The Methodist Hospital
Institute for Reconstructive Surgery (Instituto de Cirugía Reconstructiva)
Patient Information Form *(Forma De Registro Del Paciente)*

PLEASE FILL IN ALL BLANKS:
FAVOR DE LLENAR TODOS LOS ESPACIOS:

Date *(Fecha)* _____ Physician *(Médico)* _____

___ New *(Nuevo)* ___ Update *(Actualización)* _____

PATIENT DATA

Patient Name (Last, first, middle) *(Nombre del paciente-apellido, nombre, segundo nombre)*

Reason for Consultation *(Motivo de la consulta)*

Address *(Dirección)*

City *(Ciudad)* State *(Estado)* Zip Code *(C.P.)*

Home *(Casa)* Telephone *(Tel.)* ( )

Cell #

Marital Status

Age *(Edad)*

Date of Birth *(Fecha de Nacimiento)*

Sex: (M or F)

Social Security # *(Num. Seg. Soc.)*

Employer *(Trabajo)*

Occupation *(Ocupación)*

Work *(Trabajo)* Telephone *(Tel.)* ( )

Spouse's Name *(Nombre del Esposo/a)*

Work *(Trabajo)* Telephone *(Tel.)* ( )

Spouse's Employer *(Trabajo del Esposo/a)*

In Case of Emergency: (Person not living with patient)

En Caso de Emergencia: (Persona que no habite con usted)

Relationship. *(Relación)*

Home *(Casa)* Telephone *(Tel.)* ( )

Person Responsible for Bill *(Persona Responsable de la Factura)*

Address *(Dirección)*

Telephone *(Teléfono)* ( )

City *(Ciudad)* State *(Estado)* Zip Code *(C.P.)*

Relationship of patient to responsible party

☐ self ☐ spouse ☐ child ☐ other

(Relacion del paciente con el fiador)

☐ *usted* ☐ *esposo(a)* ☐ *hijo(a)* ☐ *otra relación*

Referring Source *(¿ Quién lo Refirió?)*

☐ Physician (Name) *(Nombre)*

☐ Other (Please Specify) *(Otro)*

INSURANCE

PRIMARY Insurance Company *(Compañia PRINCIPAL de Seguro)*

Telephone *(Teléfono)* ( )

Address *(Dirección)*

City *(Ciudad)* State *(Estado)* Zip Code *(C.P.)*

Group Name *(Nombre del Grupo)* / Employer Name

Group Number

Certificate or Policy Number *(Num. Póliza)*

Plan Number *(Núm. Plan)*

Insured's Name *(Nombre del Asegurado)*

Date of Birth of Insured *(Fec. Nac.)*

Insured's Social Security # *(Num. Seg. Soc.)*

Sex of insured (M or F) *(Sexo)*

Relationship of patient to Guarantor

☐ self ☐ spouse ☐ child ☐ other

(Relacion del paciente con el fiador)

☐ *usted* ☐ *esposo(a)* ☐ *hijo(a)* ☐ *otra relación*

SECONDARY Insurance Company *(Aseguradora Secundaria)*

Telephone *(Teléfono)* ( )

Address *(Dirección)*

City *(Ciudad)* State *(Estado)* Zip Code *(C.P.)*

Group Name *(Nombre del Grupo)* / Employer Name

Group Number

Certificate or Policy Number *(Num. Póliza)*

Plan Number *(Núm. Plan)*

Insured's Name *(Nombre del Asegurado)*

Date of Birth of Insured *(Fec. Nac.)*

Insured's Social Security # *(Num. Seg. Soc.)*

Sex of insured (M or F) *(Sexo)*

Relationship of patient to Responsible party

☐ self ☐ spouse ☐ child ☐ other

(Relacion del paciente con el fiador)

☐ *usted* ☐ *esposo(a)* ☐ *hijo(a)* ☐ *otra relación*

Is pre-certification required? *(¿ Se requiere la pre-certificación?)*

Yes ___ No ___

(Primary) Pre-certification Telephone # ( )

(Secondary) Pre-certification Telephone # ( )

TO PATIENT: INSURANCE WILL NOT BE FILED THROUGH OUR OFFICE UNLESS SIGNED.

