MYBODYMD
PLASTIC SURGERY

Rafi S. Bidros, M.D., P.A.
Plastic & Reconstruction Surgery

New Patient Forms

Today's Date: _____

What is the purpose for your visit with Dr. Bidros? _____

How did you hear about our practice? _____

Patient Name: _____
First Last Middle Initial

Date of birth: _____/_____/____ **Age:** _____ **Sex**: ▫ Male ▫ Female **Race:** _____

Address: _____ SS#: ____-____-____
Street & Apt# City State Zip Code

Home Phone: _____ **Mobile:** _____ **Other:** _____

Email: _____

Pharmacy name and number: _____

Primary Care Physician Name:_____
Clinic Name: _____ Tel: _____

Emergency Contact Name and number: _____

Relationship: _____

Marital Status: ▫ Single ▫ Married (Spouse's Name): _____ ▫ Other _____

Patient's Employer: _____ **Occupation:** _____

Telephone: _____ Is it ok to contact you here: ▫ Yes ▫ No

Address: _____
Street & Suite # City State Zip Code

Primary Health Insurance Company:

_____

Policy Holder: **Relationship to Patient:**

Policy Holder: _____ **Relationship to Patient:** _____

Policy Holder DOB: _____ **Policy Holder SS#:** _____

Policy #/ID #: _____ **Group#:** _____

Customer Service Tel: _____

Medical History

Patient Name: _____ Date: _____

Weight: _____ Height: _____ Date of birth: _____ Age: _____

Please list or check off any past Medical History:

_____

_____

__

▫ Heart Disease ▫ Rheumatoid Arthritis ▫ Ulcers ▫ Cold sores
▫ Heart Murmur ▫ Tuberculosis ▫ Hepatitis ▫ Asthma
▫ Heart Attack ▫ Diabetes ▫ Bronchitis ▫ Skin Cancer
▫ High Blood Pressure ▫ Thyroid Disorder ▫ Liver Disease ▫ Lung Cancer
▫ High Cholesterol ▫ Skin Disease ▫ Kidney Stones ▫ Breast Cancer
▫ Bleeding Disorder ▫ Eczema ▫ Schizophrenia ▫ Cancer
▫ Bipolar Disorder ▫ Depression ▫ ADHD/ADD ▫ Kidney/ bladder
▫ Obstructive Sleep Apnea ▫ GERD ▫ Seizure Disorder ▫ Speech Disorder
▫ Stroke ▫ Anemia ▫ Stomach/ bowel ▫ Alcoholism

Have you ever had any problems with bleeding or anesthesia in the past? If yes, please explain:

_____

Please list or check off any Surgeries/Procedures & dates:

_____

_____

▫ Hysterectomy _____ ▫ Hip Surgery _____ ▫ Gallbladder Surgery _____
▫ Tonsillectomy _____ ▫ Tubal Ligation _____ ▫ Jaw Surgery _____
▫ Hernia Repair _____ ▫ Vasectomy _____ ▫ Eye Surgery _____
▫ Breast Surgery _____ ▫ Other: _____ ▫ Hernia _____
▫ Heart Surgery _____ ▫ Knee Surgery _____ ▫ Weight loss surgery _____

Name Current Medications and Supplements/Vitamins/OTC medication: (Please print)

_____

_

_____

_____

__

Please list any ALLERGIES: drug / food / latex / adhesive tape OR circle NKDA

Name Drug/Food Reaction

Health Habits:
Do you use any type of Tobacco or Drugs? _____ if so, how much?_____ how often? _____
Do you use alcohol? _____ If so, how much? _____ How often? _____

Last menstrual cycle: _____ Are you on birth control? _____

Review of Systems:
Do you have any of the following conditions, illnesses or symptoms? Please circle all applicable and/ or none

General
Weight loss
Weight Gain
Fever or Chills
Trouble Sleeping
Fatigue
Increased Appetite
None

Cardiovascular
Murmur
Chest Pain
Palpitations
Difficulty Breathing Lying Down
Chest Tightness
Heart Attack
None

Musculoskeletal
Muscle Pain/Ache
Clubbed Feet
Swelling of Joints
Joint Stiffness
Neck Stiffness/Pain
Cold Extremities
None

Eyes
Double Vision
Blurry Vision
Redness
Vision Loss/Changes
Flashes
Glasses/Contacts
None

Integumentary/Breast
Itchiness
Redness
Recent Rash
Atypical Skin Lesions
Hair Loss
Hair and Nail Changes
Wound
None

Hematologic/lymphatic
Bleeding Tendency
Easy Bruising
Slow To Heal With Cuts
Inflammation of the Veins
Enlarges or Twisted Veins
Anemia
None

Allergic/immunologic (ENT)
Severe Allergies
Hives
Rash
None

Ears, Nose, Throat Gastrointestinal
Loose Tooth/ teeth
Loss of Hearing
Crooked Nose
Earache (s)
Drainage
Nosebleed
None

Vomiting
Diarrhea
Nausea
Constipation
Difficulty Chewing
Difficulty Swallowing
Reflux
None

