Patient Information:

Name:	Date of Birth:
Cell#:	Home#:
Address:	City, State, Zip:
SSN:	Sex: M F
Marital Status:	Employer:
Occupation:	Email:
Referring Dr:	Primary Dr:
Dermatologist:	Emergency Contact: (Name, Relation, Phone #)

elevate
MEDICAL SPA AND COSMETIC SURGERY

DALLAS SURGI CENTER

Name: ______________________________ Age: ________ Weight: ________ Height:________

Pharmacy Name: ____
Pharmacy Address: ____
Pharmacy Phone Number: ____

Past Medical History:

Do you have any of the following medical conditions?

- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Atrial Fibrillation (Irregular Heartbeat)
- □ Benign prostatic hyperplasia
- □ Bone Marrow Transplantation
- □ Breast Cancer
- □ Colon Cancer
- □ COPD
- □ Coronary Artery Disease
- □ Depression
- □ Diabetes
- □ Hearing Loss
- □ Hepatitis
- □ Hypertension
- □ Kidney: Kidney Biopsy
- □ HIV / AIDS
- □ Hypercholesterolemia
- □ Hyperthyroidism
- □ Hypothyroidism
- □ Leukemia
- □ Lung Cancer
- □ Lymphoma
- □ Prostate Cancer
- □ Radiation Treatment
- □ Seizures
- □ Stroke
- □ None
- □ Other ______________________________

Name: ______________________________

Past Surgeries:

Have you had any surgeries?

- □ Appendix (Appendectomy)
- □ Bladder (Cystectomy)
- □ Breast: Mastectomy (Right Breast)
- □ Breast: Mastectomy (Left Breast)
- □ Breast: Mastectomy (Both Breasts) □
- □ Breast: Lumpectomy (Right Breast)
- □ Breast: Lumpectomy (Left Breast)
- □ Breast: Lumpectomy (Both Breasts)
- □ Breast: Breast Biopsy
- □ Breast: Breast Reduction
- □ Breast: Breast Implants
- □ Colon (Colectomy): Colon Cancer Resection
- □ Colon (Colectomy): Diverticulitis
- □ Colon (Colectomy): Inflammatory Bowel Disease
- □ Gallbladder (Cholecystectomy)
- □ Heart: Stent
- □ Heart: Mechanical Valve Replacement
- □ Heart: Biological Valve Replacement
- □ Heart: Heart Transplant
- □ Joint Replacement: Knee (Both)
- □ Joint Replacement: Hip (Right)
- □ Joint Replacement: Hip (Left)
- □ Joint Replacement: Knee (Left)
- □ Joint Replacement: Hip (Both)
- □ Joint Replacement: Knee (Right)
- □ Kidney: Kidney Transplant
- □ Kidney: Nephrectomy
- □ Ovaries (Oophorectomy): Endometriosis
- □ Ovaries (Oophorectomy): Ovarian Cyst
- □ Ovaries (Oophorectomy): Ovarian Cancer
- □ Prostate (Prostatectomy): Prostate Cancer
- □ Prostate (Prostatectomy): Prostate Biopsy
- □ Prostate (Prostatectomy): TURP
- □ Skin: Skin Biopsy
- □ Skin: Basal Cell Carcinoma
- □ Skin: Squamous Cell Carcinoma
- □ Skin: Melanoma
- □ Spleen (Splenectomy)
- □ Testicles (Orchiectomy)
- □ Uterus (Hysterectomy): Fibroids
- □ Uterus (Hysterectomy): Uterine Cancer
- □ Other ______________________________
- □ None
- □ **Cosmetic Surgery:** ______________________ □

Cosmetic Procedures:

- □ Botox
- □ Fillers: __________________________
- □ Lasers: __________________________
- □ Facials/Peels: _____________________

□ Other: ____________________________

Name: ____

Skin Disease History

Have you ever had any of the following skin conditions?

□ Acne

□ Actinic Keratosis

□ Basal Cell Skin Cancer (Year(s):______________)

□ Blistering Sunburns

□ Dry Skin

□ Other: ____________________________________

□ Eczema

□ Melanoma (Year(s):______________)

□ Precancerous Moles

□ Psoriasis

□ Squamous Cell Skin Cancer (Year(s):______________)

□ None

Do you wear sunscreen?

