PATIENT INFORMATION

Today's Date: _____

Patient's Legal Name _____ **Nickname** _____
Last First Middle

Date of Birth: ___/____/_____ **Age**_____ **SSN:** _____-_____-_____ **Height:** __' ___" **Weight:** ____ **lbs**

Sex: ❑Male ❑Female **Marital Status:** S/ M/ D/ W **Primary Language** _____

Address: _____
Street & Apt # City State Zip

Phone	**Privacy**	**Emergency Contact, can we discuss your care?**
Home: (_____) _____ - _____	❑	Name: _____ Y❑ N❑
Work: (_____) _____ - _____	❑	Relationship: _____
Cell: (_____) _____ - _____	❑	Home: (_____) _____ - _____
Fax: (_____) _____ - _____	❑	Cell: (_____) _____ - _____

E-mail _____**Preferred Method of Contact** _____

May we send you email correspondence? (Promotions, specials, appointments) Y❑ N❑

Occupation / Employer or school: _____/_____

❑ Full Time Employment ❑ Part Time Employment
❑ Full Time Student ❑ Part Time Student
❑ Retired ❑ Other

Tell us what procedures you are interested in? _____

Whom may we thank for referring you? ❑ Patient ❑ Physician ❑ Internet ❑ Other

Name: _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT- If other than patient:

Legal Name _____ **Relationship** _____
Last First Middle

Date of Birth: ___/____/_____ **Age:** _____ **SSN:** ____-____-____ **License #/State:** _____/_____

Sex: ❑ **Male** ❑ **Female** **Phone: H:** _____ **W:** _____ **Cell/Pager:** _____

Address: _____
Street & Apt # City State Zip

PHARMACY INFORMATION:

Pharmacy Name: _____ Phone #: _____

Address: _____
Street City State Zip

PRIMARY CARE PHYSICIAN:

Name: _____ Phone #: _____

(All information is strictly confidential)

HEALTH HISTORY

Name_____ **Age**_____ **Today's Date**_____

Reason For Visit_____

For Injuries: Date of Injury _____**On the job? ❑ Yes ❑ No Occupation**_____

Height:__' ___" Weight:____ lbs. What is the most you have ever weighed: ____lbs BMI____BSA____

PAST MEDICAL HISTORY

Please check if you have, or ever had any of the following conditions: **❑NONE**

Cardiovascular
- ❑Anemia
- ❑Angina / chest pain
- ❑ Arrhythmia
- ❑ Congestive heart failure
- ❑ Heart attack
- ❑Heart murmur
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Heart valve disorder
- ❑ Pacemaker / Stent
- ❑Rheumatic heart disease

Respiratory
- ❑ Asthma / Bronchitis
- ❑COPD / Emphysema
- ❑Pneumonia
- ❑Tuberculosis

Gastro-intestinal
- ❑ Liver disease
- ❑GERD
- ❑Hernia
- ❑ Hepatitis
- ❑Peptic ulcers

Blood
- ❑ Bleeding disorders
- ❑Blood transfusion
- ❑DVT / Blood clots / Pulmonary Embolism

Neurologic
- ❑Epilepsy
- ❑ Migraines
- ❑Paralysis
- ❑Stroke/ TIA

Mental Health
- ❑Alcohol/ Drug dependency
- ❑Anorexia /Bulimia
- ❑Depression
- ❑ Psychiatric care
- ❑ Suicide attempt

Skin/ Skeletal
- ❑Jaundice
- ❑ Skin disorder
- ❑Arthritis
- ❑Gout
- ❑Fracture

Immune/Infection
- ❑AIDS / HIV
- ❑Herpes / fever blister
- ❑Immune problem
- ❑MRSA/ VRE
- ❑ Venereal disease

Endocrine
- ❑Diabetes
- ❑ Thyroid disorders

Other
- ❑Glaucoma
- ❑Kidney disorders
- ❑ Impairment: Type_____
- ❑ Cancer: Type_____

