PATIENT INFORMATION (PLEASE PRINT)

Name: _____ Date of Birth: _____ Sex: Male Female

Social Security #: _____ Marital Status: Single Married Separated Divorced Widowed

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Cell #: _____ Work #:_____

Employer: _____ Occupation: _____

Email Address: _____ Referred by:_____

Family Physician: _____ Cardiologist:_____

GUARANTOR INFORMATION (IF PATIENT IS A MINOR)

Guarantor Name: _____ Date of Birth: _____ Sex: Male Female

Social Security #:_____ Relation to Patient: Spouse Parent Other(_____)

Home Phone: _____ Cell #: _____ Work #:_____

EMERGENCY CONTACT

Name: _____ Phone #: _____ Relationship: _____

INSURANCE INFORMATION. Primary Insurance: _____Secondary:_____

ID# _____ GROUP# _____

INSURANCE POLICYHOLDER'S INFORMATION (IF NOT THE PATIENT)

Name: _____ Date of Birth: _____ Sex: Male Female

Social Security #: _____ Relation to Patient: Spouse Parent Other(_____)

PATIENT BILLING NOTICE & RELEASE OF INFORMATION

- I assign benefits and authorize payment from my insurance plan (Medicare/Medicaid/Other) directly to Rau Plastic Surgery for any claim filed on my behalf. I authorize the release of medical records and/or information to my insurance company to assist with payment for services rendered. I authorize the release of medical records to and from Rau Plastic Surgery and other medical providers when necessary for my treatment or my care.
- I accept financial responsibility for all services that I receive and agree to pay for all services that are not paid by insurance benefits, for whatever reason – including, but not limited to deductibles, co-payments, co-insurance, and/or non-covered amounts.
- I understand that if I fail to make timely payment, I may be sent to a collection agency. I agree to pay collection and/or attorney fees if charged. I consent to receive communications regarding my account from any collectors until my account is settled. I will incur NSF fees for returned checks.

Patient Signature (or representative): _____ Date: _____

If Authorized Representative, please list relationship to patient:_____

Patient History

NAME: _____ **DOB**: _____ **SEX**: MALE FEMALE

Reason For Visit:_____

PERSONAL MEDICAL HISTORY

Have you ever had or been diagnosed with any of the following: (Please circle)

High Blood Pressure? **YES** **NO**

Diabetes? **YES** **NO**

Heart Disease / Heart Attack? **YES** **NO**

Stroke? **YES** **NO**

Asthma? **YES** **NO**

Sleep Apnea? **YES** **NO**

Cancer? **YES** **NO**

Anemia? **YES** **NO**

Anxiety? **YES** **NO**

Depression? **YES** **NO**

Hepatitis? **YES** **NO** TYPE:_____

HIV/AIDS? **YES** **NO**

_____

Have you been **tested** for **HIV** or **Hepatitis**? If so, when?

YES **NO** DATE: _____

Have you ever received a **blood transfusion?** If so, when?

YES **NO** DATE: _____

Other medical issues not listed? Please list:

_____
_____
_____
_____
_____

SOCIAL HISTORY (please circle)

Smoke Tobacco? If so, how much? **YES** **NO** _____

Drink alcohol more than 2 days/wk? How much? **YES** **NO** _____

Take non-prescribed/Illegal drugs? **YES** **NO** _____

Are you married? **YES** **NO** _____

Live alone? **YES** **NO** _____

Have children? How many? **YES** **NO** _____

Employed? If so, what profession? **YES** **NO** _____

Under more than normal stress? **YES** **NO** _____

SURGICAL HISTORY (please circle)

Have you had surgery? (list dates of surgery) **DATE:**

Appendectomy?	**YES**	**NO**	_____
Cholecystectomy? (gallbladder)	**YES**	**NO**	_____
Tonsillectomy?	**YES**	**NO**	_____
Heart Surgery? If so, what surgery?	**YES**	**NO**	_____
Hysterectomy?	**YES**	**NO**	_____
Orthopedic Surgery? If so, what surgery?	**YES**	**NO**	_____
Cosmetic Surgery? If so, what surgery?	**YES**	**NO**	_____

Other Surgery not listed? If so, please list:

_____

_____

HAVE YOU EVER HAD ANY ISSUES WITH ANESTHESIA? YES NO (if so, list any complications that occurred)

_____

FAMILY HISTORY (please circle)

Do you have a family history of any of the following?

