Bradley Hubbard MD
DALLAS PLASTIC SURGERY INSTITUTE

Patient Health Questionnaire

ACCOUNT #

Please help us assure you the highest quality of care by answering carefully.

PATIENT REGISTRATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-mail: _____

How do you want us to contact you? _____

Date of birth: _____ SSN: XXX-XX-_____ Sex: Male ◯ Female ◯

Married ◯ Single ◯ Separated ◯ Divorced ◯ Widowed ◯

Emergency contact: _____

Phone: _____ Relationship: _____

Personal physician: _____ Speciality: _____

TODAY'S VISIT

Age on this visit: _____ Ht: _____ Wt: _____ Occupation: _____

This consultation is to discuss: _____

_____

Whom may we thank for this referral? _____

MEDICAL HISTORY

Please check appropriate box(es) if you currently have, or have had, any of the following:

☐ Prolonged bleeding when cut	☐ Blood disorders(anemia, etc.)	☐ Hepatitis
☐ Fainting or blackout episodes	☐ Thyroid problems	☐ Swelling of ankles
☐ High blood pressure	☐ Herpes, fever blisters	☐ Cancer
☐ Ulcer disease	☐ Skin disorders	☐ Seizures
☐ Heart disease and/or heart attack	☐ Burning, dry, itchy eyes	☐ Diabetes
☐ Irregular heart beat, palpitations	☐ Immune disorders	☐ Liver disease
☐ Kidney problems	☐ Heart murmur	☐ Keloids
☐ Lung/respiratory problems	☐ Heart valve disorders	☐ Sleep apnea

If you answered yes to any of the above, please explain: _____

_____

Are you pregnant? Yes ◯ No ◯ How many pregnancies have you had? _____

Date of last mammogram: _____

CURRENT MEDICATIONS

1. Medication: _____ Dosage: _____
2. Medication: _____ Dosage: _____
3. Medication: _____ Dosage: _____
4. Medication: _____ Dosage: _____
5. Medication: _____ Dosage: _____
6. Medication: _____ Dosage: _____

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SURGICAL HISTORY

Previous procedures and when they occurred:

COSMETIC:

☐ Breast _____ ☐ Face _____ ☐ Eye _____

☐ Body contouring _____ ☐ Nose _____ ☐ Ear _____

OTHER:

☐ Gallbladder _____ ☐ Abdominal _____ ☐ Tonsils _____

☐ Appendix _____ ☐ Orthopedics _____ ☐ Eyes _____

☐ OB/GYN _____ ☐ Hysterectomy _____ ☐ Heart _____

☐ Sinus/nose _____ ☐ Breast _____ ☐ Other _____

Have you or anyone in your family had a reaction to general anesthesia? Yes ☐ No ☐

If yes, please explain: _____

Has anyone in your family had breast cancer before the age of 50? Yes ☐ No ☐

If yes, please explain: _____

SCARRING, BLEEDING AND TRANSFUSIONS

Have you formed excessive or unsatisfactory scars in the past? Yes ☐ No ☐

If yes, give locations: _____

Have you taken aspirin or blood thinners within the past two weeks? Yes ☐ No ☐

If yes, please list: _____

Have you had any prolonged bleeding when cut or is it in your family history? Yes ☐ No ☐

Have you had a blood transfusion: Yes ☐ No ☐ If yes, when? _____

Have you experienced a reaction to a transfusion? Yes ☐ No ☐ If yes, please describe:

_____

ALLERGIES

1. Medication and type of reaction: _____
2. Medication and type of reaction: _____
3. Medication and type of reaction: _____
4. Medication and type of reaction: _____

Tape/type: _____ Soap(s): _____

Latex: Yes ☐ No ☐ Food: _____

_____

PERSONAL HEALTH HABITS

Do you use any tobacco products? Yes ☐ No ☐ If yes, how many packs per day? _____

