

HOUSTON PLASTIC AND CRANIOFACIAL SURGERY
SEAN BOUTROS, M.D.

(713) 791-0700

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? No Yes E-mail _____
Contact Drivers License # _____
Restrictions: (include State)

Age _____ Birthdate ____/____/____ SS# ____-____-____ Sex Female Male

Marital Status Single Married to: _____ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes No

Address _____
Street & Suite # City State Zip

Emergency Contact
(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____

Insured: Name _____ DOB _____ Employer _____

Referred by: _____ **Phone Number:** _____
(Physician or Source) (If applicable)

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Boutros to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Boutros and myself. I clearly understand and agree that all service rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due.

Note: Returned checks will be assessed a \$25.00 fee. Treatment may be suspended for no payment of services rendered.

Signature _____ **Date** _____

CURRENT HEALTH CONDITION

1) Are you allergic to any medications? YES / NO

If so, what kind _____

2) Do you exercise regularly? YES / NO

3) Do you currently smoke? YES / NO

If so, how many packs per day? _____

MEDICAL HISTORY

Please Indicate:

Myself: "P"- Past "C"-Current or "F" Family

___ HIGH BLOOD PRESSURE

___ HEART TROUBLE

___ DIABETES

___ HEPATITIS

___ GERMAN MEASLES

___ VENERAL DISEASE

___ HIV

___ MUSCULAR DYSTROPHY

___ MULTIPLE SCLEROSIS

___ CONVULSIONS

___ EPILEPSY

___ CONCUSSION

___ CANCER

___ RHEUMATISM

___ RHEUMATIC FEVER

___ SCARLET FEVER

___ POLIO

___ TUBERCULOSIS

___ ANEMIA

___ SINUS PROBLEMS

___ ASTHMA

___ HEADACHES

___ DIZZINESS

___ BACKACHES

___ DIGESTIVE PROBLEMS

___ ARTHRITIS

___ ALLERGIES

___ NUMBNESS

___ NEURITIS

___ NERVOUSNESS

___ OTHER: _____

Indicate which medications (if any) you are currently taking:

___ Nerve Pills

___ Pain Killers

___ Insulin

___ Birth Control Pills

___ Muscle Relaxants

___ Anti-Inflammatories

___ Anticoagulants

___ Other

___ Blood Pressure

___ Female Hormones

___ Thyroid Medication

___ Antibiotics

___ Cholesterol Medication

HOUSTON PLASTIC AND CRANIOFACIAL SURGERY

Sean Boutros M.D., P.A.

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND CARE

I _____, hereby state that by signing this Consent, I acknowledge and agree to the following:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative
(e.g., Guardian, Parent if a minor)

Relationship

Date Signed ____/____/____

Witness: _____

HOUSTON PLASTIC AND CRANIOFACIAL SURGERY

*Sean Boutros M.D., P.A.
6400 Fannin, Suite 2290
Houston, TX 77030
(713)791-0700*

By signing this form, I am requesting and consenting to procedures which may include, but are not limited to physical examination, diagnostics, invasive and non-invasive corrective procedures, and surgery performed by Sean Boutros M.D. I understand that it is my right to determine the extent of my medical care, and I may, at any time, refuse treatment and withdraw my consent for the performance of any procedure or treatment. I recognize that healing is a slow and gradual process and I must allow time for healing to occur, after any procedure, before maximum results are apparent.

By my signature below, I authorize Dr. Sean Boutros and his employees or agents to photograph me and/ or make electronic recordings of me. This consent includes the taking of photographic or electronic reproductions of any part of my body.

I authorize the use of any such photographic or electronic reproductions of me for purposes of my treatment, educational endeavors, and quality assurance review. They may be used for any purpose, including but not limited to dissemination of physicians, health professionals, and members of the public for scientific or educational purposes or publication in newspapers, magazines, and other public media as may be deemed appropriate by Dr. Sean Boutros.

I understand that I may refuse to consent to the taking of any photographic or electronic reproductions that are not intrinsic to my operation or procedure without prejudice to my care.

I have entered into this agreement in order to assist scientific treatment, educational, public relations, and/or charitable goals and hereby waive any right to compensation for these uses. I and my successors and assignees hereby hold Dr. Sean Boutros, his employees, and any other person participating in my care and their successors and assignees harmless from and against any claim for injury or compensations resulting from the activities authorized by this consent.

By signing this form, I certify that, to the best of my knowledge, I am not pregnant and the above doctor(s) and/or associates have my permission to perform diagnostic X-ray examination. I have been advised that X-rays can be hazardous to an unborn child.

I understand that Dr. Sean Boutros has ownership in the Memorial Hermann Medical Plaza Surgical Center and may profit from surgeries performed in this location.

Authorized Signature: _____

Witness: _____

Date: _____

Houston Plastic & Craniofacial Surgery
6400 Fannin, Suite 2290 Houston, Texas 77030
Sean Boutros, M.D., P.A.

ASSIGNMENTS OF BENEFITS

Upon receiving treatment from Sean Boutros, M.D., P.A. some or all of the following responsibilities must be assumed by the patient and/or legal representative of the patient.

Assignment of Benefits

This assignment of benefits allows Sean Boutros, M.D., P.A. to be paid by my insurance carrier for the services rendered to me, and I assign Sean Boutros, M.D., P.A. any and all rights and/or claims I may have pursuant to any and all insurance contracts and/or policies including, but not limited to, any and all third-party and first-party insurance policies and payors.

In return for the services rendered and to be rendered by Sean Boutros, M.D., P.A., I hereby assign and transfer to Sean Boutros, M.D., P.A., all rights and interests in all benefits payable for the health care rendered, which are provided in any and all insurance policies and health policies and health benefits plan from whom I or my dependents are entitled to recover (hereinafter referred to as Benefits). This assignment and transfer shall be for the purpose of granting Sean Boutros, M.D., P.A. an independent right of recovery against my insurer(s) and/ or health benefit plan(s), but shall not be construed to be an obligation of Sean Boutros, M.D., P.A. to pursue any such rights or recovery. In no event will Sean Boutros, M.D., P.A. retain Benefits in excess of the amounts owed to Sean Boutros, M.D., P.A. for the care and treatment rendered to me.

I have read and been given the opportunity of ask any question about this assignment of benefits, and I have signed this document freely and without inducement.

Obligation of Financial Payment

In consideration for the services rendered by Sean Boutros, M.D., P.A., including examinations, tests, treatments, supplies, surgical procedures and medications, I hereby promise to pay Sean Boutros, M.D., P.A. all costs and charges for such services rendered by Sean Boutros, M.D., P.A. in accordance with bills and invoices presented.

Signature of Insured

Date

Signature of Patient/ Authorized Party

Witness