ALDONA J. SPIEGEL, MD

PLASTIC SURGEON & BREAST DESIGNER

Breast Correction New Patient History Form

Date: _____ Patient Name: _____Age: _____

Birth date: _____ Weight _____ Height _____ Bra Size _____

Email Address:_____

Primary Care Doctor: _____ Referral source: _____

Reason for visit: _____

History of Present Illness:
(please be very specific with your answers)

When did the condition first occur? _____

At what age did you complete breast development? _____

Do you have any of the following conditions? If so, please describe severity and frequency

☐ Back Pain _____

☐ Neck Pain _____

☐ Shoulder grooving from bra straps _____

☐ Rash under breasts _____

Describe any breast asymmetry:
_____

Describe any recent weight changes:
_____

Describe any activities you have difficulty performing:
_____

Are you planning on any future pregnancies? ☐ No ☐ Yes
If yes, do you plan on breast feeding? ☐ No ☐ Yes

Is erogenous nipple sensation important to you? ☐ No ☐ Yes

Do you have any bad scars or keloids? ☐ No ☐ Yes

When was your last mammogram? _____

Past Medical History:

Have you ever been diagnosed with the following?

	No	Yes		No	Yes		No	Yes
High Blood Pressure	☐	☐	Thyroid Disease	☐	☐	Glaucoma	☐	☐
Diabetes	☐	☐	Kidney disease	☐	☐	Lymphedema	☐	☐
Asthma	☐	☐	Arthritis	☐	☐	Tuberculosis	☐	☐
Depression	☐	☐	Shingles	☐	☐	Stomach Ulcer	☐	☐
Anxiety	☐	☐	Stroke	☐	☐	Mitral Valve Prolapse	☐	☐
Blood Clots	☐	☐	Hepatitis	☐	☐	Seizures	☐	☐
Anemia	☐	☐	Multiple Sclerosis	☐	☐	Fibromyalgia	☐	☐

If yes to any of the above, please state if the condition is stable and being treated:

_____

_____

_____

Have you or any of your relatives been diagnosed with blood disorders? ☐ **No** ☐ **Yes**

If so, please list _____

List any major illnesses and dates:

Date	Illness
_____	_____
_____	_____
_____	_____
_____	_____

Past Surgical History **List all of your previous surgeries and dates**

Date	Procedure
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever had a liposuction procedure? ☐ No ☐ Yes

If yes, what part of the body? ☐ Abdomen ☐ Thighs ☐ Buttock ☐ Back ☐ Other _____

Family History:
List any blood relative diagnosed with cancer

Type of Cancer:	Relationship and age diagnosed if known
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications: (please include aspirin, ibuprofen, birth control pills etc. and dosage)

Pharmacy Name: _____ Pharmacy Phone: _____

Medication	Dosage and frequency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you currently using any birth control? ☐ No ☐Yes
Please list (oral contraceptive, nuvaring, IUD, etc) _____

Please list any supplements you are taking _____

DRUG ALLERGIES: ☐No ☐Yes

If yes, please list:

Drug:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

Social History:

Smoking (type & amount per day) _____ if former smoker, date quit: _____

Alcohol (type and amount per week) _____

Marital Status: _____

Occupation: _____

Spouse Occupation: _____

Number of Children:_____

Number of pregnancies_____

Social History Continued:

Age period began_____

Date of last mammogram _____

Have you noticed any new breast lump or nipple discharge? ☐ No ☐ Yes

Do you do regular breast self-examinations? ☐ No ☐ Yes

Did you breast feed? ☐ No ☐ Yes

Have you breast fed in the last year? ☐ No ☐ Yes

When did you stop lactating? _____

Physical Activity Level:

How often do you exercise? _____

If yes, what type of exercises do you perform? _____

What type of activities do you enjoy? _____

Does your work require any physical activity? ☐ No ☐ Yes

Do you have back pain? ☐ No ☐ Yes

Review of Systems:

Do you have now or have you had within the past year?

	No	Yes		No	Yes		No	Yes
Weight Increase	☐	☐	Swollen feet/ankles	☐	☐	Seizures	☐	☐
Weight Decrease	☐	☐	Skin rash	☐	☐	Joint or muscle pain	☐	☐
Chronic cough	☐	☐	Chronic diarrhea	☐	☐	Swollen lymph nodes	☐	☐
Chest pain	☐	☐	Jaundice	☐	☐	Easy bleeding/bruising	☐	☐
Rapid heartbeat	☐	☐	Depression	☐	☐	Dry eyes	☐	☐
Abdominal Pain	☐	☐	Heartburn	☐	☐	Urinary Symptoms	☐	☐

If yes to any of the above, please describe _____

_____

_____

_____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

x _____ _____

Signature of Patient Date

ALDONA J. SPIEGEL, MD
PLASTIC SURGEON & BREAST DESIGNER

Smoking, Second-Hand Exposure, Nicotine Products (Patch, Gum, Nasal Spray)

Patients who are currently smoking tobacco products or use nicotine products such as patches, gum or nasal spray are at a greater risk for significant surgical complications of skin necrosis and delayed healing. Individuals exposed to second-hand smoke are also at potential risk for similar complication attributable to nicotine exposure. Additionally, smoking may have a significant negative effect on anesthesia and recovery from anesthesia, with coughing and possibly increased bleeding. Individuals who are not exposed to tobacco smoke or nicotine containing products have a significantly lower risk of this type of complication.