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

Do you take any diet pills, natural herbs or health food supplements? Yes ☐ No ☐

If yes, please list: _____

Have you been on any steroids in the last year? Yes ☐ No ☐

If yes, please list: _____

Signature: _____ *Date:* _____

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Insurance Information

PRIMARY INSURANCE

Insurance company: _____

Insured: _____ Relation to the patient: _____

Date of birth: _____ SSN: _____ Sex: Male ◯ Female ◯

Policy number: _____ Group number: _____

Insurance claim address: _____

Pre-certification phone number: _____

SECONDARY INSURANCE

Insurance company: _____

Insured: _____ Relation to the patient: _____

Date of birth: _____ SSN: _____ Sex: Male ◯ Female ◯

Policy number: _____ Group number: _____

Insurance claim address: _____

Pre-certification phone number: _____

DISCLAIMER

The physicians of Dallas Plastic Surgery Institute have developed Dallas Day Surgery Center of North Texas, Pine Creek Medical Center, Dallas Metro Surgery Center and The Cloister to provide a clean, safe, caring environment for our patients. While the physicians are investors in the facility, and may at times receive an investment distribution, the management directive is to provide the best possible quality of care at the most economical cost to patients.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits for private insurance (not to include Medicare, unless specific arrangements have been made) to Dallas Plastic Surgery Institute. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure the payment.

Signature: _____ *Date:* _____

Witness signature: _____ *Date:* _____

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Assignment of Benefits

Assignment of benefits, assignment of rights to pursue ERISA and other legal and administrative claims associated with my health insurance and or health benefits plan (including breach of fiduciary duty) and designate Assignment of benefits, assignment of rights to pursue ERISA and other legal and administrative claims associated with my health insurance and or health benefits plan (including breach of fiduciary duty) and designation of authorized representative

I hereby assign and convey directly to the above named healthcare provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above named healthcare provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named health care provider to release all medical information necessary to process my claims. Further, I hereby authorized my plan administrator fiduciary insurer, and/or attorney to release to the above named health care provider any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named healthcare provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort reason insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above named health care provider (including any rights to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by the above named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damage arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me (2) submit evidence; (3) make statements about facts of law (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it were the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Signature: _____ *Date:*_____

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Patient Consent

NEWSLETTER CONSENT

Would you like to receive our quarterly e-mail newsletter? Yes ☐ No ☐

PHOTO CONSENT

Photographs will be taken before and after surgery for documentation. We would like to ask your permission to use these photographs to show to future patients, and *possibly* on our website gallery. This gives patients a realistic idea of the results they can expect should they choose to have a similar procedure. Rest assured that your identity will be kept confidential.

Please initial the following:

_____ Yes, you may use my photos to show future patients.

_____ No, please do not use my photos.

I acknowledge that photographs may be taken of my body in connection with the medical services to be performed by my physician. I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

Patient/guardian signature: _____ *Date:*_____

Witness signature: _____ *Date:*_____

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Patient Consent

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as part of the provision of healthcare services, Dallas Plastic Surgery Institute creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care and treatments.

I have been provided with Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the Notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised Notice to the address I provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and audition functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosure have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this consent is as valid as this original.

3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I mast agree to any restriction on the use and disclosure of my Protected Health Information that I request in writing, when I request in writing, agree to terminate any restrictions on the use and disclosure of my Protected Health Information which have been previously agreed upon.

Patient's name printed: _____

Patient/guardian signature: _____ *Date:*_____

Witness signature: _____ *Date:*_____

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Patient Consent

USE OF EMAIL COMMUNICATIONS

To better serve our patients, this office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at drhubbard.office@dpsi.org

Please remember, however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is 24 hours. The service provider may delay message delivery. **Should you require urgent or immediate attention, this medium is not appropriate.**

When sending email, please put the subject of your message in the subject line so we can process it more efficiently. Also be sure to put your name and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature.

Communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of the email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to me, my staff and/ or colleagues would have access to this information.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above email policy.

By signing below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

Patient's name printed: _____

Patient/guardian signature: _____ *Date:* _____

Witness signature: _____ *Date:* _____

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Credit Card Authorization

I hereby authorize the office of Bradley Hubbard, M.D., process the payments on the following credit card for medical services and/or products related to services.

Patient's name: _____

Amount charged: _____ Date of services: _____

CREDIT CARD INFORMATION

Credit card number: _____

Security code: _____ Expiration date: _____

Name on the card: _____

Billing address: _____

City: _____ State: _____ Zip: _____

Signature: _____ *Date:* _____