Jason R. Bailey M.D., P.A.
5600 Kirby Drive Suite M
West University Place, TX 77005
713-360-6857

Patient Name _____ ☐ F ☐ M **Date** _____

Date of Birth _____ **SSN** _____

Address _____ **City** _____

State _____ **ZIP** _____ **E-Mail** _____

Home Telephone _____ _____ **may contact me** _____ **may leave a message**

Office Telephone _____ _____ **may contact me** _____ **may leave a message**

Mobile Telephone _____ _____ **may contact me** _____ **may leave a message**

Pharmacy Information _____

Are you currently employed? ☐ **YES** ☐ **NO** ☐ **RETIRED**

Type of work you do or did _____

Current Employer _____

Work Address _____ **Work Phone Number** _____

Insurance ☐ **Medicare** ☐ **Medicaid** ☐ **Commercial** ☐ **Other** _____

	Primary Insurance	**Secondary Insurance**
Name		
Address		
Phone Number		
Group Number		
Policy Number		

Condition/Goals:

I am here today because I: _____

My goals for plastic surgery include: _____

I would describe the present condition(s) I wish to improve as: _____

Personal Habits:

Tobacco?_____How many packs per day?_____Smoked how many years?_____

Have you quit smoking?_____If so, When did you quit? _____

Do you currently drink alcohol?_____Beer?_____Whiskey?_____When? _____

How Much Coffee do you drink per day? _____

Do you use any recreational drugs?_____What? _____

Health History:

I am ALLERGIC TO THE FOLLOWING MEDICATIONS: _____

I have the following additional ALLERGIES: _____

I have had the following SURGERIES: _____

I am presently under a DOCTOR'S CARE for the following conditions: _____

I have the following MEDICAL CONDITIONS: _____

I would describe my PRESENT STATE OF HEALTH as: _____

I take the following medications, hormonal supplements, vitamins, herbal supplements: _____

_____

Background

I was referred to Dr. Jason R Bailey M.D. by (name and relation):

_____

Whom may we contact in an emergency?

Name: _____ **Relationship:** _____

Telephone: _____ **Mobile:** _____

Address: _____

NOTICE OF PRIVACY PRACTICES for Our Office

Your medical record is called Protected Health Information (PHI) under Federal Law 104-191 –The Health Insurance & Accountability Act of 1996 (HIPAA-1996, http://www.hhs.gov/ocr/hipaa/). We are required by law as of March 1, 2003, to notify you of your privacy rights, and will post any changes to these rights in the office. You may receive a copy of the Notice of Privacy Practices upon request.

Use of Protected Health Information with your authorization
By signing the authorization you agree that your PHI may be used or disclosed by our office staff for the purpose of treatment, payment, healthcare operations)TPO), or judicial proceedings and that we call you by name in our waiting room. You also may have authorized a release of your PHI by a written statement from your employer, attorney, or insurance carrier. Your PHI may be required for our business records, our computer/billing system, pharmacies, other physicians, laboratories, your employer, or therapists before they will process our request for TPO. You may revoke any authorization, provided we receive the request in writing.
What we mean by:

Treatment – other treating personnel, pharmacies, testing facilities.
Payment – for billing and electronic records, your diagnosis and treatment are disclosed.
Healthcare operations – compliance audits, public health, office administration or contractual requests.
Judicial proceedings – any court orders, subpoenas, legal audits, or lawful demand.

Use of you Protected Health Information without your authorization
Your PHI may be disclosed as required by law, for public health activities, victims of abuse, health and oversight proceedings, law enforcement, judicial and administrative proceedings, funeral homes, research purposes or specialized governmental functions. In such cases we will release information only if we have received a written request with documentation that the PHI disclosed in expressly authorized by the order.
What we mean by:

Law – if the law requires, we will notify you of such disclosure.
Public health activities – FDA, communicable disease, work related injury, instances of abuse or neglect.
Health and oversight – a legal oversight agency for any investigation in which you are <u>not</u> involved.
Law enforcement – properly issued subpoena, warrant, court order, or legal summons.

Disclosure of Protected Health Information requiring your authorization
This office does not engage in fundraising, e-mail, faxing information unless you request it in writing. We will not disclose your PHI to family members, personal representatives or guardians unless you request it. In an emergency we may disclose only relevant information if in our professional judgment it is in your best interest. You may request we modify or do not disclose any or part of your PHI in order to carry out treatment, payment or healthcare operations. This right to restrict does not extend to disclosures as required by law.

You may inspect or request a copy of your PHI (in writing) to be sent to you or an alternative location or by alternative means. Dr Jason R. Bailey has the right to charge a fee for cost or supplies, labor costs, postage and if you agree, the cost of preparing a summary explanation of the records. The records shall be sent within 30 days from receipt of the written request and we will notify you if it will take longer than 30 days.

I authorize the following people to have access to my PHI, and any and all of my medical information:

Name	Relationship	Date
Name	Relationship	Date

I have reviewed this notice of Privacy Practices and received the address location and contact information for the complete HIPAA-1996, the Privacy Officer for this office, and the Department and Health Services where complaints can be made.

