Welcome!

Thank you for choosing Dr. Christine Stiles to care for your child's plastic surgery needs.
All appointments are on Monday afternoons.
Dr. Stiles operates at the Pediatric Surgery Center.

Plastiks for Kids
5575 Warren Parkway, Suite 306
Frisco, TX 75034

Insurance:

- Benefits will be verified prior to your initial appointment.
- We will need for you to bring your current insurance card, as well as a valid driver's license for the responsible party.
- If your insurance plan requires a referral from your Primary Care Physician, please obtain this before your appointment.
- **The appointment will be rescheduled if the referral is not received by the initial visit.**
- You may bring this to your appointment or have it faxed to our office at 214-618-6203.

Appointment Times:

- We would like to make this the most pleasant medical experience for you and your child.
- **In order to keep the clinic on schedule, it may be necessary to reschedule your child's appointment if you are not able to make the scheduled appointment time.**
- We ask for your cooperation by completing all paperwork ahead of time and bringing any relevant information regarding your child's condition.

5575 Warren Parkway
Suite 306
Frisco, TX 75034

Located in Professional Bldg I at
Baylor Medical Center of Frisco

214-618-4000

PlastiksForKids.com

Please remember to bring:

- □ New Patient Paperwork
- □ Current Insurance Card
- □ Valid Driver's License
- □ Pediatrician's Name and Phone #
- □ Referral (if required)

Thank you for choosing Plastiks For Kids.

Please call us at 214-618-4000 if you have any questions or concerns.

We look forward to seeing you!

Minor Patient Information

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____

Date of Birth:_____Sex:_____

Social Security Number:_____-_____-_____

Student: Y N

Ethnicity: Hispanic ____ Non-Hispanic ____

Race: _____

Parent / Guardian Information

Mother's Name: _____

Work Phone:_____

Cell Phone: _____

Father's Name:_____

Work Phone:_____

Cell Phone: _____

Patient lives with: Mother ____ Father ____ Both ___

Other: _____

Who has primary custody: _____

Preferred Method of Contact: _____

Email Address: _____

In Case of Emergency (someone not living with the patient)

Name:_____
Phone:_____
Relationship:_____

Reason for Consultation

_____

_____

Whom May We Thank for Referring You?

Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_____
Relationship:_____

Staff ___ Physician ____ Internet ____ Insurance ___

Other: _____

Pediatrician/Primary Care Physician

Name:_____

Address:_____

City:_____ State:_____

Zip:_____ Phone:_____

Insured/Responsible Party

Insured's Name:_____

Relationship to Patient:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____

Work Phone:_____

Date of Birth:_____Sex:___Marital Status:_____

Social Security Number :_____-_____-_____

Employer:_____

Insurance Carrier:_____

Insurance Phone Number:_____

Policy #:_____Group #:_____

Is this Plan a: PPO_____ POS_____ HMO_____

Are Referrals Required? _____ Are we in network?____

I certify the above information is correct to the best of my knowledge. I understand that I am financially responsible for all charges whether or not covered by insurance. I also have received a Notice of Privacy Practices and Disclosure of Investment from Plastiks for Kids.

Signature:_____

Date:_____

Patient Name:

Patient Medical History (Pediatric)

Birth and infant history

1. Were there any problems during pregnancy? ____Yes ____No
2. Were there any problems during delivery? ____Yes ____No
3. Birth weight _____ lbs _____oz
4. Delivery ___Vaginal ____ C-section

Medication and Allergy History

1. List any medication and/or food allergies and include the reaction(s): _____
   _____
2. Please list all medications including dosage and reason for taking – include separate sheet if needed.
   Medication/Strength How often is it taken? Why do you take this medication?
   _____
   _____
   _____
   _____
   _____

Medical and Surgical History

1. Is there any history of the following conditions:
   __ Heart defects __Kidney disease __Hepatitis __Pneumonia
   __Meningitis __Frequent ear infections __Seizures __Diabetes
   __Asthma __Seasonal allergies __Dental problems __Trouble hearing
   __Learning disability __Broken bones – Location _____
   Please list any other medical conditions or handicaps:_____
   _____
2. Are immunizations current? ___Yes ___No
3. Please list any surgical procedures

Date	Procedure	Date	Procedure
_____	_____	_____	_____
_____	_____	_____	_____

Family History

1. Is there any family history of the following conditions? Please include family member (mother, father, etc)
   __ Asthma_____ __Skin cancer_____
   __Allergies_____ __Anesthesia problems_____
   __Accessory digits_____ __Skin tags of ears_____
   __Diabetes_____ __Keloid scar formation_____
2. Family history unknown (adopted). ____Yes _____No

The medical information provided is accurate to the best of my knowledge.

_____ _____

Signature of parent or guardian **Date**

Plastiks for Kids - Financial Policy

We are committed to providing you with the best possible health care, and we are pleased to discuss our professional fees with you at any time. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policies. Please ask if you have any questions about our fees, your responsibility, or the financial policy.

All patients must complete our Patient Information Form and inform our office of any changes in address or insurance. In order for us to treat and care for our patients, we must have complete and correct information.

