

Robert P. Schmid, M.D., P.A.
Patient Registration

Date		Acct		
PATIENT: LAST NAME		FIRST NAME		MIDDLE NAME
MAILING ADDRESS		CITY, STATE		ZIP
SEX	BIRTH DATE	SOCIAL SECURITY NUMBER	AGE	HOME TELEPHONE
EMPLOYER/SCHOOL NAME			WORK/SCHOOL TELEPHONE	
ADDITIONAL PHONE (CELL,PAGER)		MAY WE CONTACT YOU VIA EMAIL: Y or N		
PLEASE PROVIDE YOUR E-MAIL:				
SPOUSE LAST NAME		FIRST NAME		MIDDLE NAME
PATIENTS RELATIONSHIP TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER				
SPOUSE EMPLOYMENT INFORMATION				
EMPLOYER			WORK TELEPHONE	
EMPLOYER ADDRESS			CITY, STATE	ZIP
PATIENT STATUS : A) <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER B) <input type="checkbox"/> EMPLOYED <input type="checkbox"/> FULL TIME STUDENT <input type="checkbox"/> PART TIME STUDENT				
PRIVATE OR GROUP INSURANCE				
ARE YOU A MEMBER OF A MANAGED CARE PLAN? (PPO, HMO, ETC?) YES <input type="checkbox"/> NO <input type="checkbox"/>				
NAME OF PRIMARY (FIRST) INSURANCE COMPANY				
POLICY NUMBER		GROUP NUMBER	GROUP NAME	
INSURANCE COMPANY ADDRESS			CITY, STATE	ZIP
POLICY HOLDERS LAST NAMES		FIRST NAME		MIDDLE NAME
STREET ADDRESS		CITY, STATE		ZIP
SEX	BIRTH DATE	SOCIAL SECURITY NUMBER	AGE	HOME TELEPHONE
MEDICARE SUPPLEMENTAL OR ADDITIONAL INSURANCE COMPANY				
NAME OF INSURANCE COMPANY				
POLICY NUMBER		GROUP NUMBER	GROUP NAME	
INSURANCE COMPANY ADDRESS			CITY, STATE	ZIP
POLICY HOLDERS LAST NAMES		FIRST NAME		MIDDLE NAME
STREET ADDRESS		CITY, STATE		ZIP
SEX	BIRTH DATE	SOCIAL SECURITY NUMBER	AGE	HOME TELEPHONE
HOW DID YOU HEAR ABOUT OUR OFFICE? IF A PHYSICIAN REFERRED YOU, WHOM MAY WE THANK?				
NAME			TELEPHONE	
PERSON TO CALL IN EMERGENCY (NOT LIVING WITH YOU)				
NAME			TELEPHONE	
PCP (PRIMARY CARE PHYSICIAN)				
Pt Reg.Schmid.2PT				

Consent to Treatment

Robert P. Schmid, M.D., P.A.

CONSENT TO TREATMENT:

I (the patient/parent/guardian/legal representative of the patient acting on the patient's behalf) give permission for medical treatment, including radiological and laboratory procedures, to be performed by the physicians and staff of Robert P. Schmid, M.D., P.A. (Center). This consent is valid from this date forward.

Relationship to Patient: Self Child Dependent Other _____

Printed Name Signature Date

Printed Name of Witness Signature of Witness Relationship to Signer

FINANCIAL AGREEMENT:

The person signing below agrees, whether he/she signs as patient or representative of the patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the Center at the regular rates and terms of the Center. Should the account be referred to an attorney for collection, the person signing below shall pay reasonable attorney's fees and collection expenses.

"I assign payment for the unpaid charges for certain medical treatment furnished by the physicians and staff of Robert P. Schmid, M.D., P.A. and by attending physicians for whom the Center is authorized to bill. I understand that I am responsible for any health insurance deductibles and coinsurance at the time of services rendered."

Printed Name Signature Date

ASSIGNMENT OF BENEFITS:

In consideration of services rendered, I hereby assign to Robert P. Schmid, M.D., P.A., and/or any physician who has treated me, all rights, title, and interest in any payment due me for services described herein as provided in the policy, or policies, of insurance. I agree to pay the charges of the Center and/or attending physician which is greater than the amount paid by the insurance company or companies.

Printed Name Signature Date

MEDICARE AND/OR MEDICAID CERTIFICATION: (If applicable)

The person signing below certifies that he/she has read this document, and is the patient, or is duly authorized by the patient as the patient's representative, to execute the above and accepts its terms.

"I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Administration is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries/carriers any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf."

