INTERNATIONAL CRANIOFACIAL INSTITUTE

Patient Information

Name_____

Address_____

City_____ State_____ Zip_____

Home(____) _____

Work(____) _____ Cell(____) _____

Email_____

Preferred Method of Contact_____

Date of Birth_____ Sex____ Marital Status_____

Social Security Number_____

Driver's License #_____ State_____

Student: Y N Occupation_____

Employer_____

Patient's Spouse/Guardian

Spouse/Guardian_____

Address_____

City_____ State___ Zip_____

Home(____) _____ Work(____) _____

If the Patient is a Child

Mother's Name_____

Work Phone (___) _____

Father's Name_____

Work Phone (___) _____

Child Lives With_____

In Case of Emergency (2 people not living w/patient)

Name_____

Phone (___) _____ Relationship_____

Name_____

Phone (___) _____ Relationship_____

Reason for Consultation

_____

_____

Whom May We Thank for Referring You?

Name_____

Address_____

City_____ State_____ Zip_____

Phone(___) _____ Relationship_____

Pediatrician or Family Doctor

Name_____

Address_____

City_____ State_____ Zip_____

Phone(___) _____

Guarantor/Responsible Party

Name_____

Relationship to Patient_____

Address_____

City_____ State_____ Zip_____

Home Phone(____) _____

Work Phone (____) _____

Date of Birth_____ Sex____ Marital Status_____

Social Security Number_____

Employer_____

Carrier_____

Benefits Phone Number (___) _____

Policy #_____ Group #_____

Is this Plan a PPO___POS___HMO___Indemnity_____

Are Referrals Required?___ Are we in your Network?_____

If Medicaid, is this Plan an HMO?___Which Plan_____

Primary Care Physician_____

Phone Number (___) _____

Other Guarantor Information

Name_____

Relationship to Patient_____

Address_____

City_____ State_____ Zip_____

Home Phone(____) _____

Work Phone (____) _____

Date of Birth_____ Sex____ Marital Status_____

Social Security Number_____

Employer_____

Insurance Carrier_____

Benefits Phone Number (___) _____

Policy #_____ Group #_____

Is this Plan a PPO___POS___HMO___Indemnity_____

Are Referrals Required?___ Are we in your Network?_____

If Medicaid, is this Plan an HMO?___Which Plan_____

Primary Care Physician_____

Phone Number (___) _____

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* from ICI on date signed.

Signature_____ Date_____

Update Signature_____ Date_____

Update Signature_____ Date_____

INTERNATIONAL CRANIOFACIAL INSTITUTE
PATIENT MEDICAL HISTORY (ADULT)

ALLERGIES:

Do you have or have you ever had any allergies? Yes❒ No❒
If yes, please list and give type of reaction:_____

HISTORY:

Have any blood relatives had:

Diabetes?	Yes❒	No❒
Cancer?	Yes❒	No❒
Heart Disease?	Yes❒	No❒

Other_____

Are you taking medications for the following conditions?			Medication	Dosage	How Often?
Diabetes	Yes❒	No❒			
High Blood Pressure	Yes❒	No❒			
Anemia	Yes❒	No❒			
Nervousness	Yes❒	No❒			
Sleep	Yes❒	No❒			
Heart Disease	Yes❒	No❒			
Thyroid	Yes❒	No❒			
Pain Killers	Yes❒	No❒			
Birth Control	Yes❒	No❒			
Menopause	Yes❒	No❒			

Please list any other medications you are taking (including dosage & how often taken)

Do you take aspirin or aspirin products: Yes❒ No❒

PAST OPERATIONS:

Have you ever had any operations? Yes❒ No❒ (Please include cosmetic procedures)
If yes, please list below:

Year	Type of Operation/Physician

Have you ever experienced malignant hyperthermia? Yes❒ No❒
Have you ever been pregnant? Yes❒ No❒ Number of children_____

MAJOR ILLNESSES:	Yes	No	Date		Yes	No	Date
Heart Disease	❒	❒		Convulsions	❒	❒	
High Blood Pressure	❒	❒		Nervous Breakdown	❒	❒	
Angina	❒	❒		Depression	❒	❒	
Ulcers	❒	❒		Jaundice	❒	❒	
Colitis	❒	❒		Hepatitis	❒	❒	
Cancer	❒	❒		Glaucoma	❒	❒	
Diabetes	❒	❒		Cataract	❒	❒	
Kidney Disease	❒	❒		Scarlet Fever	❒	❒	
Thyroid – *Over / Under Active*	❒	❒		Rheumatic Fever	❒	❒	
Arthritis	❒	❒		Tuberculosis	❒	❒	
Blood Clots	❒	❒		Deep Vein Thrombosis	❒	❒	
Abnormal Bleeding	❒	❒		Other_____	❒	❒	

ADDITIONAL:

Height _____Weight _____Blood Pressure_____
Do you smoke? Yes❒ No❒ Do you drink alcohol? Yes❒ No❒
When was your most recent: Chest x-ray_____EKG_____Complete Physical_____
Please include any other medical condition, illness or handicap that you may have:

SIGNATURE:_____ DATE: _____

INTERNATIONAL CRANIOFACIAL INSTITUTE
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, checks, Mastercard, Visa, Discover, and American Express. We will be happy to file your insurance if you are a member of an insurance plan in which we are contracted. We *do not* file claims on insurance plans that we do not participate with. There will be a $25.00 service charge for any returned checks.

