Houston Center for Plastic Surgery
Norman H. Rappaport, M.D., F.A.C.S.
6560 Fannin St., Suite 1812, Houston TX 77030
Phone: 713.790.4500 Fax: 713.793.1299

Date:_______________________________

Welcome

Patient's Name: (First) ______________________________(Middle Int.)_____(Last)__________________________________

Date of Birth: _____________________________Male/Female:__________Social Security#:___________________________

Address: (Street)____ (City)______________(State) ______(Zip) ____________

Phone :(Home) _______________________(Mobile) __________________________(Other) ___________________________

Email: ____Driver's License #:__________________________

Marital Status: (Single/Married/Divorced/Widow/Other): ____

Spouse's/Partner's Name: ____

Please list with whom we can speak to about your care/account and their relationship to you:

(Name) ____ (Relationship) ___________________________

(Name) ____(Relationship) ____________________________

Referral Source

How did you hear about our office? ____

If you found us on the internet please let us know which website: ____

If you were referred to us by a specific person or Doctor, may we thank him/her? (**Yes** or **No**)___________________ ______

Employer

Patient's Employer: ____Occupation:__________________ __________

Emergency

Emergency Contact: ____Relationship: ___________________________

Home Phone :____________________________(Mobile) __________________________(Other) __________________________

Pharmacy Name: ____Pharmacy Phone: _________________________________

Initials

Insurance

Primary Insurance Name: ________________________________ (Please Circle Plan Type): **HMO PPO POS POSII NAP**

Are you the Policy Holder/Subscriber? **Yes** or **No** ______________________

Subscriber's Name:________________________________ Subscriber's DOB: _______________Relationship:_______________

Member ID #:____Group #:____

Customer Service #:____

Secondary Insurance Name: ______________________________(Please Circle Plan Type): **HMO PPO POS POSII NAP**

Are you the Policy Holder/Subscriber? **Yes** or **No** ______________________

Subscriber's Name:_________________________________ Subscriber's DOB: _______________Relationship:_______________

Member ID #:____Group #:____

Customer Service #: ____

Areas(s) of Interest: (Please check ALL that apply below)

Facial Procedures	**Breast Procedures**	**Other Procedures**
☐ Blepharoplasty (Eyelid Lift) ☐ Brow/Forehead Lift ☐ Earlobe Repair ☐ Facial Liposuction (Neck, Jowls) ☐ Lip Enhancement ☐ Otoplasty (Ear Pinning) ☐ Rhinoplasty (Nose Reshaping) ☐ Scar Revision ☐ Skin Resurfacing	☐ Breast Augmentation ☐ Breast Reconstruction ☐ Breast Reduction ☐ Gynecomastia (Abnormal development of mammary glands in males) ☐ Mastopexy (Breast Lift) ☐ Nipple Reduction or Inversion	☐ Chemical peels ☐ Laser Hair Removal ☐ Leg Veins ☐ Lesions/Moles ☐ Microdermabrasion ☐ Skin Care ☐ Telangectasia (Spider Veins)
Injectables	**Body Procedures**	**Products**
☐ Botox ☐ Juvederm ☐ Kybella	☐ Abdominoplasty (Tummy Tuck) ☐ Brachioplasty (Arm Lift) ☐ Full Body Lift ☐ Liposuction ☐ Thigh or Buttock Lift ☐ Panniculectomy	☐ Glo Make-up ☐ ZO (Zein Obagi) – new line ☐ Obagi ☐ Other: ______________________________

Other Please Explain):____
____
____
____

Initials____________

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Health Information as of ________________________ (Today's Date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient:			Acct #:
DOB:	Age:	Marital Status:	Weight: ___________ lbs.
What type of Procedure/Surgery are you considering?			Height: ______ft. _____in.

DO YOU NOW OR HAVE YOU EVER HAD…… (You must circle **Yes** or **No** for each individual item and **circle which item applies**)

Bleeding Tendency or Disorder	Yes	No
Blood Transfusion	Yes	No
Abnormal Bleeding after Tooth Extraction	Yes	No
Skin Disorders	Yes	No
Positive Blood Test for: HIV, AIDS	Yes	No
Family History of bleeding problems	Yes	No
Hay Fever or other Environmental Allergies	Yes	No
Visual Disturbances, Error in Refraction	Yes	No
Dry Eye, Glaucoma, Cataract	Yes	No
Thyroid Problems, Low/High	Yes	No
Arthritis, Contractures of Joints	Yes	No
Fracture of Neck/ Spine or Scoliosis	Yes	No
Airway Obstruction (Hearing Impaired)	Yes	No
Dentures, bridges, Capped teeth / Crowns	Yes	No
Loose Teeth, Periodontal Disease	Yes	No
Difficulty Chewing / Swallowing	Yes	No
Stroke, Seizures, Fainting	Yes	No
Palsy, Paralysis	Yes	No
Nervous Disorder, Insomnia	Yes	No
Drug Habit: Alcohol or Drug Dependency	Yes	No

