Wesley T. Myers, M.D., P.A.
ABPS Certified
Plastic & Reconstructive Surgery
100 Medical Center Blvd., Suite 213
Conroe, TX 77304
Ph: 936-539-8115 Fx: 936-539-8118

PATIENT INFORMATION

Name (Last, First, Middle)_____ DOB_____ SS#_____

Address_____ City, State, Zip _____

Home Phone_____ Work Phone_____ Cell Phone_____

Email address_____

Primary Employer_____

Address_____ City, State, Zip_____

Phone Number_____

Referring Physician_____ Phone_____

Address_____City, State, Zip_____

RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)

Name (Last, First, Middle)_____DOB_____ SS#_____

Address_____ City, State, Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Relationship to Patient_____

Signature of Patient/Guardian_____ **Date**_____

PLEASE PRINT

Patient Name_____

DOB_____

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Referred By _____

Primary Dr._____

Medications/Vitamins/Supplements:

_____ _____

_____ _____

_____ _____

_____ _____

Medication Allergies: _____

Pharmacy Name: Pharmacy Ph#:

Please circle Y or N for all that apply:

Y	N	Heart Attack	Y	N	Diabetes
Y	N	Angina			
Y	N	Heart Stents	Y	N	Arthritis
Y	N	Atrial Fib	Y	N	Jaundice
Y	N	Irregular Heart Beat			
Y	N	Hepatitis			
Y	N	Lupus	Y	N	Stroke
Y	N	Thyroid Problem			
Y	N	High Blood Pressure	Y	N	Kidney Problem
Y	N	Emphysema	Y	N	Crohn's Disease
Y	N	Asthma	Y	N	Diverticulosis
Y	N	Tuberculosis			
			Y	N	Skin Cancer
Y	N	Seizures	Y	N	Melanoma
Y	N	Epilepsy			
Y	N	Breast Cancer	Y	N	Other Cancer

Surgical operations and dates: _____

_____

_____

_____

Do you smoke? YES____ NO____ How much?_____ How long?_____
Do you drink alcohol? YES____ NO____ How much?_____ How long?_____
Recreational Drug Use? YES____ NO____

X _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN IF MINOR CHILD *DATE*

FOR PATIENT TO COMPLETE

PLEASE PRINT

Patient Name _____

DOB _____

Constitutional	Yes	No
Chills		
Fatigue		
Fever		
Malaise		
Weight gain		
Weight loss		

HEENT	Yes	No
Ear pain		
Eye discharge		
Eye pain		
Hearing loss		
Nasal drainage		
Sinus pressure		
Sore throat		
Visual changes		

Respiratory	Yes	No
Cough		
Shortness of breath		
Wheezing		

Cardiovascular	Yes	No
Chest pain		
Leg pain		
Swelling		
Irregular heart beat		

Genitourinary	Yes	No
Dribbling		
Frequent urination		
Blood in urine		
Increased amount		

GastroIntestinal	Yes	No
Abdominal pain		
Blood in stools		
Change in stools		
Constipation		
Diarrhea		
Heartburn		
Nausea		
Vomiting		

Metabolic/Endocrine	Yes	No
Cold intolerance		
Hair changes		
Heat intolerance		
Always thirsty		
Always hungry		

Neurological	Yes	No
Dizziness		
Extremity numbness		
Extremity weakness		
Problems walking		
Headache		
Memory loss		
Seizures		
Tremors		

Immunologic	Yes	No
Environmental allergies		
Food allergies		
Seasonal allergies		

Integumentary	Yes	No
Contact allergy		
Hives		
Itching		
Mole changes		
Rash		
Skin lesion		

Musculoskeletal	Yes	No
Back pain		
Joint pain		
Joint swelling		
Muscle weakness		
Neck pain		

Hematologic/Lymphatic	Yes	No
Easy bleeding		
Easy bruising		

Reproductive (female)	Yes	No
Abnormal pap		
Breast discharge		
Breast lump		
Dysmenorrhea		
Dyspareunia		
Hot flashes		
Irregular menses		
Vaginal discharge		

Reproductive (male)	Yes	No
Erectile dysfunction		
Penile discharge		
Sexual dysfunction		

Psychiatric	Yes	No
Anxiety		
Depression		
Insomnia		

PLEASE PRINT

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PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVE(S)

I, _____, give my authorization to release my protected health information including results of my laboratory tests, x-ray and/or other test results to the following designated representative(s):

Patient Initials

_____ My spouse (Name) _____

_____ My child (Name) _____

_____ Other (Name) _____

_____ Personal Representative _____

_____ May be left on my answering machine at home.

_____ May be left on my answering machine at work.

_____ MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF.

_____ _____
Patient Signature Date

_____ _____
Witness Date

As a patient, you have the right to revoke this authorization in writing at anytime, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, must receive the revocation in writing. The revocation must include, 1) the patient's name, address, and date of birth, 2) the patient's desire to revoke the authorization, and 3) the date of the revocation and the patient's signature.

PLEASE PRINT

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DOB_____

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AUTHORIZATION FOR RELEASE OF PATIENT PHOTOGRAPH

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the members of the Wesley T. Myers, M.D. P.A. medical staff. I hereby give my consent for Wesley T. Myers, M.D. P.A. to use the photographs under one of the following circumstances.
Please initial one of the following:

_____ **Internet:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Wesley T. Myers, M.D. P.A., can be used on the company's website in order to inform the public about plastic surgery methods. Further, I release and discharge Wesley T. Myers, M.D. P.A., any employees of Wesley T. Myers, M.D. P.A., and the American Society of Plastic Surgeons; and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name or any other identifying marks at any time during any use or publication of these materials by any party.

