TEXAS PLASTIC SURGERY – *Christian L. Stallworth, MD*

DEMOGRAPHICS

Name:_____ **Date**:_____

Home Address: _____
City :_____State: _____Zip:_____
Telephone: (___)_____ Mobile: (____)_____
Birth date:_____ Age: _____
Marital Status: Single`_____Married to:_____ Other:_____
SSN:_____
Email Address: _____ May we send information here? Yes No

Occupation: _____Employer:_____
Employer's Address: _____
City: _____State:_____Zip:_____
Work Phone: (_____)_____

****** Please provide a copy of your Driver's License and Insurance Card(s) to the staff.***

Primary Health Insurance Company:_____
Policy number:_____Group number: _____
Insured:_____ Date of Birth:_____Employer:_____

Secondary Health Insurance Company:_____
Policy number:_____ Group number:_____
Insured:_____ Date of Birth:_____ Employer:_____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party:_____Relation to patient:_____
Home Address:_____
City:_____ State:_____ Zip:_____
Telephone:_____ Birthdate:_____
Occupation:_____ SSN:_____
Employer:_____Work phone:_____

PERSONAL PHYSICIAN
Name of Personal/regular physician:_____
Address:_____
Business telephone; (____)_____Fax: (_____)_____
Date of last physical examination:_____
PCP referral required: YES NO Referral on file? YES NO

In case of emergency, contact:_____ Relation:_____
Home phone: (_____)_____Work phone :(_____)_____

Who may we thank for referring you? Radio Magazine Internet:_____
Friend/Family _____ _____ Other Physician:_____
Other: _____

Patient Signature:_____ Date:_____

I confirm to the best of my knowledge that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment today.

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MEDICAL HISTORY

Patient Name: _____ Age: _____ Height: _____ Weight:_____

MEDICAL

Do you or have you had:	YES	NO		YES	NO
Prolonged bleeding when cut	□	□	Fainting or blackout episodes	□	□
Blood clots in legs	□	□	Hepatitis	□	□
High blood pressure	□	□	Diabetes	□	□
Heart murmur or disorder	□	□	Fever blister or cold sores	□	□
Heart Disease or attack	□	□			
Chest pain or shortness of breath	□	□			
Other significant illness	□	□	if so describe:_____		

SURGICAL

PREVIOUS OPERATION(S) (CHILDBIRTH) DATE

_____ _____

_____ _____

_____ _____

ALLERGIES

Are you allergic or have reactions to medications, drugs, or local anesthetic medication?

MEDICATION REACTION WHEN LAST TAKEN

_____ _____

_____ _____

CURRENT MEDICATIONS *(List all medications including aspirin and birth control)*

Do you take or have you taken Accutane? □ YES □ NO

MEDICATION	DOSE	FREQUENCY TAKEN
_____	_____	_____
_____	_____	_____
_____	_____	_____

BLEEDING/TRANSFUSIONS

Aspirin intake past two weeks? □ YES □ NO

Prolonged bleeding when cut? □ YES □ NO

Family history or prolonged bleeding? □ YES □ NO

Have you had blood transfusions? □ YES □ NO

Reactions to blood transfusions? □ YES □ NO

SCARRING

Have you formed excessive, unsatisfactory scars, or keloid formations in the past? □ YES □ NO

FAMILY HISTORY

Is there a history of the following in your immediate family? If so, please list the family member

Heart Attack:_____ Breast Cancer :_____

Diabetes: _____ Cancer (type): _____

Blood Disorders: _____ Stroke: _____

PERSONAL HISTORY

Do you smoke? _____ If yes, how many packs per day?_____

Do you drink alcohol? Yes No Occasionally

Patient Signature:_____ Date:_____

I confirm to the best of my knowledge that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment today.

