Mark A. Deuber, MD PA

Patient Information

Patient Name: _____
Last First Middle

Address: _____
Number Street Apt. City State Zip

Home Telephone: _____ Cell: _____

Email Address: _____

Date of Birth: _____ Age: _____ SS # _____

Sex: □ Female □ Male Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

Employer: _____

Business Address: _____
Number Street Suite No. City State Zip

Referral Source: _____

Reason for visit: _____

Spouse's Name: _____
Last First Middle

Occupation: _____

Employer: _____

Business Address: _____
Number Street Suite No. City State Zip

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including private insurance and any other health plans to Dr. Deuber. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize said assignee to release all information necessary to secure payment.

_____ _____
Signature Date

Mark A. Deuber, MD PA
Acknowledgement of Review of
Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Patient or Responsible Party (Please Print)

_____

Patient or Responsible Party (Please Sign)

_____

Date

Mark A. Deuber, MD PA

Medial History Questionnaire

Past Medical History

Do you or have you had:	Y	N		Y	N
Prolonged bleeding when cut	□	□	Fainting or blackout episodes	□	□
High blood pressure	□	□	Ulcer disease	□	□
Heart disease or attack	□	□	Hepatitis	□	□
Heart murmur or disorder	□	□	Blood transfusion	□	□
Chest pain or shortness of breath	□	□	Reactions to blood transfusion	□	□
Excessive or unsatisfactory scar Formation	□	□	Other significant illness If so please describe _____	□	□
Aspirin intake in the past two weeks (avoid two weeks prior to surgery)	□	□			

Previous operations: Date

_____ _____

_____ _____

Please list any medications you are allergic to: Reaction

_____ _____

_____ _____

Please list ALL medications you are currently taking (including dosage and frequency):

_____ _____ _____

_____ _____ _____

Personal/regular physician:

Name: _____ Specialty: _____

Family History

Is there a history of the following in your immediate family? If so, please list the family member beside the disease.

		Y	N			Y	N
High blood pressure	_____	□	□	Heart disease	_____	□	□
Diabetes	_____	□	□	Cancer	_____	□	□
Hepatitis	_____	□	□	Type	_____	□	□
Stroke	_____	□	□				

Personal History

Occupation: _____

Do you smoke? □ No □ Yes _____ packs per day

Do you drink alcohol? □ No □ Occasionally □ Regularly _____ per day

Do you use any other drugs or medications not listed above? □ No □ Yes If yes, please list: _____

Mark A. Deuber, MD PA

Media Release

I understand that there may be photo(s) and/or video(s) (the "content') taken at the office of Mark A. Deuber, MD and/or Lemmon Avenue Plastic Surgery and Laser Center, located at 2801 Lemmon Ave W Dallas, TX 75204 (the "property).

I further understand that such content represents protected health information under federal HIPAA privacy regulations and may feature identifiable photographic, video and/or audio images of me including but not limited to: while on the property, while communicating with staff employed by Dr. Deuber, while communicating with Dr. Deuber, while Dr. Deuber/staff is examining me and I am clothed, while Dr. Deuber/staff is examining me and I am disrobed, while Dr. Deuber/staff is performing surgery and/or other treatments on me.

I hereby authorize Dr. Mark A. Deuber to use and disclose the above described protected health information for the following purposes:

The person or class of persons to whom the information will be disclosed to or who will use the information is: prospective patients or others by way of our website and/or social media outlets including, but not limited to: Facebook, Twitter, Instagram, and Snapchat. The practice is hereby authorized to make the disclosure to these classes of persons and the aforementioned classes of persons are hereby authorized to further use and disclose the information.

This authorization shall be in force and effective until the following event and/or date: NONE. I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice. I further understand that a revocation IS NOT effective to the extent that the practice has relied on this prior authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used to disclose pursuant to this authorization may be subject to redisclosure by other recipient(s), media outlet(s), social media platform(s) and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for this requested use or disclosure.

I acknowledge that Dr. Deuber may rely on this release at substantial cost and agree not to assert any claims—including without limitation, claims alleging libel, slander, or violations of my rights of privacy or publicity—against Dr. Deuber or any of his staff arising out of my appearance in the video/photos.

_____

Name (Please Print)

_____

Name (Please Sign)

_____

Date

Mark A. Deuber, MD PA

Information Regarding Our Financial Policies

Scheduling:

When you schedule your surgery, we are committing a large block of Dr. Deuber's time and the time of 8-10 additional personnel at the surgical facility.

For cosmetic surgery, a deposit of 10% of the surgeon's fee must be paid to reserve a surgery date.

Your scheduling deposit is nonrefundable unless Dr. Deuber deems change or cancellation is medically necessary.

Your deposit will be applied to the total surgical fee. For cosmetic procedures, your total surgical fee is due two weeks prior to your surgery date. *This fee is nonrefundable unless Dr. Deuber cannot perform your operation, it is medically necessary, or there are unavoidable circumstances.*

When scheduling energy based modality procedures a deposit is required to hold your procedure time as we are dedicating a large block of time to your care and additional personnel.

This deposit is nonrefundable, but may be credited towards other procedures or services.

Insurance Information:

If your surgery is deemed not medically necessary, it is considered cosmetic in nature and will not be reimbursed by insurance companies or other third party payors.

Any balance remaining on your account after reimbursement by your insurance company is immediately due and payable personally by you.