_____ **All Media:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Wesley T. Myers, M.D. P.A., can be used in any print or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet, and television, in order to inform the public about plastic surgery methods. Further, I release and discharge Wesley T. Myers, M.D. P.A., any employees of Wesley T. Myers, M.D. P.A., and the American Society of Plastic Surgeons; and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

_____ **Medical Care Only:** Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Wesley T. Myers, M.D. P.A. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Wesley T. Myers, M.D. P.A.

_____ _____
Signature Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of _____, a minor. I am authorized to sign this authorization oh his/her behalf and I give this authorization as voluntary contribution in the interest of public education.

_____ _____
Signature Date

_____ _____
Witness Date

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Patient Name: Date :	**What is your reason for your visit today?**

Other than the services we have already provided for you, what additional needs or concerns would you like to be addressed today? Please check all that apply

❑ Skin care advice	❑ Facial veins	❑ Neck wrinkles
❑ Skin care products	❑ Facial redness	❑ Breast size
❑ Injectable Treatments	❑ Brown spots/age spots/freckle	❑ Abdominal area
❑ Juvederm	❑ Drooping brow	❑ Hips
❑ Facial fine lines/wrinkles	❑ Drooping eyelids	❑ Legs
❑ Thin lips	❑ Nose size or shape	❑ Facial Contouring
❑ Blotchy skin	❑ Facial fullness/drooping	❑ Body Contouring
❑ Chemical peel	❑ Mole removal	❑ Unwanted Hair
❑ Make up	❑ Scar revision	❑ Length/Fullness of Eyelashes

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

How did you hear about us?

❑ My physician	*Full name:*
❑ My insurance company provider	*Name:*
❑ The yellow pages	*Specify Ad:*
❑ A friend or family member	*Name:*
❑ Internet	
❑ The Physician/Practice website	
❑ Seminar	*Date/location:*
❑ Other	

❑ Approval to contact you.	*Best phone number to reach you:*
❑ Approval to send you information on products and services (including special offers)	*Email address:*

❑ *I'm not interested in any additional services provided at this time*

↓ For Staff Use Only ↓

Physician / provider : Myers

Follow-up	*Date*	*Completed by (name)*
❑ Initial Inquiry/Information Given		
❑ Contact in future – give date		
❑ Products		
❑ Free consultation		
❑ Procedure scheduled		
❑ Procedure completed		

Comments

PLEASE PRINT

Patient Name_____

DOB_____

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CONSENT FOR TREATMENT

I voluntarily give my permission to Dr. Wesley T. Myers, M.D. P.A. and such assistants as they may deem necessary to provide medical care services to me. I understand that by signing this form, I am authorizing them to treat me as long as I seek care from Wesley T. Myers, M.D. P.A., or until I withdraw my consent.

_____

Signature of Patient or Guardian Date

_____

Printed Name of Patient or Guardian Relationship to Patient

_____

Witness Signature Date

A duplicate or faxed copy of this form is considered the same as the original document.

WESLEY T. MYERS, MD PA
NOTICE OF PRIVACY PRACTICES

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

_____

Patient Name: _____
(Please Print Name)

Patient Date of Birth: _____

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional) : ___Date:_____

Patient Copy – Yours to Keep

Wesley T. Myers, M.D. P.A.

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Payment Policy

It is the payment policy of Wesley T. Myers, MD PA to collect the appropriate payment due from the patient at the time the service is rendered. This may only be your ***co-payment*** or ***"co-pay," deductible,*** and/or ***co-insurance*** according to your health insurance company benefit plan, but we do ask for payment at the time of your visit.

Patient Medical Billing Process

The office staff at Wesley T. Myers, MD PA, as a courtesy to you, will submit a medical bill to your ***primary health insurance company*** for processing. It is important to give updated information to the office staff, since your complete and current information is necessary to submit an accurate ***claim form*** to your health insurance company. The remaining claim will be sent to a ***secondary health insurance company***, if provided, after payment is received by the primary health insurance company.

Our billing company will mail to you a ***bill/invoice/statement*** that contains the total cost of your service(s) and/or procedure(s) received during your office visit. ***The health insurance company payment will be deducted from the bill when it is received***.

You are responsible for any outstanding balance, such as ***non-covered charges*** as outlined in your health insurance policy.

For questions regarding your health insurance policy, please contact your health insurance representative.

For questions about your bill, please call Waterway Management at 281-292-7411.

Wesley T. Myers, MD

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Patient Consent for Use of Credit Cards, Debit Card, and Financing

It may become necessary to release your information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.

Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Wesley T. Myers, MD PA to use and disclose my information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment as a waiver to the Health Insurance Portability and Accountability Act (HIPAA). I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.

_____

Signature of Patient or Legal Guardian

_____

Print Patient's Name Date

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Conroe, TX 77304

Advance Beneficiary Notice of Noncoverage

Patient's Name_____ DOB_____

Insurance Company_____

There is a possibility that the above named insurance may not pay for the surgery/services. Your plan may not pay for all of your health care costs. The fact that your plan may not pay for a particular services does not mean that you should not receive them. There may be a good reason your doctor has recommended it.

The purpose of this form is to help you make an informed choice, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

Please circle **YES** or **NO** below to signify your choice

Please sign and date this form below to attest your choice

- **YES**, I want to receive these services
  I understand that my plan may not pay for services rendered. Please submit my claim to my plan. I understand that you may bill me for these services and that I may have to pay the bill while my plan is making its decision. **If my plan denies payment, I agree to be personally and fully responsible for payment**. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal my plan's decision.
- **NO**, I have decided not to receive these services
  I will not receive these services. I understand that you will not be able to submit a claim to my plan and that I will not be able to appeal your opinion that my plan won't pay.

_____

Patient Signature **Date**