LEMMON AVENUE
PLASTIC SURGERY & LASER CENTER

NAME_____ (MALE / FEMALE) AGE _____ DOB _____

REASON FOR CONSULTATION _____

HOME ADDRESS _____
street apt/suite

_____
city state zip

HOME # _____ CELL #_____ WORK # _____

E-MAIL _____

OCCUPATION _____ EMPLOYER _____

HOW DID YOU HEAR ABOUT US? FRIEND DOCTOR INTERNET SOCIAL MEDIA

PLEASE LIST NAME OF REFERRAL SOURCE _____

WHICH OTHER PROVIDERS HAVE YOU CONSIDERED FOR THIS TREATMENT? _____

PREFERRED PHARMACY

PHARMACY NAME _____ NUMBER _____

PHARMACY ADDRESS _____

MEDICATION ALLERGIES _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PHYSICIAN NAME _____

OFFICE PHONE # _____ FAX # _____

PRACTICE ADDRESS _____

With my signature below, I hereby authorize the above stated office to forward my medical records to:
Lemmon Avenue Plastic Surgery and Laser Center
2801 Lemmon Avenue Suite 300
Dallas, TX 75204

SIGNATURE _____ DATE _____

PRINT NAME _____

LEMMON AVENUE
PLASTIC SURGERY & LASER CENTER

NAME OF PRIMARY INSURANCE COMPANY _____

POLICY NUMBER _____ GROUP NUMBER _____

NAME OF PRIMARY INSURED (*if other than the patient*) _____

RELATIONSHIP TO PATIENT (*circle one*) SPOUSE / PARENT / CHILD / OTHER _____

NAME OF SECONDARY INSURANCE COMPANY _____

POLICY NUMBER _____ GROUP NUMBER _____

NAME OF PRIMARY INSURED (*if other than the patient*) _____

RELATIONSHIP TO PATIENT (*circle one*) SPOUSE / PARENT / CHILD / OTHER _____

STATEMENT OF FINANCIAL RESPONSIBILITY

The services you have elected to participate in imply a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. If applicable and indicated, we will verify your coverage and bill your insurance carrier on your behalf, as a courtesy to you. However, you are ultimately responsible for payment of your bill in full.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including private insurance and other health plans to Dr. Dauwe. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment.

YOUR INSURANCE CARRIER MIGHT NOT FULLY REIMBURSE YOU FOR HOSPITAL ADMISSION OR SURGICAL PROCEDURES.

Most group insurance policies have been amended to include preadmission certification requirements for hospital admissions and/or second surgical opinion requirements for selected surgical procedures. I understand that this is my responsibility to fulfill any preadmission or second opinion requirements contained in my insurance policy. I realize that failure to do so may result in a significant reduction in my insurance benefits. I, the undersigned, have read the above policy regarding my financial responsibility to Lemmon Avenue Plastic Surgery and Laser Center, for providing services to me or the patient mentioned below. I certify that the information, to the best of my knowledge, is true and accurate. I hereby assign Lemmon Avenue Plastic Surgery and Laser Center all payments to which I am entitled for medical and/or surgical expenses related to the services reported for my illness or injury. I understand that I am financially responsible to said provider for charges not covered by this assignment of benefits. A copy of this assignment is as valid as the original.

SIGNATURE _____ DATE _____

PRINT NAME _____

LEMMON AVENUE
PLASTIC SURGERY & LASER CENTER

ACKNOWLEDGEMENT OF RECEIPT – NOTICE OF PRIVACY PRACTICES

TO OUR PATIENTS:
The privacy of your health care information is extremely important to us. We want you to understand how we use and disclose your information and your rights to this information. We ask you to review our Notice of Privacy Practices that describes our legal duties with respect to your health care information. You are entitled to a copy of this notice if requested.

