



Referring Physician: \_\_\_\_\_

Date of Appointment: \_\_\_\_\_

- Denton Watumull, M.D.       Derek Rapp, M.D.
- Joshua Lemmon, M.D.       Chase Derrick, M.D.
- Bruce Byrne, M.D.       Chirag Mehta, M.D.

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

Richardson, McKinney, Irving: [rpscifax@create-beauty.com](mailto:rpscifax@create-beauty.com)

Rockwall: [rockwallfax@create-beauty.com](mailto:rockwallfax@create-beauty.com)

Sherman: [rpscshermanfax@create-beauty.com](mailto:rpscshermanfax@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 surgery deposit of \$250.00. In case of overpayment, you will be refunded after your insurance pays the surgery bill. ACCOUNT NOT PAID IN 90 DAYS WILL GO TO OUR COLLECTION AGENCY.

**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:**

At Home:  Yes  No Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Cell Phone:  Yes  No Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
At Work:  Yes  No Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Can Leave Message:**

Yes  No  
 Yes  No  
 Yes  No

Other Persons We May Leave a Message With:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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**Section 4: NEW PATIENT INFORMATION**

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Age: \_\_\_\_\_

Are you RIGHT or LEFT handed?

 Right LeftReason 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  NoHeart Disease  Yes  NoStroke  Yes  NoAnemia  Yes  NoTuberculosis  Yes  NoDiabetes  Yes  NoLung Problems  Yes  NoCancer  Yes  NoAsthma  Yes  NoAIDS or HIV  Yes  NoHepatitis  Yes  NoGout  Yes  NoHigh Cholesterol  Yes  NoStomach Ulcer  Yes  NoKidney Disease  Yes  NoThyroid Disease  Yes  NoBleeding Tendency  Yes  NoHigh Blood Pressure  Yes  NoMitral Valve Prolapse  Yes  NoBad Scarring/Keloids  Yes  NoDo you have SLEEP APNEA?  Yes  NoHave you had BLOOD CLOTS (DVT, pulmonary embolism):  Yes  NoOther conditions/problems: \_\_\_\_\_  
\_\_\_\_\_**PRIOR OPERATIONS:**Tonsillectomy  Yes  NoAppendectomy  Yes  NoKidney/Bladder  Yes  NoGastrointestinal  Yes  NoHysterectomy  Yes  NoHernia Repair  Yes  NoHand or Arm  Yes  NoHeart  Yes  NoOther operations: \_\_\_\_\_  
\_\_\_\_\_**FAMILY HISTORY:**Breast Cancer  Yes  NoHeart Disease  Yes  NoArthritis  Yes  NoHigh Blood Pressure  Yes  NoDiabetes  Yes  NoKidney Disease  Yes  NoDepression  Yes  NoBleeding Problem  Yes  NoDo 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  heavilyDo 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       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swollen Feet     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Seizures            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dry Eyes            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Skin Rash        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Joint/Muscle Pain   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chronic Cough       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Chronic Diarrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swollen Lymph Nodes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest Pain          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Jaundice         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Easy Bleeding       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rapid Heartbeat     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Depression       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Easy Bruising       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shortness of Breath | <input type="checkbox"/> Yes | <input type="checkbox"/> 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: \_\_\_\_\_



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. Chase Derrick

Dr. Bruce Byrne       Dr. Derek Rapp       Dr. Chirag Mehta

**LOCATIONS:**

Richardson       Los Colinas       Rockwall       Sherman       McKinney

\_\_\_\_\_  
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

6750 N. MacArthur, Ste 257  
Irving, Texas 75039  
972-470-5000  
972-470-5007 Fax

1111 E. Sara Swamy Dr.  
Sherman, Texas 75090  
903-893-6311  
903-870-0456 Fax

5236 W. University Dr., Ste 3600  
McKinney, Texas 75071  
972-470-5000  
972-470-5007 Fax

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

# REGIONAL PLASTIC SURGERY CENTER

## 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



**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 wound 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