PATIENT REGISTRATION

Last name ↑ | First name ↑ | Middle name ↑ | Nickname/"Go by" name ↑

Home address ↑ Street | Apt. # | City | State | Zip

Home phone ↑ | Cell phone | Home phone or cell phone — Preferred method of contact (circle one) ↑

Email address ↑ | Driver's license # & state | Social Security # | Date of Birth | Age

Marital status ↑ | Regular Doctor | # of children | # of pregnancies

Employer ↑ | Occupation | Okay to call you at work?

Employer's address ↑ | Work phone ext.

Spouse's name ↑ | Spouse's employer | Spouse's cell phone

Emergency contact (***not*** living w/ patient) ↑ | Relationship to patient | Contact's phone

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

INSURED / RESPONSIBLE PARTY - **Please indicate who is the INSURED EMPLOYEE (parent, legal guardian, etc)**

Name of responsible party (parent, legal guardian, etc.) ↑ | Relationship to patient ↑

Address of responsible party ↑ Street | Apt. # | City | State | Zip

Home phone ↑ | Cell phone | Work phone

Driver's license # & state ↑ | Date of Birth | Social Security #

Employer ↑ | Employer's address Street | Suite # | City | State | Zip

I understand I am responsible for payment of all charges incurred on behalf of myself or my family regardless of insurance benefits. My signature below indicates the information above is true and correct to the best of my knowledge.

Responsible party's signature | Date

PATIENT REGISTRATION (CONTINUED)

Were your referred by someone? _____ Whom? ___________________ May we thank him/her with a written note?_____

May we leave messages at home regarding an appointment or test results?_____ At work? _____

May we leave messages about your appointments with the person at work who handles your calls? _____

May we discuss your appointments/treatments with your spouse or partner? _____

May we discuss your appointments/treatments with your children or other family members? ______ If yes, please list name(s): ____

May we share your pertinent medical information with other doctors treating you? ________

For patients between ages 18-26, may we discuss your appointments, treatments, and test results with your parents or guardians? ______

I understand I am responsible for payment of all charges incurred on behalf of myself or my family regardless of insurance benefits. My signature below indicates the information above is true and correct to the best of my knowledge.

____ ______________________________________
Responsible party's signature Date

PATIENT'S HEALTH HISTORY

Patient's name ↑ Today's date ↑

Reason for visit ↑ Other family members seen in our office ↑

MEDICAL HISTORY (Please check all that apply)

__ High blood pressure
__ Heart attack
__ Palpitations/irregular pulse
__ Heart murmur
__ Other heart trouble
__ Abnormal EKG
__ Rheumatic fever
__ Stroke
__ Peripheral vascular disease
__ Shortness of breath
__ COPD or emphysema
__ Asthma
__ Sleep apnea
__ Major allergies
__ Hepatitis
__ Other liver disease

__ Bowel problems
__ Ulcers/gastritis
__ Diabetes
__ Thyroid problems
__ Kidney (or renal) disease
__ Bladder problems
__ Prostate problems
__ Seizure disorders
__ Migraines
__ Insomnia
__ ADHD
__ Depression
__ Psychiatric care
__ Chronic fatigue syndrome
__ Fibromyalgia
__ Arthritis

__ Skin disorders (i.e. Lupus)
__ Anemia
__ Bleeding tendency or disorder
__ Phlebitis
__ DVT or pulmonary embolus
__ Facial herpes (fever blisters)
__ Dry eyes
__ Bell's palsy
__ Glaucoma
__ Other eye disorders
__ Cancer – type: ___________________________
__ Blood transfusion(s)
__ Positive blood test – HIV/hepatitis
__ Loose teeth
__ Dentures/bridges/caps/crowns
__ Piercings other than ears - __________________

MEDICATIONS

Please list all medications you are currently taking (include birth control pills, aspirin, sinus medications, over-the-counter medicines, vitamins, supplements, etc.)

Drug/Supplement	Dosage	Frequency	Taken For

Please list physicians you see regularly: ____

Please list all hospitalizations and operations (including cosmetic procedures): ______________________
____
____

Is there anything else significant we should know about your personal or family history? ______________
____
____
____

Please see more health-related questions on the next page.

