

# Patient Demographic Information

Patient Name: \_\_\_\_\_

Preferred Name / Nickname: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Marital Status (circle) S M D W Gender: Male Female

May we include your address in mailings we periodically use to keep our patients informed of current happenings in the practice? Yes No

## Contact Information

*May we leave messages regarding appointments and patient care instructions at this contact? (Please Circle)*

Home: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Yes No

Work: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Yes No

Mobile: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Yes No

Pager: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Yes No

Other: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Yes No

Fax: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Yes No

e-mail: \_\_\_\_\_ Yes No

Please circle your preferred contact number (please circle): Home / Work / Mobile / Pager / Other

## Emergency Contact

Name: (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last) \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Home: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Primary Care Provider (Physician): \_\_\_\_\_

Where did you hear about us (Please circle one):

Plano Profile Living Magazine Brochure Radio Physician Referral

Google Ad Internet Search Health Grades Yellow Pages AAFPRS Website

Friend – if so, please let us know their name: \_\_\_\_\_

Other: \_\_\_\_\_

## Employment Information

Employment (circle one): Full time Part time Full time student Part time student Retired Other

Occupation: \_\_\_\_\_ Company or School: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Insurance Information

Insurance Company Name: \_\_\_\_\_

Insurance Plan Name or Group Name: \_\_\_\_\_

Patient's Insurance ID Number \_\_\_\_\_ Policy Group or FECA Number \_\_\_\_\_

**Please fill out this section if primary insured is other than patient.**

Name of Primary Insured: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Insured's relationship to Patient: \_\_\_\_\_ Insured's Gender: Male Female

D.J. Verret, MD, PA files claims for any of the Managed Care Plans with which we participate. **Any applicable co-payment, co-insurance or deductible is expected to be paid at the time of service.** Our office is willing to assist in claim filing for insurance carriers with which we are not contracted. We require that these arrangements be made with our office staff prior to your visit. \_\_\_\_\_initial

I assign D.J. Verret, MD, PA all payments for medical services rendered to me or my dependents for services filed to insurance on my behalf. \_\_\_\_\_initial

I hereby authorize D.J. Verret, MD, PA to release my medical or incidental information that may be necessary for medical care or to process medical insurance claims for which payment is assigned to the provider. \_\_\_\_\_initial

I hereby give my consent for medical treatment by the physician or under the direction of the physician of D.J. Verret, MD, PA to myself or my dependent. \_\_\_\_\_initial

\_\_\_\_\_  
Patient/Parent/Guardian Signature

\_\_\_\_\_  
Date

## Financial Policy

We consider it a privilege that you have chosen us for your needs. We strongly believe that an informed patient is a good patient. We strive to inform you of all the medical aspects of your needs and also would like to advise you on our financial policy.

### Office Visits:

- Office visits can be rescheduled or cancelled without penalty with at least 24 hours notice of date of the office visit. If the office visit is rescheduled or cancelled less than 24 hours from the date of appointment, or failure to show within 15 minutes of scheduled appointment time, a \$50 rescheduling/cancellation fee will be assessed. This is done to maintain the continuity of our carefully maintained schedule and to assure that all patients are provided excellent service in a timely manner.
- Office procedures can be rescheduled or cancelled without penalty with at least 24 hours notice of date of the office procedure. If the office procedure is rescheduled or cancelled less than 24 hours from the date of appointment, or failure to show within 15 minutes of scheduled appointment time, a \$100 rescheduling/cancellation fee will be assessed. This is done to maintain the continuity of our carefully maintained schedule and to assure that all patients are provided excellent service in a timely manner.

### Insurance Reimbursed Procedures:

- We will do our best to estimate your deductibles and copays for your procedure. These estimates are due 5 days in advance of your procedure. If payment is not received, the procedure can be cancelled.
- While we will do our best to obtain all preoperative certifications from insurance with which we are contracted, patients are hereby reminded that they are ultimately responsible for all charges not reimbursed by insurance.