□ Yes

□ No

If yes, what SPF?

____

Do you tan in a tanning salon?

□ Yes

□ No

Do you have a Family history of Melanoma?

□ Yes **If yes, which relative?** ____

□ No

****MEDICATIONS AND DOSAGE****

List all medications you are currently taking (including over-the-counter).

If none, please write none. Please print:

____

____

____

____

____

Please list any drug allergies and your reaction.

If none, please write none. Please print:

____

____

____

Name: ____

Social History:

Smoking Status (check one)

□ Current every day smoker

□ Current some day smoker

□ Former smoker

□ Never

Start Smoking:

- **Mm/dd/yyyy** ______________________________________

Quit Smoking:

- **Mm/dd/yyyy** ______________________________________

Number of Pack Per Day: ________

Total Years of Smoking: ________

Alcohol Status (check one)

□ Less than 1 drink per day

□ 1-2 drinks per day

□ 3 or More drinks per day

□ None

Reason for visit: Please place a checkmark by the choices below that apply:
□ Skin Cancer/ Mohs Surgery____
□ Skin Check/ Mole Check____
□ Cosmetic Surgery____
□ Cosmetic Non-Surgical (skin care, laser, botox, fillers) ___________________________
□ Cyst/ Lipoma/ Wart____
□ Other (Please specify) ____

Unfortunately, skin cancer sometimes occurs in areas where the sun does not shine. We would like to give you the most thorough exam possible. If there are any areas **you do not** want examined please indicate below:

□ Back, Chest, Abdomen
□ Breast
□ Genitalia
□ Legs

Name: ____

Are you experiencing any of the following today?

- □ Chest pain
- □ Difficulty breathing
- □ Abdominal pain
- □ Bloody stool
- □ Bloody urine
- □ Immunosuppression
- □ Autoimmune suppression
- □ Problems with scarring (hypertrophic or keloid)
- □ Changing mole
- □ Cold sores
- □ Dentures
- □ Fever or chills
- □ Unintentional weight loss
- □ Headaches
- □ Seizures
- □ Blurry Vision
- □ Glasses or contact lenses
- □ Anxiety
- □ Depression
- □ Require walker or wheelchair
- □ None

Please check if any of the following apply to you:

- □ Pacemaker
- □ Defibrillator
- □ Artificial joints within past two years
- □ Artificial heart valve
- □ Premedication prior to procedures
- □ Allergy to adhesive
- □ Allergy to topical antibiotic ointments
- □ Allergy to lidocaine
- □ Rapid heartbeat with epinephrine
- □ GI upset with antibiotics
- □ Blood thinners
- □ Problems with bleeding
- □ Pregnant or planning a pregnancy
- □ West Africa: Travel or contact in last 21 days
- □ Fever > 100.4 degrees (F)
- □ Traveled to country with wide spread Ebola in 21 days
- □ Contact with Ebola patient in last 21 days
- □ Flu-like symptoms in last 21 days
- □ None

Additional comments or questions:

____

____

____

CONDITIONS OF ADMISSION

For your convenience, we have consolidated our new patient paperwork into this single document to cover the three affiliated covered entities ("**ACE**") under HIPAA which comprise our practice: Thornwell H. Parker, III, MD, PA (d/b/a Skin Cancer Consultants), Elevate Medical Spa and Cosmetic Surgery, and the Dallas Surgi Center, Inc. (collectively "**The Practice**")

Patient Financial Responsibility

Although patients are ultimately responsible for all charges, as a courtesy, assignment is accepted for most insurance carriers. Applicable estimated copays and deductibles are to be paid at the time of service, as well as uncovered or cosmetic procedures. Some operations/procedures may incur charges for any professional services rendered in The Practice.

