



Seton Institute of Reconstructive Plastic Surgery

A member of the Seton Healthcare Family

Hand • Breast • Advanced Facial Surgery • Wound Care • Plastic Surgery

Dear New Patient:

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

In this packet you will find the Seton Institute of Reconstructive Plastic Surgery 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. Next, 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.

James Cullington, MD • Nabil Habash, MD • Raymond Harshbarger, MD • Steven Henry, MD
Patrick Kelley, MD • Sanjay Sharma, MD • Adam B. Weinfeld, MD



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FINANCIAL AND CANCELLATION POLICY FOR COSMETIC SURGERY

We consider it an honor and privilege that you have chosen us for your cosmetic needs. Fees for cosmetic surgery are generally not covered by insurance. A detailed quote for the proposed surgery will be provided after your in-office consultation. If you elect to have surgery, a \$250 scheduling fee is due at the time the surgery is scheduled. This fee will be applied toward the surgery.

Payment of Balance

Full payment for cosmetic surgery is due in full two weeks (14 days) in advance of the surgery date. We accept all forms of payment including cash, checks, and major credit cards. If payment is not received within two weeks of your surgery, the surgery will be cancelled and the \$250 scheduling fee will be forfeited.

Cancellation & Refund Policy

We understand that a situation may arise that could force you to reschedule, postpone or cancel your surgery or procedure. If you decide or need to cancel your surgery, you must do so two weeks (14 days) in advance of the surgery date in order to receive a refund.

If you cancel your surgery between 7 – 13 days prior, 20% of the surgeon's fee will be forfeited as well as the \$250 surgery scheduling fee.

If you cancel 6 days or less from the date of the surgery, 90% of the surgeon's fee will be forfeited as well as the \$250 surgery scheduling fee.

If there is a medical reason to cancel surgery within the two week period (i.e. pregnancy, injury, illness) a full refund will be given, however the \$250 scheduling fee will be forfeited to apply towards the lost operating room time.

By signing this form I acknowledge and agree that I have read, understand, and agree to be financially responsible for all fees incurred for my cosmetic surgery.

Patient Signature

Date

Patient Printed Name

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DRIVING & PARKING DIRECTIONS

FOR OUR AUSTIN LOCATION

The Seton Institute of Reconstructive Surgery 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 Brackenridge Hospital 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 Clinical Education Center:

Once in the Clinical Education Center lobby, take the elevator to the third floor. The Seton Institute of Reconstructive Plastic Surgery 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 Seton Institute of Reconstructive Plastic Surgery is located in Suite 320, down the hallway to the left.

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Seton Institute of Reconstructive Plastic Surgery

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1400 N. IH-35, Suite 320 Austin, Texas 78701

Phone: (512) 324-8320 • Toll-Free Phone: (877) 977-3866 • Fax: (512) 324-8323

Demos:

How were you referred to our practice? Friend _____ Dr. _____ Hospital _____ Clinic _____ Ins _____ Ad _____ 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.**

Date of birth _____ Social Security # _____ Drivers license# _____

Employer/School Name _____ Occupation _____

Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Primary Insurance Company _____ Policy# _____ Group# _____

InsuranceCo.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# _____

InsuranceCo.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 Seton Institute of Reconstructive Plastic Surgery 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 Seton Institute of Reconstructive Plastic Surgery 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 Seton Institute of Reconstructive Plastic Surgery.

I understand and agree that I am financially responsible for any and all charges incurred.

May we contact you at your email address? Yes _____ No _____

Patient or Guardian Signature _____ 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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Authorization to Release Medical Photographs:

I, _____, hereby authorize the physician and/or his associates, to take pre-operative, intra-operative, and post-operative photographs, appropriate for my surgery. I further authorize the physician and his associates to use the photographs for professional medical purposes deemed appropriate, including, but not limited to chart documentation, testing and credentialing, educational purposes for other physicians and patients, and for medical presentations, teaching, and/or journal articles. I will also allow my photographs to be used for other practice marketing purposes such as brochures, newsletters, and/or physician's websites. The physician or his associates will notify me if my photos will be utilized in any of the above manners, and I agree to have the right to refuse their usage. 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.

Patient or Guardian Signature: _____

Printed Name: _____

Date: _____



Breast New Patient Information Form

Reason for visit: _____

Which Breast Right Left Both

When were you diagnosed with this problem? _____

Who referred you to us? _____

Circle the symptoms that describe your problem: mass pain discharge swelling asymmetry

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: _____

Current Bra Cup Size _____ Desired Bra Cup Size _____

Is there a chance you might be pregnant? Yes No

Have you ever had a miscarriage? Yes No

Have you ever been pregnant? Yes No If yes, how many times? ___ how many children? ___

Any complications with pregnancies? Yes No If yes, specify _____

Did you breast feed? Yes No If yes, how many times? ___ for how long? _____

Date of last mammogram _____ Normal Abnormal Please specify abnormality _____

Breast Biopsy? Yes No If yes, specify date _____ Right Left Both

Breast Cancer Treatment? Yes No If yes, date and type of treatment _____

Mastectomy? Yes No If yes, specify date & type of treatment _____

Breast Surgeon name & phone # _____

Oncologist name & phone # _____

Name: _____ Date: _____



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Please list any surgeries: None

Date	Surgery	Date	Surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any 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? _____

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, explain _____

Name: _____ Date: _____



Breasts 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)	<input type="checkbox"/>	<input type="checkbox"/>	
Vision (glasses, contact lenses, cataracts, glaucoma)	<input type="checkbox"/>	<input type="checkbox"/>	
Ear / Nose / Throat (sinus problems, hearing loss, ringing in ears)	<input type="checkbox"/>	<input type="checkbox"/>	
Heart (irregular heartbeat, murmur, high blood pressure, heart disease)	<input type="checkbox"/>	<input type="checkbox"/>	
Pulmonary (short of breath, lung disease, persistent cough, sleep apnea)	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach and Intestinal (decreased appetite, constipation, heartburn, nausea, vomiting, diarrhea, hepatitis A, B, C)	<input type="checkbox"/>	<input type="checkbox"/>	
Muscle and Skeletal (arthritis, fractures, sprains, spine problems)	<input type="checkbox"/>	<input type="checkbox"/>	
Genital Organs and Urinary System (kidney stones, bladder or kidney infections, kidney disease, prostate problems)	<input type="checkbox"/>	<input type="checkbox"/>	
Skin (swelling, blisters, dermatitis, eczema, acne, keloids)	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological (problems with swallowing, seizures, tingling sensation, numbness, severe headaches)	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric (anxiety, depression, bulimia, anorexia, other)	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine (increased thirst, diabetes, thyroid disease)	<input type="checkbox"/>	<input type="checkbox"/>	
Hematology (bleeding problems or clots, anemia)	<input type="checkbox"/>	<input type="checkbox"/>	
Immune (swollen or enlarged lymph nodes, cancer)	<input type="checkbox"/>	<input type="checkbox"/>	

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

Patient Signature: _____ Date: _____

Name: _____ Date: _____

Physician Signature: _____ Date: _____