HOW WE USE HEALTHCARE INFORMATION:
We use information about you to:

- Provide treatment to you
- Ensure appropriate payment for the treatment we provide, and
- Monitor the quality of our operations

WHEN WE MAY DISCLOSE INFORMATION:
In certain limited cases we are permitted to disclose health care information about you. Examples include when there is a serious threat to health or safety, for insurance reimbursement, in any situation regarding a billing dispute, to reduce public health risks, for health oversights, and in certain cases for law enforcement. In addition, we may disclose information to tell you about health-related services and alternative treatments, and to conduct health-related research with your permission.

YOUR INFORMATION RIGHTS:
We create a record of the care we give you.

- You have the right to know how we use your health information, who we can give it to, and your rights to this information. (Please see our Notice of Privacy Practices.)
- You have the right to ask us to restrict uses and disclosures where we believe such restrictions will not harm you and where it is possible for us to do so.
- You have the right to confidential communication of your health information. For example, you can ask for a conversation to held in private or for us to send a copy of your bill to a different address.
- You have the right to look at and receive a copy of information in our records unless your doctor has indicated this would be harmful to you or someone else.
- You have the right to request that our records be amended if we agree it is inaccurate or incomplete.
- You have the right to ask for a list when we have disclosed your health information to someone other than those treating you, handling your bills, for our internal operations, or when you have authorized release of information.

I acknowledge that I understand and agree with the above information, and I have received and reviewed the Notice of Privacy Practices. If you have any questions, please speak with any member of the office staff.

SIGNATURE _____ DATE _____

PRINT NAME _____

LEMMON AVENUE
PLASTIC SURGERY & LASER CENTER

PROTECTED HEALTH INFORMATION DISCLOSURE AUTHORIZATION

Protected health information is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services ("PHI"). As required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Lemmon Avenue Plastic Surgery and Laser Center ("Practice") has provided a Notice of Privacy Practices describing how it may use and disclose PHI. It is important to understand that any uses or disclosures outside those circumstances described in the notice will be made only with your written authorization including most disclosures to family members or friends. This means that we will not disclose information to a person despite their relationship with you unless you are specifically authorized them to receive such information. There, this authorization must be completed to identify those individuals who will be permitted to receive information about your medical care.

AUTHORIZATION

I give permission for Dr. Dauwe and all office employees to discuss all aspects of my health information with the following person(s):

NAME	RELATIONSHIP	CONTACT NUMBER

My PHI is being disclosed at my request, and I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practice. I understand that a revocation is not effective to the extent that the Practice has relied on the use or disclosure of the PHI or situations where PHI disclosure is necessary to prevent serious threat to health or safety, for insurance reimbursement, any situation regarding a billing dispute, and to reduce public health risks. I understand that PHI already disclosed by this authorization may be subject to re-disclosure after revocation by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act or other applicable laws or regulations.

This authorization will be in full force and effect until otherwise changed by me in writing.

SIGNATURE _____ DATE _____

PRINT NAME _____

LEMMON AVENUE
PLASTIC SURGERY & LASER CENTER

PHOTOGRAPH AND VIDEO DISCLOSURE AUTHORIZATION & RELEASE

I HEREBY GIVE PERMISSION to Dr. Phillip Dauwe and/or any Associate(s) or any assistant he may designate, to take photographs/videos of me or my body parts in connection with the plastic surgery procedure(s) to be performed by them and/or for diagnostic purposes. I agree that these photographs/videos will remain their property and a part of my permanent medical record.

I PROVIDE THIS AUTHORIZATION as a voluntary contribution in the interests of patient education. I understand that such photographs/videos shall become the property of Dr. Phillip Dauwe and may be retained and/or released by them for the purpose of including them in any print, visual or electronic media, specifically including, but not limited to publication in medical journals and textbooks, physician photo books, physician website, social media, or for the purpose of informing the medical profession, the general public, or a patient about plastic surgery procedures and methods. I understand that publication of these photographs/videos on the World Wide Web will render such photographs/videos visible on a worldwide scale.

It is specifically understood that I shall not be identified by name. However, I understand that in some circumstances the photographs/videos may portray features that will make my identity recognizable, such as facial features, tattoos, or birthmarks and that my identity may be disclosed in connection with the medical treatment I am undergoing.

