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

*Indicates Required Fields

PATIENT INFORMATION

*** Last Name:** _____ ***First Name**_____ **Middle Initial:** ____

***Date of Birth:** ___/___/_____ **SSN**_____-____-_____ ***Gender:** ☐ Male ☐ Female

***Marital Status:** _____ ***Email:**_____

***Street Address:**_____ **Apt#:**_____

***City:** _____ ***State:**_____ ***Zip:**_____

***Home Phone:** (____)_____-_____ ***Cell Phone:** (____)_____-_____ **Preferred:** ☐Home ☐Cell

Employer Name:_____ **Work Phone:** (____)_____-_____ **Ex** _____

***Referring Doctor:** _____ *** Primary Care Doctor:** _____

***Phone #:** (____) _____-_____ ***Phone #:** (____) _____-_____

Emergency Contact

***Full Name** _____ ***Relation:**_____

***Primary Contact Ph #:** (____) _____-_____ ***Secondary Contact Ph #:** (____)_____-_____

Preferred Pharmacy

***Pharmacy Name:** _____ ***Phone #:** (____) _____-_____ **Address:**_____

The above information is complete and accurate to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. If any changes occur I understand it is my responsibility to advise the office. I understand that I am financially responsible for any balance. I also authorize Myers Plastic Surgery or insurance company to release any information required to process my claims.

***Print Patient Full Name:**_____ ***Date:**_____

***Patient or Legal Guardian Signature:**_____

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Patient Name_____ Referred by_____

DOB_____ Primary Dr._____

Medication/Vitamins/Supplements:

_____ _____

_____ _____

_____ _____

_____ _____

Medication Allergies:_____

Pharmacy Name:_____

Please circle Y or N for all that apply

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

PLEASE PRINT Patient Name_____ DOB _____

FOR PATIENT TO COMPLETE

CONSTITUTIONAL	Yes	No
Chills	____	____
Fatigue	____	____
Fever	____	____
Malaise	____	____
Weight gain	____	____
Weight loss	____	____
HEENT		
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	**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	____	____
Seasonal allergies	____	____

INTEGUMENTARY	Yes	No
Contact allergies	____	____
Hives	____	____
Itching	____	____
Mole changes	____	____
Rash	____	____
Skin lesion	____	____
MUSCULOSKELETAL	**Yes**	**No**
Back pain	____	____
Joint pain	____	____
Joint swelling	____	____
Muscle weakness	____	____
Neck pain	____	____
HEMATOLOGIC	**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	____	____

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Authorization to Release Information

PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVE(S)

I, _____, give my authorization to **release**
(**Patient/Legal Guardian Full Name)**
my protected health information including results of my laboratory tests, X-rays, and/or other test results to the following designated representative(s).

***Patient/Guardian Initials**

_____ My Spouse (Name) _____

_____ My Child (Name)_____

_____ Other (Name)_____

_____ Personal Representative_____

_____ May leave a **detailed message** on answering machine at home.

_____ May be left on my answering machine at work.

_____ May leave a **detailed message** on my cell #_____

_____ **MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF**

***Print Patients Full Name:**_____

***Patient or Legal Signature:**_____**Date:**_____

As a patient, you have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance in this authorization or, it application, during contestability period. In order for the revocation of this authorization to be effective, this office must receive revocation in writing, The revocation must include, 1. The patient's name, address, DOB, 2. The patient/legal guardian desire to revoke the authorization, 3. The date of the revocation and the patient/legal guardians signature. All revocations must be sent in writing to our office and will not be considered effective until receive by our office.

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PLEASE PRINT
Patient Name_____ DOB_____

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:

_____ **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.

_____**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 or any other identifying marks at any time during any use or publication of these materials by any party.

_____ _____
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 on 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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PLEASE PRINT
Patient Name_____ DOB_____

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 Dr. 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** Date

_____ _____
Witness Date

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

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NOTICE OF PRIVACY PRACTICE

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:

_____

_____

_____

_____

_____

_____ _____

Print Patient Name Date of Birth

_____ _____

Patient/Legal Guardian Signature Date

If Legal Representative, relationship to Patient:_____

_____ _____

Witness (optional) Date

MYERS PLASTIC SURGERY

Patient Copy – Yours to Keep

Wesley T. Myers, M.D. P.A.
PLASTIC & RECONSTRUCTIVE SURGERY
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PH – 936-539-8115 FAX – 936-539-8118

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 ***copayment*** 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 department will mail 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.

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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 payment.

Services that are performed that are paid with a credit card, debit card, or financing third-party are eligible for payment challenge after services are provided. By signing this form, I am irrevocably consenting to allow
Wesley T. Myers M.D.P.A. 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 care 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

_____ Date _____
Print Patient's Name

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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**

APPOINTMENT CANCELLATIONS

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Wesley T. Myers, MD is committed to providing quality care. Unfortunately, when one patient cancels without giving notice, they prevent another patient from being seen. Please call us at 936-539-8115 by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday. If you call after hours, leave a message.

* If prior notification is not given, you will be charged $50 for the missed appointment or $100 for a missed surgical procedure.

Please sign and date below to consent to these terms.

_____ _____

Signature Date