### Cosmetic Procedures:

- The quote you are given at your initial consultation is good for six months from the time of consultation. If you decide to postpone your surgery past the six months time period, you will be required to undergo a new consultation to ensure that your goals for surgery have not changed.
- The larger of either a \$750 scheduling fee or 10% down payment is due to schedule a surgery date for procedures not performed in our office. For minor procedures performed in our office which take less than an hour, a \$100 scheduling fee is required to schedule a procedure date.
- Surgery can be rescheduled without penalty 14 calendar days prior to the date of surgery. If surgery is rescheduled or cancelled less than 14 calendar days from the date of surgery, a \$750 rescheduling fee will be assessed. This is done to maintain the continuity of our carefully maintained surgery schedule and to assure that all patients are provided excellent service in a timely manner. The only exception to this is life threatening emergencies, death in the immediate family, or medical illness of the patient or patient's primary family prior to the operation. In these exceptional circumstances the rescheduling fee will not apply. We reserve a considerable amount of discretion in implementing this difficult but necessary policy.
- Payment for all cosmetic surgery procedures is due in full 10 business days before the surgery date. If fees are not rendered at that time a hold will be placed on the operation. If fees are not provided 5 business days before the operation the surgery will be cancelled.
- At times, it may be necessary to obtain preoperative laboratory examinations or a preoperative medical clearance from the patient's primary care physician. The patient is responsible for obtaining the appropriate testing and clearances. If the required laboratory tests or medical clearances are not obtained 7 calendar days before surgery, the surgery will be cancelled. Failure to obtain the appropriate clearance will result in the rescheduling fee being assessed.
- Every effort is made to maintain the predicted operating room and anesthesia hours. However results are NEVER compromised for time. In these rare occasions that the surgery outruns the determined time, you may be billed for additional operating room and anesthesia fees.
- Plastic surgery is an art and occasionally revisions will be necessary. These will always be within one year of the operating date. The majority of the time no surgeon fees will be charged, however facility and anesthesia fees will apply for the procedure. Dr. Verret reserves the right to determine a revision versus a separate procedure that is being requested.

### General Policies:

- All returned checks will have a \$35 service charge. Any accounts which are past due and for which collections efforts are initiated will be assessed appropriate collections fees and any attorney's fees associated. All legal claims must be filed in the jurisdiction of the office where services are rendered.
- We accept cash, cashier's check, personal check, and major credit cards including Visa, MasterCard, American Express, and Discover
- All financing is done through CareCredit®. This must be arranged at least 10 business days in advance of any procedures. We will be happy to assist you with financing if that is necessary.
- We are contracted with several insurance companies. We will be happy to assist you in filing your insurance. It is the patient's responsibility to ensure that all referrals are obtained prior to the initial visit. Failure to obtain proper referrals can result in the need to reschedule a visit.
- **Payment is expected at time of service for all patients. All co-payments and deductibles are due at the time services are rendered, or in the case of surgery, at least 5 business days in advance of surgery.**
- **The written financial procedures and indigent care policies are available for review. All financial complaints should be addressed in writing to: Business Manager of D.J. Verret, MD, PA, 6545 Preston Road, Suite 200, Plano, TX 75024.**

### Receipt of Notice of Financial Policy

**I have been allowed to review the Financial Policy for D.J. Verret, MD, PA.**

\_\_\_\_\_  
Patient/Parent/Guardian Signature

\_\_\_\_\_  
Date

## Privacy Practices

A complete copy of the HIPAA related privacy practices for D.J. Verret, MD, PA is available online at <http://innovationsfps.com/PDF/Notice%20of%20Privacy%20Practices.pdf> or can be obtained by asking the office staff for a copy or in writing by mailing: Office Manager; D.J. Verret, MD, PA; 6545 Preston Road, Suite 200; Plano, TX 75024.