Diabetes?	**YES**	**NO** _____	**Any other Medical Family History?** (please list)
Heart Disease?	**YES**	**NO** _____	_____
Cancer? If so, what kind?	**YES**	**NO** _____	_____
Bleeding Disorder?	**YES**	**NO** _____	_____

MEDICATIONS:

PLEASE LIST NAME AND DOSAGE PER DAY:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any medications? YES NO

Please list: _____

_____

REVIEW OF SYSTEMS: (please circle)

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

Unexpected weight loss? If so, how much? **YES** **NO**

Unexpected weight gain? If so, how much? **YES** **NO**

New unexplained fatigue? **YES** **NO**

Fevers or chills? **YES** **NO**

Difficulty with vision? **YES** **NO**

Sinus issues? **YES** **NO**

Difficulty swallowing? **YES** **NO**

Chest pain? **YES** **NO**

Shortness of breath? **YES** **NO**

Abdominal pain or symptoms? **YES** **NO**

Skin rashes? **YES** **NO**

Balance issues? **YES** **NO**

Joint pains? **YES** **NO**

Tendency to bleed? **YES** **NO**

Leg pain or swelling? **YES** **NO**

Clotting issues? If so, please explain. **YES** **NO**

_____

Do you take any herbs or OTC supplements? If so, please list. **YES** **NO**

_____

Have you taken any steroids in the last year? **YES** **NO**

Do you take Aspirin/Blood Thinners/NSAIDS Daily? **YES** **NO**

Are you experiencing pain? **YES** **NO**

**If so, on a scale from 1-10, what level of pain are you experiencing? _____

Name of PCP: _____ **Date last seen by PCP? _____**

Were you referred here by a physician? YES NO **Name of Physician: _____**

Have you had any recent bloodwork or diagnostic tests? YES NO

Type: _____Where was it done? _____

WOMEN PATIENTS ONLY:

Number of Pregnancies_____ Number of Children _____ Last Menstrual Period_____ Did you breastfeed? YES NO

Bra Size _____ Last MMG _____ Results _____

COSMETIC PATIENTS ONLY:

How did you hear about us? Circle all that apply:

Website Facebook Instagram Real Self Billboard Friends/Family Other:_____

FOR OFFICE USE ONLY:

Height_____ Weight_____ B/P_____ P_____ T_____ PO_2_____

AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION (PHI)

Patient Name	Request Date
Address	Date of Birth
City, State, Zip	SSN

I AUTHORIZE:

Rau Plastic Surgery, LLC
5619 Hwy 311 Ste C Houma, LA 70360
Phone: 985-709-0467 Fax: 877-218-5120

☐ TO RELEASE INFORMATION TO or ☐ TO OBTAIN INFORMATION FROM

(Mark the box that indicates if the information is being released or requested)

Name	
Address	Phone
City, State, Zip	Fax

Purpose of this disclosure:	O Further Medical Care	O Personal
	O Legal	O Other _____

Authorization expiration date or event: (If not indicated, authorization will expire 12 months from date signed)

Health information to be released under this authorization:			
Service Dates:	O Medical Notes/Summary	O History & Physical	O Pathology
O Operative/Procedure Reports	O X-Rays, EKG	O Recent Labs	O All Medical Records
O Other: *(please specify)*			

The following information will be released when included in the above **unless you indicate otherwise**. Do not release:	
O AIDS or HIV test results	O Mental health or psychiatric care
O Alcohol/substance abuse treatment	O Other: *(please specify)*

- I hereby authorize the use and disclosure of my individually identifiable health information as described above.
- I understand that if the person or entity receiving this information is not a health plan or health care provider covered by federal privacy regulation, the released information may not be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying Rau Plastic Surgery in writing. However, if I choose to do so, I understand that my revocation will not affect any information that was released prior to my revocation.
- I understand that this authorization is voluntary and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.
- I have a right to receive a copy of this form after I sign it.

Signature of Patient:	Date:
Signature of Authorized Representative (if necessary):	

Rau
PLASTIC SURGERY

Financial Policy

Payment is due in full at the time of service or pre-operative appointment.

A deposit is required to schedule a procedure/surgery. The deposit is nonrefundable (in the event of cancellation), and transferrable to another date (in the event of reschedule). In the event that you decide your surgery needs to be rescheduled, a $200 rescheduling fee is required to reserve the new date as well as each time the date is transferred. Should the surgery be rescheduled by Rau Plastic Surgery or the facility the surgery is being performed at, a rescheduling fee will not occur. Additionally, should your scheduled procedure/surgery be cancelled a refund, excluding the nonrefundable deposit, may be issued 7-10 business days after the scheduled date of your surgery.

The remaining balance of your Rau Plastic Surgery Fee is due in full at the time of your scheduled pre-op. If you are unable to pay the balance, your surgery will be rescheduled, and a $200 rescheduling fee will be added to your balance. We accept all major credit/debit (Visa, Master Card, Discover, and American Express) cards, cash, and cashier's check. We also accept Care Credit payment plans.

I understand that payment is due in full at the time of service or pre-operative appointment. I understand that I am responsible for any outstanding balance. I, the undersigned, agree to pay all cost of collecting money past due including reasonable attorney's fees and to pay interest rate of 1 ½% per month until the account is paid in full. I hereby waive all rights of exemption under the constitution and laws of the State of Louisiana.

