STEWART & THAXTON PLLC
ANDY STEWART, MD ■ JEFF THAXTON, MD
4415 MacCorkle Avenue, SE, Charleston, WV 25304 · p: 304-925-8949 · f: 304-925-8953
Plastic Surgery - Reconstructive Surgery - Aesthetics

PATIENT MEDICAL HISTORY

Patient Name: _____ **Date:** _____

Height: _____ **Weight:** _____ **Age:** _____

Yes No Do you smoke? Packs per day: _____ Number of years: _____
Yes No Do you use tobacco products? Packs/cans per day: _____ Number of years: _____
Yes No Have you ever smoked or used tobacco products in the past?
Packs per day: _____ Number of years: _____ When did you quit? _____
Yes No Do you consume alcohol? # of drinks per week _____
Yes No Do you take or have you taken recreational drugs?

Yes No Are you allergic to latex (rubber) products? Tapes? _____
Yes No Have you experienced chest pain or tightness?
Yes No Do you have a heart condition? Explain: _____
Yes No Do you have hypertension (high blood pressure)?
Yes No Do you have high cholesterol/triglyderides?
Yes No Do you or have you experienced shortness of breath? Explain: _____
Yes No Do you have (please circle): asthma bronchitis COPD emphysema other breathing problem
Explain: _____
Yes No Do you have a history of strokes or seizures?
Yes No Do you have diabetes?
Yes No Insulin dependent?
Yes No Have you had (please circle): hepatitis liver disease jaundice Explain: _____
Yes No Do you have a thyroid condition? (Please circle one.) Hypo Hyper Explain: _____
Yes No Do you have or have you had kidney disease?
Yes No Do you have or have you had ulcers or other stomach disorders? Explain: _____
Yes No Do you have a hiatal hernia or any other hernias? Explain: _____
Yes No Do you have reflux or frequent heartburn?
Yes No Do you have back or neck pain? Explain: _____
Yes No Do you have numbness, weakness, or paralysis of your extremities? Explain: _____
Yes No Do you have any muscle or nerve disease? Explain: _____
Yes No Do you have or have you ever had any bleeding problems? Explain: _____
Yes No Have you ever had a blood transfusion? Explain: _____
Yes No Do you use a CPAP or do you have sleep apnea?
Yes No Have you ever been tested for sleep apnea? Explain: _____
Yes No Have you ever had congestive heart failure? Explain: _____
Yes No Do you have anxiety?
Yes No Do you have a depression disorder? Explain: _____
Yes No Have you had breast cancer?

PATIENT MEDICAL HISTORY (cont.)

Yes No Have you had any other types of cancer? Please list: _____
Yes No Have you had any skin cancers? Please list type(s) and area(s): _____
Yes No Have you ever had any problems with anesthesia? Please list: _____
Yes No Have you had any other illness not indicated above? Please list: _____
_____
Yes No Is there anything else that would be valuable for us to know? Please list: _____
_____

Drug Allergy	**What reaction did you have to this medication?**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medication	**Dose**	**Frequency (How many times/day)**	**Reason for taking this medication**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Surgeries	**Date of surgery**	**Name of Surgeon**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY MEDICAL HISTORY Mark any diseases that have occurred in your immediate family. (Parents, grandparents, siblings.)

Yes No Diabetes: who has it? _____
Yes No High blood pressure: who has it? _____
Yes No Heart disease: who has it? _____
Yes No Cancer: who has it and what type? _____
Yes No Thyroid disease: who has it? _____
Yes No Lung disease: who has it? _____
Yes No Kidney disease: who has it? _____
Yes No Problems with anesthesia? Who and what type of problem? _____
Any other medical issue not listed above: Who and what? _____

I hereby certify that the forgoing information is correct. If there are any changes in my medical history I will notify Stewart & Thaxton.

Patient Signature: _____ **Date:** _____
Patient Printed Name: _____

STEWART & THAXTON PLLC
ANDY STEWART, MD ■ JEFF THAXTON, MD

Consent for Peer Review / Disclosure of Information

I authorize Dr. W. Andrew Stewart OR Dr. Jeffrey N. Thaxton to disclose complete information concerning his medical findings and treatment of the undersigned, from the initial office visit until the date of conclusion of such treatment, to those individuals who, in Dr. W. Andrew Stewart's or Dr. Jeffrey Thaxton's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

Patient Signature: _____ Date: _____

Consent for Photographs

I, _____, ☐ GIVE ☐ DECLINE

my consent for Dr. W. Andrew Stewart OR Dr. Jeffrey N. Thaxton to show my before and after photographs to other patients desiring a similar procedure. I realize my identity will be protected and my name will not be released.