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STALLWORTH FACIAL PLASTIC SURGERY PATIENT PHOTOGRAPHIC / VIDEO RELEASE AND CONSENT FORM

PATIENT'S NAME: _____ DATE OF BIRTH: ____/____/____

I hereby acknowledge that I am a patient of **Christian L. Stallworth, MD**, and have been or will be photographed/filmed during the course of treatment. The undersigned grants to the treating physician, Christian L. Stallworth, MD, PLLC, Stallworth Facial Plastic Surgery, Texas Plastic Surgery, the American Academy of Facial Plastic and Reconstructive Surgery and to the Educational and Research Foundation for the American Academy of Facial Plastic and Reconstructive Surgery the on-going and unrestricted right to use those photographs/film for general information, education, scientific, medical and public relations purposes and to permit others to use them for those purposes. The undersigned also authorizes the treating physician and the American Academy of Facial Plastic and Reconstructive Surgery and to the Educational and Research Foundation for the American Academy of Facial Plastic and Reconstructive Surgery the use and display of said photographs/film in any publication, multimedia production, display, advertisement, World-Wide Web Broadcast or World-Wide Web Publication.

The undersigned further acknowledges that he/she relinquishes all right, title, and interest in these photographs/film, or any right to profit or gain directly or indirectly realized through the use of the photographs/film. The persons to whom disclosure may be made include physicians, medical students, patients and prospective patients, examining boards, medical and other periodicals, medical editors, insurers (if any), outside firms, the staff of the Academy and the Foundation, readers of medical literature and the general public. The undersigned releases Christian L. Stallworth, MD, Christian L. Stallworth, MD, PLLC, Stallworth Facial Plastic Surgery, Texas Plastic Surgery, the American Academy of Facial Plastic and Reconstructive Surgery and the Educational and Research Foundation of the American Academy of Facial Plastic and Reconstructive Surgery and their officers, directors, employees and members from any liability of any kind whatsoever arising out of or relating to use of the photographs/film.

This authorization may only be revoked in writing, signed by the undersigned and delivered to the physician, Christian L. Stallworth, MD, and to the American Academy of Facial Plastic and Reconstructive Surgery at its office in Alexandria, Virginia. Such revocation shall thereafter be effective as to any further use not already committed to by the physician or the Academy or the Educational and Research Foundation. Unless earlier revoked, this authorization will expire on the end of the treating physician's practice of facial plastic and reconstructive surgery, except there will be no expiration for the purpose of medical or scientific research or education. Revocation will not affect uses and disclosures made before receipt of the revocation. If the photographs are disclosed, there is obviously potential for re-disclosure, some of which would not be subject to this authorization. Photographs/film, as used in this document, include digital images. This authorization includes uses on the Internet and web sites. This authorization is in consideration of services performed and consultations conducted or to be performed or conducted by the physician, and there have been no representations or inducements concerning this authorization except as set forth herein. The treating physician will not condition treatment on whether the individual signs this authorization, but, if any portion of the treating physician's services is to be covered under any insurance or third-party-payment plan, the signing individual will be responsible for authorizing release as required by that insurance or third-party-payment plan.

I have been advised that Christian L. Stallworth, MD, Christian L. Stallworth, MD, PLLC, Stallworth Facial Plastic Surgery, and/or Texas Plastic Surgery may take and use preoperative, intraoperative, and/or postoperative photographs of my person for confidential and clinical record purposes. Photographs are taken by Christian L. Stallworth, MD or his designated representative and will remain the property of Christian L. Stallworth, MD. I hereby give my consent for Dr. Stallworth to use the photographs under the following circumstances:

Please initial the following:

ALL MEDIA

_____ Photographs taken of me or parts of my body as well as details regarding medical services I have received from Dr. Stallworth may be used in any print or broadcast media, including but not necessarily limited to newspapers, pamphlets, educational films, the company website and television, in order to inform the public about facial plastic surgery methods. Further, I release and discharge Dr. Stallworth, all employees of Texas Plastic Surgery, Stallworth Facial Plastic Surgery, Christian L. Stallworth MD, PLLC, the facilities used, and the American Academy of Facial Plastic and Reconstructive Surgery, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I have in such photographs and details regarding medical services rendered me, including any claim for payment in connections with any such use or publication. I give my consent as a voluntary contribution in the interest of public education and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