Name	Signature	Date

Jason R. Bailey M.D., P.A.
Cosmeteik Med Spa

VIDEOTAPE AND PHOTOGRAPHS RELEASE AND AUTHORIZATION

I hereby irrevocably consent to and authorize the use and reproduction by Jason R. Bailey MD PA of any and all photographs, electronic images or video footage of me taken by Jason R Bailey MD PA, provided either by me or by a third party (collectively, Images) for the purpose of informing the medical profession and the general public about plastic surgery and plastic surgery procedures and techniques without compensation to me. Such use shall include, but not be limited to, distributing the Images via print, visual and electronic media, specifically including the Jason R Bailey MD PA/ Cosmeteik Med Spa website and social media sites such as YouTube, Facebook and Twitter. The Images (including any photographic negatives) shall be the sole property of Jason R Bailey MD PA. Jason R Bailey MD PA also shall have the right to use my name in connection therewith if it so chooses.

I hereby waive any right to inspect or approve the finished product, photograph, video, DVD, CD-ROM or matter that may be used in conjunction therewith or to the eventual use that it might be applied.

I hereby release, discharge and agree to hold harmless Jason R Bailey MD PA and their respective representatives, assigns, and employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and name and the reproduction thereof as stated above, including any claim for payment in connection with distribution or publication of the video and/or photographs.

I hereby warrant that I am over twenty-one years of age, and competent to contract in my own name insofar as the above is concerned.

I have read and understand the foregoing release, authorization and agreement, before signing my name below, and enter into it knowingly and voluntarily.

Date:_____ Printed Name:_____

Signature:_____

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

Date:_____ Printed Name: _____

Signature: _____

Authorization to Communicate and Disclose PHI Via Email and/or Text Message

PATIENT INFORMATION	
NAME:	
DATE OF BIRTH:	

CONSENT AND AUTHORIZATION FOR DISCLOSURE OF PHI VIA EMAIL	
EMAIL ADDRESS:	

CONSENT AND AUTHORIZATION FOR DISCLOSURE OF PHI VIA TEXT MESSAGE	
TEXT NUMBER:	

Communication over the Internet or via text message pursuant to this Authorization will not be encrypted and is generally NOT considered a secure communication. There is no guarantee of privacy when sending information via email or text message. Yet, you may ask that we communicate with you via email or text message. To do so, you must complete this Authorization and return it to your physician. Your physician will not condition treatment, payment, enrollment, eligibility for benefits, or other healthcare operations based upon whether you choose to sign or not sign this Authorization.

NOTE:

a. Your physician will not share information that is specially protected by law. This includes HIV/AIDS, substance abuse and mental health information.

b. Your Authorization will not be effective until you receive and respond correctly to a test message to your email address and/or text number. Your physician or his/her office will send the test message to confirm the email address and/or text number. Please select the test question you want to use below and give the answer.

- ☐ My mother's maiden name: _____
- ☐ The name of my first pet: _____
- ☐ The name of my high school: _____

Please initial each blank and sign below:

_____ The email address on this Authorization is correct. I hereby authorize all disclosures of my protected health information ("PHI") as defined by HIPAA and state law via email sent to this email address.

_____ The text number on this Authorization is correct. I hereby authorize all disclosures of my protected health information ("PHI") as defined by HIPAA and state law via text message sent to this text number.

_____ I understand and acknowledge that communications over the Internet and via text message are not secure. There is **no** guarantee of privacy of information when shared this way.

_____ I fully understand and acknowledge the potential that any of my PHI disclosed over the Internet or via text message may be subject to redisclosure and is no longer protected by HIPAA once transmitted to the email address or text number on this Authorization.

_____ I agree to hold Caroline E. Clarke MD and all individuals associated with it harmless from any and all claims and liabilities related to this Authorization.

Patient Signature Today's Date

EXPIRATION

Unless revoked below in writing, this Authorization will expire upon the later of the following events: (1) one (1) year after the date of my signature; or (2) the date on which I terminate care by Caroline E. Clarke MD and its physicians and transfer my care to another physician or medical practice.

RIGHT TO REVOKE

I request that my physician no longer use the above email address and/or text number to communicate with me.

Patient Signature Today's Date

I will no longer be using the email address and/or text number above to communicate with the above-named patient.

Provider Signature Today's Date

I attest the above history is completed to the best of my knowledge and understand and accept that my failure to disclose any of the above information can adversely affect a prescribed course of treatment to meet my goals, my safety, or the outcome of any treatment I elect to undergo with Dr. Jason R. Bailey M.D. or any member of his staff.

Treatment and payment agreement
I authorize examination and treatment for this and all following physician visits.
I authorize to release any medical information necessary to process any insurance billings. I authorize payment and assignment of insurance benefits to the doctor's office.
I understand I am financially responsible for all charges and deductibles not covered by my insurance. I am personally responsible for supplying accurate and current insurance information.
I authorize a photocopy of this statement to serve as an original.

Patient signature_____ Date _____