

Patient Information as of \_\_\_\_\_ (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: \_\_\_\_\_ Drivers License# \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Gender [ ] Female [ ] Male

Marital Status [ ] Single [ ] Married to: \_\_\_\_\_ [ ] Other: \_\_\_\_\_

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 M.D. Aesthetic Plastic Surgery?

(Mark all that apply)

- [ ] TV News [ ] TV Ad [ ] Phone Book [ ] Magazine [ ] Newsletter [ ] Seminar [ ] Salon [ ] Web
[ ] 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 \_\_\_\_\_

Primary Health Insurance Company

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Referral Required? [ ] No [ ] Yes Copay? [ ] No [ ] Yes, \$ \_\_\_\_\_

Insured: Name \_\_\_\_\_ DOB \_\_\_\_\_ Employer \_\_\_\_\_

Secondary Health Insurance Company

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Referral Required? [ ] No [ ] Yes Copay? [ ] No [ ] Yes, \$ \_\_\_\_\_

Insured: Name \_\_\_\_\_ DOB \_\_\_\_\_ Employer \_\_\_\_\_

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Mark Schusterman M.D., P.A. or Dr. Patrick Hsu, M.D./M.D. Aesthetic Plastic Surgery to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Mark Schusterman and/or Dr. Patrick Hsu, M.D. Aesthetic Plastic Surgery and myself.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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

# MD AESTHETIC PLASTIC SURGERY

7137940368

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 within the last 10 years: (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? \_\_\_\_\_

Are you pregnant or planning to become pregnant? No Yes Last menstrual cycle: \_\_\_\_\_

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 \_\_\_\_\_

# MD AESTHETIC PLASTIC SURGERY

---

## PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, \_\_\_\_\_, authorize Dr. Mark A. Schusterman M.D., P.A. and/or Dr. Patrick Hsu M.D. or **his** representative(s), to take photographs, slides or videotapes of me or parts of my body for the following procedure(s) and for medical purposes to be used for my care, medical presentations and/or articles.

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

Yes	No	Medium
		In the office <b>photo album</b> for prospective patients.
		In office <b>seminars</b> for prospective patients.
		On our <b>website</b> for prospective patients.
		In print <b>advertisements</b> .
		On <b>television</b> .

Additional Comments:
----------------------

I understand that:

1. Such photographs, slides or videotapes may be published by Dr. Mark Schusterman and/or Dr. Patrick Hsu 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. I understand that such uses may also include marketing on behalf of Dr. Schusterman, for which Dr. Schusterman may be receive direct or indirect remuneration.
2. I will not be identified by name in any of the media described above; however, I understand that in some 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 the office of **M.D. Aesthetic Plastic Surgery** at 1200 Binz, Suite 1200 Houston, TX 77004.
4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Mark Schusterman and/or Dr. Patrick Hsu.

# MD AESTHETIC PLASTIC SURGERY

---

5. The information disclosed under this Authorization, or some portion thereof, is protected by  
Texas state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").
6. Any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by applicable federal and/or state confidentiality rules.
7. 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. Mark Schusterman and/or Dr. Patrick Hsu 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 a voluntary contribution in the interest of public education and I certify that I have read this Authorization and Release carefully and fully understand its terms.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_

If I have questions about the use or disclosure of my photographs, slides, or videotapes, I can contact the office at **713-794-0368**



*Mark A. Schusterman, M.D., P.A.*  
*Aesthetic Plastic Surgery*

To maintain a timely schedule and provide patients with the best service possible, we have implemented policies to lessen the occurrence of patients who are late for appointments or who do not show up for scheduled appointments.

**NO SHOW POLICY FOR APPOINTMENTS:** We will charge \$175 if you do not come for your scheduled appointment or cancel your appointment with less than 24 hours notice.

**LATE POLICY FOR APPOINTMENTS:** Since we allot a certain amount of time for each appointment, if you arrive late for your appointment one of two things will occur: 1) your appointment will end as scheduled, thereby limiting the time available to accomplish the services scheduled for your appointment, or 2) we will work you into our schedule that day to the extent possible in order to accomplish the services for which you are scheduled, possibly pushing your appointment to the end of the day.

By my signature below, I agree that I am aware of and understand the above noted policies.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## MD Aesthetic Plastic Surgery

### Consent of Privacy Practices for Purposes of Protected Health Information For Treatment, Payment, and/or Healthcare Operations

I, \_\_\_\_\_, hereby give my consent for MD Aesthetic Plastic Surgery to use and disclose protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations by MD Aesthetic Plastic Surgery. I understand that diagnosis or treatment of me by MD Aesthetic Plastic Surgery may be conditional upon my consent as evidenced by my signature on this document. The release of Protected Health Information with regard to my medical treatment may be sent by fax, telephone, mail or email to other physicians, healthcare facilities or insurance companies.

I understand I have the right to request a restriction as to how my Protected Health Information is used or disclosed to carry out treatment, payment or healthcare operations of this practice. My treating physician is not required to agree to the restrictions that I, the patient, may request if the restriction falls within the exceptions to confidentiality by law. However, if MD Aesthetic Plastic Surgery agrees to a restriction that I request, the restriction is binding on MD Aesthetic Plastic Surgery and my treating physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that MD Aesthetic Plastic Surgery, or its physicians has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my demographic information, collected from me and created or received by my physician, another health care provider, a health insurance plan, my employer or a health care clearinghouse. This relates to my past, present or future physical or mental health or condition that may identify me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to preview and request a copy of MD Aesthetic Plastic Surgery Notice of Privacy Practices prior to signing this document. 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 of MD Aesthetic Plastic Surgery. The Notice of Privacy Practices for MD Aesthetic Plastic Surgery is posted in the waiting room area and on MD Aesthetic Plastic Surgery, website at [www.alwaysyouthful.com](http://www.alwaysyouthful.com). This Notice of Privacy Practices also describes my rights and MD Aesthetic Plastic Surgery duties with respect to my Protected Health Information.

- A. You have the right to request and be provided with a description of the procedures for exercising, the following with respect to your Protected Health Information:
- (i) Inspecting and copying;
  - (ii) Amending or correcting; and
    - a. An accounting of the disclosures of such information by MD Aesthetic Plastic Surgery

MD Aesthetic Plastic Surgery may change its policies and procedures relating to Protected Health Information at anytime. Should the Protected Health Information policies change, a revised Notice will be available at MD Aesthetic Plastic Surgery and posted on the website, [www.alwaysyouthful.com](http://www.alwaysyouthful.com). If you believe that there has been a violation of you Privacy Rights, a complaint may be filed with MD Aesthetic Plastic Surgery, by contacted Melissa Soukis Practice Manager, address: 1200 Binz St., Suite 1200, Houston, TX 77004, or at 713-794-0368. Further, a complaint may be filed with the U.S. Department of Health and Human Services. \

I have read and received a copy of the Notice of Privacy Practices.

I have read and refuse to accept a copy of the Notice of Privacy Practices.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_