DOCTORS' WEBSITE ONLY

_____ Photographs taken of me or parts of my body as well as details regarding medical services that I have received from Dr. Stallworth may be used on the company website in order to inform the public about facial plastic surgery methods. Further, I release and discharge Dr. Stallworth, all employees of Texas Plastic Surgery, any facility used, and the American Academy of Facial Plastic and Reconstructive Surgery, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I have in such photographs and details regarding medical services rendered me, including any claim for payment in connections with any such use or publication. I give my consent as a voluntary contribution in the interest of public education and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

Signed: _____ _____ Witness: _____ _____

(Patient) (Date) (Staff or Provider) (Date)

SIGNATURE BY PARENT OR GUARDIAN

I am the parent or guardian of _____, a minor. I am authorized to sign this authorization and release on his/her behalf, and I agree on my own behalf and his/her behalf to the terms of the foregoing authorization.

Parent/Guardian _____ _____ (Date)

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Attached, you will find the Notice of Privacy Practices for Texas Plastic Surgery, Stadia Med Spa, and Renew Surgery Center. Your name and signature on this form indicates that you have reviewed a copy of the Notice of Privacy Practices on the date indicated, of which a copy can be provided to you at your request. If you have any questions regarding the information set forth in the form, please do not hesitate to ask the clinic staff. If you need further assistance, please contact the Office Administrator/Practice Manager at: (210) 616-0301.

_____

DATE PATIENT/GUARDIAN SIGNATURE

_____

DATE WITNESS SIGNATURE

STATEMENT of PATIENT FINANCIAL RESPONSIBILITY AND PATIENT PAYMENT POLICY

Thank you for choosing Stadia Skin and Laser Spa for your spa treatments. Dr. Jaime R. Garza, Dr. Christian L. Stallworth and the staff are committed to providing you with the highest quality of care. We ask that you read, initial, and sign this form to acknowledge your understanding of our patient financial policies.

_____ As a courtesy to our patients, the office informs all patients of recommended services and the costs associated with them. Our office will help you contact your insurance provider and obtain a general quote of coverage and benefits as it applies to the procedure/services in question and the current status of your individual policy. Please note that each medical insurance company or health insuring agent(s) makes the final determination regarding medical necessity of all services rendered.

_____ Our office policy is to file a claim of benefits to the insurance institution provided to us by the patient. The claim of benefits is submitted with diagnosis and procedure codes that most appropriately reflect the procedures performed by our doctor. If the insurance carrier fails to issue payment 90 days after services are rendered, the patient then becomes financially responsible for all non-paid fees. Accounts with any remaining balance may be turned over to a third-party collection agency. Further action to collect from the insurance carrier can be made by the patient, even after they have issued payment to our office. Our office can provide you with the needed information to pursue a claim with your insurance carrier.

_____ In the even that your insurance company does not agree to pay for the performed services, for any reason, including services deemed not medically necessary, you are financially responsible for all unpaid fees and charges. By signing this, you acknowledge full financial responsibility for all services rendered, and promise to pay any balance in full.

- **Payment Policy**: All professional services rendered are charged to the patient. The patient is responsible for payment regardless of Insurance coverage.
- **Surgery Fees**: All Surgeon's fees not covered by your insurance plan or when your deductible has not been met are to be paid in full prior to the date of surgery.
- **Cancellations of Surgical Procedures**: Any scheduled surgical procedure will be assessed a $500 administration fee if cancelled. Any surgical procedure that is cancelled 7 days or less prior to the scheduled date will be subject to a forfeiture of the full 20% surgery deposit.
- **Assignment of Benefits**: I hereby consent to and authorize my insurance benefits to be paid directly to Texas Plastic Surgery. I am financially responsible for non-covered services. I also authorize Texas Plastic Surgery's office to release any information required to process this claim. I am responsible for all invoices being paid in timely manner.
- **Release of Medical Information**: I consent to the release of any medical information necessary to process any and all insurance claims. I also authorize the release of medical records to any referring physicians.
- **Skin Care/ Cosmetic Products Return Policy**: All skin care and cosmetic products are non-refundable items.

Your signature verifies that you have read the above statements, understand your patient responsibility, and agree to all of the terms and policies of our office listed above.

SIGNATURE: _____ DATE:_____