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

We will gladly answer questions regarding your insurance. 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 "reasonable and customary".

We will file all surgery claims to your insurance carrier and we will make every reasonable effort to maximize their reimbursement for you. If your insurance coverage is through a plan that we are ***not*** contracted with, a 20% surgery deposit will be required no later than 14 days prior to the scheduled surgery date. If your insurance carrier reimburses more than the balance due, you will receive a prompt refund of the overpayment.

We must emphasize that as a medical care provider, our 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.

This form must be signed prior to services being rendered. It will become a part of your permanent record with this office.

"I hereby assign, transfer and set over to the International Craniofacial Institute all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with my current insurance company."

Signature:_____ Date: _____

PHOTOGRAPHY RELEASE

I, _____(patient's name) hereby give the International Craniofacial Institute the absolute and irrevocable right and permission, with respect to photographs he has had taken of me and/or in which I may be included with others:

a) To copyright the same in his own name or any other name he 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 by limitation) illustration, promotion and/or advertising and/or trade.
c) To use my name in connection therewith if he so chooses.

I hereby release and discharge the International Craniofacial Institute from any and all claims and demands arising out of or in connection with the use of the photographs, including any and claims for libel. This authorization and release shall also ensure to the benefit of the legal representatives, licensees and assigns of International Craniofacial Institute as well as the person(s) for whom he took the photographs. I have read the foregoing and fully understand the contents thereof.

_____ _____
(patient signature or legal guardian if minor) (date)

_____ _____
(witness) (date)

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

You have the right to privacy. This means all information obtained as a part of this study will only be used as described below. The results of this study may be published in a scientific book or journal. If this is done, your name will not be used without your specific written permission. In addition, if photographs, audiotapes or videotapes are taken during the study, then you must give special written permission for their use. All information about you from this research project will be kept in a locked space.

By signing this Agreement you agree to allow the International Craniofacial Institute and his/her staff and the study sponsor, _____ (Sponsor), to use and disclose health information that identifies you for the purposes described below. You also agree to permit Medical City Dallas Hospital, its staff, your doctors, and your other health care providers to disclose health information in your medical records to the Researchers and Sponsor for the purposes described below.

The Researchers and the Sponsor may use and share your health information to conduct the research. They may use your health information as described in the informed consent. They may disclose your health information as required by law and to representatives of government organizations, review boards, and other persons who are required to watch over the safety and effectiveness of medical products and therapies and the conduct of research.

If information that could be used to identify you has been removed, then the information that remains is no longer subject to this Authorization and may be used and disclosed by Researchers and Sponsor as permitted by law. Once your health information has been disclosed to another party as indicated above, federal privacy laws may no longer protect it from further disclosure. However, the Researchers and Sponsor agree to protect your health information by using and disclosing it only as permitted by you in this Authorization. These limitations will continue even if you revoke (take back) your Authorization.

You do not have the give this permission and it is all right to refuse to sign this section of the consent form. Your doctor will still treat you even if you do not give your permission for this release of information. Your insurance will still pay your medical bills if you do not give your permission. However, since it is important for the people listed above to have access to your information, if you do not sign this Agreement, you cannot be in the research study.

While the research is in progress, you will not be allowed to see any health information that is created or collected. After the research is finished, you may see the information if you wish. Unless permission is specifically withdrawn, this permission will NOT expire at the end of the research study. You may request a copy of this Authorization after you have signed it.

(printed name of patient) (patient signature or legal guardian if minor) (date)

Patient Authorization for Personal Representative

Please print all information, then sign and date form at bottom.

Type of Authorization: Personal Representative

Patient Name: (please print)_____

Purpose of request: I authorize International Craniofacial Institute to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, they may exercise my right to inspect, copy and correct my protected health information. They may also consent or authorize the use or disclosure of my protected health information:

_____
Name of Personal Representative

_____
Address

_____
City, State, Zip

_____
Phone

Description of information to be disclosed: I authorize International Craniofacial Institute to disclose all of my protected health information to my designated personal representative.

Expirations or termination of authorization: This authorization will remain in effect until terminated by you, your personal representative or another individual(s) at legal entity authorized to do so by court order or law.

Right to revoke or terminate: As stated in out Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

International Craniofacial Institute
ATTN: Privacy Manager
11970 N. Central Expressway, Suite 270
Dallas, TX 75243

Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer by the responsibility of the International Craniofacial Institute.

_____ _____
Patient Signature Date