LOU PLASTIC SURGERY

(713) 932-7290

Patient Information as of 11/14/2022 (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

Contact Restrictions: _____

Age _____ Birthdate _____ SS # _____ Gender

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

Pharmacy : _____ Pharmacy Telephone #: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

How did you hear about Dr. Lou? *(Check all that apply)*

❒ Instagram ❒ Facebook ❒ Realself ❒ Google ❒ Yelp

❒ Friend/Relative: _____ ❒ Doctor: _____ ❒ Other: _____

If you were referred by a specific person, may we thank them? ❒ Yes ❒ No

Emergency Contact
(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Areas of Interest: (mark all that apply)

Would you like a complimentary skin evaluation while you are here today? ☐ Yes ☐ No

Body Procedures
- ❒Abdominoplasty (Tummy Tuck)
- ❒Brachioplasty (Arm Lift)
- ❒Full Body Lift
- ❒Liposuction (Thighs, Abdomen, Etc.)
- ❒Thigh Lift
- ❒BBL / Fat Transfer
- ❒Lesions / Moles
- ❒Labiaplasty
- ❒Scar Revision
- ❒Hand Surgery

Breast Procedures
- ❒ Breast Augmentation
- ❒ Breast Reconstruction
- ❒ Breast Reduction
- ❒ Mastopexy (Breast Lift)
- ❒ Nipple Reduction or Inversion

Facial Procedures
- ❒Blepharoplasty (Eyelid lift)
- ❒Rhinoplasty
- ❒Brow or Forehead Lift
- ❒Earlobe Repair
- ❒Facial Liposuction (Neck, Jowls)

Med Spa Services
- ❒Skin Care
- ❒ Skin Tightening
- ❒Fat Reduction/Body Contouring
- ❒Acne Treatment
- ❒Chemical Peels
- ❒Dermaplaning/Facials
- ❒Pigment Treatment
- ❒Botox/Fillers
- ❒Weightloss Program
- ❒Hair Restoration

I understand that office visit charges are payable on the day service is rendered.

Signature _____ **Date** _____

Patient's Name _____
First Middle Last

Primary Insurance Company _____

Policyholder's Information:

Name _____ Birthdate _____

Employer _____ Relationship to Patient _____

Subscriber ID # _____ Group # _____

Does this insurance require a referral? ❒ Yes ❒ No Copay Amount $ _____

Secondary Insurance Company _____

Policyholder's Information:

Name _____ Birthdate _____

Employer _____ Relationship to Patient _____

Subscriber ID # _____ Group # _____

Does this insurance required a referral? ❒ Yes ❒ No Copay Amount $ _____

Is this visit due to any type of accident? ❒ No ❒ Yes: Date of Accident _____

Type of Accident ❒ Auto: State? _____ ❒ Work Related ❒ Other: _____

All Insurance Patients – Signature on File

I request that payment of authorized benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services.

Beneficiary Signature _____ Date _____

Medicare Patients Only – Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

LOU PLASTIC SURGERY

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Health Information as of _____(enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Name: _____ Reason for Visit: _____

Age: _____ Height: _____ Feet _____ Inches Weight: _____ Lbs.

Current Physician(s): _____

List all Surgeries (Hospitalization and the Date of Occurrence):

List any Serious Illnesses and/or Accidents:

Do you have or have you had any of the following: (circle for each, give date occurred if Yes)

Aids / HIV	No	Yes	Epilepsy / Seizures	No	Yes	Kidney Problems	No	Yes
Arthritis	No	Yes	Facial Pain	No	Yes	Pneumonia	No	Yes
Asthma	No	Yes	Fever Blisters	No	Yes	Sinus Problems / Infections	No	Yes
Bronchitis	No	Yes	Goiter / Thyroid	No	Yes	Stroke	No	Yes
Cancer	No	Yes	Hay Fever / Allergies	No	Yes	Tonsillitis	No	Yes
Depression	No	Yes	Headaches / Migraine	No	Yes	Tuberculosis	No	Yes
Diabetics	No	Yes	Heart Trouble	No	Yes	Ulcers	No	Yes
Dizziness / Vertigo	No	Yes	Hepatitis	No	Yes			
Ear Infection	No	Yes	High Blood Pressure	No	Yes			

Do you smoke? No Yes If yes, how much? _____ Pack(s)/day How long? _____ Years

Do you drink alcohol? No Yes If yes, how much? _____ How often? _____

Do you use recreational drugs? No Yes If yes, describe: _____

Do you have bleeding or bruising problems? No Yes If yes, describe: _____

Do you have problems with scarring? No Yes If yes, describe: _____

Do you have any history of problems with anesthesia? No Yes If yes, describe: _____

List the name of all medications you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency.

List ALL drug and/or latex allergies.

The above information is accurate and complete to the best of my knowledge.

