Institute of Reconstructive Plastic Surgery of Central Texas

A member of the Seton Family of Doctors

Dear New Patient:

We would like to take this opportunity to welcome you to our practice.

In this packet you will find the Institute of Reconstructive Plastic Surgery of Central Texas new patient paperwork for you to fill out and bring with you to your first appointment. Our HIPPA Privacy Policy is also included; please read the policy and it is yours to keep for your records. We ask that you please arrive to the clinic for your appointment at least 30 minutes early to allow for processing of your paperwork so that we may be prepared to see you at your scheduled appointment time. Enclosed you will find driving directions to our Austin clinic which also includes instructions on how to get to our clinic from the Clinical Education Center and University Medical Center Brackenridge parking garages.

For the benefit of our patients we are contracted with several insurance carriers as a provider. As part of our contract with the insurance companies we are legally required by the terms of the contract to collect any co-pays or deductibles from you at the time of service. Prior to your appointment, our office will verify your insurance benefits, if any, and you will be notified during your pre-appointment reminder call of what your co-pay/co-insurance obligations will be for each visit. We do ask that you be prepared to pay your co-pay/ co-insurance payment at the time of check in. For your convenience we accept cash, check, MasterCard and Visa.

We look forward to seeing you at the clinic, and we will do our best to make your visit as pleasant and efficient as possible. If you have any questions regarding our clinic or specifically your visit to our clinic please feel free to contact us at 1-877-977-3866. Please visit our website at www.SetonPlasticSurgery.com for more detailed information on our practice and physicians.

Thank you for giving us the opportunity to serve you and your family.

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DRIVING & PARKING DIRECTIONS

FOR OUR AUSTIN LOCATION

The Institute of Reconstructive Plastic Surgery of Central Texas is located at 1400 N. IH 35, Suite 320. The clinic can be found in the Clinical Education Center (CEC) which is a part of University Medical Center Brackenridge. If you have any issues finding the clinic please feel free to call our office at (512) 324-8320 and we will be happy to help direct you to the clinic.

From North Austin:
Head south on I-35. Take Exit 235A toward 15th St. Merge onto East Ave/I-35 Frontage Road. When you reach 15th Street you will see UMC Brackenridge on your right. Proceed through the light at 15th Street and take your first right turn into the CEC driveway. At that time you will see the entrance for the CEC parking garage on your left.

From South Austin:
Head north on I-35. Take Exit 235A toward University of Texas/15th St./Martin Luther King Blvd./State Capitol. Merge onto the I-35 Frontage Road. Take the U-turn that is available just before the 15th Street light to head back south on the IH 35 frontage road. When merging onto the IH 35 frontage road you will need to get in the far right lane. After the u-turn you take your first right turn into the CEC driveway. At that time you will see the entrance for the CEC parking garage on your left.

Entering through the CEC:
Once in the Clinical Education Center lobby, take the elevator to the third floor. The Institute of Reconstructive Plastic Surgery of Central Texas is located in Suite 320, down the hallway to the left.

Entering from University Medical Center Brackenridge:
From the UMC Brackenridge Lobby on the 2nd floor, pass the main elevators and follow the hallway around to the right. The hallway will wind around, but continue to follow, staying to the right when needed. You will eventually cross the skywalk and enter the CEC. Stay to the right (you will pass classrooms and offices). At the end of the hallway, turn to the right and enter the CEC elevator bank. Take the elevator to the 3rd floor. The Institute of Reconstructive Plastic Surgery of Central Texas is located in Suite 320, down the hallway to the left.

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AUTHORIZATION TO RELEASE MEDICAL PHOTOGRAPHS

I, _____ [patient name], hereby acknowledge that Institute of Reconstructive Plastic Surgery of Central Texas and Seton Healthcare (d/b/a Seton Family of Hospitals), together with their employees, agents, and/or officers (the "Authorized Parties") will take pre-, intra- and post-operative/treatment photographs (the "Photographs") of the following surgery or treatment [purpose, hospital/location]:

_____

I acknowledge that the Photographs may be stored in electronic and/or paper medical records and used in my clinical care related to the above-described surgery by the Authorized Parties.

