Hall Plastic Surgery & Rejuvenation Center, LLC

300 Beardsley Ln Bldg C Ste. 101
Austin, TX 78746
512-327-5337

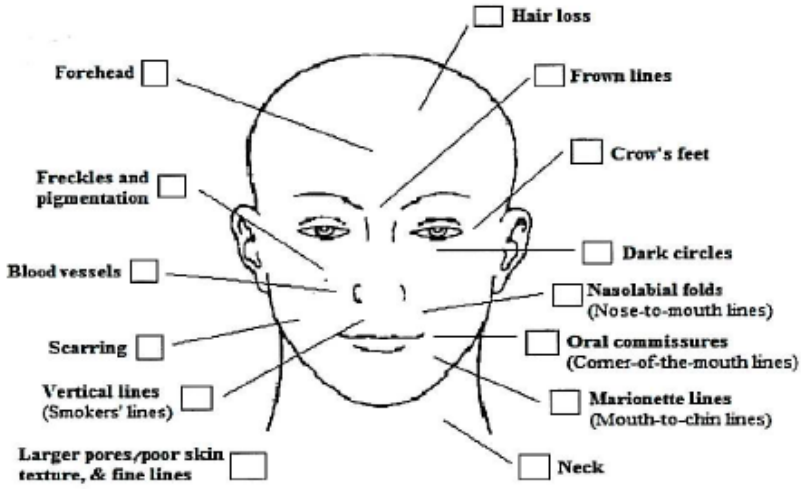
Patient Name: _____ Date of Birth: _____

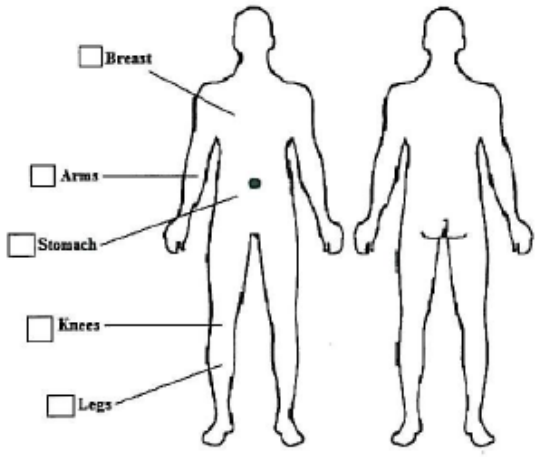
Skin Care Product History:

Please check and list brand names that apply:

	No	Yes	If yes, Please specify
Cleanser			
Eye Cream			
Mask			
Moisturizer			
Night Cream			
Retinol			
Sunscreen			
Toner			
Other			

Areas of Concern (Please check all that apply):





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Patient Registration Form

Last Name:_____ First Name:_____ M.I._____

Address:_____ Apt.#_____

City:_____ State:_____ Zip:_____

Home Phone:(___)_____ Work Phone:_____ Cell:_____

Which phone number would you like us to call for appointment confirmation?_____

By what name would you like to be addressed?: _____

E-mail address:_____ Driver's License#_____

Date of Birth:_____ Social Security Number:_____ Sex: M / F

Pharmacy location and phone number:_____Occupation:_____

Reason for consultation:_____ Referred by:_____

Please read each paragraph and initial that you have read and understand the information.

I understand that I will be charged $30.00 for any insufficient check written to Hall Plastic Surgery or Hall Rejuvenation Center.

I understand that Hall Plastic Surgery or Hall Rejuvenation Center has a 48 hour appointment cancellation policy. I understand that I will be charged $50.00 for any missed or cancelled appointment if less than a 48 hour notice is given.

I hereby state that all the facts or information, including pertinent facts concerning my past medical and surgical history, that have been furnished to the treatment provider during my preoperative evaluation are complete and correct. The treatment provider has explained, in terms clear to me, the effect and nature of the procedure(s) to be performed, foreseeable risks involved and alternative treatment methods. I know that the practices' of medicine, cosmetics and laser are not exact sciences and that reputable professionals cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the procedure(s), which I herein have requested and authorized. I have been advised that the goal of the procedure(s) that I have requested, have the possibility of imperfections which ensue and that the results may not live up to my expectations or to the goals that have been established.

I certify that the below information is correct to the best of my knowledge and I will not hold Jeffrey Hall, MD or his staff responsible for any errors or omissions that I have made on this form.

_____ _____
Patient Signature Date

_____ _____
Witness Date

Medical History:

Height: _____ft _____in Weight: _____lbs Age: _____ Blood Pressure: _____

Please Check All That Apply (**Current or Past**):

None		Eczema		Kidney Stones/Disease	
Abnormal Bleeding		Hair Loss/Age first noticed		Liver Disease	
Anemia		Heart Disease		Low Blood Pressure	
Asthma		Heart Murmer		Radiation Therapy	
Breast Cancer		Hernia		Skin Cancer	
Chest Pain/Tightness		High Blood Pressure		Skin Disease	
Cold Sores		HIV		Stroke	
Colitis		Hives		Thyroid Disorder	
Diabetes		Hypoglycemia		Tuberculosis	
Diverticulitis		Keloid/Thick Scarring		Ulcers	

Past Surgeries/Hospitalizations (if none, please write none):

	Surgery/Hospitalization	Date	Anesthesia Complications	Notes
None				
1				
2				
3				
4				
5				

Family History (please check all that apply):

	Check here if applicable	Family Member Affected	Notes
None			
Abnormal Bleeding			
Anesthesia Problems			
Breast Cancer			
Malignant Hyperthermia			