Psychiatric Care, Obsessive Compulsive Disorder	Yes	No
Esophageal Varices, Vomiting Blood	Yes	No
Hepatitis , Jaundice, Cirrhosis, Gallstones	Yes	No
Frequent Indigestion , Gastritis, Peptic Ulcers	Yes	No
Constipation, Diarrhea, Colitis	Yes	No
Breast Cysts, Tumors, Abscesses	Yes	No
Nipple Discharge (Apart from Normal Lactation)	Yes	No
Heart Attack, Chest Pain, Shortness of Breath	Yes	No
Palpitations, Irregular Heart Beat	Yes	No
Heart murmur, Rheumatic Fevers	Yes	No
Hypertension ,Blood Pressure Abnormalities	Yes	No
Abnormal EKG	Yes	No
Asthma, Emphysema, Shortness of Breath	Yes	No
Bronchitis, Pneumonia, Tuberculosis	Yes	No
Smokers Cough or Spitting of Blood	Yes	No
Diabetes, Pancreatic Disorders	Yes	No
Kidney or Renal Disease	Yes	No
Personal/Family Hx of Complications with Anesthesia	Yes	No
Family History of Cancer, Heart trouble, Stroke	Yes	No
History of Cancer (type:_______________________)	Yes	No

♦ If you circled **Yes** to any of the above please explain**:**

____

____

____

♦ Please list **ALL** present Medications including Birth Control Pills, Hormones,Vitamins, Herbal Medication, Diuretics,Weight Loss Drugs (Include Over-theCounter Medications as well).

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

Initials_______________

- Please list **ALL** Hospitalizations and Surgeries, including procedures done for elective/cosmetic reasons:

SURGICAL OPERATIONS (include When, Where and Why for each surgery):

Type of Surgery	When	Where	Why

HOSPITALIZATIONS (include When, Where and Why for each admission **IF** diffent from above):

Hospitalization	When	Where	Why

- Are you allergic to any medication(s)? **Yes** or **No** If **Yes**, please list: ____________________
- Do you react abnormally to any medication(s)? **Yes** or **No** If **Yes**, please explain:____________________
- Are you allergic to anesthesia? **Yes** or **No** If **Yes**, please explain:____________________
- Have you ever been on cortisone or steroid treatment? **Yes** or **No** If Yes, When? ____________________
- Do you consume alcohol **Yes** or **No** If Yes, how much? ____________________
- Do you smoke? **Yes** or **No** If Yes, how much? ____________ For how long? ____________
- Are you pregnant? **Yes** or **No** Last normal menstrual period? ____________Irregular Menses? **Yes** or **No**
- How many pregnancies? ________ Births? ________ Breast Fed? **Yes** or **No** If **Yes**, how long? ________
- When was your last physical exam? ____________ By whom? ____________
- When was your last eye examination? ____________ By whom? ____________
- When was your last mammogram? ____________ By whom? ____________
- Who is your Primary Care Physician? ____________________
- Please list ALL physicians presently caring for you: ____________________
- Is there anything else you think the doctor should know? ____________________

As evidence by my signature below, I agree that all information that I have provided is accurate and complete.

Signature:______________________________ **Date**: ____________________

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PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, ______________________________, authorize **Dr.** and/or **Houston Center for Plastic Surgery PA**, and/or **his** representative(s), to take photographs or video of me or parts of my body to be used for surgical planning and if applicable, insurance pre-determinations.

In addition, I authorize the use of these images, without compensation to me, for the following specific purposes: (Please Check **Yes** or **No** for each item)

Yes	No	Use
		in the **Office Photo Album** for prospective patients.
		in **Seminars** for prospective patients.
		on our **Website** for prospective patients.
		in print **Advertisements**.
		on **Television**.
		in **Articles** or **Professional Presentations**
		on **Social Media (Instagram, Facebook, etc)**

Additional Comments:

____
Initials

I, ______________________________ understand that:

1. If my services are deemed reconstructive, my insurance carrier may require photos to be submitted for the processing of claims and obtaining authorizations.