Is the charge related to employment ___

auto accident ___

other accident ___

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS

I hereby authorize any physician who has treated or attended me or my dependent to furnish any medical information requested. In consideration of services rendered, I hereby transfer and assign to the Division of Plastic Surgery for the benefit of the doctors in the Division of Plastic Surgery, The Methodist Hospital who have treated me or my dependents, any benefits of insurance that I may have. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that this authorization does not release me from my personal obligation for all charges incurred.

DIRIGIDO AL PACIENTE: NUESTRA OFICINA NO SE HARÁ RESPONSABLE SOBRE EL REGISTRO DE INFORMACIÓN EN SU COMPAÑÍA DE SEGURO A MENOS QUE ESTA FORMA SEA FIRMADA POR USTED.

AUTORIZACIÓN PARA LA LIBERACIÓN DE INFORMACIÓN Y PAGO DE BENEFICIOS

Por medio del presente documento, autorizo a mi(s) médico(s) tratante(s), o tratante(s) de mi dependiente legal, para que libere(n) cualquier información médica que se requiera. Así mismo, por medio del presente, transfiero a la División de Cirugía Plástica del The Methodist Hospital o a cualquier médico de la misma, los beneficios económicos que de mi seguro derivan por concepto de servicios recibidos y gastos generados. Afirmo también, que una copia fotostática de esta autorización tendrá la misma validez que la que posee el documento original. De igual forma estoy en el entendido, que la firma de esta autorización no me exime de mis obligaciones personales de pago por los cargos que se generen.

Signed (Firma): _____

Houston Methodist Specialty Physicians Group
Institute for Reconstructive Surgery

HISTORY AND PHYSICAL CONSULTATION

DATE: _____ **AGE:** _____

PATIENT: _____ **SEX:** M _____ F _____
HEIGHT: _____ **WEIGHT:** _____

HISTORY OF PRESENT ILLNESS:
When did the condition first occur? _____

Describe your current condition: _____

_____

_____

Date of last exam by your Primary Care Physician or Internist: _____

Allergies: (include reaction) _____

_____

Current Medications: (please include aspirin, ibuprofen, birth control pills, etc. and dosage) _____

_____

_____

Medical Illnesses: _____

_____

Previous Surgery: _____

_____

Family and Social History:
Occupation: _____ Spouse Occupation: _____
Marital Status: _____ No. of Children: _____
History of family illnesses: _____

_____

_____

Alcohol uses (describe type & amount): _____
Never Occasionally Daily Weekly
Tobacco uses (describes type & amount): _____
Never Occasionally Daily Weekly
Special Diet (describe type & amount): _____
Never Occasionally Daily Weekly
Exercise (describe type & amount): _____
Never Occasionally Daily Weekly

Patient Name:

_____

REVIEW OF SYSTEMS – Please indicate any history or problems with the following:

	YES	NO		YES	NO		YES	NO
Wt. Loss/Gain			Heartburn			Fainting/Dizziness		
Fever/Chills			Reflux			Stroke		
Thyroid			Indigestion			Seizures		
Cough			Nausea/Vomiting			Depression/Anxiety		
Shortness of Breath			Hernia			Hepatitis		
Palpitations			Jaundice			Implants		
Chest Pain			Urinary Symptoms			Skin or Breast Mass		
High Blood Pressure			Change in Bowel Habit			Abnormal Mouth		
Arthritis			Hemorrhoids			Ear, Nose, Throat		
Abdominal Pain			Anemic			Diabetes		
Ulcer			Bleeding					

COMMENTS:

