KIRBY PLASTIC SURGERY, PLLC | Emily J. Kirby, MD
7250 HAWKINS VIEW DRIVE, SUITE 412 | FORT WORTH, TX 76132 | 817.292.4200 P | 817.292.4205 F

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MI):				TODAY'S DATE:
HOME ADDRESS:			EMAIL:	
CITY:	STATE:	ZIP:	HOME PHONE:	
BIRTHDATE:	AGE:	SS#:	GENDER: M F PREFERRED CONTACT: phone / email	
OCCUPATION:		EMPLOYER:		
EMPLOYER ADDRESS:				
CITY:	STATE:	ZIP:	WORK PHONE:	
Complete this section only if the patient is not the responsible party				
RESPONSIBLE PARTY:		RELATIONSHIP TO PATIENT:		
HOME ADDRESS:				
CITY:	STATE:	ZIP:	HOME PHONE:	
BIRTHDATE:	AGE:	SS#:		
OCCUPATION:		EMPLOYER:		
WORK ADDRESS:			WORK EMAIL:	
CITY:	STATE:	ZIP:	WORK PHONE:	
MARITAL STATUS: S M D W		NAME OF SPOUSE:		
SPOUSE'S OCCUPATION:		SPOUSE'S EMPLOYER:		
PRIMARY CARE PHYSICIAN:		**REFERRING PHYSICIAN**:		
EMERGENCY CONTACT NAME:		RELATIONSHIP TO PATIENT:		
EMERGENCY HOME PHONE:		EMERGENCY WORK PHONE:		
PRIMARY INSURANCE:		POLICY HOLDER'S NAME:		
POLICY HOLDER'S SS#:		POLICY HOLDER'S BIRTHDATE:		
RELATIONSHIP TO PATIENT:		ID#:		
POLICY HOLDER'S EMPLOYER:		GROUP#:		
SECONDARY INSURANCE:		POLICY HOLDER'S NAME:		
POLICY HOLDER'S SS#:		POLICY HOLDER'S BIRTHDATE:		
RELATIONSHIP TO PATIENT:		ID#:		
POLICY HOLDER'S EMPLOYER:		GROUP#:		

Our office will file insurance for appropriate services to your primary and secondary insurance carriers.
You are responsible for all deductible, copay, and non-covered service charges.

REASON FOR VISIT:	DATE OF INJURY:
DID THE INJURY HAPPEN AT WORK? YES NO	WAS THE INJURY REPORTED? YES NO
IS YOUR INJURY COVERED BY WORKER'S COMPENSATION INSURANCE? YES NO	CONTACT PERSON AT WORK: NAME: _____ PHONE: _____
HOW DID YOU HEAR ABOUT US: ☐ Doctor Referral ☐ Internet ☐ Friend ☐ Magazine Ad ☐ Other_____	

PHARMACY NAME:	PHARMACY PHONE:

_____ I give consent to be treated by Emily J. Kirby, MD.
(initial)

_____ I understand that office visit charges are payable on the day service is rendered. I agree that, regardless of my insurance
(initial) status, I am responsible for the balance of my account for any/all professional services rendered.

_____ I authorize the payment of medical benefits to be made directly to **Emily J. Kirby, MD** for services rendered, and I authorize
(initial) the release of medical information to determine benefits, including medical, surgical, psychiatric, and/or substance abuse information.

_____ I have been informed that if my account becomes delinquent, it will be referred to an outside collection agency. I
(initial) understand that I will be held responsible for any additional fees incurred due to my account delinquency.

Signature: _____ Date: _____

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice.

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MEDICAL HISTORY

PATIENT NAME (LAST, FIRST, MI):		TODAY'S DATE:
DATE OF BIRTH:	HEIGHT	WEIGHT:

HAVE YOU EXPERIENCED ANY OF THESE CONDITIONS? (circle YES or NO)