Payment for services rendered is ***due at the time of service***. We accept cash, check, MasterCard, Visa, Discover, and American Express. There will be a $25.00 service charge for any returned checks.

We expect TOTAL PAYMENT two weeks prior to all aesthetic procedures unless you have been pre-approved with one of our financial plans.

The charges on your account with our office will reflect ***our*** doctor's fees only, *unless otherwise noted*. Any hospital, x-ray, laboratory, anesthesia, pathology, etc. will be billed by the provider performing the service.

Insurance policy:
We will gladly answer questions regarding your insurance. If the proposed services are medically necessary, we will attempt authorization from your insurance company. You must realize, however, that:

- Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
- Not all services are a covered benefit in your contract. Some insurance companies arbitrarily select certain services they will not cover and these are a patient responsibility.
- If your insurance coverage is through a plan that we are ***not*** contracted with, regardless of your carrier's rate of reimbursement, you will be responsible for the **FULL** balance of your account. This includes any amount over the "reasonable and customary".

We must emphasize that as a medical care provider, the relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. It is understood that temporary financial problems may affect timely payment of your account. If such problems arise, you are encouraged to contact us promptly for assistance in the management of your account.

"I hereby assign, transfer, and set over to The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy with my current insurance company."

_____***Initials***

As part of your treatment, we require both before and after treatment photographs for which the fees are included in our charges.

If at any time after your initial surgery you feel that you need a revision surgery, facility and anesthesia fees will be applicable. Surgeons' fees are at the discretion of your surgeon.

"I authorize The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids and personnel of their choosing to photograph me prior to, during, and following any surgery. I understand these photographs will be a part of my medical records and are vital to my quality of care and post surgical result."

Signature:_____ Date;_____

Plastiks for Kids - Photography Release

Dated: _____

I, _____(patient's name) hereby give The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids the absolute and irrevocable right and permission, with respect to photographs they have taken of me and/or in which I may be included with others:

a. To copyright the same in their own name or any other name they may choose.
b. To use, re-use, publish and/or re-publish the same in whole or in part, individually, or in conjunction with other photographs, in any medium and for any purpose whatsoever, including (but not limited to) illustration, promotion and/or advertising and/or trade.
c. To use my name in connection therewith if they so choose.

I hereby release and discharge The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids from any and all claims and demands arising out of or in connection with the use of the photographs, including any and all claims for libel.

This authorization and release shall also ensure to the benefit of the legal representatives, licensees, and assignees of The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids as well as the person(s) for whom they took the photographs.

_____ Please do not use my photos on the website or for marketing purposes.
(Initials)

I have read the foregoing and fully understand the contents thereof.

_____
(patient signature or legal guardian if minor)

_____
(witness signature)

_____
(legal guardian relationship to patient if minor)

_____
(patient address)

_____

HIPAA Privacy Rule

In effort to comply with the Privacy Rule to implement the requirement of the Health Insurance Portability & Accountability Act of 1996 (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

Please circle your response to the following:

May we leave messages concerning your appointments with a co-worker, receptionist or secretary that regularly answers your calls? YES NO N/A

May we leave messages on a voice mail at work/home regarding an appointment, referral or test results? YES NO N/A

May we discuss your appointments/treatments with your spouse? YES NO N/A

May we discuss your appointments/treatments with your children or other family members? Please list names: _____

_____

YES NO N/A

May we share your pertinent medical information with specialists you may be seeing? YES NO N/A

Request for Electronic Communication:

I request that the following communications from the practice be delivered to me by the provided electronic means. I understand that this form of communication may not be secure, creating a risk of improper disclosure to unauthorized individuals. I am willing to accept that risk, and will not hold the practice responsible should such incident occur.

Communications: ____ Appointment Reminders
____ Prescription Refill Reminders
____ Other (list specifically)

Method: ____ Email: _____

____ Text - Phone Number: _____

Acknowledgment and Agreements:
I understand and agree that the requested communication method is not secure, making PHI (Private Health Information) at risk for receipt by unauthorized individuals. I accept the risk and will not retaliate against the practice in any way should this occur.

You must inform us, in writing, of any changes in your directives. This record takes effect immediately and will be kept in your file along with acknowledgement of Receipt of Your Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Witness Date

Print name: _____ Phone No.: _____

Address: _____

Personal Representative: _____ Request Received By Date: _____

Pharmacy Authorization

Dated: _____

In order to maintain accurate medication records and history, we are requesting authorization to access your medication history. Please notate your pharmacy information below:

_____ _____
Pharmacy Name and Location Phone

_____ _____
Pharmacy Name and Location Phone

_____ _____
Pharmacy Name and Location Phone

I, _____(patient's name) hereby give The Center for Breast and Body Contouring, P.A. and/or Plastiks for Kids authorization to access my medication history for the purpose of maintaining accurate medication records and history.

This authorization will remain in effect as long as I am an active patient under the care of Dr. Christine Stiles.

I may terminate the authorization at any time with a written request.

_____
(patient signature or legal guardian if minor)

_____ _____
(witness signature) (legal guardian relationship to patient if minor)

_____
(patient name printed)