient, not to insurance,** since insurers, including Medicare, do not typically cover this. The patient and/or their agents are entirely responsible for settling such charges promptly.

Medication Refill Charge
_______(Initials) Due to an increasing volume for prescription refills, as well as diminishing reimbursements from insurance payers, most especially Medicare, it has become necessary to now charge a fee for refilling prescriptions requested outside of an office visit. Such requests must be received by our clinical staff and attached to the patient's medical record (which must be searched and retrieved). The request is then reviewed by a nurse who forwards it along with a note displaying the patient's recent pattern of refills and office visits. That information is then presented to the physician for a decision on whether a refill without a clinical visit and/or lab work is appropriate.

_______(Initials) As it is obvious, this entire process takes staff time (which must be compensated by this practice) and professional decision-making. As our fixed overhead costs have increased without commensurate compensatory increases in payment for services by insurers, we are forced to apply a charge of $25.00 per event. As always, we will try our best to provide a prescription med supply sufficient to last until your next appointment.

_______(Initials) Finally, in your best medical interests, it may be necessary to require an office appointment prior to refilling a medication.

_______(Initials) We have always given unparalleled service to our patients and commitment to their medical interests. Knowing this, we hope for your understanding and acceptance of this policy.

Refill Process:

1. Staff takes phone call and spends time documenting and understanding the request.
2. Staff looks up patient file and pulls it for review by medical staff.
3. Nurse looks over the request and gives to physician and looks at pattern of med requests and usage.
4. Doctor reviews request, prior pattern of med refills and usage, and reviews patient's personal medical history.
5. Doctor makes a judgement on appropriateness of refill at that time; whether further refills are medically justified and whether he needs to see the patient.
6. Staff is given back the file with the physician's instructions attached.
7. Patient is contacted regarding the above information.
8. If a refill is approved, a pharmacy must be called (with wait time) or refill faxed or sent by email to pharmacy.
9. All of above must be done according standard of care set forth by the Texas Medical Board and requires time and expense. This expense must be recouped by a service charge or office visit.
10. We can never provide more than one year's supply of any medication (including refills) without seeing the patient to maintain a proper standard of care.

I have read and understand the above policy and accept its terms and obligations. I agree to assign insurance benefits to whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by collection agency for costs of collections if such action becomes necessary.

Signature of Insured or Authorized Representative: ____

Signature of Witness: ____ Date:____________________

1201 Dairy Ashford Rd. Suite 117
Houston, Texas 77079
Phone: (713) 932-7290 Fax: (281)741-4544

Effective April 1, 2017

Short Notice Cancellation Policy and No Show Policy:

Lou Plastic Surgery is committed to scheduling each patient with enough time to allow for the attention necessary to give the best care possible.

Because we do not over-book, no-shows, short notice cancellations (48-hour notice), and same-day cancellations can pose a significant hardship on our practice.

Additionally, appointment slots that are booked and then result in no-shows, short notice cancellations, and same-day cancellations contribute to the length of time it takes for all patients to schedule an appointment.

Therefore, effective April 1,2017, Lou Plastic Surgery will charge a fee of $50 for all no-shows, short notice cancellations, and same-day cancellations.

Patients are asked to arrive 10 minutes prior to all scheduled appointments, all patients arriving more than 15 minutes past the scheduled appointment time will be required to reschedule the appointment for another day. Please contact our office for any questions or concerns regarding this policy.

Patient Signature: ______________________________

Witnessed by: ______________________________

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, _________________, Authorize Dr. Lou and/or Lou Plastic Surgery, and/or all representative(s), to take photographs, slides and/or videotapes of me or parts of my body pre-operatively, intra-operatively, and post operatively for the following procedure(s) and understand that these photographs/videos will be utilized as medical purposes to be used for my care, medical presentations, articles, website, and social media (including but not limited to Facebook, Instagram, Twitter, SnapChat)without compensation to me.

I understand that all pictures and/or videos will remain anonymous and any identifying features will be blurred/blacked out as best as possible.

*** The patient's face/identity will not be revealed in photographs/videos of body and/or breast procedures. Patient's having any facial procedures, the eyes will be blacked out. All identifying features will be blurred/blacked out as best as possible***

I understand that:

1. Such photographs, slides or videotapes may be published by *Dr. Lou and/or Lou 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/Social Media(Including but not limited to Facebook, Instagram, Twitter, SnapChat), for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that such uses may also include marketing on behalf of Dr. Lou , for which Dr. Lou 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 rare 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 **Erica Musto** at 1201 Dairy Ashford Rd. Ste 117, Houston, Texas 77079. A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization.

4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Lou and/or Lou Plastic Surgery, as this authorization is completely voluntary.

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.

Patient Initials: _________

6. A copy of this Authorization is as 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. Lou and/or Lou 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 an informed and voluntary contribution in the interest of public education and 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 **Erica Musto** at **(713) 932-7290.**

If patient is a minor, we, the undersigned, are the parents or guardian of the patient and do herby consent for the Patient.

Consent:

Signature ______________________________ Date ______________

Do not consent:

Signature ______________________________ Date ______________

Witness ______________________________

Patient Initials: _________