Harbour Plastic Surgery

Patient Information (Please Print) **Today's Date**:_____

Name_____
Last First M.I.

Mailing Address_____

Home Phone_____ Work Phone_____ Cell Phone_____

May we leave personal medical information on your home phone? □ Yes □No

May we email you? □Yes or □ No Email address_____

SS#_____ Date of Birth_____ Age_____ Sex □M □F Marital Status □S □M □D □W

Patient Occupation_____ Patient's Employer_____

Reason for seeking treatment at this time_____

PARENT OR RESPONSIBLE PARTY (If different from patient)

Name_____
Last First M.I

Mailing Address_____

Home Phone_____ Work Phone_____ Cell Phone_____

SS#_____ Date of Birth_____

INSURANCE INFORMATION (Please present insurance card at time of check-in)

Primary Insurance Name_____ Secondary Insurance Name_____
Ins Address_____ Ins Address_____
Name of Insured_____ Name of Insured_____
Insured's ID#_____ Insured's ID#_____
Group#_____ Group#_____
Employer Name_____ Employer Name_____
Insured's SS#_____DOB_____ Insured's SS#_____DOB_____
Relationship to patient_____ Relationship to patient_____

In case of an Emergency, who should be notified? _____ Phone#_____
Referred By: _____ Primary Care Physician_____

I authorize my physician to obtain and/or release any medical insurance to my primary care or referring physician to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.
Patient or Responsible Party Signature_____ Date_____

Harbour Plastic Surgery

Elena Grantcharova Geppert, M.D.
100 Enterprise Avenue
League City, TX 77573
Office: 281.334.3223 Fax: 281.334.4930

Harbour Plastic Surgery

Name_____ DOB_____ Height_____ Weight_____

Allergies:_____

Are you allergic to any of the following:

Latex	□Y □N	Lidocaine	□Y □N	Bee Stings	□Y □N
Vaccines	□Y □N	Eggs	□Y □N	Peanuts	□Y □N
Milk	□Y □N	Adhesive Tape	□Y □N	Other_____	□Y □N

Family History:

Anesthesia	□Y □N	Clotting	□Y □N	Lung Problems	□Y □N
Bleeding	□Y □N	Diabetes	□Y □N	Skin Cancer	□Y □N
Breast Cancer	□Y □N	Blood Clots	□Y □N	Slow Healing	□Y □N
Cleft lip/Palate	□Y □N	Heart Problems	□Y □N	Stroke	□Y □N
Other Cancer_____	□Y □N				

Social History:

Drink Alcohol/Ethanol	□Y □N	If yes, how many drinks per week? Beer___ Wine___ Liquor___
Smoke Tobacco	□Y □N	If yes, how many packs per day? ____ for how many years____
Chew Tobacco	□Y □N	
Street Drugs	□Y □N	If yes, list_____

Dietary Restrictions:

Vegetarian	□Y □N	Vegan	□Y □N	Limit Protein	□Y □N

Review of Systems: Do you have any of these symptoms?