I hereby authorize the release of information including diagnosis and the records of any treatment of examination rendered to my child or me during the period of such care, to third party payers and/or other health practitioners. I hereby authorize photocopies of this form to be valid as the original.

I have read, understand, and agree to the Financial Policies described above. I agree that I will be responsible for the payment of all professional fees and will not dispute the charges. I fully understand that the procedure(s) being done are cosmetic and elective. I have chosen to pay for said procedure(s) out of pocket and will not try to seek reimbursement from Rau Plastic Surgery.

Patient Name: _____Date: _____

Patient Signature: _____ Date: _____

Physician Signature: _____Date: _____

Witness: _____Date: _____

PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as part of the provision of healthcare services, Rau Plastic Surgery LLC creates and maintains health records and other information describing, among other things, my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

A copy of Rau Plastic Surgery Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information as permitted under federal and state law has been made available to me and is posted in our office. I understand that the organization reserves the right to change their Notice and practices and that I may obtain a current copy from the office at any time.

This consent is freely given with the understanding that:

1. Any and all records are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.

CONSENT TO SHARE INFORMATION WITH FAMILY / FRIENDS

I authorize Rau Plastic Surgery to verbally discuss my care using their best judgement and grant permission to disclose health information that is relevant to my care or payment for my care (including but not limited to test results, appointments, medications, diagnosis, and treatment) with the following family member(s) / friends until I revoke said authorization in writing:

Name: _____Phone #: _____

Name: _____Phone #: _____

Name: _____Phone #: _____

Name: _____Phone #: _____

Patient's Printed Name: _____ DOB: _____

Patient's Signature (or representative): _____ Date: _____

If Authorized Representative, please list relationship to patient: _____

MR# _____

Patient Photographic Consent, Authorization, & Release

- I consent to the taking of photographs, digital imaging or video footage by Rau Plastic Surgery, LLC of me or parts of my body in connections with procedure(s) to be performed by this practice.
- I certify my understanding that there is no warranty, expressed or suggested, as to my own final appearance after surgery by the use of electronically altered images.
- I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become property of Rau Plastic Surgery, LLC and may be retained of released for the limited purpose of:

  _____ Personal Viewing (Patient, Physician, and Nurse Only)
  _____ Before & After Photo Book in Dr. Rau's Consultation Room
  _____Medical publications/representation
  _____Digital presentations for medical education purposes
  _____Research or marketing including social media, radio, & television
  _____Website (www.rauplastics.com)
  _____Medical Seminars, symposiums, or events suitable for patient education
  _____Other(Specify)_____
  _____I give my permission to disclose my name with the use of my testimonial

- I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive from any provider from Rau Plastic Surgery, LLC.
- I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it will not have any effect on any actions taken prior to my revocation. Unless otherwise revoked, this authorization will expire in 5 years.
- Re-disclosure. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPPA").
- I release and discharge Rau Plastic Surgery, LLC and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such in publication, including and claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Consent, Authorization, & Release and fully understand its terms.

I understand that I will receive a copy of this signed authorization.

Patient or Guardian (if minor) Signature Date

_____ _____

Controlled Substances Management Agreement

The purpose of this agreement is to prevent misunderstanding about certain medications you may be prescribed. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

- I understand that this agreement is essential to the trust and confidence necessary in a doctor patient relationship and that my provider undertakes to treat me based on this agreement.
- I understand that if I break this agreement, my provider will stop prescribing controlled substances.
- In the event that this agreement is violated, my doctor will taper off the medication over a certain period of days, as necessary to avoid withdrawal symptoms. Also, a drug dependence program may be recommended.
- I will communicate fully with my doctor about the character and intensity of my condition, the effect of the symptoms upon my daily life, and how well the medication helps to relieve my symptoms.
- I will not use any illegal controlled substance, including marijuana, cocaine, etc.
- I will not share, sell, or trade my medication with anyone.
- I will not attempt to obtain any controlled substances from any other provider.
- I will safeguard my medication from loss or theft**. Lost or stolen medication will not be replaced.**
- I agree that refills of my prescriptions for controlled substances will be made only at the time of scheduled office visits or during regular office hours. No refills will be available during evenings or weekends.
- If there is a request for any early refills on (3) occasions, controlled substances will be discontinued.
- I understand that consecutive missed appointments may result in the disruption of services.
- I agree that I will submit a blood or urine test if requested by my doctor to determine my compliance with the controlled substances agreement and to determine the use of other controlled substances.
- I agree that I will use my medication at a rate no greater than the prescribed rate and that use at a greater rate will result in my being without my medication for a period of time.
- I will bring all unused controlled substances to every office visit.
- I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

I agree to use_____pharmacy at_____location.

This agreement has been entered into on this_____day of_____.

Printed Patient Name_____DOB____/____/_____

Patient Signature_____