Dr. D.J. Verret and D.J. Verret, MD, PA (collectively labeled "*Physician*") agree to provide treatment to and maintain Privacy of \_\_\_\_\_ ("*Patient*") as outlined in the HIPAA form. The Physician takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician believes this is improper and may not be in the patients' best interest. Accordingly, Physician agrees not to provide medical information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Physician has invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about the Physician on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares commentary for publication on web pages, blogs, and/or mass correspondence about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be in force and enforceable for a period of five years from Physician's last date of service to Patient. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship.

Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

\_\_\_\_\_  
Patient/Parent/Guardian Signature

\_\_\_\_\_  
Date

### AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean \_\_\_\_\_.

"Physician" shall be understood to mean D.J. Verret, MD of D.J. Verret, MD, PA.

Further, I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use American Board of Medical Specialties ("ABMS") board-certified expert medical witness (es) in the same specialty as Physician. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and / or code of conduct defined for expert witnesses by the American Board of Otolaryngology Head & Neck Surgery. In further consideration for this, Physician agrees to the same stipulations.

\_\_\_\_\_  
Patient/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Date

Health Information as of \_\_\_\_\_ (enter today's date)  
 (Please Print Legibly & Fill In or Correct All Fields)

<b>Patient:</b>			
DOB	Age		Weight lbs
What are you seeing the doctor for?			Height ft in

DO YOU NOW OR HAVE YOU EVER HAD..... ( You must circle an answer for each individual item)

Heart Trouble	Yes	No	Glaucoma or Eye Problems	Yes	No
Heart Attack	Yes	No	Visual Disturbances	Yes	No
Palpitation or Irregular Pulse	Yes	No	Error in Refraction	Yes	No
Extra Heart Beats	Yes	No	Other Eye Problems	Yes	No
Stroke	Yes	No	Hepatitis	Yes	No
Hypertension	Yes	No	Yellow Jaundice	Yes	No
Blood Pressure Abnormalities	Yes	No	Gallstones or Gallbladder Trouble	Yes	No
Abnormal EKG	Yes	No	Cirrhosis of the Liver	Yes	No
Rheumatic Fever	Yes	No	Alcoholism or Drug Dependency	Yes	No
Dropsy or Heart Failure	Yes	No	Esophageal Varices	Yes	No
Digitalis Treatment	Yes	No	Frequent Indigestion	Yes	No
Shortness of Breath	Yes	No	Ulcers	Yes	No
Chest Pain	Yes	No	Gastritis	Yes	No
Asthma	Yes	No	Colitis	Yes	No
Bronchitis	Yes	No	Vomiting Blood	Yes	No
Pneumonia	Yes	No	Tarry or Bloody Bowel Movements	Yes	No
Tuberculosis	Yes	No	Hemorrhoids	Yes	No
Smokers Cough	Yes	No	Goiter or Thyroid Disorders	Yes	No
Emphysema	Yes	No	Diabetes	Yes	No
Coughing or Spitting of Blood	Yes	No	Skin Disorders	Yes	No
Hay Fever	Yes	No	Arthritis	Yes	No
Major Allergies	Yes	No	Fracture of Neck or Spine	Yes	No
Palsy or Paralysis	Yes	No	Bleeding Tendency or Disorder	Yes	No
Nervous Breakdown	Yes	No	Abnormal Bleeding after Tooth Extraction	Yes	No
Nervous Disorder	Yes	No	Airway Obstruction (Nasal)	Yes	No
Insomnia	Yes	No	Neurologic Disorder	Yes	No
Drug Habit	Yes	No	Kidney Disorder	Yes	No
Self-Destructive Tendencies	Yes	No	Blood Transfusion	Yes	No
Psychiatric Hospitalization or Care	Yes	No	Seizures or convulsions or fainting spells	Yes	No
Thyroid Problems	Yes	No	Black outs	Yes	No
Kidney or Renal Disease	Yes	No	Dentures, bridges, capped teeth or crowns	Yes	No
Heart murmur	Yes	No	Loose teeth	Yes	No
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No	Cosmetic bonding to teeth	Yes	No
Missed or irregular last menstrual period	Yes	No	Any family members with bleeding problems	Yes	No
Family history of cancer, heart trouble, stroke	Yes	No			

