Dr. M. Scott Haydon - New Patient Information Sheet

Name: _____ Date of Birth: _____ Age: _____

Sex: Female / Male / Transgender

Address: _____City/State: _____ Zip: _____

Contact Number: _____

Please specify the reason for your consultation today: _____

When are you contemplating having this surgery or procedure?_____

Marital Status: Single / Married / Divorced / Widowed

Occupation and Employer: _____

Person to be contacted in case of an emergency: _____

Relationship to Patient: _____

Emergency Contact Phone Number/Email:

_____

Referral Source: Previous Patient / Physician / DrHaydon.com / AustinPSI.com / Internet Search / Facebook / RealSelf / Instagram / TikTok / Friend/Family / Other

If you found us via the internet, what did you type in the search:

_____

If referred by physician, patient, family, or friend, may we please have the name:

_____

HEALTH INFORMATION

Height: _____ Weight: _____ BMI if known: _____

Current medical conditions: _____

Past medical conditions:

_____

_____

Previous surgical procedures (specify year of operation):

_____

_____

Have you ever had issues with post-surgical nausea: Yes / No

Significant family medical history:

_____

Current Medications (dosage, length, reason):

_____

_____

Allergies to medication (Include your reaction):

_____

Is there anything we need to know about your health or health history:

_____

Do you ever use any amount of nicotine products? (Including Vape, Chewing Tobacco, Patches, Gum)

Yes / No If yes, what kind & how often?_____

_____

Do you drink alcohol:

Yes / No If yes, how many drinks do you consume per week: _____

Primary care physician name/number: _____ Last seen: _____

When was the last time you had full labs done: _____

Pharmacy name/number: _____

FEMALE PATIENTS ONLY

Date of Last Mammogram: _____ Results: Normal / Abnormal / NA

OBGYN physician name/number: _____

Number of Pregnancies: _____ How many children/ages: _____

Do you plan on having more children: Yes / No

If so, do you plan on breast feeding: Yes / No Have you had a Cesarean Section: Yes / No

Sign: _____ Date: _____

Print Patient Name: _____ Date: _____

M. Scott Haydon, M.D.
FINANCIAL POLICY

Dr. Haydon has a responsibility to provide quality healthcare services to patients. In the interest of maintaining a good doctor-patient relationship and continuing the delivery of quality healthcare, it is our hope that you will take responsibility for your financial obligation to our practice. The following are general policies we have established for our patients, which we believe allow the flexibility that some patients need. We encourage you to discuss your account, and any payment arrangements that you desire, with our office personnel. Discussion of these issues early on in your treatment process will prevent most concerns or misunderstandings.

1. Insurance – Dr. Haydon's office **does not** accept or process insurance payments for patients. You are responsible for submitting to your insurance company any tests required (EKG, Mammogram, Prescription/Medication) that you wish to document and/or obtain reimbursement if applicable. Please remember insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits rests with you.

2. Payment - The consultation fee is non-refundable and will be applied to your procedure if you decide to move forward. Please note that we do require a non-refundable deposit to schedule a surgery date. Dr. Haydon accepts cash, credit card, or third-party financing for the procedure portion of the surgery. Dr. Haydon reserves the right to charge a surgery re-scheduling fee. We will discuss this further with you at the consultation.

3. Referrals – Dr. Haydon's office is happy to accept you as a patient from a referred provider once a consultation and evaluation is complete and he can determine that he is able to help you with your specific need or request. A referral is not required given we do not accept insurance at this practice.

4. Returned Checks – Your account will be charged a $25 fee for each returned check. In addition, you will be asked to bring cash to our office to cover the returned check and the fee.

5. Past Due Accounts – Patients who have not tried to make payment arrangements or have not expressed an interest in meeting their financial obligation to us will be turned over to a collection agency. Patients who have allowed their account to be turned over to an agency will be expected to satisfy their financial obligation to us, and to pay for any future services in advance.

6. Please arrive 10 minutes prior to appointment time for all consultations, pre-ops, post-ops and follow-up appointments. You will be advised of your approximate surgery arrival time when your surgery date is scheduled. Surgery dates and times are subject to change.

Patient Statement: I have been informed of Dr. Haydon’s financial policy and agree to its terms. I have been notified that Medicare and other insurance companies may deny payment for visits/procedures for the reasons stated above. If Medicare or my insurance company denies payment, I agree to be personally and fully responsible for all payments. I understand that all cosmetic surgery must be paid in full prior to surgery.

Signature Date

M. SCOTT HAYDON, M.D.
CONSENT FOR RELEASE OF PHOTOGRAPHS

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 or social media platforms. 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 on all galleries and websites.

Initial the following:

_____**Yes**, you may use my photos to show future patients
(including Austinpsi.com/DrHaydon.com/Realself.com)

_____**No**, please do not use my photos to show future patients

_____**Yes**, you may use my photos/videos for social media purposes
(including, but not limited to Instagram, Facebook, SnapChat, etc)

_____**No**, please do not use my photos/videos for social media purposes

I acknowledge that photographs may be taken of my body in connection with the medical services to be performed by my physician.

Patient Signature **Print Name** **Date**

Parent/Guardian Signature **Print Name** **Date**

AUSTIN PLASTIC SURGERY INSTITUTE

Acknowledgement of Notice of Health Information Practices

The attached notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please sign this cover sheet acknowledging receipt of the policy and return it to the office. You may review the policy in our office and let us know if you have any questions or requests.

By my signature below, I acknowledge that I have received the Notice of Health Information Practices of APSI.

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 have provided I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon**.**

Name of Patient **Signature of Patient** **Date**