I hereby _____ authorize _____ do not authorize the Authorized Parties to also use the Photographs for professional medical purposes including but not limited to testing and credentialing, educational purposes for other physicians and patients, and for medical presentations, teaching, and/or medical journal articles.

I hereby _____ authorize _____ do not authorize the use of those Photographs attached to this Authorization by the Authorized Parties for marketing purposes, including publication in brochures, newsletters, and websites of any one or more of the Authorized Parties.

I hereby _____ authorize _____ do not authorize 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, Inc. Note: The Board requires that all identifiable characteristics, with exception of a full face photograph or photograph of a uniquely identifiable characteristic, be blanked out for submission of materials for the Oral Examination of the American Board of Plastic Surgery to protect patient privacy.

I understand that I will not be entitled to any payment or other form of compensation as a result of any use of the Photographs, which shall be the property of the Authorized Parties. I understand that my clinical care will not be affected by my choice to authorize or not authorize use of the Photographs above. I hereby release and hold harmless the Authorized Parties of and from any and all claims, demands, damages or causes of action in connection with the uses of the Photographs I have hereby authorized.

Patient Signature: _____
[Patient must be 18 years or older]

Printed Name: _____

Date: _____

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Report of Accident Details:

Name of Individual Injured: _____

Date of Accident: _____

Did this Accident Occur at Work: YES NO

Accident Location: _____

Body Part Injured: _____

Brief Description of Accident: _____

_____

_____

_____

Patient or Guardian Signature: _____

Printed Name: _____ Date: _____

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Demos: _____

How did you hear about our practice? (Check all that apply)
Friend____ Dr.____ Hospital____ Clinic____ Ins____ Ad____ Web search____ Ph book____ Other____
Have you been seen in the ER? _____Yes _____No If Yes, Where _____

PATIENT INFORMATION

Patient Name (Last, First, MI)_____ Sex (circle) Female Male
Address _____Apt#_____ City_____ State_____ Zip _____
Home phone _____ Work phone_____ Cell phone _____
Email address_____ ***Please circle the number/email at which you prefer to be contacted.*** *Our staff may contact you by any methods provided (e.g., email, mail, text, phone) with regard to your treatment and care.*
Date of birth_____/_____/_____ Social Security #_____-_____-_____ Drivers license# _____
Employer/School Name _____Occupation_____
Address _____City_____ State_____ Zip _____

This section optional. Primary language spoken: _____ Please indicate patient race:
White ____ American Indian/Alaskan native ____ Asian ____ Native Hawaiian/Other Pacific Islander ____
Black or African American ____ Hispanic ____ Other Race ____ Other Pacific Islander ____

INSURANCE INFORMATION

Primary Insurance Company_____ Policy#_____ Group#_____
Insurance Co. Address _____City_____ State_____ Zip _____
Insurance Co. Phone_____**Primary Care Physician**_____Phone_____
Policy Holder Name (Last, First, MI)_____ Relationship to patient_____
Policy Holder Address _____City_____ State_____ Zip _____
Policy Holder Date of Birth_____/_____/_____ Policy Holder Social Security #_____-_____-_____
Policy Holder Employer_____
Employer Address _____City_____ State_____ Zip _____

Secondary Insurance Company_____ Policy#_____ Group#_____
Insurance Co. Address _____City_____ State_____ Zip _____
Insurance Co. Phone_____
Policy Holder Name (Last, First, MI)_____ Relationship to patient_____
Policy Holder Date of Birth_____/_____/_____ Policy Holder Social Security #_____-_____-_____
Policy Holder Address _____City_____ State_____ Zip _____
Policy Holder Employer_____
Employer Address _____City_____ State_____ Zip _____

RELEASE OF INFORMATION
With whom may we share your medical information: _____

EMERGENCY INFORMATION
Name of Person to Contact in an Emergency _____Relation to patient _____

Phone_____ Alternate Phone_____

AUTHORIZATION
Consent for treatment: I authorize the physicians at Institute of Reconstructive Plastic Surgery of Central Texas to provide me with reasonable and proper medical care according to today's standards.
Financial Responsibility, Authorization to Release Information, Assignment of Benefits: I authorize Institute of Reconstructive Plastic Surgery of Central Texas to release information in connection with my treatment to my insurance company or companies, my employer or any third party payer at such time as information is requested. I authorize assignment of benefits to Institute of Reconstructive Plastic Surgery of Central Texas. **I understand and agree that I am financially responsible for any and all charges incurred.**