Signature _____ **Date** _____

LOU PLASTIC SURGERY
plastic | reconstructive | aesthetic

Financial, Cancellation, and No-Show Policy

We the staff at Lou Plastic Surgery thank you for choosing us as your healthcare provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact our Office Manager and Patient Care Coordinator, Erica Bruce at (713) 932- 7290.

We make payments as convenient as possible by accepting cash, cashier's check, Care Credit, Alphaeon, PatientFi and all major credit cards. We do not accept any form or personal checks. Additionally, we require all active patients to have a valid credit card on file and you may authorize us to keep such credit card on file for your convenience knowing that we adhere to the highest level of information security.

Cosmetic Consultation- A nonrefundable $100.00 consultation fee will be charged to the credit card provided at the time of scheduling the appointment. If the patient chooses to schedule surgery within 90 days of Quoted services, the $100.00 will be applied to the total cost of surgery otherwise the $100.00 is forfeited. _____ *(Patient Initial)*

Cancellation / No-Show Policy- Because we do not over- book, no-shows, short cancellations, and same day cancellations can pose a significant hardship on our practice. **Therefore, we do need a 48-Hour written or verbal notice to cancel or reschedule all appointments.** If a 48-hour notice is not given, a non-refundable fee of $100 will be charged to the card on file. All fees must be paid in full before the patient is allowed to schedule any further appointments.

Appointment Timeliness- Patients are asked to arrive 15 minutes prior to all scheduled appointments, all patients arriving more than ***15 minutes past the scheduled appointment time*** will be needed to reschedule the appointment for another day, and a fee not to exceed ***$100*** could occur based on practice discretion.

Patient Name/Guardian Printed: _____

Signature of Patient/Guardian: _____ Date: _____

Witnessed by: _____ Date: _____

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

The primary purpose for taking photos/Videos before, during, and after all procedures (surgical, non-surgical, medspa,etc) is to discuss with you, the patient, the appropriate plan for such procedures as well as to compare before and after pictures/videos to evaluate results and progress.
I hereby acknowledge that pictures/videos may be taken and stored only in my HIPAA compliant patient chart regardless of my authorization or denial of the following Photo Consent.

Patient/Guardian Signature:_____Date:_____

I authorize Dr. Lou and/or Lou Plastic Surgery, and/or all representative(s), to take photographs, slides and/or videotapes of me or parts of my body pre-operatively, intra-operatively, and post operatively for the following procedure(s) and understand that these photographs/videos will be utilized as medical purposes to be used for my care, medical presentations, articles, website, and social media (including but not limited to Facebook, Instagram, Twitter, SnapChat)without compensation to me.

I understand that all pictures and/or videos will remain anonymous and any identifying features will be blurred/blacked out as best as possible.

*** The patient's face/identity will not be revealed in photographs/videos of body and/or breast procedures. Patient's having any facial procedures, the eyes will be blacked out. All identifying features will be blurred/blacked out as best as possible***

I understand that:

1. Such photographs, slides or videotapes may be published by Dr. Lou and/or Lou Plastic Surgery 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/Social Media(Including but not limited to Facebook, Instagram, Twitter, SnapChat), for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that such uses may also include marketing on behalf of Dr. Lou , for which Dr. Lou may be receive direct or indirect remuneration.

2. I will not be identified by name in any of the media described above; however, I also understand that in some rare circumstances the photographs, slides, or videotapes may display features that identify me.

3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to Erica Bruce at 1155 Dairy Ashford Rd Suite 610, Houston, Texas 77079. A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization.

4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Lou and/or Lou Plastic Surgery, as this authorization is completely voluntary.

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 redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.

Patient Photographic Authorization and Release

6. A copy of this Authorization is as valid as the original. I have received a copy of this Authorization. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

I release and discharge Dr. Lou and/or Lou Plastic Surgery 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, slides or videotapes 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, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as an informed and voluntary contribution in the interest of public education and 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, slides, or videotapes, I can contact **Erica Bruce at (713) 932-7290.**

If patient is a minor, we, the undersigned, are the parents or guardian of the patient and do herby consent for the Patient.
By signing this form, I acknowledge that this consent form will supersede any other photo consent forms with a date prior to the date written below and that this consent form will remain valid until revoked by written request or by completion of a new form.

Patient Consent Signature:_____Date: _____

Patient does **NOT** Consent Signature:_____Date: _____

Witnessed by: _____

Patient Initials: _____

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

Date _____ Signature _____

PATIENT CONSENT FOR USE OF CREDIT CARDS, DEBIT CARD, AND FINANCING - DISCLOSURE OF PROTECTED HEALTH INFORMATION

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.

Services that are performed and 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 Dr. Lou 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.

____ I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.

____ I agree that this non credit card challenge agreement is irrevocable.

Date _____ Signature _____

Patient Initials: _____