TEXAS SURGICAL ARTS

PATIENT INFORMATION **Today's Date_____**

Name: _____ Date of Birth: _____ Age: ____ Sex: ____

Address: _____

Cell Phone: _____ Home Phone: _____ E-mail: _____

Marital Status: Single Married Widowed Divorced Employed By: _____

Family Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

In Case of an Emergency, Contact: _____

Relationship to Patient: _____ Phone: _____

How were you referred to our practice? _____

Have you had any testing done recently? Yes No (*If Yes, please list name of test, date & place of service below*)

_____

What is the purpose of today's visit: Cosmetic Surgery Weight Loss Surgery General Surgery

_____

If here for weight loss surgery would you be interested in cosmetic surgery in the future? _____

MEDICAL HISTORY: (*Check all appropriate boxes that you currently have or have been diagnosed with in the past*)

Heart Attack / Heart Failure	Sleep Apnea	Hepatitis B / C
History of Heart Stent Placement	Musculoskeletal or Autoimmune conditions	HIV Positive
Diabetes – Non-Insulin	Pulmonary Embolism	Osteoarthritis
Diabetes – Insulin	Cirrhosis of the Liver	Reflux/GERD
High Blood Pressure	Taking Steroids (i.e. Prednisone)	Back Pain
High Cholesterol	Fatty Liver	Asthma
Blood Clots (i.e. Legs)	History of Stroke	Pregnancy

Other: _____

MEDICATIONS:

(*List all medications you are currently taking or provide a separate Medication list*)

_____

_____

_____

DRUG ALLERGIES:

_____

_____

_____

18211 Katy Freeway, Suite 250 Houston, TX 77094 Phone: 281. 579.5638 Fax: 281. 579.5636
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PAST SURGICAL HISTORY:

(*List all previous surgeries. If there is no history of surgeries, indicate 'no surgeries')*

Year:	Type of Surgery:	Complications: (*If any*)

FAMILY HISTORY: (*Check all appropriate boxes*)

Disease:	Relationship to Patient:
Cancer	
Diabetes	
Heart Disease	
Other (*Please write*)	

HEALTH HABITS: (*Check all appropriate boxes*)

Habit:	How often?
Caffeine & Type	
Tobacco	
Illegal Drugs	
Alcohol	

Have you ever had a blood transfusion?

No

Yes – *Approximate Date*: _____

REVIEW OF SYSTEMS: (*Check all appropriate boxes of symptoms you currently have*)

General	*Gastrointestinal*	*Eye, Ear, Nose, Throat*	*Genito-Urinary*
Chills	Rectal Bleeding	Bleeding Gums	Blood in Urine
Dizziness	Constipation	Double Vision	Frequent Urination
Fainting	Diarrhea	Earache Difficulties	Painful Urination
Fever	Nausea	Hay Fever	
Headache	Hemorrhoids	Hoarseness	

Muscle/Joint/Bone		*Cardiovascular*	*Skin*	***Women Only***:
Pain, Weakness or Numbness in:		Chest Pain	Bruise Easily	Last Menstrual Period:
Arms	Hips	Irregular Heart Beat	Hives	Pregnancies How many___
Back	Legs	Blood Clots	Itching	
Feet	Neck		Change in Moles	
Hands	Shoulders		Sores that do not heal	

To the best of my knowledge, the above information is complete and correct.
I understand it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Print Name | Date

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FINANCIAL POLICY

Welcome and thank you for choosing Texas Endosurgery for your healthcare needs. We strive to work hard to provide you with the best quality of care. If we are filing with your insurance carrier, you are responsible for **ANY** charges that your insurance carrier does not pay. We will verify your insurance and pre-certify procedures; however, **this does not guarantee payment for services**. Any dispute regarding unpaid claims must be addressed with your insurance carrier. It is **your** responsibility to contact your insurance carrier and resolve the problem.

Any past due balances, co-pays, and or co-insurance for office visits, treatment and surgery, are due **before services are rendered**.

We accept cash, money orders, or VISA/MASTERCARD/DEBIT. **NO personal checks will be accepted.**

There is a $25 charge for copies of medical records and/or any paperwork that needs to be filled out by Dr. Bonnor/staff such as, disability, FMLA, or any paperwork that you bring. Such paperwork will not be processed until after payment has been received. Paperwork can sometimes take up to 4-5 business days to complete. Payment can be made in person or over the phone using a credit card.

In the event that we need to reimburse you, you will be issued a check that will need to be picked up from our office. If your payment was made using a credit card, there will be a credit card processing fee that will be deducted from the amount refunded.

