REGIONAL PLASTIC SURGERY CENTER & Spa

Referring Physician: _____

Date of Appointment: _____

- Denton Watumull, M.D.
- Bruce Byrne, M.D.
- Joshua Lemmon, M.D.
- Derek Rapp, M.D.

Submit completed form to your patient coordinator's email, print out or email to:

Richardson: rpscfax@create-beauty.com
Rockwall: rockwallfax@create-beauty.com

PATIENT REGISTRATION

Section 1: PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Marital Status: Married Single Divorced Separated Widow

Sex: Female Male Date of Birth: _____ Age: _____

Social Security Number: _____ Driver's License Number: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____- _____ Cell Phone: (_____) _____ - _____

Email: _____

Please add me to your email list for Events and Spa Specials: Yes No

Student Status: Full Time Part Time Not a Student

Section 2: INSURANCE

GUARANTOR (Primary Insured):

Last Name: _____ First Name: _____ Middle Initial: _____

Guarantor's Address if different from Patient's: _____

City: _____ State: _____ Zip: _____

Relation to Patient: _____ Sex: Female Male

Home Phone: (_____) _____- _____ Cell Phone: (_____) _____- _____

Email: _____

Date of Birth: ____/____/____ Social Security Number: _____ Driver's License Number: _____

Employer: _____ Work Phone: (_____) _____- _____

Address: _____

City: _____ State: _____ Zip: _____

Employment Status: Full Time Part Time Not Employed/ Retired

Occupation: _____ PCP _____

PRIMARY: Carrier: _____ **SECONDARY:** Carrier: _____

Policy/ID#: _____ Policy/ID#: _____

Group: _____ Group: _____

Effective: _____ Effective: _____

Copay: _____ Copay: _____

Patient Name: _____ Date of Birth: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize Regional Plastic Surgery Center to furnish information to insurance carriers concerning my illnesses, accidents, and treatments, and also assign to them all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I also understand that any additional copay, coinsurance, and/or deductibles are due at the time of service.

This office will request a deposit of $500 for cosmetic surgeries.

REGIONAL PLASTIC SURGERY CENTER NO-SHOW POLICY:
Our policy is to charge $50 for no-shows to office appointments if we do not have a 24-hour notification of cancellation; and $100 for no-shows to office surgery if we do not have a 48-hour notification of cancellation.

_____ _____ _____
Patient's signature or responsible party Date

I (We) voluntarily request Dr. _____ as my physician, and such associates, technical assistants, and other health care providers they need necessary.

_____ _____ _____
Patient's signature or responsible party Date

Section 3: EMERGENCY CONTACT (Any person not residing with patient)

Name: _____ Relation to Patient: _____

Address: _____

Home Phone: (_____) _____- _____ Cell Phone: (_____) _____ - _____

Email: _____

CONTACT CONSENT

I, _____ the undersigned patient, authorize Regional Plastic Surgery Center to contact me at the following numbers:

Via Phone:				**Can Leave Message:**	
At Home:	○ Yes ○ No	Number: (_____) _____ - _____		○ Yes	○ No
Cell Phone:	○ Yes ○ No	Number: (_____) _____ - _____		○ Yes	○ No
At Work:	○ Yes ○ No	Number: (_____) _____ - _____		○ Yes	○ No

Other Persons We May Leave a Message With:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Section 4: NEW PATIENT INFORMATION

Age: _____ Are you RIGHT or LEFT handed? ○ Right ○ Left

Reason for Today's Visit: _____

_____

Date of Injury (if applicable): _____ Height: _____ Weight: _____

Prior treatment or studies for this problem: _____

_____

_____

Referred by: _____ Primary Doctor: _____

PAST MEDICAL HISTORY:

Melanoma	○ Yes	○ No	Cancer	○ Yes	○ No	Kidney Disease	○ Yes	○ No
Heart Disease	○ Yes	○ No	Asthma	○ Yes	○ No	Thyroid Disease	○ Yes	○ No
Stroke	○ Yes	○ No	AIDS or HIV	○ Yes	○ No	Bleeding Tendency	○ Yes	○ No
Anemia	○ Yes	○ No	Hepatitis	○ Yes	○ No	High Blood Pressure	○ Yes	○ No
Tuberculosis	○ Yes	○ No	Gout	○ Yes	○ No	Mitral Valve Prolapse	○ Yes	○ No
Diabetes	○ Yes	○ No	High Cholesterol	○ Yes	○ No	Bad Scarring/Keloids	○ Yes	○ No
Lung Problems	○ Yes	○ No	Stomach Ulcer	○ Yes	○ No			

Do you have SLEEP APNEA? ○ Yes ○ No

Have you had BLOOD CLOTS (DVT, pulmonary embolism): ○ Yes ○ No

Other conditions/problems: _____

_____

PRIOR OPERATIONS:

Tonsillectomy	○ Yes	○ No	Gastrointestinal	○ Yes	○ No	Hand or Arm	○ Yes	○ No
Appendectomy	○ Yes	○ No	Hysterectomy	○ Yes	○ No	Heart	○ Yes	○ No
Kidney/Bladder	○ Yes	○ No	Hernia Repair	○ Yes	○ No			

Other operations: _____

_____

FAMILY HISTORY:

Breast Cancer	○ Yes	○ No	High Blood Pressure	○ Yes	○ No	Depression	○ Yes	○ No
Heart Disease	○ Yes	○ No	Diabetes	○ Yes	○ No	Bleeding Problem	○ Yes	○ No
Arthritis	○ Yes	○ No	Kidney Disease	○ Yes	○ No			

Do you smoke? ○ Yes ○ No How much? _____ How many years? _____

If you quit smoking, when did you quit? _____

Do you drink alcohol? ○ Yes ○ No If yes, ○ rarely ○ socially ○ daily ○ heavily

Do you take any non-prescription or illicit drugs? ○ Yes ○ No

Patient Name: _____ Date of Birth: _____

Do you have any of the following problems?

