**Robert Najera, M.D.**

**Cosmetic and Plastic Surgery**

**GENERAL OFFICE POLICIES:**

Appointments: Patients are seen by appointment only. We try our best to run on time. Therefore, if you are more than 15 minutes late, it is up to the discretion of the doctor whether we will be able to see you at your time slot. You may be asked to reschedule.

We call one to two days in advance for appointment reminders. This allows us to see all the patients who have requested appointment times that day. Thus, we do request that you cancel your appointment 24 hours in advance, or you may be billed $25.

Office Hours: Our office hours are 8:30 A.M. to 4:30 P.M. Monday through Friday, and we are closed from noon to 1pm for lunch. Dr. Najera or a covering physician is available 24 hours a day for urgent situations.

**FINANCIAL POLICIES:**

Insurance Cards: You will be asked to present your insurance card at every visit. Although this might be inconvenient, it is necessary. Insurance plans and ID numbers are changing in order to keep social security numbers off the ID card.

Benefits: Insurance benefits can be very confusing. Each company has many different types of policies. Our office will try to help you as best we can. However, ultimately, it is your responsibility to know your benefits, including limitations and exclusions, as you are responsible for payment. If you have any questions regarding any of this, including covered services, deductibles, maximum benefits, please contact the insurance administrator of your employer or your insurance company.

New Insurance: If you have new insurance, please let us know at the time you schedule an appointment in order that we can verify benefits prior to your appointment. If we are unable to verify, you will be responsible for the total allowable charges. When your insurance company does pay, we will refund your overpayment.

Co-Pay: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please be aware that your insurance company may require a second co-pay if you address multiple problems during a physical exam or at the same time you have a procedure scheduled.

HMO/POS: You are required to be directed/referred by your Primary Care Physician (PCP) that you have selected or been assigned to by your insurance company before your appointment with Dr. Najera. If you have not done this, your insurance will not pay for your visit and you would be responsible for payment in full.

Insurance payments: We will sometimes ask your assistance to get the insurance company to pay the submitted charges. If they request some information from you, it is extremely important that you get them the information they request in a prompt manner. Always keep a copy of what you send them, along with the person’s name to send it to. Please follow up with that person within 24 hours to verify that they have received the information you sent and will be processing your claims. Ultimately, it is your responsibility for payment of the services provided.

Responsible Party: The patient being a child or minor, the parent or guardian bringing the child to the appointment is responsible for all co-payments, co-insurances, and outstanding balances. We will provide a receipt of payment in order that retrieval for payment can be refunded to the paying parent.

Self-Pay: Payment is required in full at the time of service.

**TREATMENT:**

Your treatment will be based on medical necessity. Some procedures and labs may not be covered under your particular plan. It is not our responsibility to verify that everything is covered before treatment is provided.

Medication: We prescribe the medication that we feel is best suited to your condition. If this medication is not covered, or has a very high co-pay, we would need to be provided with alternatives that are financially acceptable to you.

Refills: Please plan ahead for your prescription refills. If your prescription says no refills, please call your pharmacy. They will process an electronic or fax request to us. We need at least 24 hours’ notice to process the authorization.

**MEDICAL RECORDS AND FORMS:**

Our office follows the rules set forth by the Texas Medical Board when preparing and furnishing medical records. A $25.00 charge for the first twenty pages and $.50 per page for every copy thereafter is what they consider to be a reasonable fee. This fee includes the cost of copying and postage. Payment must be made prior to the release of the records. We ask that you allow 15 business days to process this from the date of the written request.

Copies of diagnostic tests or immunization records only will be provided at no charge with 48 hours’ notice.

If you require a form or a letter to be completed by the physician (other than excuse notes), a 48 hours’ notice is required. There will be a $25.00 charge for this service.