Endocrine
Excessive Thirst
Heat/Cold Tolerance
None

Neurological
Confusion
Migraines
Seizures
Fall/Head Injury
Numbness
Dizziness
None

Respiratory
Shortness of Breath
Difficulty Breathing
Wheezing/Rattling
Chronic/Frequent Coughing
None

Genitourinary
Frequent Urination
Painful Urination
Incontinence
Hernia
None

Psychiatric
Feeling Anxious
Feeling Sad
Sudden Mood Changes
Decreased Energy Level
Nervousness
Stress
None

HIPAA OVERVIEW

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

- **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party.
- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services.
- **Healthcare Operations**: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you or your appointment.
- We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.
- Other Permitted and Required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to Object unless required by law.
- You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.
- **Your Rights:** You have the right to inspect and obtain a copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of , or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
- You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request health information not be disclosed to family members or friends. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
- You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
- You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

- We reserve the right to change terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.
- **Complaints**: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.
- We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form,

please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

- Federal Law mandates that patients have the right to expect their health information to be protected from disclosure. The Health Insurance Portability and Accountability Act (HIPAA) protects those records from access via fax, mail or verbal exchange without written consent.
- In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). The intent of HIPAA was three fold:
  - Provide Insurance Portability for Patients
  - Promote Simplification or Consistent Standards
  - Prevent Fraud and Abuse of the Healthcare System
- All health care providers, including physicians, hospitals, health plans and healthcare providers that conduct certain financial and administrative transactions such as enrollment, billing and eligibility verification electronically must comply with of the provisions of HIPAA.
- The HIPAA Privacy Regulation was first published December 28, 2000 and the rule became effective April 14, 2001. Violation of the regulation can possibly result in civil fines of up to $25,000.00 per violation with up to a one-year prison sentence. Criminal fines are up to $250,000.00 or up to ten years in prison or both. The final compliance deadline for most entities, (physician practices included) was April 14, 2003. The regulation will be enforced by the Office of Civil Rights, Department of Health and Human Services.

I authorize:

▫ Family: Name-_____ Relation to patient: _____

▫ Referring Physician(s): _____ Specialist(s): _____

This authorization is valid for 12 months from date of signature. This authorization may be revoked in writing at any time.

_____ _____

Printed Patient Name Signature of Patient/Personal Representative

_____ _____

Relationship to Patient Date

_____ _____

Practice Representative Name Practice Representative Signature

PATIENT PRIVACY and CONSENT

FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby consent to the use or disclosure of my protected health information by the practice of Rafi S. Bidros, M.D., P.A., hereinafter referred to as Rafi S. Bidros, M.D., P.A., and MyBodyMD, for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Rafi s. Bidros, M.D., P.A. and MyBodyMD may be conditioned upon my consent as evidenced by my signature on this document.

I understand that payment for procedures that are aesthetic or cosmetic in nature are my sole responsibility and will not be billed to any third party. I understand that payment for such procedures may be requested in advance of any treatment. I understand there are no warrantees, implied or otherwise, to the outcomes of any treatments or procedure.

I have been offered, read and/or understand the Rafi s. Bidros, M.D., P.A. and MyBodyMD Notice of Privacy Practices, which has been offered to me by the practice, prior to signing this document. I understand that patient privacy rights and disclosure varies state by state.

I also understand that the Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations. This Notice of Privacy Practices also describes my rights and the practice's duties with respect to my protected health information. The Notice of Privacy Practices for the Practice is available at the offices of the Practice:

920 Frostwood Dr Suite 690 Houston TX 77024-2468

Terms of the Notice of Privacy Practices may change. If changes are made, I may obtain a revised Notice of Privacy

Practices by: calling the offices of the practice requesting a revised copy be sent in the mail, or by requesting one at the time of my next appointment.

"I hereby grant permission for the use of any of my medical records including illustrations, photographs or imaging records for examination, testing, credentialing and/or certification purposes by The American Board of Plastic Surgery, Inc." All information provided is necessary for our practice and will remain confidential. All efforts are routinely made to ensure privacy is upheld.

_____ _____

Printed Patient Name Signature of Patient/Personal Representative

_____ _____

Relationship to Patient Date

_____ _____

Practice Representative Name Signature of Practice Representative and Witness

No Show/Cancellations Policies

To Our Patients:

Our goal is to provide quality individualized medical care in a timely manner. "No shows" and late cancellations inconvenience those individuals who need access to medical care.

We understand that sometimes you may have to cancel or reschedule your appointment. Office policy requires that you give us at least 24 notices for office visits and 72 hours' notice for scheduled procedures/surgeries.

Failure to cancel or reschedule your appointment 24 hours in advance for office visits will result in a $25 fee. Failure to cancel or reschedule your procedure visit/surgery 72 hours in advance will result in a fee of $150 or loss of your deposit.

To Cancel or reschedule an appointment, please call our office at 713-467-0102. Thank you for your adherence to our policies.

I have reviewed and understand the No Show/Cancellation Policy.

_____ _____

Printed Patient Name Signature of Patient /Personal Representative

_____ _____

Relationship to Patient Date

_____ _____

Practice Representative Name Signature of Practice Representative /Witness