Weight Change	Yes	No	Swollen Feet	Yes	No	Seizures	Yes	No
Dry Eyes	Yes	No	Skin Rash	Yes	No	Joint/Muscle Pain	Yes	No
Chronic Cough	Yes	No	Chronic Diarrhea	Yes	No	Swollen Lymph Nodes	Yes	No
Chest Pain	Yes	No	Jaundice	Yes	No	Easy Bleeding	Yes	No
Rapid Heartbeat	Yes	No	Depression	Yes	No	Easy Bruising	Yes	No
Shortness of Breath	Yes	No						

Do you have any medication allergies? Yes No
(Hives, welts, severe itching, facial/oral/airway swelling)

If yes, please list: _____

_____

Do any medications cause adverse side effects for you? Yes No

If yes, please list: _____

_____

List all current medications (including over-the-counter/herbal):

_____

_____

_____

Are you currently working? Yes No Job Title: _____

If yes, in what capacity? Full Time Part Time Light Duty

Do you have any current work restrictions? Yes No

If yes, please explain: _____

_____

_____ _____ _____
Patient's signature or responsible party Date

Reviewed: _____ Date: _____

☐ Dr. Watumull ☐ Dr. Lemmon ☐ Dr. Byrne ☐ Dr. Rapp ☐ Dr. Derrick ☐ Dr. Mehta

Patient Name: _____ Date of Birth: _____

REGIONAL PLASTIC SURGERY CENTER & Spa

Date: _____

To Whom It May Concern:

I authorize the release of all my medical records with your office to:

☐ Dr. Denton Watumull ☐ Dr. Joshua Lemmon

☐ Dr. Bruce Byrne ☐ Dr. Derek Rapp

LOCATION

☐ Richardson ☐ Rockwall

_____ _____ _____

Patient's signature or responsible party Date

3201 E. President George Bush Hwy, Ste 101
Richardson, Texas 75082
972-470-5000
972-470-5007 Fax

1407 Ridge Road, Ste 101
Rockwall, Texas 75087
972-470-1000
972-772-9561 Fax

VIDEO AND PHOTOGRAPH RELEASE AND AUTHORIZATION

I hereby give permission to Regional Plastic Surgery Center or its designated representatives to obtain photographs and/or video recordings of my person in connection with the plastic surgery procedure intended or performed.

I understand that photographs may be taken before, during or after my procedure as a routine part of my medical care.

I understand that the images will not be identified by my name, unless otherwise authorized. I understand that some photographs and video may, by their representation make me identifiable in appearance to others.

I further understand that these photographs and video recordings shall remain the property of Regional Plastic Surgery Center. Specifically, the photographs, video recordings or case information may be used for the office photo album, educational material for prospective patients, medical textbooks and journals, news media, television, radio, social media and any form of advertising.

I understand that the obtained photographs and/or videos can be used for the following:

- ☐ **All of the above**
- ☐ Patient Education (Office Only)
- ☐ Website
- ☐ Instagram
- ☐ Twitter
- ☐ TikTok
- ☐ Medical Presentations and/or Publications
- ☐ Facebook
- ☐ Snapchat
- ☐ YouTube

I hereby waive any right to inspect or approve the finished product, photograph, video or other use that may be used in conjunction therewith or to the eventual use that it might be applied. I understand that no renumeration will be provided to me now or in the future for usage of these images, videos or case information. I understand that such consent is strictly on a voluntary basis.

I release, discharge and agree to hold harmless Regional Plastic Surgery Center and its affiliates and their representatives and employees from and against any claims whatsoever in connection with the use of my images and the reproductions thereof as stated above, including any claim for payment in connection with the distribution or publication of the video and/or photographs.

Photo Limitations: _____
(For example: no face, no tattoos, etc.)

- ◉ I give authorization for photographs to be taken
- ○ I give authorization for videos to be taken

_____
Print Name

Signature

Date

Patient Name: _____ Date of Birth: _____

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiner, including physician assistants and acupuncturists, may be reported for investigation to the following address:

Texas State Board of Medical Examiners
Attn: Investigations
Centre Creek Drive, Suite 300
Austin, Texas 78714-9134
1-800-201-9353

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with the government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of personalization in they feel that an even in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you for being one of our highly valued patients.

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal healthcare information is protected for privacy. The "Privacy Rule" was also created in order to provide a standard for certain healthcare providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take responsible precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information and information about treatment, payment or healthcare operations, in order to provide healthcare that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

In an effort to provide appropriate care for you, if you have refused to sign this consent, it may be necessary for us to refuse treatment.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Your personal health information will be shared in the exam rooms. If you do not wish for the person accompanying you to hear your information, please have them remain in the waiting room. Otherwise, your signature below gives consent for anyone in the exam room with you to be allowed to hear your personal information. This consent may be revoked at any time in writing.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative Date:

_____ _____

Name of Personal Representative Description of Personal Representatives Authority

REGIONAL PLASTIC SURGERY CENTER & Spa

Advanced Beneficiary Notice of Non-Coverage

Patient Name: _____ Date of Birth: _____

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under the Medicare program standards, Medicare will deny payment for that service. Please be aware of some of the following:

- **Medicare does not cover the removal of moles, skin lesions and other dermatologic conditions unless verified as medically necessary.**
- **Medicare does not cover any type of cosmetic surgery.**
- **Medicare does not cover splints or would care supplies because they consider them "durable medical equipment."**

My physician has notified me that Medicare may deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

This waiver applies to the following procedure or materials.

Splints

(list other) _____

_____ _____

Signature Date