2. As previously authorized, I understand that photographs or videos may be published by **Dr.** and/or **Houston Center for Plastic Surgery PA** in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods.

3. I will not be identified by name in any media described above; however, I also understand that in some circumstances the photographs, slides, or videotapes may display features that identify me. **We will make every reasonable effort to obscure identifiable information like tattoos, unique jewelry or recognizable apparel.**

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE (*Continued*)

4. I have the right to revoke this authorization at any time and if I decide to do so, I will present written revocation to **Dr. Rappaport.** Revocation shall not affect any release of information made prior to revocation

5. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by applicable federal and/or state confidentiality rules.

6. A copy of this **"Patient Photographic Authorization and Release"** form is as valid as the original. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

7. I release and discharge **Dr. Rappaport** and/or **Houston Center for Plastic Surgery PA** from all liability, including liability for negligence, that in any way arises out of:

   - any and all rights that I may have or may have had in the photographs or videos of me that I have authorized to be used and disclosed in this Authorization; and

   - any claim that I may have or may have had relating to such use and disclosure of those photographs or videos of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public and medical education. I certify that I have read this Authorization and Release carefully and fully understand its terms. If I have questions about the use or disclosure of my photographs or videos, I can contact **Dr. Rappaport** at **713-790-4500.**

Signature:____ **Date:**_______________

Witness:____ **Date**_______________

HOUSTON CENTER FOR PLASTIC SURGERY

6560 Fannin, Suite 1812 ♦ Houston, TX 77030 ♦ (713)790-4500

GENERAL FINANCIAL POLICY AGREEMENT

- I hereby authorize **Houston Center for Plastic Surgery** to submit claims to my insurance carrier and/or Medicare for all of the covered services that are rendered and further my insurance company to issue payment to **Houston Center for Plastic Surgery**. I additionally authorize the release of any medical information needed by the above intermediaries to evaluate any insurance claim.

  ___________ Initials

- I understand that I am financially responsible for all charges whether or not covered in whole or in part by my insurance carrier. I further understand that in order to initiate any **Pre – Certifications** and /or **Pre –Determinations,** I will be responsible to pay **Houston Center for Plastic Surgery** a **Non-Refundable** fee of **$75.00 - $150.00**.

  ___________Initials

- I agree to maintain a major credit card on file at **Houston Center for Plastic Surgery** to satisfy any and all balances that I may incur as a result of, but not limited to, the following applicable circumstances with **Houston Center for Plastic Surgery:** insurance co-pay(s), insurance deductible(s), co-insurance, uncovered services as determined by my insurance carrier contract and returned checks. I understand that **any outstanding patient balance(s) will be automatically charged** to the credit card on file **under the amount of $150.00** and that I will receive a receipt via e-mail once payment has been processed. I understand that my financial obligation to **Houston Center for Plastic Surgery** is payable no later than 90 days from the date of service and that delinquency may lead to collection efforts associated with additional fees and interest in the amount maximally allowed by the State of Texas.

  ___________Initials

- I am aware and agree that **Houston Center for Plastic Surgery** will not bill my health insurance carrier for cosmetic surgery, nor will **Houston Center for Plastic Surgery** be responsible for refund of claims that are submitted independently or if my insurance carrier releases its determination.

  ___________Initials

- I am aware that **Houston Center for Plastic Surgery** has a **"24 hour Cancellation Policy"** which holds me responsible to cancel 24 hours in advance of my scheduled appointment time. In failure to do so will result in a charge to my credit card of **$100.00**, as explained when I set up my appointment.

  ___________Initials

- I am aware of the **"Return Check Policy"** of **Houston Center for Plastic Surgery.** I am responsible for the original amount of the returned check and the **Return Check Fee** of **$50.00** payable by major credit card or cashiers' check.

  ___________Initials

- I am aware of the **"Surgery/Procedure Cancellation Policy"** of **Houston Center for Plastic Surgery** which states that I will incur a **service charge** for cancellations within 1 month of the date of any scheduled surgery/procedure.

  ___________Initials

I understanding and accept the terms and conditions of the agreement.