_____

_____

_____

_____

_____

_____

Reviewed by: _____

(Attending Physician Signature)

HOUSTON METHODIST HOSPITAL SPECIALTY PHYSICIAN GROUP
INSTITUTE FOR RECONSTRUCTIVE SURGERY
OFFICE POLICY ON INSURED PATIENTS

Many carriers require certain prerequisites such as the pre-certification of a particular procedure. Within the same insurance company the plans differ depending upon what type of contract your employer has negotiated. We are more than willing to follow any and all necessary guidelines to ensure that your encounter with the Institute for Reconstructive Surgery is reimbursed properly, but you must inform us of those guidelines.

Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently order services, such as lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility. This will hold true for any Managed Care contract as well as any group/individual policies which may cover you and your dependents.

With your cooperation and assistance, you should be able to receive all of the benefits offered to you.

*****

I have read and understand the office policy stated above and agree to accept responsibility as described.

_____ _____

Signature Date

HOUSTON Methodist℠
LEADING MEDICINE

Institute for Reconstructive Surgery
18400 Katy Freeway, Suite 500
Houston, Texas 77094
Office: 832.522.8400
Fax: 832.522.8401

Warren A. Ellsworth IV, MD, FACS
Rodger Brown, MD

MEDICAL RECORDS RELEASE

DATE: _____

RE: _____

DOB: _____

SS#: _____

I hereby request that all medical records be released to:

_____

_____

_____

_____
(Signature of Patient/Parent or Guardian)

_____
(Signature of Witness)

HOUSTON Methodist
SPECIALTY PHYSICIAN GROUP

INSTITUTE FOR RECONSTRUCTIVE SURGERY

PHOTO CONSENT AND RELEASE

I, _____, hereby grant consent for taking photographs of me, and the use of photographs taken of me in relation to my treatment at Houston Methodist Specialty Physician Group, Institute for Reconstructive Surgery for the purpose of medical documentation, education, news, publicity, advertising, trade, website content, scientific publications and/or development programs

I hereby release Houston Methodist Specialty Physician Group, The Institute for Reconstructive Surgery and any other person participating in my care or dealing with my photographs from any and all liability which may or could arise from the taking or use of such photographs.

My photographs will be used and stored in compliance with HIPAA regulations.

I understand that I have the right to revoke authorization for use of my photographs at any time. Request to revoke use of my photographs will be in writing, and mailed at 18400 Katy Freeway, Ste. 500; Houston, TX 77094.

Date: _____

Patient name: _____

Signature: _____

Witness Signature: _____

HOUSTON METHODIST SPECIALTY PHYSICIAN GROUP
Institute For Reconstructive Surgery

Patient - Provider E-Mail Agreement

E-mail offers an easy and convenient way for patients and physicians to communicate. However, there are distinct differences between communicating via e-mail as opposed to calling in to the office. Remember: there is no person on the other side of the email – just a computer. You cannot tell when your message will be read, or even if your doctor is in the office or on vacation. Nevertheless, we believe that the ease of communication by email affords us a benefit to patient care, below are our rules for contacting us using email.

- E-mail is **NEVER** appropriate for urgent or emergency problems. If you have an urgent or emergent problem, please call 911 or go to the closest Emergency Department for immediate treatment.
- E-mail is **NOT** confidential. My staff may read your emails to handle routine, non clinical matters; also, you should know that if sending emails from work, your employer has a legal right to read your email.
- E-mail is **NOT** a substitute for seeing me. If you think that you may need to be seen, please call and make an appointment.
- E –mails will become a part of your medical record; a copy will be placed in your chart.
- E-mail is great for asking those straight forward questions that do not require in depth discussion. Appropriate uses of e-mail include prescription refill requests, referral and appointment scheduling requests and billing/insurance questions.
- E-mails should **NOT** be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, development disability, or substance abuse.
- Please identify the nature of your request in the subject line of your message.

