

ALDONA J. SPIEGEL, MD

PLASTIC SURGEON & BREAST DESIGNER

Enhance New Patient History

Date: _____ Patient Name: _____ Age: _____

Birth date: _____ Weight _____ Height _____ Bra Size _____

Email Address: _____

Primary Care Doctor: _____ Referral source: _____

Reason for visit: _____

Past Medical History: Have you ever been diagnosed with the following?

	No	Yes		No	Yes		No	Yes
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Lymphedema	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>

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:

<u>Date</u>	<u>Illness</u>
_____	_____
_____	_____
_____	_____
_____	_____

Past Surgical History:

List all of your previous surgeries and dates

<u>Date</u>	<u>Procedure</u>
_____	_____
_____	_____
_____	_____
_____	_____

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

<u>Type of Cancer:</u>	<u>Relationship and age diagnosed if known</u>
_____	_____
_____	_____
_____	_____
_____	_____

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

Pharmacy Name: _____ Pharmacy Phone: _____

<u>Medication</u>	<u>Dosage and frequency</u>
_____	_____
_____	_____
_____	_____
_____	_____

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 _____

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

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

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

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

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: _____

**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: _____

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: _____:

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

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 you 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) _____