Fever/chills	YES NO	Sleep apnea	YES NO	Joint, neck, back pain	YES NO
Weight gain/loss	YES NO	Shortness of breath	YES NO	Difficulty urinating	YES NO
Dry or tearing eyes	YES NO	Cough	YES NO	Diabetes	YES NO
Vision problems	YES NO	Asthma	YES NO	Kidney disease	YES NO
Acid reflux	YES NO	Abnormal bleeding/bruising/clotting	YES NO	Headaches	YES NO
Chest pain	YES NO	Sunburn or skin conditions	YES NO	Seizures	YES NO
Heart attack	YES NO	HIV	YES NO	Numbness	YES NO
Racing or irregular heartbeat	YES NO	Hepatitis	YES NO	Hearing problems	YES NO
High blood pressure	YES NO	Cancer	YES NO	Hernia	YES NO
Stroke	YES NO	Thyroid disease	YES NO	Anxiety or depression	YES NO

SOCIAL HISTORY:

Do you smoke/dip/chew tobacco? YES NO	Do you drink alcohol? YES NO	Do you use recreational drugs? YES NO
Do you drink coffee/cola? YES NO	Do you exercise? YES NO	

MEDICATIONS (INCLUDING SUPPLEMENTS, OVER-THE-COUNTER & VITAMINS): ❑ none	ALLERGIES: ❑ none

PREVIOUS SURGERIES (date, type of surgery): ❑ none	PREVIOUS HOSPITALIZATIONS (date, reason): ❑ none

FAMILY HISTORY:

Heart disease	YES NO	Bleeding disorder	YES NO	Hepatitis	YES NO
Heart murmur	YES NO	Blood clots	YES NO	Thyroid disease	YES NO
High blood pressure	YES NO	Asthma	YES NO	Depression	YES NO
Stroke	YES NO	Lung disease	YES NO	Anesthetic problems	YES NO
Cancer	YES NO	Kidney disease	YES NO	Other:	
Diabetes	YES NO	Liver disease	YES NO		

FOR FEMALE PATIENTS ONLY:

Date of last menstrual period:_____	Number of pregnancies:_____	Date of last mammogram:_____
Age period began:_____	Did you breastfeed? YES NO	Results:_____

I verify that the information I have provided is true to the best of my knowledge.

Patient Signature: Date:

Physician:

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice.

Kirby Plastic Surgery, PLLC
Notice of Privacy Practices for Protected Health Information
Effective Date: September 1, 2011

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

- A nurse obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Example of Use of Your Health Information for Payment Purposes:

We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Appointment Reminders:

We utilize your contact information to generate automated appointment reminders to the email address you provide to us.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office – we are not required to grant the request, but we will comply with any request granted;
- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full – we must comply with this request;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for the office;
- Is not part of the information that you would be permitted to inspect and copy; or,
- Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.

If you want to exercise any of the above rights, please contact Randol Kirby, office manager for Kirby Plastic Surgery, PLLC at 7250 Hawkins View Drive, Suite 412, Fort Worth, TX 76132, 817-292-4200, in person or in writing, during regular, business hours. He will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Randol Kirby, office manager for Kirby Plastic Surgery, PLLC at 7250 Hawkins View Drive, Suite 412, Fort Worth, TX 76132, 817-292-4200.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Randol Kirby, office manager for Kirby Plastic Surgery, PLLC. You may also file a complaint by mailing it or e-

mailing it to the Secretary of Health and Human Services, Kathleen Sebelius, at The U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201, 877-696-6775.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office/hospital.

- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person that you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Research

- We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief

- We may use and disclose your protected health information to assist in disaster relief efforts.

Food and Drug Administration (FDA)

- We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

- If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect

- We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written

notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

- We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight

- Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

- We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat

- To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

- We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Coroners, Medical Examiners, and Funeral Directors

- We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients of Covered Entities to funeral directors as necessary for them to carry out their duties.

Other Uses

- Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."

Website

- If we maintain a website that provides information about our entity, this Notice will be on the website.

Kirby Plastic Surgery, PLLC

Name of Patient: _____

Patient Date of Birth: _____

Communication Preferences

Kirby Plastic Surgery does not share or sell your contact information. I give permission to receive communication from Kirby Plastic Surgery in the following forms (check all that apply):

- ❑ Home phone
- ❑ Cell phone
- ❑ Work phone
- ❑ Email (appointment reminders, news and special offers from Kirby Plastic Surgery)
- ❑ Mail
- ❑ Other _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of _____.

_____ _____

Signature of Patient/Patient Representative Date

_____

Relationship to Patient