Signature:____ **Date**:____________________

HOUSTON CENTER FOR PLASTIC SURGERY

6560 Fannin, Suite 1812 ♦ Houston, TX 77030 ♦ (713)790-4500

COSMETIC SURGERY FINANCIAL POLICY AGREEMENT

♦ **Surgical Quotes** are valid for **six months**. Facility and Anesthesia Fees are estimates **only** and may change at any time. Additional Fees for Laboratory Services, Pathology, Radiology and/or any other testing services, may be incurred. As prescriptions for medications vary from patient to patient, they are therefore not included in any quote.

__________Initials

♦ Your Consultation Fee of **$100.00** is applicable to your **Surgical Quote** for up to **three months** from the date that you were given your **Surgical Quote**.

__________Initials

♦ **Revision** of the **Original Procedure**, **if** performed within in **one (1) year** and is deemed appropriate by **Dr. Rappaport**, will incur no additional Surgeon's Fee, however, cost of the Facility, Hospitalization, Anesthesia, Supplies, etc. will remain your responsibility.

__________Initials

♦ I am aware of the **"Cosmetic Surgery Scheduling and Cancellation Policy**" of **Houston Center for Plastic Surgery** as follows:

- **Surgery Scheduling**
  - A **Non-Refundable Deposit** of **10%** of your **Surgical Quote** is required to secure your surgery date.
  - The remaining balance of your **Surgical Quote** must be received in full at least (3) **three weeks** in advance of your scheduled surgery date. Deviation from this schedule may cause forfeiture of your reserved time. Payment in full would then be required prior to rescheduling.

- **Rescheduling, Cancellation, or Reduction of Procedures Fees as follows:**
  - Within **one month** of Surgery/Procedure – **10%** of the Original Fee
  - Within **three weeks** of the Surgery/Procedure – **50%** of the Original Fee
  - Within **one week** of the Surgery/Procedure – **100%** of the Original Fee

- **Payment in full at the time of rescheduling will be required for prior cancellations.**
  The above listed policies will otherwise remain in effect.

__________Initials

I understanding and accept the terms and conditions of the agreement.

Signature:____ **Date:**__________

Credit Card Information/Patient Consent for Use of Credit Cards, Debit Cards and Financing

I,____, agree to have the following Credit Card

information on file with the **Houston Center for Plastic Surgery**, as per disclosure in the **Houston Center for Plastic**

Surgery "**General Financial Policy Agreement".** I will not challenge such credit, debit or financing card payments once services are provided. **Houston Center for Plastic Surgery** encourages complete post - op care and follow – up interaction to address any issues that might arise. I understand that services that are performed that are paid with a credit card, debit card or financing third party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow **Houston Center for Plastic Surgery** to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment.

Credit Card Type: ____

Name on Credit Card: ____

Credit Card Number:____

Expiration Date: ____

I understanding and accept the terms and conditions of the agreement.

Signature:____**Date:**____________________

NOTICE OF PRIVACY PRACTICES
HIPPA
PATIENT ACKNOWLEDGMENT FORM

Our **"Notice of Privacy Practices**" provides information about how we may "use" and "disclose" protected health information about you. You have the right to receive and review our **"Notice of Privacy Practices"** before signing this acknowledgment. As stated in our **"Notice of Privacy Practices**,**"** the terms of our **"Notice of Privacy Practices**" may be subject to change. If such changes occur, you may obtain a revised copy of our **"Notice of Privacy Practices."**

By signing this form, you acknowledge that you have been informed of the "uses" and "disclosures" of your protected health information. The "uses" and "disclosures" of your health information are stated in our **"Notice of Privacy Practices."**

By signing this form, you also acknowledge that a copy of our **"Notice of Privacy Practices"** has been made available or provided to you and that you understand the contents of our **"Notice of Privacy Practices"** and how it applies to you. Your signature on this form also ensures that all of your questions regarding the contents of our **"Notice of Privacy Practices"** have been answered.

Signature:____ **Date**:_________________________

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

DATE: ________________

PATIENT NAME:____ DATE OF BIRTH:__________________

I authorize ____ to release the following records:

☐ office visit notes/ consultation reports
☐ imaging/diagnostic study reports (MRI, CT, EMG/NCV, x-ray, etc)
☐ lab results, pathology reports, etc
☐ operative reports
☐ all patient records
☐ ____

TO: Norman Rappaport, M.D.
6560 Fannin #1812
Houston, TX 77030

PLEASE FAX TO 713-793-1299 or email: info@hcps.cc

I am requesting this release of records for the purpose of:

___________Continuity of care ___________Moving

___________Changing provider ___________Other reason

If other reason, please explain :

____

____

Patient signature: ____ Date: ___________________