Failure to notify our office in advance to cancel or reschedule an appointment with Dr. Bonnor will result in the following fees:

$50.00 Fee will be processed if the appointment is missed or rescheduled without giving a 24 hour notice to our office.
$100.00 Fee will be processed if testing is scheduled with Dr. Bonnor (Endoscopy, Manometry, etc.) and the appointment is not cancelled or rescheduled within at least 2 weeks' notice in advance.
$250.00 Fee will be processed if surgery appointment is not cancelled or rescheduled at least 3 weeks' notice in advance

******These fees are non-refundable and are due before rescheduling and/or before any services are rendered.***

After Hours Calls:

After hours calls are for URGENT issues ONLY. Please do not call our physician after-hours to make appointments, discuss non-urgent issues that can wait for the next business hours. We reserve the right to bill you for any after hour call that we deem was unnecessary. We do not refill medications after hours. Please call in refill requests during business hours only.

Termination of Doctor-Patient relationship:

You as a patient can terminate your relationship with us at any time. We , as your physician, can also elect to terminate our relationship with you . Once our relationship has been terminated, we are no longer responsible for your care.

Texas State Law allows a doctor to terminate a relationship with a patient without giving a reason. However, we often have reasons when we exercise this right.

Examples of behaviors that can lead to termination of your care at our clinic includes, but not limited to:

1. Fraudulent activity
2. Abusive to our staff, physician, or other patients
3. Repeated missed appointments
4. Refusal to pay for services

I attest to all of the following information above.

_____ _____ _____

Print Name Signature Date

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TEXAS SURGICAL ARTS

PHOTO CONSENT

I hereby acknowledge that I have been advised that photographs and video will be taken of me or parts of my body before, during and after surgery. I hereby give my consent for Texas Surgical Arts to use the photographs/video under the following circumstances: Please initial ONLY ONE of the following selections:

WEBSITE & MEDIA _____

Photographs, electronic images and video footage taken of me or parts of my body as well as details regarding medical service I have received at Texas Surgical Arts may be used in any print or electronic media, including but not limited to our website, Facebook, Snapchat, Instagram, Real Self, and YouTube to inform the public about cosmetic surgery methods.

WEBSITE ONLY _____

Photographs, electronic images and video footage taken of me or parts of my body as well as details regarding medical services that I have received at Texas Surgical Arts, may be used only on our website in order to inform the public about cosmetic surgery methods.

MEDICAL ONLY _____

Photographs and electronic images taken of me or parts of my body can be solely used for the purpose of my medical care with Texas Surgical Arts. The photographs and electronic images and details regarding medical services rendered to me will be kept confidential in my medical file at Texas Surgical Arts

I acknowledge that I will not receive any compensation for the use of my representation and hereby release Texas Surgical Arts, Ricardo M. Bonnor, M.D., F.A.C.S. and the personnel from any and all claims which arise out of, or are in any way connected with such case.

I do further certify that I am of legal age and possess full legal capacity to execute the preceding authorization and release.

I have read this release before signing below, and fully understand the conditions of this release.

_____ _____ _____

Print Name Signature Date

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RELEASE OF MEDICAL INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____ Date of Birth: _____

Social Security #_____ Phone #: _____

I hereby authorize my doctor/medical provider to disclose any information needed by:

Texas Surgical Arts
18211 Katy Freeway, Suite 250 Houston, TX 77094
Phone: (281) 579-5638
Fax: (281) 579-5636

Please release the following:

___ALL MEDICAL RECORDS

___OTHER (*Please specify)*_____

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

____YES, I CONSENT TO THE RELEASE OF THIS INFORMATION

____NO, I DO NOT CONSENT TO THE RELASE OF THIS INFORMATION

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patients is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

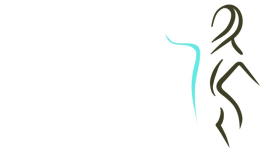
This authorization will expire 180 days from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure and the information, I can contact the office at (281)579-5638

I understand that Texas Surgical Arts may disclose with other doctors reason for medical records needed.

_____ _____

Signature of Patient or (Legal Representative) Date



AUTHORIZATION OF DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Texas Surgical Arts to disclose my protected health information (PHI) to my family member(s) and/or friend(s) for the purpose of information, treatment and healthcare.

I understand that this authorization is valid until the time if and when it is revoked in writing.

☐ YES

Name:	Phone Number(s):	Relationship to Patient:

☐ NO

I hereby authorize medical information to be discussed with me via: (Check all that may apply)

- ☐ Phone
- ☐ Email
- ☐ Leave on voicemail or answering service

_____ _____ _____

Print Name Signature Date

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