Patient or Guardian Signature: _____Date:_____

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Craniofacial New Patient Information Form

Reason for visit: _____

Where is the problem located? Right, Left, or Both (please be specific): _____

When and how did this problem begin? _____

Who referred you to us? _____

Date of injury/problem: _____

Circle the symptoms that describe your problem: pain numbness swelling double vision chewing

If you have pain, please circle the description that is most appropriate:

sharp throbbing dull aching burning stabbing heavy

Circle the number corresponding to the intensity of your pain or symptoms (1 is no pain and 10 is the worst pain imaginable) 1 2 3 4 5 6 7 8 9 10

Circle all that apply: Is your pain getting:

better better gradually better rapidly getting worse worse gradually worse rapidly

What improves your symptoms?

_____

What makes your symptoms worse?

_____

Please list the specialists that you see:

_____

Please list any surgeries: ☐ **None**

Date	**Surgery**	**Date**	**Surgery**

Do you have problems with anesthesia? Yes No If yes, explain _____

_____

Family History (Parents, Siblings, Children)

Bleeding Disorder	Yes	No	Problems with anesthesia	Yes	No
Diabetes	Yes	No	Asthma	Yes	No
High Blood Pressure	Yes	No	Breast Cancer	Yes	No
Heart Disease	Yes	No	Other Cancer	Yes	No
Arthritis	Yes	No	Stroke	Yes	No

Social History:

Marital Status: Single Married Divorced Widowed

Do you smoke or use any tobacco products? Yes No How much per day? _____

Do you consume alcohol? Yes No How many per week? _____

Name: _____

Date: _____

REV1012

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Craniofacial New Patient Information Form (Continued)

Current Medications: Please list all prescription and over the counter medicines you are taking: ☐ None

Medication	**Dose**	**Medication**	**Dose**

Medication Allergies: *Yes* No If yes, to what? _____

Other Allergies: *Yes* No If yes, to what? _____

Labs: Have you had any labs for this problem? _____

Studies: Have you had any radiographic studies for this problem? _____

_____

Are there any special needs for this visit? *Yes* *No* If yes, please explain:

_____

Are you interested in learning about cosmetic surgery? Yes No If yes, please explain:

_____

Name: _____

Date: _____

REV1012

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Craniofacial New Patient Information Form (Continued)

Review of Systems:

Do you have any of the following medical problems? Please circle and check boxes below

	YES	NO	Comments
General (weight gain, weight loss, fatigue, insomnia, fever)	☐	☐	
Vision (glasses, contact lenses, cataracts, glaucoma)	☐	☐	
Ear / Nose / Throat (sinus problems, hearing loss, ringing in ears)	☐	☐	
Heart (irregular heartbeat, murmur, high blood pressure, heart disease)	☐	☐	
Pulmonary(short of breath, lung disease, persistent cough, sleep apnea)	☐	☐	
Stomach and Intestinal (decreased appetite, constipation, heartburn, nausea, vomiting, diarrhea, hepatitis A, B, C)	☐	☐	
Muscle and Skeletal (arthritis, fractures, sprains, spine problems)	☐	☐	
Genital Organs and Urinary System (kidney stones, bladder or kidney infections, kidney disease, prostate problems)	☐	☐	
Skin (swelling, blisters, dermatitis, eczema, acne, keloids)	☐	☐	
Neurological (problems with swallowing, seizures, tingling sensation, numbness, severe headaches)	☐	☐	
Psychiatric (anxiety, depression, bulimia, anorexia, other)	☐	☐	
Endocrine (increased thirst, diabetes, thyroid disease)	☐	☐	
Hematology (bleeding problems or clots, anemia)	☐	☐	
Immune (swollen or enlarged lymph nodes, cancer)	☐	☐	

Please list any other medical problems for which you are being treated: _____

_____

_____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Name: _____

Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been given a copy of the Privacy Notice.

Patient or Guardian Signature: _____

Date: _____