Jason R. Bailey, M.D.
Plastic, Reconstructive & Cosmetic Surgery

Thank you for choosing my practice for your care; be it as a new, referred patient or followup from an inpatient referral or surgical care. It is my responsibility to report under Section 102.006 of the Texas Occupations Code that I am affiliated with Lone Star Surgical Partners, PA. That practice serves to assist with the care of patients by providing hospital consultation, surgical assist, responsibility fulfillment, and outpatient followup. There are multiple providers which are under this professional entity. I am the sole owner of this entity and am responsible for the care you receive from those providers and would direct you to communicate any complaints you may have pertinent to the care you received by either Caroline Clarke, MD, or Elizabeth Rosamond, PA-C, directly to me. As owner of Lone Star Surgical Partners, it is my duty to inform you that I may receive directly or indirectly remuneration for care you may have received by these other providers, both of which maintain active licenses with the State of Texas to practice medicine, licensure through the DA for the dispensing of controlled substances, and hospital credentials. Information pertaining to any of those you may receive may be directed to the corresponding address listed above. We maintain our rates as a reflection of fair market value, publicized through FAIR Health, which is a national, independent, not-for-profit Corporation, whose mission is comprehensive information through data products and consumer resources, which is available through the web and includes unbiased, educational articles about the healthcare insurance reimbursement system. Our office can provide you with additional paraphernalia if you have interest in how we use FAIR Health's data to arrive at fair market value rates for the services you have been provided.

You will see the following assignment of benefits form with verbiage. The insurance providers require that we obtain benefit allowance on your behalf to bill for the services which have been provided. You are welcome to independently communicate with your insurance company and provide your own billing services, and we will facilitate that for that if you so wish. Otherwise, your signing of the documents which follow will provide our office the needed documentation so that we may participate in this process for you.

JASON R BAILEY MD
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: _____

Is the reason for the visit due to: ☐ Illness ☐ Accident ☐ Other: _____

Please Describe: _____ Date of Injury (if applicable): _____

Employment: Are you employed? ☐ YES ☐ NO ☐ RETIRED

Type of work you do or did: _____

Employer: _____

Work Address: _____ Work Phone Number: _____

Insurance: ☐ Medicare ☐ Commercial ☐ Worker's Compensation ☐ Auto

☐ Other (Crime Victims, Student Insurance, etc): _____

	Primary Insurance	Secondary Insurance
Name	_____	_____
Address	_____	_____
Phone Number	_____	_____
Group Number	_____	_____
Policy Number	_____	_____
Policy Holder	_____	_____
Adjuster Name	_____	_____

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 Jason R. Bailey MD PA

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. 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: _____

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH

BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to Dr. Jason R. Bailey, M.D., P.A. and Lone Star Surgical Partners, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to Dr. Jason R. Bailey, M.D., P.A. and Lone Star Surgical Partners, any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to Dr. Jason R. Bailey, M.D., P.A. and Lone Star Surgical Partners, all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Section 102.006 of the Texas Occupations Code states that a person commits an offense if the person accepts remuneration to secure or solicit a patient or patronage for a person licensed, certified, or registered by a state health care regulatory agency and does not, at the time of initial contact and at the time of referral, disclose to the patient: (A) the person's affiliation, if any, with the person for whom the patient is secured or solicited; and (B) that the person will receive, directly or indirectly, remuneration for securing or soliciting the patient.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____ _____

Patient Signature Date

_____

Print Name

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 JASON R BAILEY MD PA 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 JASON R BAILEY MD PA 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

Financial Policy

Our office is available to discuss any question(s) you may have regarding your insurance or account. The following is our financial policy, please review carefully then sign and date at the bottom of the form.

- All co-pays are due at the time of service.
- We accept cash, credit, debit or check
- Payment in full may be required at the time of service depending upon service rendered

Insurance: Your insurance policy is a contract between you and the insurance company we are not a party to that contract. We will bill your insurance plan for you, as long as you provide us with the correct and current information. Your contract dictates the services that are covered and the amount of payment for those services. You are ultimately responsible for payment of services provided.

Secondary Insurance: As Courtesy, we will bill your secondary insurance, but we require all the plan details at the time of service. Once the primary insurance pays, we allow 45 days for the secondary insurance to process their portion. At the end of 45 days, the balance becomes the patient's responsibility.

Worker's Compensation Claims/Self-insured claims: we request your private insurance information at the time of service. In the event State Labor and Industry or the third party administrator does not accept your claim, we will bill your private insurance. *You are ultimately responsible for your payment of services rendered, if your claim is not accepted.*

Doctor Referrals: You are responsible for obtaining the appropriate referral from your physician prior to your appointment. It is your responsibility to make sure we have a valid and current copy of your referral in the office at the time of your appointment.

Payment issues: if financial problems arise, please contact our office as soon as possible. If an account becomes past due, necessary action will be taken, up to and including turning the account over to our attorney or collection service. The undersigned understands that he/she, or his/her agent, is responsible for charges incurred.

Uninsured Patients: A $150 deposit is required at time of check-in for our patients without insurance and $50 for each subsequent follow up. Evaluation by the Doctor is needed before a surgical quote be given.

Cosmetic Patients: $50 for Cosmetic consultation only

No Shows: Patients who no show their appointment(s) are at risk of being discharged from the practice

I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that the benefits quoted to me are not a guarantee of claim payment. I understand that payment is dependent on my eligibility at the time of service and all terms and conditions of my insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. I have carefully read the financial policy. I understand and agree to the terms therein.

Patient signature _____ Date _____

Print Name _____

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 _____

Print Name _____