PATIENT'S HEALTH HISTORY (CONTINUED)

Patient's name ↑	Today date

MISCELLANEOUS

Do you consider your general health to be (circle one): excellent good fair poor

Do you have allergic reaction to any medicines? Yes No If yes, list: ______________________________

Do you have allergic reaction to any adhesive tapes? Yes No

Do you have allergic reaction to any topical medicines (creams, ointments, etc.)? Yes No

Do you exercise (circle one): daily 3-5 times a week weekly hardly ever

Do you need to take antibiotics for prophylaxis before dental work? ______

Does your religious affiliation (i.e., Jehovah's Witness) prevent use of blood products? Yes No

Have you had recent (past two years) weight changes? Yes No If yes, how much? ________________

Do you make thick scars or keloids? Yes No

Do you smoke? Yes No If yes, amount per day: ____

Have you smoked in the past? Yes No If yes, number of years and amount: _______________________

Do you have any sensitivity to rubber or latex products? Yes No

Have you had any problems with anesthesia in the past? Yes No

Do you drink alcoholic beverages? Yes No If yes, how much per week? ___________________________

When was your last physical? __________________________ By whom? _________________________________

When was your last eye exam? ________________________ By whom? _________________________________

When/where was your last chest X-ray? _______________________________ EKG? _______________________

When/where was your last mammogram? ____

Have you had blood work done in the last year? Yes No By whom? ______________________________

FOR OFFICE USE ONLY IN THIS BOX

Height _____________ Weight ______________ B/P ___________________

Assessment:

____

____

____

____

____

____

PLASTIC &
RECONSTRUCTIVE
SURGERY

Please release medical records to:

ELIZABETH KERNER, M.D.
6130 West Parker Road
Suite 110
Plano, Texas 75093

(972) 981-3265 (fax)

I, ____, do authorize medical records
Patient, Parent or Legal Guardian (please print)

including radiology films for____
Patient's Full Name

be released to the above-named physician.

____
Signature of Patient (or Legal Guardian)

____
Date

____
Signature of Witness

PLASTIC &
RECONSTRUCTIVE
SURGERY

OFFICE APPOINTMENT CANCELLATION POLICY

As Dr. Kerner's office appointment time is limited due to her heavy surgery schedule, it is necessary to institute a policy for canceling an office appointment.

Botox® comes frozen and must be used quickly after opening. Three patients are treated from each vial, so when one person cancels on short notice, two other patients are penalized and forced to reschedule. Thus 48 hours' notice will be required. **If 48 hours' notice is NOT given for the cancellation or rescheduling of a Botox appointment**, a $150 non-refundable credit card deposit will be required to schedule your next appointment. The $150 will be applied to your Botox treatment if you keep the appointment and is not in addition to the cost of the Botox.

Consultation visits for cosmetic surgery require one hour of Dr. Kerner's office time be set aside. **If two one-hour visits are missed or canceled with less than 48 hours' notice, no further appointments will be granted.**

By your signature below, you acknowledge you have read and understand the above policy and agree to abide by its terms.

______________________________	______________________________
Printed name of patient	Signature of Patient
______________________________	______________________________
Date	Signature of witness

PLASTIC &
RECONSTRUCTIVE
SURGERY

CONSULTATION FEE POLICY

An initial consultation for surgery is normally between 45 and 60 minutes and is $125. An initial consult with multiple surgical procedures is an hour and a half and is $195. The consult is face-to-face time with Dr. Kerner and her nursing staff. Dr. Kerner does not offer free consultations as she feels it is reasonable to be compensated for her time and expertise.

If you proceed with a cosmetic surgery on a cash basis within six (6) months of the consultation and the surgeon's fee is greater than $1,800.00, this initial consultation fee will be deducted from the total surgeon's fee. In addition, the second discussion/preoperative visit time (usually another 45-to-90-minute visit) will not be charged to you.

If your surgery is processed through insurance, the initial and second consultation fees will be submitted to your insurance company, and any copays for which you are responsible will not be deducted from the surgeon's fee. Dr. Kerner is bound by the terms of the insurance contracts to collect any and all deductibles, copays, and coinsurance.

Consultations fees for in-office procedures including (but not limited to): fillers, Botox®, CoolSculpting®, skin checks, lesion removals, scar revisions, earlobe repair, etc. are not deducted from the eventual fees for these services.

If you have had prior cosmetic surgery in the operating room with Dr. Kerner, normally a 15% reduction of the surgeon's fee is offered as our thanks for your confidence in and return to Dr. Kerner. However, this discount is only given at Dr. Kerner's discretion.