I understand that after authorization, photographs and videos disclosed may not be undisclosed and are subject to permanent public exposure. However I understand that I have the right to request by written notice that such photographs and videos are no longer subject to further disclosure.

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 ("**HIPAA**").

RELEASE
I release and discharge Dr. Phillip Dauwe and all parties acting under their licenses and authority from all rights that I may have to the photographs/videos and from any claim that I may have relating to such use in publication or digital media, including any claim for payment in connection with distribution or publication of the photographs/videos.

I certify that I have read the above authorization and release, and fully understand the terms.

SIGNATURE _____ DATE _____

PRINT NAME _____

LEMMON AVENUE
PLASTIC SURGERY & LASER CENTER

PRACTICE POLICY FOR SURGICAL AND NON-SURGICAL PROCEDURES

We know having surgery is an enormous commitment on your part, so our priority is to provide you as much predictability and permanence in our schedule as possible.

We also commit time and resources to you when we make a reservation for your procedure or surgery. Arranging surgery requires careful coordination between our office, the surgery center, anesthesiologist, and postoperative care facility if applicable. Therefore, when planning your surgery, please consider our commitment and the importance of our cancellation policy.

SURGERY CANCELLATION POLICY
We require full payment for surgery (Surgeon fee + OR Facility fee + Anesthesia fee + Postoperative care facility if applicable) **2 weeks prior** to your surgery date. We require down payment of $1000 to secure a surgery date. This deposit will be refundable **greater than 2 weeks** prior to your original requested surgery date. Cancellation within 2 weeks of your original surgery date will result in refund of your down payment only if cancellation is mandated by medical necessity.

NON-SURGICAL CANCELLATION POLICY
Full payment for non-surgical procedures will be taken at the time of scheduling to secure your appointment. Cancellation of scheduled procedures on prepaid packages will result in debit of that procedure session from the prepaid package pursuant to the same schedule. All balances must be paid in full prior to scheduling any future procedures.

SURGERY TIME OVERAGE POLICY
In an effort to minimize facility and anesthesia costs to our patients, Dr. Dauwe estimates the operative time as accurately as he can. However, if your surgery takes longer than expected, you will be responsible for any fees that may result from the operating room or anesthesiologist.

REVISION POLICY
Our goal is to provide the optimal results with your plastic surgery. However, operative revisions may be required. In this instance, the surgeon's fee will be negotiable, however, you will be responsible for the fees related to the operating room, anesthesia and hospitalization.

I like to inform my patients of these policies prior to the surgery, so that we may discuss this during the preoperative evaluation and consultation. We value your loyalty and do everything to maximize your care and result from plastic surgery. If you have any questions or want to discuss this further, please do not hesitate to discuss with me or any of my staff.

I have read and understand the above stated policies.