Please indicate your current status regarding the items below:

☐ I am a non-smoker and do not use nicotine products. I understand the risk of second-hand smoke exposure causing surgical complications.

☐ I am a smoker or use tobacco and nicotine products. I understand the risk of surgical complication due to smoking or the use of nicotine products. I have been informed that **I MUST NOT SMOKE, MUST NOT USE ANY NICOTINE PRODUCTS AND AVOID SECOND-HAND SMOKE 3 months prior to** and **3 months after my surgery.** I understand that a nicotine test may be performed prior to my surgery. If positive, surgery will be cancelled and/or rescheduled.

☐ I take Wellbutrin or Chantix.

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____	_____	_____
Patient Signature	Date	Aldona J. Spiegel, MD

6560 Fannin, Suite 2200, Houston, TX,
77030 Phone: 713-441-6102
Fax: 713-790-2085

ALDONA J. SPIEGEL, MD
PLASTIC SURGEON & BREAST DESIGNER

TMHPO Patient-Provider E-Mail Agreement

E-mail offers an easy and convenient way for patients and physicians to communicate. However, there are distinct differences between communicating via e-mail as opposed to calling or coming in to the office. Remember: there is no person on the other side of the email – just a computer. You cannot tell when your message will be read, or even if your doctor is in the office or on vacation. Nevertheless, we believe that the ease of communication e-mail affords is a benefit to patient care. Below are our rules for contacting us using e-mail.

- E-mail is **NEVER** appropriate for urgent or emergency problems. If you have an urgent or emergent problem, please call 911 or go to the closest Emergency Department for immediate treatment.
- E-mail is NOT confidential. My staff may read your e-mails to handle routine, non-clinical matters. Also, you should also know that if sending e-mails from work, your employer has a legal right to read your e-mail.
- E-mail is NOT a substitute for seeing me. If you think that you may need to be seen, please call and make an appointment.
- E-mail will become a part of your medical record; a copy will be placed in your chart.
- E-mail is great for asking those straight forward questions that do not require in depth discussion. Appropriate uses of e-mail include prescription refill requests, referral and appointment scheduling requests and billing/insurance questions.
- E-mails should NOT be used to communicate sensitive medical information.
- Please identify the nature of your request in the subject line of your message.

Finally, either one of us can revoke permission to use the e-mail system at any time.

☐ I DO want to communicate with my physician electronically. I have read the above information and understand the limitations of security on information transmitted. I understand that my physician may not be able to communicate with me electronically about my specific condition if I live outside of the state in which my doctor is licensed.

Patient Name: _____ Date: _____

Patient Signature: _____ State of Residence: _____

E-mail Address: _____

ALDONA J. SPIEGEL, MD
PLASTIC SURGEON & BREAST DESIGNER

Photo Consent

I, _____, hereby consent to the use of photographs taken of me by the office of Aldona J. Spiegel, M.D. at The Methodist Hospital, Institute for Reconstructive Surgery for the purpose of education, training and surgical planning. I understand the photographs will be taken from the neck down and I will not be identified by name.

(Please initial your acknowledgement and the statements you approve)

____I hereby release Aldona J. Spiegel MD, her personnel, The Methodist Hospital, The Institute for Reconstructive Surgery and any other persons participating in my care or dealing with the photographs from any and all liability which may or could arise from the taking or use of such photographs.

____I authorize the use of my photographs for the clinical chart.

____I authorize the use of my photographs in Dr. Aldona J. Spiegel's Internet photo gallery.

____I authorize the use of my photographs in Dr. Aldona J. Spiegel's Office Photo Album.

____I authorize the use of my photographs in affiliated products website (i.e. Mentor Direct) for physician and patient education.

____I authorize the use of my photographs to be used in medical journals, book chapters, and educational presentations.

____I authorize the use of my photographs on social media.

____I authorize the use of my video on Dr. Aldona J. Spiegel's website.

____I authorize the use of my video on social media.

_____ _____
Patient Name (Print) DOB

_____ _____
Patient Signature Date

_____
Consent Reviewed With

*We need written notice to retract your consent for any digital usage and future print.

6560 Fannin, Suite 2200, Houston, TX 77030
Phone: (713) 441-6102
Fax: (713) 790-2085

Updated August 2019

INSTITUTE FOR RECONSTRUCTIVE SURGERY
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

You have been given the Notice of Privacy Practices for TMH Physician Organization and its Physicians. This Notice describes your legal rights regarding your health information and will inform you of the legal duties and privacy practices of TMH Physician Organization and its Physicians with respect to health information created for services generated by TMH Physician Organization and its Physicians. If you receive services by your physician or other health care provider at a different location, you may want to ask about that office or clinic's health information privacy policies and notices because they could be different.

Your name and signature below indicate that you have been provided with a copy of this Notice of Privacy Practices.