Weight change	□Y □N	Shortness of breath	□Y □N	Keloids	□Y □N
Fatigue/Energy Loss	□Y □N	Wheezing	□Y □N	Rash	□Y □N
Fevers	□Y □N	Cough	□Y □N	Itching	□Y □N
Heat or Cold Intolerance	□Y □N	Abdominal Pain	□Y □N	Scar Easily	□Y □N
Night Sweats	□Y □N	Heartburn or Ulcers	□Y □N	Hair Loss	□Y □N
Changes in nails	□Y □N	Loss of Appetite	□Y □N	Headaches or Migraines	□Y □N
Blurry Vision	□Y □N	Nausea or Vomiting	□Y □N	Dizziness	□Y □N
Blindness	□Y □N	Constipation	□Y □N	Fainting	□Y □N
Dry Eyes	□Y □N	Diarrhea	□Y □N	Muscle Weakness	□Y □N
Light Sensitivity	□Y □N	Blood in stools	□Y □N	Numbness	□Y □N
Wear Glasses	□Y □N	Loss of bladder control	□Y □N	Tingling	□Y □N
Sore Throat	□Y □N	Frequent Urination	□Y □N	Panic Disorder	□Y □N
Changes in voice	□Y □N	Painful Urination	□Y □N	Mood Changes	□Y □N
Trouble Swallowing	□Y □N	Blood in Urine	□Y □N	Depression	□Y □N
Frequent runny nose	□Y □N	Menstrual Problems	□Y □N	Anxiety/Nervousness	□Y □N
Hearing Loss	□Y □N	Muscle Pain	□Y □N	Anemia	□Y □N
Murmur	□Y □N	Arthritis or joint pain	□Y □N	Bleed or Bruise easily	□Y □N
Chest Pain	□Y □N	Back or neck pain	□Y □N	Blood Clots	□Y □N
Irregular Heartbeat	□Y □N	Fibromyalgia	□Y □N	Frequent Infections	□Y □N
Swelling in Feet	□Y □N	Swollen glands	□Y □N	Dyspnea on Exertion	□Y □N

Patient Signature_____ Date:_____

Harbour Plastic Surgery

Date:_____ Name_____ DOB_____ Sex □M □F

Referring Physician_____ Primary Care Physician_____

Reason for today's visit_____

PAST MEDICAL HISTORY: Have you ever had any of the following:

Skin cancer	□Y □N	Are you on blood thinners	□Y □N	Asthma	□Y □N
Breast cancer	□Y □N	Pulmonary embolism	□Y □N	Emphysema	□Y □N
Cleft lip/palate	□Y □N	Deep vein thrombosis (DVT)	□Y □N	Bronchitis	□Y □N
Are you pregnant	□Y □N	EKG	□Y □N	Tuberculosis	□Y □N
Cataracts	□Y □N	Peripheral vascular disease	□Y □N	Pneumonia	□Y □N
Permanent vision loss	□Y □N	Echocardiogram	□Y □N	GERD	□Y □N
Glaucoma	□Y □N	Heart attack	□Y □N	Diverticular disease	□Y □N
Dental extraction	□Y □N	Heart failure	□Y □N	Liver disease	□Y □N
Depression	□Y □N	Heart murmur	□Y □N	Pancreatitis	□Y □N
Diabetes	□Y □N	Artificial heart value	□Y □N	Gout	□Y □N
Wound healing problems	□Y □N	Rheumatic fever	□Y □N	Osteoporosis	□Y □N
Thyroid disease	□Y □N	Stroke	□Y □N	Joint replacement	□Y □N
High cholesterol	□Y □N	Seizures/Epilepsy	□Y □N	HIV infection/AIDS	□Y □N
High blood pressure	□Y □N	Meningitis	□Y □N	Hepatitis	□Y □N

Other Medical Problems: Please list all not included in above checklist

_____

_____

_____

Surgical/Hospitalization History: Please list any surgery or hospitalization you have had and when they took place.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications/Supplements: Please list all medication you are taking. Include over the counter medications and any herbal nutritional, vitamin supplement or steroid. Please include the dose and how often you take them.

_____ _____ _____

_____ _____ _____

_____ _____ _____

HARBOUR PLASTIC SURGERY

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

PATIENT NAME: _____ DATE:_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____
Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone ☐ Home Phone Confirmation
☐ Email Confirmation ☐ Work Phone Confirmation

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone ☐ Home Phone Confirmation
☐ Email Confirmation ☐ Work Phone Confirmation

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ Text Message ☐ Email ☐ **None of the above** (opt out)

I AUTHORIZE MYSELF TO BE REGISTERED FOR BRILLIANT DISTINCTIONS WHEN RECEIVING ALLERGAN PRODUCTS. MY INFORMATION AND EMAIL WILL BE GIVEN TO ALLERGAN ***ONLY*** FOR REGISTRATION PURPOSES:
☐ Opt in ☐ Opt out