Are you being treated for any other illness at this time? ❑Yes ❑ No. If yes, please explain:

_____

_____

Date of Last Physical _____ **Results** _____

Have you ever had SURGERY? ❑Yes ❑No If yes, please list:

Have you, or a family member ever had a problem with anesthesia? ❑Yes ❑No. If yes, please explain:

Have you been diagnosed with a sleep disorder/sleep apnea? ❑Yes ❑No
Do you use a C-Pap Machine for your sleep disorder? ❑Yes ❑No

Do you have any DRUG ALLERGIES? ❑Yes ❑No. If yes, please note name of drug and reaction:

FAMILY HISTORY (Only list blood related relatives.) **❑None**

❑Diabetes		❑ Blood Clots		❑High Blood Pressure	
❑Stroke		❑Heart Disease		❑Cancer/ type	
❑ Other					

LIST ALL MEDICATIONS YOU ARE TAKING WITH NAME AND DOSAGE: ❑ No Meds

		❑Weight control	❑Estrogen/ hormones
		❑Accutane (past year)	❑Chemotherapy
		❑Antibiotics	❑Antidepressants
		❑Aspirin/ NSAID's	❑Steroids
		❑Blood thinners	❑Vitamins/ supplements
		❑Birth control	❑Herbal/ homeopathics

(All information is strictly confidential)

Are you taking or have you ever taken recreational drugs? ❑ Yes ❑ No What type_____
Please give more details _____

Nicotine Use (smoke, vape, chew, patch, etc.) ❑ Yes ❑ No Quit?_____ **How much?**_____ # per day
Alcoholic beverages? ❑ Yes ❑ No ❑ Socially ❑ Occasionally ❑ Moderately

♀ WOMEN'S HEALTH ❑ N/A

Pregnancies: _____ Live births: _____ Miscarriages: _____ Abortions: _____

Date of Last Menstrual Period: _____ Are you pregnant? ❑ **Yes** ❑ **No**

Date of Last Mammogram:_____ Results: _____

Current Bra Size: _____ Breast Cancer ❑ **Yes** ❑ **No** History of Breast Biopsy ❑ **Yes** ❑ **No**

REVIEW OF SYSTEMS

Please circle the following symptoms you have had recently: ❑ **No Symptoms**

General:	Fatigue. Fever. Chills. Sweats. Sleep disturbance. Recent weight gain or loss.
Eyes, Ears, Nose, & Throat:	Blindness. Blurred vision. Cataracts. Contact lenses. Double vision. Dry eyes. Eye irritation. Eye pain. Excessive tearing. Red eyes. Sensitivity to light. Visual changes. Ear discharge. Difficulty breathing through nose. Dizziness. Hearing loss. Ringing in the ears. Chronic nasal congestion. Nose bleeds. Loss of sense of smell. Past nasal injury. Sinus problems. Ulcer/sore. Capped teeth. Loose teeth. Tooth pain. Dental problems. Dentures. Difficulty swallowing. Hoarseness. Snoring.
Cardiovascular:	Chest pain. Congestive heart failure. Irregular / rapid heartbeat. Heart attack. Low blood pressure. Mitral valve prolapse/ need for antibiotics for dental procedures. Foot swelling. Palpitations/ Skipped beats. Poor circulation. Rheumatic fever. Varicose veins.
Respiratory:	Bronchitis. Bloody cough. Shortness of breath. Pneumonia. Recent cough. Wheezing. Tuberculosis.
Gastrointestinal:	Bloating. Blood in vomit / stools. Changes in appetite. Change in bowel habits. Chron's colitis. Constipation. Diarrhea. Hemorrhoids/ rectal bleeds. Gastritis/ reflux. Hepatitis/ jaundice. Irritable bowel syndrome. Nausea/ vomiting. Peptic ulcers. Ulcerative colitis.
Genitourinary:	Urinary infections. Urinating: Blood/ Difficulty/ Frequent/ Pain/ incontinent. STD. Yeast infections.
Musculoskeletal:	Arthritis. Difficulty walking. Extremity pain. Injuries. Joint pain. Leg cramps. Lupus Erythematosus, Rheumatoid arthritis. Unusual muscle weakness. Swelling.
Neurologic:	Dizziness/ fainting. Numbness. Migraines/ headaches. Seizures/ epilepsy. Sensory loss. Stroke. Weakness/ loss of balance.
Psychiatric:	Alcoholism. Anxiety. Depression. Drug abuse. Financial trouble. Marital problems. Schizophrenia.
Heme/ Immunologic:	Bleeding gums. Blood clot/ clotting disorder. Blood transfusion. Easy bruising. HIV complications. MRSA / VRE infections. Sickle Cell Anemia. Swollen lymph nodes.
Endocrine/ Hormonal:	Adrenal disorders. Labile blood glucose levels. Neuropathy. Steroid use. Thyroid symptoms.
Skin Disease:	Acne. Burn injury. Difficulty healing wounds. Excessive or unsatisfactory scarring. Itching/ Hives. Moles changing in appearance. Skin Cancer. Unexplained rash/ inflammation.
Breasts:	Abnormal Mammogram. Bloody discharge. Benign lump/ tumor. Cancer. Clear discharge. Milky discharge. Fibrocystic breasts. Pain. Reduction. Saline breast implants. Silicone breast implants.