If you have a question regarding any of the information set forth in this Notice of Privacy Practices, please do not hesitate to call TMH Physician Organization's Business Practices Officer at 713.383.5125.

Patient Name: _____

_____ _____
Signature of Patient or Patient's Qualified Personal Representative — Date

_____
Printed Name of Qualified Personal Representative

_____
Legal Authority to Act on Behalf of the Patient

For Staff Use Only

Date Acknowledgment noted in HIS/patient management system: _____

Comments if Notice not provided or Acknowledgment not obtained:

_____

_____

Processed by: _____

HOUSTON Methodist
SPECIALTY PHYSICIAN GROUP

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I. PATIENT INFORMATION

Patient Name:		Date of Birth:
Patient Mailing Address:		
City/State		Zip Code:
Work #:	Home #:	Cell #:

II. INFORMATION TO BE DISCLOSED

I authorize _____to disclose my health information as follows, for service dates: _____:

- ☐ All paper chart records
- ☐ Entire medical record/outpatient clinical record
- ☐ History and physical(s)
- ☐ Operative report(s)
- ☐ Discharge summary(ies)
- ☐ Films and pictures
- ☐ All electronic medical records
- ☐ Laboratory results
- ☐ Radiology and imaging reports
- ☐ Pathology slides, blocks or reports
- ☐ Other test results: _____
- ☐ Other: _____

I understand that information used or disclosed pursuant to this authorization form may include information relating to Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

III. INFORMATION IS TO BE DISCLOSED TO/FROM:

Disclose to:	Disclose from:

IV. PURPOSE OF USE OR DISCLOSURE: _____

V. I authorize the disclosure of health information as described above. I understand:

- This authorization is valid for 180 days unless otherwise stated here: _____
- A photocopy or fax of this authorization is as valid as the original.
- I may revoke this authorization at any time by submitting a revocation in writing to Aldona J. Spiegel, MD.
- If I revoke this authorization, the revocation will not apply to information that has already been released in good faith before the revocation was received.
- Treatment or payment may not be conditioned on my completion of this authorization form.
- Information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by the federal privacy laws.

_____ _____

Signature of Patient or Qualified Personal Representative* **Date**

*If signed by a Qualified Personal Representative, the following must be completed:

Printed name of Qualified Personal Representative: _____

Legal Documentation showing Authority to Act on Behalf of the Patient: _____

(Example: Guardian of Patient, Executor of Estate)

ALDONA J. SPIEGEL, MD
PLASTIC SURGEON & BREAST DESIGNER

Financial Policies

Please review and sign this document regarding our current office financial policies.

We ask that our patients please understand that the following policies are set forth by The Methodist Physician Organization and not the office, doctor or staff.

If you have any questions about financial or billing issues, please direct these to the insurance coordinator at 713-441-1667.

Patient Financial Responsibility

- Please bring your insurance card with you at the time of your appointment.
- Please notify our office if your insurance changes.
- Co-payments are collected at the time of your visit.
- If your insurance requires you to obtain a referral to see a specialist and you do not have one on the date of service, please be aware that your insurance company will hold you responsible for payment of services rendered.
- Please note you will be responsible for any co-insurance, deductibles or non-covered services not paid by your insurance.
- Your co-insurance (out of pocket) for surgical procedures must be paid in full 3 weeks prior to the date of surgery, otherwise we will need to reschedule your procedure.
- Houston Methodist Hospital will usually expect your deductible to be paid in full on the date of surgery, therefore, we suggest you contact your insurance company to find out the amount that your are responsible for inpatient or outpatient hospital charges.
- For patients who do not have insurance coverage, we will require that payment be made in full at the time of service or three weeks prior to any scheduled surgery.

I assign my insurance benefits be made on my behalf directly to Institute for Reconstructive Surgery for services rendered.

Print Name _____

Signature _____ Date _____

Print Guardian Name (If minor) _____

Guardian Signature (If minor) _____

ALDONA J. SPIEGEL, MD
PLASTIC SURGEON & BREAST DESIGNER

Office Policy for Insured Patients

Many insurance carriers require pre-certification of particular procedures. Within the same insurance company the plans differ depending upon what type of contract your employer has negotiated. We are more than willing to follow any and all necessary guidelines to ensure that your encounter with the Institute for Reconstructive Surgery is reimbursed properly, but you must inform us of those guidelines. If you do not inform us of any special requirements in your contract and we subsequently order services, such as lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility. This will hold true for any Managed Care contract as well as any group/individual policies which may cover you and your dependents.

Please be advised that prior authorization or pre-determination is required prior to your scheduled surgical date. If your insurance does not provide authorization prior to the surgical date, your surgery may be postponed. Any non-covered services will be the patient's financial responsibility and payment will be required three weeks prior to the date of service.

With your cooperation and assistance, you should be able to receive all of the benefits offered to you. If you have any insurance related questions or concerns, please feel free to call our billing specialist at 713-441-1667.

I have read and understand the office policy stated above and agree to accept responsibility as described.

_____

Printed Name

_____ _____

Signature Date

August 2019