We will make every effort to accommodate your needs and wishes concerning scheduling, but must adhere to the above policies to assure prompt, courteous use of other patients', personnel, and Dr. Deuber's time.

Acknowledgment:

I have read and understand the financial policies above.

I understand that any scheduling deposit paid by me is nonrefundable for any reason other than Dr. Deuber deeming it medically necessary.

I understand that I am fully responsible for all surgical fees for surgery deemed nonmedically necessary.

For reconstructive surgery, I agree to personally pay any balance remaining on my account after reimbursement by my insurance company.

_____ _____

Patient Signature Date

LEMMON AVENUE
PLASTIC SURGERY & LASER CENTER

Corona Virus Screening Assessment and Safety Measures

Within the past 2 weeks have you…

been on an airplane?	□ yes □ no
travelled outside of Texas?	□ yes □ no
had contact with known COVID-19 patient?	□ yes □ no
had fever, chills, sore throat, cough?	□ yes □ no
Have you been practicing social distancing?	□ yes □ no
Have you been tested for the coronavirus?	□ yes □ no
What was the result?	□ negative □ positive

Do your part:

Complete this form and all paperwork ***prior*** to your arrival for your appointment. Please email these forms to **Shannon@drdeuber.com**

Please arrive ***on time*** for your appointment; if you arrive early or late, please wait in your car and contact the practice to alert us of your status. We will work you in when safely possible.

Please arrive wearing a mask that you ***bring from home***. You ***may not*** be admitted for service if you do not have a mask.

Please ***do not*** bring unnecessary companions to your procedure/service. (children will not be allowed to accompany you into our facility). Surgery/laser patients may bring a companion to receive aftercare instructions and to have a ride home; We will ask that your companion please wait off-site while you are being treated.

Upon your arrival you will undergo a temperature scan by our staff. If your temperature exceeds 99.6 degrees F, you ***will not*** be permitted to enter our facility.

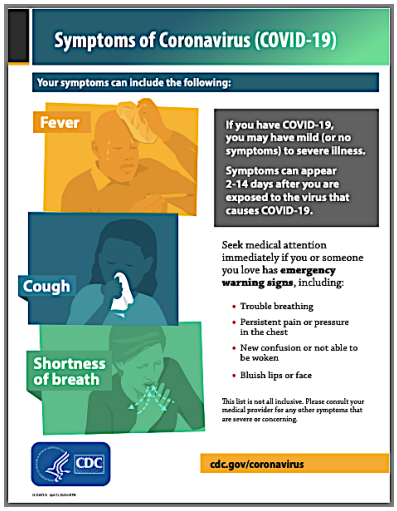
Thank you for adhering to these instructions during this challenging time.

COVID-19 INFORMED CONSENT AGREEMENT

☐ I, the undersigned patient, consent to have Dr Deuber and/or his/her staff (hereinafter collectively "my Doctor") perform medical procedures, whether regarded as necessary, elective or aesthetic, during the time of the COVID-19 pandemic and after. I understand having my procedure performed at this time, despite my own efforts and those of my Doctor, may increase the risk of my exposure to COVID-19. I am aware that exposure to COVID-19 can result in severe illness, intensive therapies, extended intubation and/or ventilator support, life-altering changes to my health, and even death. I am also aware of the possibility that the procedure itself, whether performed in my Doctor's office or in a hospital, may result in a more severe case of COVID-19 than I might have had without the procedure.

☐ I also understand having my procedure performed at this time increases the risk of my transmission of COVID-19 to my Doctor. This virus has a long incubation period, there may be as yet unknown aspects of its transmission, and I realize that I may be contagious, whether or not I have been tested or have symptoms. To reduce the possibility of COVID-19 exposure or transmission at my Doctor's office, I accept that my Doctor will implement infection-control procedures with which I must comply, before, during and after my procedure, for my own protection as well as that of my Doctor. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures to be necessary.

☐ I have informed my Doctor of any COVID-19 testing I or any person living with me during the past 14 days has received, as well as the results of that testing, and if I am tested between now and the date of my procedure, I will immediately provide the results of that testing to my Doctor. I understand my Doctor may require that I be tested, possibly at my own expense and regardless of any prior testing, and that the results of that testing must be satisfactory to my Doctor, before I may receive my procedure.



☐ I confirm neither I nor any individual living with me has any of the COVID-19 symptoms listed by the Centers for Disease Control https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf, which website I have consulted; neither I nor any individual living with me during the past 14 days has experienced any such symptoms; and that I and all persons living with me for the past 14 days have practiced all personal hygiene, social distancing and other COVID-19 recommendations contained within all governmental orders issued by my city and state. I understand I must honestly disclose this information to avoid putting myself and others at risk.

☐ All topics above have been discussed with me, and all my questions have been answered to my satisfaction. Being fully informed, I accept the risk of COVID-19 exposure and I will bear the cost of any COVID-19 treatments required. I have been given the opportunity to postpone my procedure until the COVID-19 pandemic is less prevalent, but I choose to have my procedure performed now. If I am the parent, guardian or conservator of the patient, I hold his/her health care power of attorney. I have read this COVID-19 Informed Consent Agreement and am authorized to consent on the patient's behalf.

☐ _____ _____

Patient/Authorized Representative Signature and Initials Print Name & Date **[First encounter]**

☐ _____ _____

Patient/Authorized Representative Signature and Initials Print Name & Date **[Day of procedure]**