PATIENT INFORMATION SHEET
M. SCOTT HAYDON, M.D.

4701 Bee Cave Rd., Ste. 202 Austin, TX 78746 • (512) 300-2600
www.drhaydon.com

Name:_____
(Last) (First) (Middle Initial) **Today's Date**
S.S #:_____-_____-_____Date of Birth:_____Age:_____
Driver's License #:_____State:_____ Sex: Female_____Male_____
Address:_____
City:_____State:_____Zip Code:_____
Home Ph:_____Work Ph:_____Cell Ph:_____
Marital Status: Single____ Married____ Divorced____ Widowed____
E-Mail Address:_____
Would you like to be notified of special offers? Yes____ No____
Occupation:_____Employer:_____
Person to be contacted in case of an emergency:_____
Relationship to Patient:_____Phone Number:_____hm/wk/mobile
Specify the reason for your consultation today:_____
Who referred you to us: Physician DrHaydon.com RealSelf Online Search Facebook
Instagram AustinPSI.com Family/friend seen by Dr. Haydon:_____

HEALTH INFORMATION

Height:_____Weight:_____ BMI: _____ General Doctor:_____
Current or past medical illnesses:_____
_____
_____
Previous Surgical Procedures:_____
_____
Have you ever had issues with post-surgical nausea?_____
Significant Family Medical History:_____
_____
Current Medications:_____
_____
_____
Allergies to Medication (What is your reaction):_____
_____
_____
Do you smoke? Yes/No If so, how often?_____
Do you drink alcohol? Yes/No If so, how often?_____

Pharmacy: _____ Phone #: _____
Location/Intersection: _____

Female Patients:
OBGYN doctor: _____ City: _____
Number of Pregnancies:_____Number of live births:_____
Date of Last Mammogram:_____Results: Normal:_____Abnormal:_____

INSURANCE INFORMATION

Please provide insurance card to be photocopied if necessary. A referral from your primary care physician is required if you have HMO Insurance.

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** – As a courtesy to our patients, we will file claims on all insurance- related visits and procedures, whether they are delivered in our office or the hospital. When we file a claim on your behalf, it is with the understanding that benefits will be assigned to Dr. Haydon (that is, the insurance company will reimburse Dr. Haydon directly). We do require pre-payment of an estimated amount due to Dr. Haydon prior to any scheduled procedure based on the procedure codes and benefits with your insurance plan. You are responsible for payment of all deductibles, co-insurance and non-covered services. Please remember insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits and for payment to your doctor rests with you.

2. **Referrals** – You are required to 1) know whether or not your insurance requires a referral and 2) obtain that referral before you are scheduled to see our physician. Our office will be happy to assist you in determining the status of Dr. Haydon on your insurance plan; however, this is not a guarantee of coverage. You should take the time to call your insurance company to ask specifically about Dr. Haydon and your covered benefits. Referrals typically have an expiration date and a limited number of visits so you should be careful to monitor the dates and visits. Our office will not see a patient who does not have a valid referral.

3. **Cosmetic** – Patients are expected to pay for all non-insurance services rendered prior to surgery. We will request all payment for cosmetic procedures 2 weeks prior to the procedure performed. We understand that individual situations may make it difficult to meet these financial expectations, and are happy to discuss third party financing with you such as Care Credit or Prosper.

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 made an effort 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 to an agency will be expected to satisfy their financial obligation to us, and to pay for any future services in advance, before being seen by Dr. Haydon.

6. **Non-Covered Services** – You have scheduled a visit with Dr. Haydon that he believes to be relevant to evaluate, monitor and protect your health. However, Medicare and certain other insurance companies will only pay for services that they determine to be "reasonable and necessary". If Medicare or another insurance company determines that your visit with our physician is not "reasonable and necessary", they will deny payment for that service. Dr. Haydon recommends an office visit prior to the performance of any procedure, in order that the patient's general health may be evaluated and so that the patient is well informed about any recommended procedure. We are required to inform you in this policy that your insurance company may not cover the office visit or surgery and in that case, you will be responsible for payment.

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 my initial office visit for the reasons stated above. If Medicare or my insurance company denies payment, I agree to be personally and fully responsible for payment. I understand that all cosmetic surgery must be paid in full prior to surgery.

_____ _____
Signature Date

If patient is a minor:

_____

Guardian or Parent 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

NOTICE OF HEALTH INFORMATION PRACTICES ACKNOWLEDGEMENT FORM

AUSTINPLASTIC SURGERY INSTITUTE

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 _____