

HOUSTON PLASTIC AND CRANIOFACIAL SURGERY

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

Welcome to Our Office!

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. If you need any help, please don't hesitate to ask.

Name: _____ Home Phone: _____

Email: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: Male or Female Ethnicity: Caucasian Hispanic Asian African-American Other

Birthday: ___/___/___ Age: ___ Marital Status: M S W D No. of Children: ___

Social Security Number: _____ Driver License Number: _____ State: _____

Employer: _____ Position: _____ Work Phone: _____

SPOUSE: _____ Home/Mobile Phone: _____

IN CASE OF EMERGENCY: NAME OF NEAREST RELATIVE OR FRIEND

1. _____ Relationship: _____ Phone: _____

2. _____ Relationship: _____ Phone: _____

Referring Physician/Source _____

Primary Care Physician _____

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

- | | |
|----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> MUSCULAR DYSTROPHY |
| <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> MULTIPLE SCLEROSIS |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> CONVULSIONS |
| <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> EPILEPSY |
| <input type="checkbox"/> GERMAN MEASLES | <input type="checkbox"/> CONCUSSION |
| <input type="checkbox"/> VENERAL DISEASE | <input type="checkbox"/> CANCER |
| <input type="checkbox"/> HIV | |
|
 | |
| <input type="checkbox"/> RHEUMATISM | <input type="checkbox"/> DIZZINESS |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> BACKACHES |
| <input type="checkbox"/> SCARLET FEVER | <input type="checkbox"/> DIGESTIVE PROBLEMS |
| <input type="checkbox"/> POLIO | <input type="checkbox"/> ARTHRITIS |
| <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> ALLERGIES |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> NUMBNESS |
| <input type="checkbox"/> SINUS PROBLEMS | <input type="checkbox"/> NEURITIS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> NERVOUSNESS |
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> OTHER: _____ |

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

- | | | | |
|-------------------------------------------|-------------------------------------------------|---------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Nerve Pills | <input type="checkbox"/> Pain Killers | <input type="checkbox"/> Insulin | <input type="checkbox"/> Birth Control Pills |
| <input type="checkbox"/> Muscle Relaxants | <input type="checkbox"/> Anti-Inflammatories | <input type="checkbox"/> Anticoagulants | <input type="checkbox"/> Other |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Female Hormones | <input type="checkbox"/> Thyroid Medication | |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Cholesterol Medication | | |

I understand and agree that health insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that the office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, 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 and payable.

NOTE Returned checks will be assessed a \$25.00 fee.

Signature: _____ Date: _____

NOTE: Treatment may be suspended for no payment of services rendered.

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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: _____

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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. To the extent that I am not identifiable from such photographic or electronic reproductions, 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: _____

Sean Boutros, M.D., P.A.

PT NAME: _____

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