Assignment of insurance Benefits and Financial Agreement:

The below signed irrevocably assigns and transfers to the center the Contract Rights, and orders and directs such insurer(s) specified on the registration to pay all monies due or to become due hereunder directly to The Practice. The Practice has irrevocably constituted power, to collect and settle any claim under the Contract Rights as insured without further notice or approval of insured and to endorse in the name of insured any check or other instrument for payment of monies hereunder. If the insured receives monies direct from the insurer, same shall be held in trust for and immediately transferred to The Practice for amount due. This assignment is irrevocable until full and complete payment of all monies due The Practice from this event of admission or otherwise. Money received by The Practice from insurer(s) or other third party sources, less the expense in procuring same, shall be deducted from the principal amount due for services rendered Patient. It is the policy of The Practice to comply with all Federal, State, and Department of Insurance regulations related to collection of co-pays and deductibles. You may be responsible for higher co-pays and deductibles. The Practice may or may not be in-network for your insurance. If your insurance company does not pay the amount within 90 days, you will be responsible for the payment in full. We do not determine payment of a claim, the insurance company does. Please contact your insurance company for any questions regarding your claims. Any deviation from this standard procedure must have arrangements made in advance.

Medicare Assignment:

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Professional Services Agreement:

To the extent that fees for professional services rendered to the patient are payable, the undersigned hereby assigns to said physicians and authorizes payment directly to said physicians all insurance benefits, including major medical, for professional services rendered to the patient.

Patient Rights/Responsibilities:

I acknowledge that I have been given a copy of the Patient Rights and Responsibilities at time of admission.

Name: ____

Personal Valuables:

The Practice will make its best effort to protect Patient valuables but will not be responsible for any loss.

Physician Disclosure of Ownership:

Pursuant to Texas Law please note that Dr. Thornwell H. Parker III, M.D. has financial agreements with Dallas Surgi Center, Inc., one of the ACE. If you are referred to this entity, Dr. Thornwell H. Parker III, M.D. will receive direct remuneration. If you have any questions regarding this paragraph, please discuss it with Dr. Thornwell H. Parker III, M.D. directly.

Authorization for Release of Information:

The Practice is authorized to furnish from the patient's record requested information or excerpts to the referring physician, primary care physician and to any insurance company or third party payer for the purpose of obtaining payment of the account of The Practice or any physician for services provided to the patient. The Practice is authorized to release information from my medical record to any health care facility to which I may be transferred.

Verification of Third Party Benefits:

The below signed authorizes the verification of third party benefits, any item referenced herein, statements and other data obtained from Patient and/or below signed and all other persons pertaining to the respective credit and financial responsibilities, understanding that an investigative consumer report may be made whereby information is obtained through personal interviews with third parties. The Practice or its contractor is authorized to investigate all information given by the below signed verbally and other such areas as reasonable connected with The Practice efforts in collection, now or in the future. Below signed hereby releases from liability, indemnifies from loss and specifically authorizes any requesting entity to make such disclosure to The Practice or its agents as they deem necessary in considering and verifying any application for credit. Below signed acknowledges that a complete and accurate disclosure of the nature and scope of the investigation will be given upon written request and herby declares that all information furnished hereon and subsequently is and shall be true.

______________________________________ ____________

Patient Signature (or Legal Representative) Date

______________________________________ ____________

Witness Signature (The Practice) Date

Patient Financial Responsibility Agreement

For your convenience, we have consolidated our new patient paperwork into single documents to cover the three affiliated covered entities ("**ACE**") which comprise our practice: Thornwell H. Parker, III, MD, PA (d/b/a Skin Cancer Consultants), Elevate Medical Spa and Cosmetic Surgery, and the Dallas Surgi Center, Inc. (collectively "The Practice") .

I clearly understand and agree that all services rendered to me by The Practice will be charged directly to me and that I am personally responsible for full payment to Practice. In order to reserve an initial appointment with The Practice, I acknowledge that I was required to provide a credit card to a Practice representative over the phone.

I understand that my credit card information will be saved by The Practice to file for future transactions on my account, even if I may choose to pay in cash or other form of payment from time to time.

I authorize Practice to charge my credit card for fees resulting from late cancellations of—or no-shows to—a scheduled appointment pursuant to the 24 Hour Cancellation Notice or No-Show Fee Consent.