Relationship to Patient: Self Child Dependent Other _____

Printed Name Signature Date

Printed Name of Witness Signature of Witness Relationship to Signer

R O B E R T S C H M I D

4102 24TH STREET, SUITE 305 • LUBBOCK, TX 79410 • 806.797.6398 • TOLL FREE 866.797.6398 • FAX 806.797.6399

AUTHORIZATION FOR RELEASE OF PATIENT PHOTOGRAPH

Name _____

Address _____

I consent to the taking of photographs by Dr. Robert P. Schmid or his designee of me or parts of my body in connection with the surgical procedure(s) to be performed by Dr. Robert P. Schmid. I understand that my face or parts of my face will not be revealed in the photographs unless the surgical procedure(s) I inquire about are involved.

I understand that such photographs shall become the property of Robert P. Schmid, M.D., P.A., and my medical records. These may be retained or released by Robert P. Schmid, M.D., P.A., for the purpose of before and after pictures for myself and/or for patient educational purposes. I understand that should my photographs be selected for the use of the patient education purposes, my written permission shall be required and obtained prior to publication.

Neither I, nor any member of my family, will be identified by name in any publications. I understand that in some circumstances the photographs may portray features that may make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information, will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Robert P. Schmid.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so, it won't affect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from this date written below.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 "(HIPAA)". I also understand that Dr. Robert P. Schmid, M.D., P.A. is HIPAA compliant. I further understand that, because the American Society of Plastic Surgery (ASPS) is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA. In essence, should your insurance company require copies of photographs, or for any legal purposes, my photographs may no longer be protected by HIPAA.

I certify that I have read the above Authorization and Release and fully understand its terms.

****Your pictures maybe used in Dr. Robert P. Schmid's before and after photo album for other patients to view**** patient's initials giving consent _____

Signature

Date

Office Staff Witness

Date

ROBERT P. SCHMID, M.D., P.A.

**Consent For Use And Disclosure Of Protected Health Information For
Treatment, Payment, Or Healthcare Operations**

I understand that as part of my healthcare, the Physician originates and maintains medical records describing my health history, symptoms, examination and test results, diagnosis, treatment, financial and demographic information, and any plans for future care or treatment. The Physician also originates and maintains billing records. I understand and consent to this information being used or disclosed for the following purposes:

- Planning my care and treatment;
- Communications between my Physician and healthcare professionals that act under the direction of my Physician and participating in my diagnosis, evaluation, or treatment;
- Collection of fees for medical services;
- Determining liability for payment and obtaining reimbursement;
- Conducting healthcare operations, including the evaluation of healthcare services, appropriateness and quality of healthcare treatment, and the qualifications of healthcare practitioners.

I have been provided with a copy of the Physician's *Notice of Privacy Practices* that provides information about how the Physician uses and discloses Protected Health Information about me. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent; and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. The Physician is not required to agree to the requested restrictions, but is bound to any restrictions agreed to.

I understand that as provided in the *Notice of Privacy Practices*, the terms of the *Notice* may change. If they do, I may obtain a revised copy from the privacy officer by calling (806) 797-6398.

I understand that I may revoke this consent in writing, except to the extent that the Physician has already taken action in reliance thereon. I also understand that by refusing to sign or revoking this consent, the Physician may refuse to treat me. I wish to restrict the use or disclosure of my health information as follows:

I understand that my confidential information may be released to the following individuals:

Signature of Patient or Representative

Date

Patient Name

Patient Identification Number (SSN)

Name of Representative (if applicable)

Relationship

Robert P. Schmid, M.D., P.A.

Patient Financial Responsibility

We are committed to providing you with the best possible surgical and medical care; if you have special needs; we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. The total patient balance due is required to be paid at the time services are provided. For your convenience, we accept cash, checks, Visa, MasterCard, Discover, and American Express.
2. Our office participates with a variety of insurance plans. It is your responsibility to:
 - Bring your insurance card at every visit
 - Be prepared to pay your co-payment and/or co-insurance at each visit. Payment can be made by cash, check, or credit card.
 - For medical care not covered, deemed medically unnecessary, or deemed cosmetic by your insurance company, payment in full is due at the time of the visit.
3. If you have insurance that we do not participate in, our office is happy to file the claim upon request; however, payment in full is required at the time of service. A deposit will be required for all surgeries.
4. If the total patient balance due cannot be paid in full, arrangements must be made prior to services being rendered. Failure to make arrangement with Robert P. Schmid, M.D., P.A. will result in the immediate collection turnover or payment in full.
5. Referrals: It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have the referral, your visit may be rescheduled or you will be financially responsible for all services rendered.
6. If the patient is a minor (18 years or younger), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at time of service, bringing the necessary referrals and insurance card.
7. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department.
8. If you fail to make payment in full for the services that are rendered to you, your outstanding balance will be sent to a collections agency. If you consistently refuse to pay for services rendered, Robert P. Schmid, M.D., P.A. may choose to cease providing services to you.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be asked prior to services provided.