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

X_____
Signature of Patient, Parent, Guardian or Personal Representative Date Time

X_____
Name of Patient, Parent, Guardian or Personal Representative Date Time

_____
Reviewed by (Clinic Personnel, if applicable) Date Time

_____
Reviewed by (Pre-Op Personnel) Date Time

(All information is strictly confidential)

COCCO CLINIQUE MD, PA

FINANCIAL POLICY

Thank you for choosing our Plastic Surgery Practice. We are committed to providing you the best care possible. Please understand that all encounters or treatments will incur a financial charge. By signing below, you agree to adhere to our financial policies:

1. This is a fee for service practice at the time of services.
2. You will be responsible for payment of:
   - Charges incurred for Cosmetic or Non-Cosmetic services
   - Outside Exams such as Pathology, Labs, Imaging, or Cardiac Evaluation, Etc.
   - Prescriptions purchased at Pharmacy
3. Each office visit can be reserved with *a Credit/Debit card*, we will charge a $100.00 missed appointment fee, we request that you give us one business day notice for cancellation or re-scheduling of an appointment, otherwise a $100.00 fee will be charged. A fee of $250.00 will be charged for "No Shows" or cancellations on scheduled In-Office Procedures without a 48-hour notice.
4. Patient requests to speak to Dr. Cocco for any Non-Emergency issue are subject to a $75.00 charge per call.
5. We accept cash and most types of credit cards. Personal checks are accepted in established accounts only. A $35.00 *bounced-check fee* will be applied to your account for a returned check. Dr. Cocco does not fill extended work absence packets short or long –term disability, FMLA, and extended insurance forms.
6. If you purchase skin-care products, make-up or other medical supplies from our office, please understand that these are non-refundable items. In the event the product is defective or expired, we will gladly credit your Cocco Clinique account.
7. All surgery fees are due 10 business days prior to completion or immediately at the time of service. A Non-Refundable/Transferable $500.00 *Booking fee* is required in order to secure a surgery. Payment plans have a maximum term of 12 months, Payment in full is required to proceed with surgery and all fees are non-refundable once services have been provided. A *Surgery cancellation* fee of $1000.00 will be charged if cancellation notice is not given 7 days before your scheduled procedure. Payments made via credit card for surgery may be refunded minus 6% for processing charges. Services rendered that are paid with a credit card, data card, or third–party financing are NOT eligible for payment challenges after services are provided.