SIGNATURE _____ DATE _____

PRINT NAME _____

LEMMON AVENUE
PLASTIC SURGERY & LASER CENTER

NAME _____ **DATE** _____

AGE _____ **HEIGHT** _____ **WEIGHT** _____

HPI

_____

_____

_____

_____

_____ Current Cup Size: _____

_____ Desired Cup Size: _____

MEDICAL HISTORY

_____

_____

_____

_____

SURGICAL HISTORY

_____

_____

_____

_____

_____

MEDICATIONS

_____

_____

_____

_____

FAMILY HISTORY

MOTHER_____ MATERNAL GRANDPARENT_____

FATHER_____ PATERNAL GRANDPARENT _____

OTHER RELATIVE_____

SOCIAL HISTORY

Relationship Status SINGLE / MARRIED / DIVORCED / WIDOWED

Occupation _____

pregnancies _____ # Deliveries _____ # Children _____

Nicotine Use? YES / NO / FORMER Quit day _____ Amount _____

Alcohol? YES / NO / SOCIAL

ALLERGIES NKDA

MEDICATION_____REACTION_____

MEDICATION_____REACTION_____

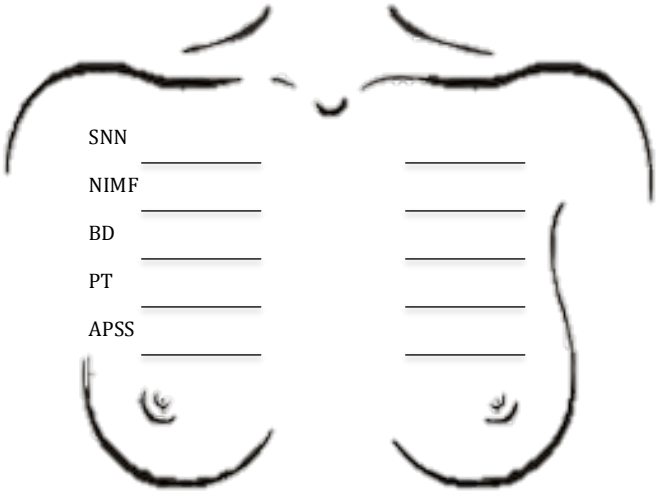
LEMMON AVENUE
PLASTIC SURGERY & LASER CENTER

DO YOU TAKE ANY MEDICATIONS THAT THIN YOUR BLOOD? NO ____ YES _____
HAVE YOU OR A FAMILY MEMBER EVER HAD A BLOOD CLOT? NO ____ YES _____
DO YOU HAVE ANY THICK SCARS OR KELOIDS? NO ____ YES _____
FAMILY MEMBER EVER HAD DIFFICULTY WITH ANESTHESIA? NO ____ YES _____

REVIEW OF SYSTEMS

GENERAL	NO ____ YES ____	RECENT WEIGHT LOSS, FEVER, CHILLS, MALAISE, CHRONIC FATIGUE
EYES/VISION	NO ____ YES ____	VISUAL CHANGES, EYE PAIN
EARS/NOSE/THROAT	NO ____ YES ____	NASAL AIRWAY BLOCKAGE, HEARING LOSS
CARDIOVASCULAR	NO ____ YES ____	CHEST PAIN, HIGH BLOOD PRESSURE, PALPITATIONS, ARRYTHMIA
CHEST/BREAST	NO ____ YES ____	MASS, LUMP, DISCHARGE, PAIN, SKIN CHANGES
RESPIRATORY	NO ____ YES ____	COUGH, SHORTNESS OF BREATH, WHEEZING, DIFFICULTY WITH EXERTION
GASTROINTESTINAL	NO ____ YES ____	ABDOMINAL PAIN, HEARTBURN, BLOODY STOOL
GENITOURINARY	NO ____ YES ____	FREQUENT URINATION, URGENCY
MUSCULOSKELETAL	NO ____ YES ____	JOINT PAIN, SWELLING, STIFFNESS, BACK PAIN
SKIN	NO ____ YES ____	SUSPICIOUS MOLES, NONHEALING WOUNDS, RASH, ABNORMAL GROWTHS
NEUROLOGICAL	NO ____ YES ____	NUMBNESS, TINGLING, WEAKNESS
PSYCHIATRIC	NO ____ YES ____	ANXIETY, DEPRESSION, SUICIDAL THOUGHTS
ENDOCRINE	NO ____ YES ____	HEAT/COLD INTOLERANCE, EXCESSIVE THIRST
HEMATOLOGIC	NO ____ YES ____	BLOOD CLOT, EASY BRUISING, PROLONGED BLEEDING
IMMUNE/LYMPHATIC	NO ____ YES ____	SWOLLEN LYMPH NODES, ALLERGIES

PHYSICAL EXAM



PLAN

[ ] MMG _____

[ ] PHOTOS [ ] QUOTE [ ] LABS [ ] EKG [ ] PREOP CLEARANCE OR _____ **TIMEFRAME** _____

PHYSICIAN SIGNATURE _____ DATE _____