AUSTIN PLASTIC SURGERY INSTITUTE
& SKIN CARE CLINIC

Dr. Justin Booth
4701 Bee Cave Rd Ste. 202
Austin, Tx 78746

New Patient Intake

Name: ____ DOB: ____________________ SS:____________________
First Last Middle Initial

Address:____ Phone:_________________________
Street City State Zip

Sex: __Female __Male Marital Status: __ Single __Married __ Divorced

Email: ____ Best Contact Method: ___ Cell ___ Email

Job Employment :________________________________ Occupation:__________________ Phone: _____________

Emergency Contact: ____ Relationship to Patient:________________

Cell:______________________ Home:___________________________ Other:___________________________________

How did you hear about us?

___ Google ___Website __Social Media Site __Family/Friend _____________________________

_ _

Interested Procedures- Check all that apply, (if not listed): ____

Breast Procedures:

- ☐ Breast Augmentation
- ☐ Breast Reduction
- ☐ Mastopexy
- ☐ Breast Implant Removal
- ☐ Gynecomastia
- ☐ Breast Implant Exchange
- ☐ Breast Reconstruction

Face Procedures:

- ☐ Blepharoplasty
- ☐ Face Lift
- ☐ Neck Lift
- ☐ Rhinoplasty
- ☐ Earlobe Repair
- ☐ Otoplasty (Ear Pinning)

Body Procedures:

- ☐ Abdominoplasty (Tummy Tuck)
- ☐ Body Lift
- ☐ Brachioplasty (Arm Lift)
- ☐ Buttock Augmentation
- ☐ Liposuction
- ☐ Labiaplasty
- ☐ Thigh Lift/Buttock Lift
- ☐ Fat Transfer
- ☐ Scar Revision

Other Services:

- ☐ Botox
- ☐ Fillers

I certify that the above information is correct to the best of my knowledge.

Signature: ____ Date:_________________________

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Health History Questionnaire

Name:_____________________________________ DOB: ____________________ Age:__________

Vitals: HT: _____________ WT:______________ BP: ____________ HR:__________ O2:____________

	Yes	No	If So, explain
Heart			
Heart Attack			
Chest Pain			
High Blood Pressure			
Family history of heart disease			Which family member?
Lung			
Respiratory issues			
Sleep apnea			
Asthma			
Digestive Tract			
Reflux/Heartburn			
Hepatitis			
Muscle/Bone			
Muscle Weakness			
Arthritis			
Neurological			
Seizures			
Depression			
Headaches			
Bleeding			
Bleeding/Clotting problems			
Metabolic			
Diabetes			
Thyroid			
Breast			
Breast masses			
Family history of breast cancer, or masses?			Which family member?

Medication List: Please list all medication including over the counter, herbals and vitamins.

Name:	Dosage:	How long have you been taking it?

I certify that the above information is correct to the best of my knowledge. I will not hold the staff at Austin Plastic Surgery Institute responsible for any errors or omissions that I may have made in the completion of this form. I acknowledge that I have received the Notice of Privacy Practices.

Signature:____ Date:_________________________________

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Any Previous Surgeries:

Name of Procedure:	When/Where:	Why?:

Additional Questions:

Preferred Pharmacy(include location):____

Primary Doctor(include address and phone number): ____

Any drug allergies(if yes, please list allergy and reaction):____

Do you smoke tobacco? (if yes, please list for how long): ____

Do you drink alcohol?: ____

Any Pregnancies: _________________ How many?________________________ Did you breastfed?___________________________

Any other health concerns that your doctor should know?____

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Signature:____ Date:________________________________

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes: how we may use and disclose your Protected Health Information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law; and your rights to access and control your Protected Health Information. "Protected health information" ("PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Uses and Disclosures of Protected Health Information
Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment
We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment
Your PHI will be used, as needed, to obtain payment for your health care services. For example, your health plan may require that your relevant PHI be disclosed to the health plan to obtain approval for treatment.

Healthcare Operations
We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk were you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other Permitted and Required Uses and Disclosures
Other uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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Your Rights with Respect to Your PHI

- • **You have the right to request a restriction of your PHI.** Under federal law, however, you may not inspect or copy the following

  records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

- • **You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.
- • **You have the right to have your physician amend your PHI**. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- • **You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI**.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

PRIVACY PRACTICES ACKNOWLEDGEMENT

This sheet is a supplement to the materials provided. Please refer to these handouts for more complete information. I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- • Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- • Obtain payment from third-party payers.
- • Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing the consent. I understand that this organization has the right to change its *Notice of Privacy Practices* and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this content.

Name: ____ Relation to patient, if applicable:_______________

Signature: ____ Date: __________________________________

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AUTHORIZATION FOR RELEASE OF PATIENT PHOTOGRAPHS/VIDEOS

I consent to the taking of photographs and/or videos by Dr. Justin Booth or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Justin Booth. I further authorize Dr. Justin Booth or one of his/her associates to release to the American Society of Plastic Surgeons ("ASPS"), and/or The American Board of Plastic Surgery ("ABPS") such media.

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.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of ASPS and may be retained by ASPS or released by ASPS for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Justin Booth.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA.

I release and discharge Dr. Justin Booth, ASPS, and all parties acting under their license and authority from all rights that I may have in the photographs/videos and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs and/or videos.

I certify that I have read the above Authorization and Release and fully understand its terms.

For Minors:
I have read the above Authorization and Release. I am the parent, guardian, or conservator of
_____________________________________, a minor. I am authorized to sign this

authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

____________________________________Patient Name (relationship)

____________________________________Patient/Parent Signature

____________________________________Witness Signature

____________________________________Date

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Financial Policies

There is a $50 consultation fee and any quotes given today are valid from the day of the initial consultation to 60 days after the initial consultation.

Scheduling / Payments
To schedule and save your date for surgery, a non-refundable 20% deposit of the total cost of the procedure will be required to schedule your surgery. Total payment is due in full two weeks prior to the procedure for all forms of payment.

If scheduling your surgery less than 2 weeks prior to your surgery date, full payment must be made at the time of scheduling.

If paying by check, a certified bank check will be required.
Credit card payments will require a copy of your driver's license to be present in your patient file.

Cancellations:
Full payment is required 2 weeks prior to the surgery. If payment is not received, your surgery will be cancelled unless arrangements have been made.

Disputes / Refunds
Any disputes with the credit card company used for payment after the procedure is completed, patients acknowledge by signing below that they will waive their right to portions of the HIPAA policies and that portions of their medical records will be used to clarify the dispute with the credit card company. This can include all documents that authorized the procedure by you the patient.

Please note that surgeons' fees are based on the procedure(s) performed. Along with our fees, this quote includes facility and anesthesia fees which are based on our estimate of time needed to perform the surgery. If the scheduled time is exceeded, there may be additional charges from the facility and the anesthesia group that are billed to you following the surgery. If the procedure takes less time than anticipated, a refund may be given. In either case, there will be no adjustments to our fee.

COSMETIC WAIVER
I understand that this surgery is cosmetic in nature and is not medically necessary. Therefore, it is not reimbursable by any insurance payor and I am financially responsible. I have been advised that if I want a predetermination to assess eligibility for insurance coverage for this surgery that this must be done in advance of the surgery. By signing this waiver, I agree the surgery is cosmetic in nature and no insurances will be billed. I am fully responsible for payment.

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____
Signature

____
Print Name

____
Date