Initials _____

CONSENT FOR IRREVOCABLE NON-ASSIGNMENT

I hereby understand and consent for Dr. Jennyfer F. Cocco M.D. to provide care for me, as explained to me in additional informed consent documents. I understand the procedure(s) I seek are cosmetic in nature, not medically necessary, and therefore would be fraudulent and unethical to submit a fee to any insurance company for coverage. I have been explained and shown the financial costs of having Dr. Jennyfer F. Cocco M.D. provide surgical care for me and accept these terms. I further understand that Dr. Jennyfer F. Cocco M.D. will not accept insurance for this (these) procedure (s). My consent to have Dr. Jennyfer F. Cocco M.D. provide care and not accept assignment from any insurance company, managed care provider, or other coverage source is irrevocable and final. I understand I will be fully responsible for the surgical fees for the surgery I seek.

Initials _____

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice may been provided to you, that you Understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

Initials _____

NOTICE OF BUSINESS OWNERSHIP

In accordance with Federal Regulations (42 CFR 416.50). The Surgery Center of Texas must disclose the names of the physicians who are owners of the facility as they receive direct or indirect remuneration from this ownership. Dr. Jennyfer F. Cocco M.D. is part owner of The Surgery Center of Texas: 6020 West Plano Pkwy. Plano TX 75093

By signing this form, you acknowledge that you have been notified of Dr. Cocco's business ownership.

Initials _____

CONSENT FOR TRANSMISSION OF PHI BY NON-SECURE MEANS

I give permission to Cocco Clinique MD, PA and Affiliates to use unsecured email and mobile phone text messaging to transmit to me the following protected health information (PHI):

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment
- Information related to medical care and treatment

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time in the future in writing.

Initials _____

RELEASE OF PHOTOGRAPHIC IMAGES

I authorize Dr. Jennyfer F. Cocco M.D., Cocco Clinique MD, PA and /or its representative(s) to take photographs, slides, videos of me for medical purposes to be used for my care, and for surgery planning. In addition, I authorize the use of these images, without compensation to me, for the following specific purposes

- Medical Presentations.
- In-office photo album for prospective patients.
- Office seminars for prospective patients.
- In print advertisement
- On our website, newsletters, bulletin, publications, and social media outlets, (i.e. Facebook, Instagram, Snapchat, etc.).

I understand that:

1. I will not be identified by name in any of the media described above; however, I also understand that in some circumstances, the photographs, slides or videos may display features that identify me (only on procedures that involve face and eyes).
2. I have the right to revoke this authorization in writing at any time and, if so, I must present my written revocation to Cocco Clinique MD, PA at 8305 Walnut Hill Ln. Ste 120 Dallas TX 75231. Revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization.
3. The information disclosed under this Authorization, or some portion thereof, is protected by state law and /or the federal Health Insurance Portability and Accountability Act of 1996 ('HIPAA"). Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by applicable federal and/or state confidentiality rules.
4. A copy of this Authorization is valid as the original. I have full access to a copy of this Authorization. I may inspect or copy information to be used or disclosed under this Authorization, as provided by federal and/or state law.

I release and discharge Dr. Jennyfer F. Cocco M.D., Cocco Clinique MD, PA., and Surgery Center of Texas from all liability, including liability for negligence that in any way arises out of:

- Any and all rights that I may have or may have had in the photographs, slides or videos of me that I have authorized to be used and disclosed in this Authorization
- Any claim that I may have or may have had relating to such use and disclosure of those photographs, slides or videos of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public education and I certify that I have read this Authorization and Release carefully and fully understand its terms.

If the patient is a minor, the undersigned, are the parents or legal guardian of them and do hereby have legal authority to consent and do consent for them.

Initials _____

If you have any questions about this policy, please do not hesitate to ask. We also offer the translation for this form in Spanish. We are here to work with you and make your visit and/or surgery experience the best possible. Your signature below signifies that you understand your responsibility regarding charges incurred at Cocco Clinique MD PA and agree with our policies.

La firma a continuación significa que usted entendió nuestra póliza y sus responsabilidades en relación a cargos incurridos en Cocco Clinique MD PA, y que está de acuerdo con nuestra póliza

_____

Patient/Guardian Name

_____

Signature

_____/_____/_____

Date