1. **Please list all present medications and dosages**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. **Include over-the-counter medications.**

\_\_\_\_\_

\_\_\_\_\_

2. Do you have an allergic reaction to any medication?  Yes  No Which? \_\_\_\_\_

3. Do you react abnormally to any medication?  Yes  No Which? \_\_\_\_\_
4. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?  
 Yes  No If yes, when and where? \_\_\_\_\_
5. Have you ever been on cortisone or steroid treatment?  Yes  No When? \_\_\_\_\_
6. Are you currently taking or have you taken Accutane or its generic form tretinoin in the last 6 months?  Yes  No
7. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?  
 Yes  No If so, how much? \_\_\_\_\_
8. Do you smoke?  Yes  No If so, how much? \_\_\_\_\_ For how long? \_\_\_\_\_
9. Are you pregnant?  Yes  No When was your last normal menstrual period? \_\_\_\_\_
10. When was your last physical exam? \_\_\_\_\_ By whom? \_\_\_\_\_
11. When was your last eye examination? \_\_\_\_\_ By whom? \_\_\_\_\_
12. When and where was your last chest x-ray? \_\_\_\_\_ EKG? \_\_\_\_\_
13. Who is your personal physician, if any? \_\_\_\_\_ Please list all physicians presently caring for you.  
\_\_\_\_\_  
\_\_\_\_\_
14. Have you ever been under psychiatric care?  Yes  No When? \_\_\_\_\_ Why? \_\_\_\_\_
15. Have you had any recent blood work done?  Yes  No Where? \_\_\_\_\_
16. Is there anything else you think the doctor should know? \_\_\_\_\_  
\_\_\_\_\_
17. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:  
SURGICAL OPERATIONS (include where, when and why for each surgery): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
  
HOSPITALIZATIONS (include where, when and why for each admission): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**By signing below, I agree that the above information is complete and accurate to the best of my knowledge.**

\_\_\_\_\_  
Patient/Parent/Guardian Signature

\_\_\_\_\_  
Date

# Understanding Your Insurance Coverage

Your health insurance policy is an agreement between you and your insurance company. The policy lists a package of medical benefits such as tests, drugs and treatment services. The insurance company agrees to cover the cost of certain benefits listed in your policy. These are called “covered services.”

Your policy also lists the kinds of services that are not covered by your insurance company. You have to pay for any uncovered medical care that you receive. Keep in mind that a medical necessity is not the same as a medical benefit. A medical necessity is something that your doctor has decided is necessary. A medical benefit is something that your insurance plan has agreed to cover. In some cases, your doctor might decide that you need medical care that is not covered by your insurance policy.

Insurance companies determine what tests, drugs and services they will cover. These choices are based on their understanding of the kinds of medical care that most patients need. Your insurance company’s choices may mean that the test, drug or service you need isn’t covered by your policy.

There are so many different insurance plans that it’s not possible for your doctor to know the specific details of each plan. By understanding your insurance coverage, you can help your doctor recommend medical care that is covered in your plan.

- Take the time to read your insurance policy. It’s better to know what your insurance company will pay for **before** you receive a service, get tested or fill a prescription. Some kinds of care may have to be approved by your insurance company before your doctor can provide them.
- If you still have questions about your coverage, call your insurance company and ask a representative to explain it.
- Remember that your insurance company, **not your doctor**, makes decisions about what will be paid for and what will not.

Some of the things your doctor recommends will be covered by your plan, but some may not. When you have a test or treatment that isn’t covered, or you get a prescription filled for a drug that isn’t covered, your insurance company won’t pay the bill. This is often called “denying the claim.” You can still obtain the treatment your doctor recommended, but you will have to pay for it yourself. You are ultimately responsible for all costs associated with all medical care you seek.

If your insurance company denies your claim, you have the right to appeal (challenge) the decision. Before you decide to appeal, know your insurance company’s appeal process. This should be discussed in your plan handbook. Let your doctor know if this is something you may pursue, so that you can make payment arrangements with the doctor’s office in the mean time.