By your signature below, you acknowledge you have read and understand the above policy and agree to abide by its terms.

______________________________ ______________________________
Printed name of patient Signature of patient

______________________________ ______________________________
Date Signature of witness

PLASTIC &
RECONSTRUCTIVE
SURGERY

CONSENT TO TAKING OF PHOTOGRAPHS

In connection with the medical services which I am receiving from my physician, Dr. Elizabeth Kerner, I consent that photographs may be taken of me or parts of my body, under the following conditions:

1. The photographs may be taken only with the consent of my physician and under such conditions and at such time as may be approved by her.

2. The photographs shall be taken by my physician, or a photographer approved by my physician.

3. The photographs shall be used for medical records and if in the judgment of my physician, medical research, education or science will be benefitted by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which she may deem proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name and a separate written consent is required.

____
Patient's Name (please print)

____
Signature of Patient or Legal Guardian

____
Date

____
Signature of Witness

PLASTIC &
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SURGERY

PAYMENT/INSURANCE BENEFITS FOR SURGICAL PROCEDURES

As a service to you, we will request written predetermination of surgical benefits from your insurance company before surgery in an attempt to determine insurance benefits (if any). This process usually takes approximately six to eight weeks. Most insurance companies will respond regarding your coverage and proposed benefits. ***HOWEVER, SUCH A RESPONSE SHOULD NOT BE MISTAKEN FOR THE INSURANCE COMPANY'S GUARANTEE OF PAYMENT.*** The actual claim cannot be submitted to the insurance company until after surgery is done. The operative report sent after the claim will be used by the insurance company to determine actual medical necessity, and therefore, their payment.

If surgery is covered by insurance, the patient's portion of Dr. Kerner's fees (coinsurance percentage as dictated by the carrier plus unmet deductible amounts) is payable in full prior to surgery. If you elect to have your surgery before receiving a written response from the insurance company or without insurance benefits, you will be required to pay this office in full *PRIOR* to surgery, and you will *not* be able to file with insurance for reimbursement.

Sometimes, insurance carriers will not disclose exactly how much will (or will not) be paid. Caution should be exercised in making a financial decision based on information furnished by your carrier. Your insurance policy is a contract between you (or your employer) and the insurance company. This office is not a party to that contract. Most insurance companies have set their own fee schedules that may or may not coincide with our fees. If Dr. Kerner's fees do not fall within your insurance company's fee schedule (i.e., above "usual and customary"), ***IT WILL BE YOUR RESPONSIBILITY TO PAY ANY REMAINING BALANCE*** after insurance has paid. Even in the event written approval has been obtained, you will be responsible for payment of any balance not paid by your insurance company, regardless of their reason for nonpayment.

Per Article 21.55 of Texas Insurance Code, state law requires insurance carriers to: 1) acknowledge claims, begin their investigations, and request any needed information from claimants within 15 days after claims are received; 2) notify claimants in writing of the acceptance or rejection of their claims within 15 days after receiving all required information; 3) give their reasons in writing when they reject claims; and 4) make payment within five business days after notifying claimants their claim will be paid. (If payment is conditioned on some action by the claimant, then payment must be made within five business days after that action.) Unfortunately, we are unable to carry account balances for more than 90 days. Some carriers complicate payment of claims by continuing to ask for further information even after the claim has been filed. If we have provided all requested information and the carrier continues to "review the claim" and withhold payment, you will be required to assume negotiations at that point. If after 90 days your insurance company has not settled in full with this office, you will be responsible for immediate payment in full and any necessary follow-up with your carrier.

Additionally, the American Medical Association guidelines provide for postoperative visits at no charge to the patient/insured for a specified period of time. This "global period" ranges from 30 to 90 days (with a few exceptions) depending upon the procedure performed. Following the expiration of the global period, charges will resume for office visits.

This office utilizes electronic billing for insurance claims with most major insurance carriers including Medicare. Your signature below indicates you understand your claims may be sent electronically and you have given your consent and authorization.

By your signature below, you confirm that you understand these policies and agree to comply with them.

______________________________	______________________________
Patient's Name (please print)	Signature of Patient/Responsible Party
______________________________	______________________________
Date	Signature of Witness

PLASTIC &
RECONSTRUCTIVE
SURGERY

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, acknowledge I have read and received a copy of Elizabeth Kerner, M.D., P.A.'s Notice of Privacy Practices. This notice describes how Dr. Kerner and her staff may use and disclose my/my child's protected health information, certain restrictions on the use and disclosure of my/my child's healthcare information, and rights I may have regarding my/my child's protected health information.