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent. You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

_____ Date: _____
Please *print* your name

_____
Please *sign* your name

HARBOUR PLASTIC SURGERY

NOTICE OF PRIVACY PRACTICES

HIPAA OMNIBULE RULE UNDER SECTION 164.500

I, _____ have received a copy of this office's HIPAA OMNIBULE RULE UNDER SECTION 164.500 Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

Harbour Plastic Surgery
Elena G. Geppert, M.D.
100 Enterprise Avenue
League City, Texas 77573

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____
_____
_____

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www.drgeppert.com
281.334.FACE(3223) *or* **281.334.BODY(2639)**

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PATIENT CONSENT FORM

I hereby consent to be photographed and allow the use of any of my medical records, illustrations, photographs, or other imaging records by you, or anyone you may authorize in writing, for the purpose of advancing scientific or scholastic news, in published professional journals, presentations at scientific meetings, examination, testing, credentialing and/or certifying purposes by the American Board of Plastic Surgery, Inc., patient information & viewing, as well as for media and marketing purposes, including but not limited to our website and social media platforms. To protect patient privacy and for confidentiality reasons, I will not be identified by name.

Print Name

Signature

Date

Witness

If the person photographed is under age of 18, please sign below:

Print Patient Name

Print Parent/Guardian Name

Signature of Parent/Guardian

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OUR FINANCIAL POLICY

FREE CONSULTATIONS FOR NON-INSURANCE / COSMETIC PATIENTS ONLY

• Please discuss all arrangements regarding payment of your account with us. As patients approach surgery, they frequently need information about the various payment options and have questions about their potential insurance benefits. We hope the following information will be helpful. Our financial coordinators are readily available to meet with you personally to provide the specific information you desire.

INSURANCE:
The benefits paid by insurance companies for plastic surgery vary greatly from carrier to carrier and plan to plan. Therefore, we make every effort to determine in advance if insurance coverage exists. We ascertain the projected insurance payment and the required co-payment. We do this because we believe you need to be as informed as possible before surgery. We know you realize that you are ultimately responsible for the full payment of your account, but we have found that our knowledge and experience can be an important factor in assisting you to collect your maximum benefits.

PAYMENT OPTIONS:
Payment for cosmetic plastic surgery is due in full at the time of your pre-operative visit. We provide a number of payment options which may be used individually or combined according to your wishes.

CASH OR CASHIERS CHECK:
Personal checks (NO PERSONAL CHECKS) we take cashier's checks, and cash.

CREDIT CARDS:
Visa, Master Card, Discover or American Express.

OPTIONAL FINANCING PLAN:
We will be happy to assist you with applying for financing should you so desire.

CANCELLATION:
We understand that a situation may arise that could force you to postpone your surgery.

POLICY:
Please understand that such changes affect not only your surgeon, but other patients as well. Dr. Geppert's time is a precious commodity, so we request your courtesy and concern.

If you need to cancel your surgery or in-office procedure after your payment has been made, then you are entitled to a refund**, except $500.00 of that payment,** which will be used for processing, shipping and restocking fees; as well as any fees that maybe charged to us for payments made with a credit card.

• If you have any questions or need assistance with financial matters, please ask our Coordinator to help you. Call us at (281)334-3223.

_____DATE:_____
Signature

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HARBOUR PLASTIC SURGERY
PATIENT CONSENT FOR USE OF CREDIT CARDS, DEBIT CARD, AND FINANCING – DISCLOSURE OF PROTECTED HEALTH INFORMATION

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.

Services that are performed that are paid with a credit card, debit card or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Harbour Plastic Surgery to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment.

Please initial:

_____ I will not challenge such credit, debit, or financing card payments, once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise.

_____ I agree that this non-credit card challenge agreement is irrevocable.

_____
Signature of Patient or Legal Guardian

_____
Print Patient's Name Date