Paragon Plastic Surgery & Med Spa

HAIR LOSS HISTORY

Name:_____ Phone:_____ Occupation: _____

Address: _____ City:_____State:_____Zip:_____

Email Address:_____ SSN#:_____

Date of Birth:_____ Age:_____ Gender:_____

Race: Caucasian African American Hispanic Asian Other

How did you hear of our Office? TV, Yellow Pages, Newspaper, Magazine, Radio, Friend_____ , Other

Reason for visit, why are you here today?_____

Health Insurance: Company_____:Policy number: _____Group number:_____

Hair-loss History:

At what age did you first notice hair loss? _____ What family members also have hair loss?_____

What products of treatments have you used to try to improve you hair? _____

What concerns you most about your hair loss? _____

What concerns do you have with restoring you hair? _____

What concerns you most about your hair loss? _____

Do you use: Rogaine: Yes / No Propecia: Yes / No

What medications are you currently taking? _____

Are you allergic to any drugs or medications (if so, which?) _____

Have you ever had a SEVERE allergic reaction to anything? _____

Have you ever taken over the counter remedies or supplements for hair loss? _____

Have you discussed your hair loss with your doctor or dermatologist? _____

What surgeries have you EVER had in the past? _____

Have you ever had any of the following? (Circle those that apply)

a. heart disease
b. high blood pressure
c. hepatitis
d. ulcer disease
e. diabetes
f. thyroid / endocrine disease
g. iron deficiency anemia

Have you ever had a blood transfusion?_____

Do you have any other chronic health conditions not listed above? _____

Primary Care Doctor: _____

Phone: _____

I would like further information about:

_____

_____

1101 Matlock Road
Mansfield, TX 76063

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Consent To Treatment, Release of Information, Financial Agreement

CONSENT TO TREATMENT: I understand and acknowledge that Texas Law provides that if any health care worker is exposed to my blood or other bodily fluid, this practice may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including HIV, with or without my consent. I understand that such testing is necessary to protect those who will be caring for me while I am a patient of this surgical practice. I understand the results of tests taken under these circumstances are confidential and do not become part of my medical record. I give my consent to Dr. Mark A. Bishara or his designees to perform or administer all tests and treatment that, in the judgment of Dr. Mark A. Bishara, is advisable during my visit to this surgical practice.

RELEASE OF INFORMATION: I authorize to release/obtain information contained in my financial and medical records, including diagnosis and test results, to/from (a) any of my treating practitioners, (b) my insurance company or health care plan or its representative, or its agents or independent contractors or (c) any other person or entity that is responsible for paying or processing for payment any portion of my medical treatment bill or (d) to any person or entity for the purposes of administration, billing, collecting, and quality assessment and risk management or to any hospital, nursing home, home health agency or to any healthcare institution to which I am transferred. I understand this consent applies to all records created in the course of and relating to my care. I release and agree to hold harmless the surgical practice of Dr. Mark A. Bishara and his representatives and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand this surgical practice cannot be responsible for use or redisclosure of information by third parties.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: In consideration for the medical and surgical services to be or have been rendered to me, I agree to pay for those services. I agree to assign to Dr. Mark Bishara , the benefits under my insurance policies or prepaid health care plan or other reimbursement source. I acknowledge that any balance not covered or paid by such policy or plan is my legal and financial responsibility. I acknowledge that I am aware this practice does not charge interest for late payments. I acknowledge that I am aware that any balance not covered or paid after 120 days, will be turned over to a collection agency and this practice will initiate termination of my patient-physician relationship as described by Texas Law. I acknowledge that any billing-related complaint will be directed to the billing compliance officer. I acknowledge and I am aware that cosmetic surgery procedures are not covered by the benefits under my insurance company and Dr. Mark A. Bishara does not accept insurance reimbursements for cosmetic surgery procedures and all charges related to cosmetic surgery are my own financial responsibility. I understand that there is a $35 NSF for all returned checks. I acknowledge that I am aware the policy of billing practices and the policy of charity care are both available upon request.

THIS IS A LEGAL CONSENT, FINANCIAL AGREEMENT, AND ASSIGNMENT OF BENEFITS FORM. PLEASE READ IT CAREFULLY AND BE SURE YOUR QUESTIONS HAVE BEEN ANSWERED BEFORE SIGNING.

Signature :_____ Name:_____

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PHOTOGRAPHIC CONSENT

Date_____Full Name_____

I, hereby authorize and consent that any and all photographs, images, or videos taken by Dr. Mark A. Bishara at Bishara Cosmetic Surgery Center of any part of my body, whether originals or reproductions, may be utilized for such purposes as he may desire in connection with his research, writing, professional activities, and may be used, exhibited and published through any medium whatsoever as part of or in connection with his research, writing, and professional activities, even though such use may be for advertising purposes or purposes of trade. This consent is not retractable, either by oral or written means.

I certify that I have read and understand the aforementioned and sign my name below giving authorization and consent to the foregoing and any photographs, image, or videos taken for future surgeries.

Date: _____ Patient Signature:_____

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Acknowledgement of Receipt of Notice of Privacy Practices

Health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice maybe changed at any time. I may obtain a revised copy of the Notice by requesting one at this office.

Do you have any restrictions as to how we contact you?_____

Special Instructions:_____

_____

Signature:

Patient Name*: _____

Date:_____

*** If signed by a personal representative, please state your authority to act for _(Name)**
_____

THIS SPACE TO BE USED BY PRACTICE ONLY

Patient Acknowledged Notice of Privacy Practices on Form Provided and Returned Signed Copy.
Accepted _____Denied_____

If Refuse to Sign, Document Reason in Chart: _____

Note: Cannot refuse to see patient if patient refused to sign Acknowledgement

Signed Acknowledgement _____

Accepted or Denied _____

Name of Employee Documenting _____

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