Please list all **drug allergies** (check none if none):

Name of Drug:	Reaction:
None	

Please list your **current medications** (check none if none):

Drug:	Dose:
None	

Hair Loss Treatments Used (check none if none):

Treatment:	Check if Yes	Length of time used:
None		
Rogaine/Propecia		
Laser Treatment		
Other		

Social History:

Do you drink alcohol or have a history of drinking alcohol?
_____No _____Yes If yes, please specify how much/often: _____

Do you use any illegal drugs or have a history of using illegal drugs?
_____No _____Yes If yes, please state what kind/how often:_____

Do you have any sexually transmitted diseases or have a history of sexually transmitted disesases?
_____No _____Yes If yes, please state which one(s):_____

Do you smoke cigarettes or cigars or have a history of smoking?
_____No _____Yes If yes, please specify how often/how long: _____

Wellness questions:

General:	Yes	If Yes, Please Specify
None		
Convulsions		
Depression		
Fainting/Dizziness		
Fatigue		
Fever/Chills		
Headache		
Insomnia		
Nervousness		
Sweats		

Genito-Urinary:	Yes	If Yes, Please Specify
None		
Frequent urination		
Incontinence		
Painful urination		
Prostate trouble		

Gastrointestinal:	Yes	If Yes, Please Specify
None		
Constant hunger		
Constipation		
Diarrhea		
Gas/bloating		
Hemorrhoids		
Lack of appetite		
Pain over lower stomach/abdomen		
Vomitting/nausea		

What is your bowel movement pattern? ___times per___day/week

Eyes, Ears, Nose, Throat:	Yes	If Yes, Please Specify
None		
Ear ache		
Nose bleeds		
Sore throat		
Swollen glands		
Vision change		
Muscle, Bone, Joint		
None		
Lower back ache		
Pain in joints		
Respiratory:		
None		
Chest pain		
Chronic cough		
Difficulty breathing		
Spitting up phlegm		

Women's Health:	Yes	If Yes, Please Specify
None		
Hot flashes		
Menopause		
Painful periods		
Pregnant		
Births		
Miscarriages/Abortions		

Patient Photographic Authorization and Release

By signing below, I, _____, authorize Dr. Hall and/or Hall Plastic Surgery & Rejuvenation Center, and/or his/their representative(s), to take photographs, slides or videotapes of me or parts of my body showing before and after results of procedure(s). In addition, I authorize the use of these images, without compensation to me, to be used in the office, for office seminars, on websites owned by or operated on behalf of Hall Plastic Surgery & Rejuvenation Center for prospective patients, in print advertisements, medical presentation, articles, and on television. (This acknowledgement does not pertain to photographs, slides, or videotapes required for medical charts and/or records.)

I understand that:

1. Such photographs, slides or videotapes may be published by Dr. Hall and/or Hall Plastic Surgery & Rejuvenation Center in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that such uses may also include marketing on the behalf of Dr. Hall, for which Dr. Hall may receive direct or indirect remuneration.
2. I will not be identified by name in any of the media described above; however, I also understand that in some circumstances the photographs, slides or videotapes may display features that identify me.
3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to Tricia Hall (Privacy Officer). A revocation shall not affect any release of information made prior to revocation in reliance upon this authorization.
4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Hall and/or Hall Plastic Surgery & Rejuvenation Center.
5. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Information Portabiity and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.
6. A copy of this Authorization is valid as the original. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

I release and discharge Dr. Hall and/or Hall Plastic Surgery & Rejuvenation Center from all **photographic liability**, including **photographic liability** for negligence, that in any way arises out of:

any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization; and

any claim that I may have had relating to such use and disclosure of those photographs, slides or video tapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public education and I certify that I have read this Authorization and Release carefully and fully understand its terms.

[ ] Patient is a minor, _____ years of age, and we, the undersigned, are the parents or guardian of the patient and do hereby consent for the patient.

Signature: _____ Date: _____

Printed Name: _____

[ ] Decline to give consent, please initial.

HALL
PLASTIC SURGERY
& REJUVENATION
CENTER

Financial Policy

Consultation/Office Visits

(please initial after reading)

_____ If your office visit or consultation is covered by insurance, we will gladly prepare and file your claim with any participating insurance carrier. As our contracts with these carriers require, we will be collecting your specialist co-pay for this visit.

Surgery/Office Procedures

_____ All surgeries and procedures will be authorized through your insurance company. We will contact your insurance carrier, check your specific benefits and we will inform you of any out of pocket expenses. Any deductible and/or co-insurance will be due prior to any surgery or office procedure being performed.

_____ A cosmetic surgery deposit of $200 will be required at surgery scheduling. This deposit will be refunded to you unless you decide to cancel your surgery less than 72 hours before and not reschedule within 30 days.

_____ Full payment for cosmetic surgeries and procedures will be due 2 weeks prior to surgery date.

_____ We will keep you informed of any outstanding balances not covered via monthly statements. Any balance not paid by 60 days will be forwarded to our collections agency. In case of default of payment, you will be responsible for any collections cost or reasonable attorney fees incurred to satisfy this account.

_____ I understand that I will be charged $30.00 for any non-sufficient funds checks.

Referrals

_____ If your insurance plan requires a referral, it is your responsibility to have a valid referral on file at the time of service. Any visits not covered due to an expired referral or lack of a referral will be your responsibility.

Medical Records

_____ I authorize the release of all medical information necessary to process any claims pertinent to my medical care. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all insurance benefits directly to my physician, on my behalf.

_____ I have read the above policies and agree to them.

_____ _____

Signature Date