Patient Signature _____

Date: _____

New Patient Information Form

Patient _____ Chart#: _____ Age: _____

Date: _____ Referring Physician _____

Reason for today's visit? _____

Any medication allergies? _____

If so, list reactions to these? _____

Latex Allergy: Yes No Reaction: _____

Current medications:

_____	_____
_____	_____
_____	_____
_____	_____

Use of aspirin? Yes No Use of herbs/vitamins Yes No

Use of anti-inflammatories? Yes No

History

Past medical problems

_____	_____
_____	_____
_____	_____
_____	_____

Pertinent Social History

Use of alcohol? Yes No How often? _____

Use of tobacco? Yes No How often? _____

Previous Surgeries	Date	Performing Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

• CONSTITUTIONAL SYMPTOMS

Good general healthy lately No Yes
 Recent weight change No Yes
 Fever No Yes
 Fatigue No Yes
 Headaches No Yes

• EYES

Eye disease or injury No Yes
 Wear glasses / contact lens No Yes
 Blurred or double vision No Yes
 Glaucoma No Yes

• EARS / NOSE / MOUTH / THROAT

Hearing loss or ringing No Yes
 Earaches or drainage No Yes
 Chronic sinus problems or rhinitis No Yes
 Nose bleeds No Yes
 Mouth sores No Yes
 Bleeding gums No Yes
 Bad breath or bad taste No Yes
 Sore throat or voice change No Yes
 Swollen glands in neck No Yes

• CARDIOVASCULAR

Heart trouble No Yes
 Chest pains or angina pectoris No Yes
 Palpitation No Yes
 Shortness of breath with walking or lying flat... No Yes
 Swelling of feet, ankles or hands No Yes

• RESPIRATOR

Chronic or frequent coughs No Yes
 Spitting up blood No Yes
 Shortness of breath No Yes
 Asthma or wheezing No Yes

• GASTROINTESTINAL

Loss of appetite No Yes
 Change in bowel movements No Yes
 Nausea or vomiting No Yes
 Frequent diarrhea No Yes
 Painful bowel movements or constipation .. No Yes
 Rectal bleeding or blood in stool No Yes
 Abdominal pain or heartburn No Yes
 Peptic ulcer (stomach or No Yes

• GENITOURINARY

Frequent urination No Yes
 Burning or painful urination No Yes
 Blood in urine No Yes
 Change in force of strain when urinating No Yes
 Incontinence or dribbling No Yes
 Kidney stones No Yes
 Sexual difficulty No Yes
 Male - testicle pain No Yes
 Female - pain with periods No Yes
 Female - irregular periods No Yes
 Female - vaginal discharge No Yes
 Female - # pregnancies ___ # miscarriages ___ No Yes
 Female - date of last pap smear _____ No Yes

• MUSCULOSKELETAL

Joint pain No Yes
 Joint stiffness or swelling No Yes
 Weakness of muscles or joints No Yes
 Muscle pain or cramps No Yes
 Back pain No Yes
 Cold extremities No Yes
 Difficulty in walking No Yes

• INTEGUMENTARY (skin, breast)

Rash or itching No Yes
 Change in skin color No Yes
 Change in hair or nails No Yes
 Varicose veins No Yes
 Breast pain No Yes
 Breast lump No Yes
 Breast discharge No Yes

• NEUROLOGICAL

Frequent or recurring headaches No Yes
 Light headed or dizzy No Yes
 Convulsion or seizures No Yes
 Numbness or tingling sensations No Yes
 Tremors No Yes
 Paralysis No Yes
 Stroke No Yes
 Head injury No Yes

• PSYCHIATRIC

Memory loss or confusion No Yes
 Nervousness No Yes
 Depression No Yes
 Insomnia No Yes

• ENDOCRINE

Glandular or hormone problem No Yes
 Thyroid disease No Yes
 Diabetes No Yes
 Excessive thirst or urination No Yes
 Heat or cold intolerance No Yes
 Skin becoming dryer No Yes
 Change in hat or glove size No Yes

• HEMATOLOGIC / LYMPHATIC

Slow to heal after cuts No Yes
 Bleeding or bruising tendency No Yes
 Anemia No Yes
 Phlebitis No Yes
 past transfusion No Yes
 Enlarged glands No Yes

• FAMILY HISTORY

Cancer No Yes
 If Yes, what type _____
 Malignant Hyperthermia No Yes
 Major health Problems No Yes
 List: _____