Thank you for choosing Dr. Robert Najera, M.D. Please let the receptionist know if you would like a copy of this for your records.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Legal Guardian Signature Date

**PATIENT TESTIMONIAL CONSENT**

By signing below, you are consenting to Najera Cosmetic and Plastic surgery’s use and disclosure of the information in your testimonial and acknowledgement that the testimonial and acknowledgement that the testimonial may be used, all or in part, in our advertising, publications, website, etc. Both now and in the future.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Legal Guardian Signature Date

**HIPPA Disclosure**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. Protected Health Information (PHI) may originate in your medical record at Texas Elite Plastic Surgery or may be received from outside health entities and filed in your medical record. I understand that this information can and will be used by Texas Elite Plastic Surgery to (a) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly (b) Obtain payment from third-party payers (c) Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its

Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy

Practices from my local office or by contacting the Privacy Officer at 4401 N. Coit Rd, Ste 305 Frisco, TX

75035. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release of Information Authorization**

Please mark below for release of information concerning your healthcare and/or financial arrangements:

Release information ONLY to me: \_\_\_ Yes \_\_\_\_ No

Release of Information to Spouse: \_\_\_ Yes \_\_\_\_ No

 Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Release of Information to Other Individual: \_\_\_ Yes \_\_\_\_ No

 Name & Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferences**

I prefer to be contacted in the following manner:

 Phone#: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Leave message with detailed information.

 Leave message with contact number only.

 Do **not** leave message.

I am fully aware my health information will be transmitted by electronic transmission, fax transmittal, internet or e-mail.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient/Guardian

**Consent to receive text messages about appointment reminders:**

**Patients in our practice**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number to receive appointment reminders. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing.

* The **CELL PHONE NUMBER** that I authorize to receive
	+ TEXT Reminders
		- Is: (\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

**Revocation**

* + I hereby revoke my request to receive any future appointment reminders for future communications via text.

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Patient Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Robert Najera, M.D. Cosmetic and Plastic Surgery**

**PATIENT INFORMATION SHEET**

Name: First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone# (\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Work# (\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Cell# (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Emergency# (\_\_\_) \_\_\_\_-\_\_\_\_\_ Emergency Contact Name \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_

Social Security Number \_\_\_\_ -\_\_\_\_\_-\_\_\_\_\_ Date of Birth\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_ Male Female

E-mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ @\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_ Marital Status S M D W

Who is your primary care physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: (\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_

(If you go to a group please specify the name of the physician you see most often.)

Pharmacy Name, Address & Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Status: Employed Student Retired

Employer Name, Address, & Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

­­­­­­­­­­­­­­­­­­­**­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE INFORMATION**

Name of Primary Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_

Name of Secondary Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_

**POLICY HOLDER INFORMATION (If Other Than Patient)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Address: (if different from patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOW DID YOU HEAR ABOUT OUR PRACTICE?**

\_\_\_A Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Family Member/Friend Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Newspaper/Television Which publication/program \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Seminar Date & Topic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Internet Website: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Other Please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization to Release Information:** I authorize Robert Najera, M.D. to release any information necessary, acquired in the course of my treatment, to process insurance claims. **Initial Here \_\_\_\_\_\_\_**

**Authorization to Pay Benefits Directly:** I authorize my insurance company to pay Robert Najera, M.D. directly for medical service rendered. I understand that I will be responsible for non-covered charges, balances after company benefits, deductibles and copayments. **Initial Here \_\_\_\_\_\_\_**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_**

**Robert Najera, M.D.**

**Cosmetic and Plastic Surgery**

**Patient Medical History**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe briefly your reason for coming to my office: (date of injury, if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the care of or have you ever been treated by a Medical Physician for any significant illness other than colds, flu or virus? If so, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following conditions: If YES, please explain:

Cardiac History No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding Problems No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hypertension No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIV/AIDS No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any significant illnesses or cancer that runs in your family? Please provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any surgical procedures in the past?

Date (mm/yy) Type of Surgery Name of Doctor Hospital

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ vaginal delivery/C-Section

When was your last mammogram? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last EKG? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

Alcohol Use: Never \_\_\_\_\_\_\_\_ Occasional \_\_\_\_\_\_\_\_\_ Drinks per week \_\_\_\_\_\_\_\_\_\_\_\_

Do you Smoke Cigarettes: Yes No If yes, how many per day? \_\_\_\_\_

Do you use smokeless tobacco Yes No

**CURRENT MEDICATIONS**

**(Include herbs, vitamins & any other over-the-counter medications.)**

Aspirin Yes No

Oral Contraceptives Yes No

Blood Thinners Yes No

Name of Medication Dosage Frequency Purpose

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies to Medications?