Finally, either one of use can revoke permission to use the e-mail system at any time.

☐ I DO want to communicate with my physician electronically. I have read the above information and understand the limitations of security on information transmitted. I understand that my physician may not be able to communicate with me electronically about my specific condition if I live outside of the state in which my doctor is licensed.

PATIENT:

Patient Name: _____

Patient Signature: _____

E-mail Address: _____

Date: _____

State of residence: _____

HOUSTON Methodist
SPECIALTY PHYSICIAN GROUP

INSTITUTE FOR RECONSTRUCTIVE SURGERY
FINANCIAL POLICIES

Thank you for selecting the Institute for Reconstructive Surgery for your medical needs. We look forward to working with you to provide the highest quality of care possible. As one of our patients we would like to keep you informed of our current office and financial policies. We require that you read and sign this document prior to any further treatment/services rendered. We recommend that you keep a copy of this document for your records.

We ask that you please bring your insurance card with you at the time of your appointment. If your insurance plan has changed from your last visit we ask that you please notify our billing department so that the information can be update in our system. With insurance plans where we have agreed to participate in the network as a provider, your carrier requires that all co–pays be collected for any services being rendered. The co-pay requirements cannot be waived by our practice as it is a requirement placed on you by your insurance carrier.

Plans that are HMO or POS where we participate as a provider, and require a referral, obtaining the referral will be the **patient's responsibility**. We ask that you please keep track of the referrals on file allowed by your primary care provider. If for any reason there is no current referral on file for the particular date of service and the insurance carrier denies payment for not referral a bill will be generated to you for full payment of services.

Please note that you will be responsible for any co-insurance, deductibles or non-covered services not paid by your insurance. When a surgical procedure is being scheduled we ask that your co-insurance (out of pocket) and/or percentage be paid in full 3 weeks prior to your scheduled surgery date. If this not completely paid for by the due date then we will need to reschedule for anther date. Houston Methodist Hospital will usually expect your deductible to be paid in full on the date of services; therefore, we suggest that you please contact your insurance to see the amount that you are responsible for any inpatient or outpatient procedures. There will also be a $25.00 charge to the patient, for all Short Term Disability information that is generated from our office for this service.

For patients who do not have insurance coverage or are having cosmetic services, we require that payment be made in full at the time of services, or 3 weeks prior to any scheduled surgical procedure as mentioned above.

We ask that our patients please understand that these are the policies set forth by Houston Methodist Specialty Physician Group and not the office, the doctor or its staff. If any time you have any questions about financial or billing issues, please direct these to the Billing Department at 713-441-6679.

_____

Patient's Name

HOUSTON Methodist
SPECIALTY PHYSICIAN GROUP

INSTITUTE FOR RECONSTRUCTIVE SURGERY

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

You have been given the Notice of Privacy Practices for Houston Methodist Specialty Physicians Group – Institute For Reconstructive Surgery. This Notice describes your legal rights regarding your health information and will inform you of the legal duties and privacy practices of Houston Methodist Specialty Physician Group and its Physicians with respect to health information created for services generated by Houston Methodist Specialty Physician Group and its Physicians. If you receive services by your physician or other health care provider at a different location, you may want to ask about that office or clinic's health information privacy policies and notices because they could be different.

Your name and signature below indicate that you have been provided with a copy of this Notice of Privacy Practices.

If you have a question regarding any of the information set forth in this Notice of Privacy Practices, please do not hesitate to call Houston Methodist's Business Practices Officer at 713.383.5125.

Patient Name: _____

Signature of Patient or
Patient's Qualified Personal Representative: _____
Date _____

Printed Name of Qualified Personal Representative:
_____

Legal Authority to Act on Behalf of the Patient:
_____

For Staff Use Only

Date Acknowledgment noted in HIS/patient management system: _____

Comments if Notice not provided or Acknowledgment not obtained:
_____
_____

Processed by: _____