I understand that even if I suspend or terminate treatment, any fees for professional services rendered to me or to my dependent up to the point of termination will be immediately due and payable. I acknowledge that I am responsible for any outstanding fees for services provided to me by The Practice. Any other arrangements that may involve a payment plan or payment deferral must be made in writing with the Office Manager of the Practice. Verbal agreements are not acceptable.

By signing this Patient Financial Responsibility Agreement, I authorize Practice to bill my credit card for the services rendered to me.

Patient Name: ____

____ ____________

Patient Signature (or Legal Representative) Date

____ ____________

Witness Signature (The Practice) Date

24 Hour Cancellation Notice or

No-Show Fee Consent

For your convenience, we have consolidated our new patient paperwork into single documents to cover the three affiliated covered entities ("**ACE**") which comprise our practice: Thornwell H. Parker, III, MD, PA (d/b/a Skin Cancer Consultants), Elevate Medical Spa and Cosmetic Surgery, and the Dallas Surgi Center, Inc. (collectively "The Practice") .

I acknowledge that **The Practice** reserves the right to charge a fee of $100.00 if I do not attend a scheduled appointment or cancel a scheduled appointment without providing at least 24 hours' prior notice. I understand that this fee will be billed to the credit card on file and is not covered by insurance.

By signing below, I acknowledge that I have received this notice and understand this policy.

Patient Name: ____

____ ____________

Patient Signature (or Legal Representative) Date

____ ____________

Witness Signature (The Practice) Date

Notice of Privacy Practices Acknowledgement

I understand that, under the **Health Insurance Portability & Accountability Act of 1996** (HIPPA), 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 acknowledge that I have been provided the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time 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 acknowledge that my medical information/records will be released to The Practice. I further acknowledge that my medical information/records will be released from The Practice to my primary care provider, referring/consulting providers, and to my insurance company to process insurance claims.
I also allow release of my medical information to the following individuals: (i.e. family, caregivers, etc.)

Name:	**Relationship:**
______________________________________	______________________________________
______________________________________	______________________________________

Patient Name: ____

____ ____________
Patient Signature (or Legal Representative) Date

____ ____________
Witness Signature (The Practice) Date

Patient Questionnaire

For Patients 65 years of age and older

Name: ______________________________________ Date of Birth: ___________________________________

Have you received a pneumonia vaccination?

○ Yes ○ No

Do you have a healthcare proxy in the event you are unable to make your own medical decisions?

○ Yes ○ No

Do you have a living will?

○ Yes. ○ No

Which statement best reflects your wishes or advanced care recommendations?

○ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

○ Do Not Resuscitate: If my heart were to stop, I do

not wish to have chest compressions or an automated external defibrillator to start by heart, even if it's necessary to save my life.

○ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

____ _____________

Patient Signature (or Legal Representative) Date

____ _____________

Witness Signature (The Practice) Date

Dallas Surgi Center, Inc. Patient Consent to Resuscitative Measures

Not a Revocation of Advance Directive
Or Medical Powers Of Attorney

All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers Of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. This Dallas Surgi Center, Inc. respects and upholds those rights.

No surgery is without risk. However, unlike an Acute Care Hospital, the Dallas Surgi Center, Inc. does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an Acute Care Hospital for further evaluation. At the Acute Care Hospital, further treatment measures may be ordered in accordance with your wishes, Advance Directive or Health Care Power of Attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current Health Care Directive or Health Care Power of Attorney.

If you do not agree to this policy, we are pleased to assist you to reschedule the procedure.

Please check the appropriate box:

	Yes	No
Do you have an Advance Directive, Living Will or Health Care Power of Attorney?	☐	☐
If yes, would you like to provide us with a copy?	☐	☐
Would you like to create an Advance Directive, Living Will or Health Care Power of Attorney today? -Forms will be provided upon request.	☐	☐

By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described. If I have indicated I would like additional information; I acknowledge receipt of that information.

Patient Signature:____

OR

Guardian Signature:____

Date:_________________________________

Relationship of Guardian to Patient:

- Court Appointed Guardian
- Attorney in Fact
- Health Care Surrogate
- Other