Penicillin Yes No if YES, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Local Anesthesia Yes No if YES, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

General Anesthesia Yes No if YES, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any others Yes No if YES, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies such as creams, tape, latex etc.? Yes No

Do you have any bleeding tendencies? Yes No

**Symptoms Review:** Please circle any symptoms you’ve had in the past few months:

**General Symptoms Hematologic/Allergy Gastrointestinal Cardiovascular**

Fever/Chills Clotting Problems Abdominal pain Chest pain

Change in appetite Swollen Glands Diarrhea Chest palpitations

Headache Hay fever Blood in stools Shortness of breath

Wt. loss/gain>10 lbs. Prolonged bleeding Bloating Swelling of legs

Nausea /vomiting Easy bruising Constipation Palpitations

**Neurological** **Endocrine Musculoskeletal ENT**

Memory loss Excessive thirst Joint pain Cold

Dizzy spells Intolerance to hot/cold Back pain Sore throat

Numbness Excessive fatigue Weakness Hearing loss

Insomnia History of Glaucoma

Tremors

Loss of balance

**Skin Respiratory Gynecologic Psychiatric**

Skin Rash Wheezing Breast pain or lump Depressive symptoms

Boils Frequent cough Hot flashes Thoughts of suicide

Change in - Cough up blood Vaginal Bleeding Anxiety

Appearance of mole Trouble breathing vaginal discharge High Stress level



Dear Patient,
Dr. Najera uses the services of American Surgical Professionals for assistance in the operating room. He has requested an ASP assistant to assist on your procedure. We would like to acquaint you with who we are and with the professional services we provide to you in the operating room. First assistants are highly skilled allied health professional trained in specific surgery specialties.

When scheduling a surgical procedure with a hospital or surgery center (“Facility”), your surgeon may determine that surgical assistant services are medically necessary for that procedure to provide you with the most optimal surgical care and outcome; such physicians’’ order for surgical assistant service is relayed to us either by the Facility or directly by your surgeons office. Surgical assistant services are performed strictly under the direction and supervision of the surgeon and within the scope of practice for surgical assistants defined by the rules and regulations of your state.

In the event we are unable to bill your insurance and you are considered “Self Pay” patient, you would then receive a bill in the amount of $300.00, for the service rendered. IF you have a qualified health savings account, you may use this method of payment. Please contact our office at the number below.

Should you have inquiries about our service or billing, please do not hesitate to contact us at 972-363-8200 during our regular business hours (8:00 am – 5:00 pm) CDT.

Acknowledgement
I the patient have read, understand and give consent to American Surgical Professionals to assist with my surgical procedure as requested by my surgeon. I understand I will be responsible for services not covered by any commercial insurance carrier.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Permission to Use Photograph/Video

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give my informed and voluntary consent to Texas Elite Plastic Surgery and/or his associates to take photographs and/or video of me pre-operatively, intra-operatively, and post-operatively. I understand that these photographs and/or videos will be utilized and posted on social media, advertising, and web content to show the transformation process to the general public which includes current and prospective patients. All pictures will remain anonymous and any identifying features will be blurred out as best as possible, however, I also understand that in some rare circumstances the photographs and/or videos may display features that identify me.

I understand entirely that this authorization is completely voluntary. I understand that any disclosure of information has the potential of unauthorized disclosure and the information may not be protected by applicable federal and/or state confidentiality rules. Dr. Robert Najera or a representative cannot guarantee, nor have liability should you disclose any identifying factors to a third party as they may not be required to maintain your privacy.

By signing this consent, I hereby, knowingly and voluntarily authorize Robert Najera, M.D., to use my photograph(s) and videos in the manner described above.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature, parent or guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If under age 18)

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_