____
Patient's Name (***please print***)

____
Signature of Patient/Legal Guardian

____
Date

____
Signature of Witness

PLASTIC &
RECONSTRUCTIVE
SURGERY

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Protected health information about you, your condition, treatment, contacts or visits with this office for healthcare services with Elizabeth Kerner, M.D., P.A. will be routinely maintained in our files. This material is called "Protected Health Information" (hereafter referred to as "PHI") and is specifically information about you, including demographics (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Elizabeth Kerner, M.D., P.A. is required by law to follow specific rules on maintaining the privacy of your PHI, how our staff uses it, and how we disclose or share this information with other healthcare professionals or insurance companies involved in your care and treatment. This Notice describes how we follow those rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. Additionally, it describes how we follow those rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes permitted or required by law. If you have questions about this Notice, please contact our Privacy Manager at (972) 981-7144.

Your Rights Under the Privacy Rule

Following is a statement of your rights under the Privacy Rule in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with a copy of this Notice of Privacy Practices. We are required to follow the terms of this notice. We reserve the right to change the terms of this notice at any time. If needed, new versions of this notice will be effective for all PHI we maintain at that time. Upon your request we will provide you with a revised Notice of Privacy Practices if you call our office and request a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

You have the right to authorize other use and disclosure. This means you have the right to authorize or deny any other use of disclosure of PHI not specified in this notice. You may revoke an authorization at any time in writing, except to the extent Dr. Kerner or her staff has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to designate a personal representative. This means you may designate a person with the delegated authority to consent to or authorize the use or disclosure of PHI.

You have the right to request a restriction of your PHI. This means you may ask us in writing not to use or disclose any part of your PHI for the purposes of treatment, payment for services, or healthcare operations. You may also request any part of your record be withheld from family members or friends who may be involved in your care or for notification purposes as described in this Notice. In certain cases, we may deny your request for a restriction.

You have the right to have us amend your PHI. This means you may request an amendment of your records for as long as we maintain your PHI. In certain cases, we may deny your request for an amendment.

You have the right to request a disclosure accountability. This means you may request a list of disclosures we have made to entities or persons outside our office.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Security Officer of your complaint.

How We may Use or Disclose PHI

Following are examples of use and disclosures of your PHI we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For Treatment: We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party who is involved in your care and treatment. For example, we would disclose your PHI as necessary to a pharmacy that would fill your prescriptions or a pathology lab who would be examining tissue sent for biopsy. We will also disclose PHI to other physicians who may be involved in your care and treatment.

We may also call you by name in the waiting room when Dr. Kerner or her staff is ready to see you. We may use or disclose your PHI as necessary to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. We may contact you to provide information about health-related benefits and services offered by our office.

For Payment: Your PHI will be used as needed to obtain payment for our healthcare services. This may include certain activities your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations: We may use or disclose as needed your PHI in order to support the business activities of our practice. This includes, but is not limited, business planning and development, quality assessment and improvement, medical credentialing, certification, underwriting, rating, or other insurance related activities. Additionally, it may include business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, and due diligence in connection with the sale or transfer of assets.

Other Permitted and Required Uses and Disclosures

We may also use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI.

To Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any person YOU IDENTIFY your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such PHI as necessary if we determine it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person responsible for your care, general condition, or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then Dr. Kerner may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only PHI relevant to your healthcare will be disclosed.

As Required by Law/For Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading the disease or condition.

For Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
In Cases of Abuse or Neglect: We may disclose your PHI to a public health agency as authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

To The Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance as required.

For Legal Proceedings: We may disclose your PHI in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in the response to a subpoena, discovery request or other lawful process.

To Law Enforcement: We may also disclose PHI so long as applicable legal requirements are met for law enforcement purposes.

To Coroners, Funeral Directors, and Organ Donation Organizations: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death, or for the coroner/medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. PHI may be used or disclosed for cadaveric organ, eye, or tissue donation process.

In Case of Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent treat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

For Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for 1) activities deemed necessary by appropriate military command authorities; 2) the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; 3) to foreign military authority if you are a member of that foreign military service.

For Worker's Compensation: Your PHI may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally established programs.

When An Inmate: We may disclose your PHI if you are an inmate of a correctional facility and Dr. Kerner created or received your PHI in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures about you if/when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.