Patient Signature: _____ Date: _____

Medicare Authorization

I authorize Stewart & Thaxton, PLLC to submit billing claims to Medicare on my behalf. I also request that payment of authorized Medicare benefits be made either to me or on my behalf to Stewart & Thaxton, PLLC for any services furnished me by that group. I authorize the release of medical information needed to determine these benefits. My signature below authorizes payment to be made directly to Stewart & Thaxton, PLLC. If other health insurance is in effect as a supplemental policy, I further authorize payment to Stewart & Thaxton, PLLC and also authorize the release of information to that company for payment of benefits. I acknowledge that I will be responsible for any balance not covered by Medicare. I further acknowledge that I was given this advance notice prior to the services being rendered.

Patient Signature: _____ Date: _____

Assignment of Benefits

I hereby irrevocably assign to, and direct my insurance company to pay to Stewart & Thaxton, PLLC all medical benefits payable to me therefrom as a result of such illness or injury to the extent of the medical or surgical services rendered. I also authorize the release of my medical records to my insurance company upon their request for pre-authorization of services or to secure payment on my account.

I acknowledge that I will be responsible for any balance not covered by my insurance company. I further acknowledge that I was given this advance notice prior to the services being rendered.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Members
AMERICAN SOCIETY OF PLASTIC SURGEONS
4415 MacCorkle Avenue, SE Charleston, WV 25304 Phone: (304) 925-8949 Fax: (304) 925-8953

STEWART & THAXTON PLLC

ANDY STEWART, MD ■ JEFF THAXTON, MD

Patient Information

First Name:	**Last Name:**	**MI:**	**Select Primary # Below** ↓
Address:			**Home Ph:** ☐
City	**State:**	**Zip:**	**Work Ph:** ☐
DOB:	**Age:**	**Sex:**	**Cell Ph:** ☐
SSN:	**Marital Status:**		**Spouse Name:**
Race:	**Ethnicity:**		**Email:**
Occupation/Job:		**Employer:**	
Primary Care Physician:	**PCP Ph:**		**If Retired, Date:**

***Our Physicians would love to keep you updated on special offers/events for Botox, Juvederm, Latisse, and Obagi via email or US mail.**

Please contact me via ☐ Email ☐ Mail ☐ I do not wish to be contacted about promotions or events.

Emergency Contact

First Name:	**Last Name:**	**Relationship to Patient:**
Home Ph:	**Cell Ph:**	**Work Ph:**

Insurance Information:

Primary Insurance Name:		
Primary Insured's Name:	**Insured Social Security #:**	**Insured DOB:**
Secondary Insurance Name:		
Secondary Insured Name:	**Secondary Social Security:**	**Secondary DOB:**

Parent/Legal Guardian (If Patient is a Minor)

Mother's Name:	**DOB:**	**Home Ph:**
Employer:	**Work Ph:**	**Cell Ph:**
Father's Name:	**DOB:**	**Home Ph:**
Employer:	**Work Ph:**	**Cell Ph:**

Other Information

Referred By:	**Reason for Visit:**	
Workers Compensation: Yes No	**Auto Accident:** Yes No	**Other:**
Does this involve litigation: Yes No	**If yes, please explain:**	

Patient Signature **Date:**

Witness Signature: **Date:**

Members AMERICAN SOCIETY OF PLASTIC SURGEONS

4415 MacCorkle Avenue, SE Charleston, WV 25304 Phone: (304) 925-8949 Fax: (304) 925-8953

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed
The information covered by this authorization includes:

_____

_____

_____

Persons Authorized to Use or Disclose information
Information listed above will be used or disclosed by:

Stewart and Thaxton Plastic Surgeons

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to:

_____
Name of person or organization

_____
Name of person or organization

Expiration Date of Authorization
This authorization is effective through _____/_____/_____ unless revoked or terminated by the patient or the patient's personal representative.

_____
Name of Patient (Print or Type)

_____
Signature of Patient Date

_____
Signature of Patient Representative Relationship to Patient Date

STEWART & THAXTON PLLC
ANDY STEWART, MD ■ JEFF THAXTON, MD

Consent for Peer Review / Disclosure of Information

I authorize Dr. W. Andrew Stewart OR Dr. Jeffrey N. Thaxton to disclose complete information concerning his medical findings and treatment of the undersigned, from the initial office visit until the date of conclusion of such treatment, to those individuals who, in Dr. W. Andrew Stewart's or Dr. Jeffrey Thaxton's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.

Patient Signature: _____ Date: _____

Consent for Photographs

I, _____, ☐ GIVE ☐ DECLINE

my consent for Dr. W. Andrew Stewart OR Dr. Jeffrey N. Thaxton to show my before and after photographs to other cosmetic patients desiring a similar procedure. I realize my identity will be protected and my name will not be released.

Patient Signature: _____ Date: _____

Cosmetic Advance Notice and Beneficiary Agreement

This is to acknowledge that the consultation and/or procedure to be performed by:

☐ W. Andrew Stewart, MD ☐ Jeffrey N. Thaxton, MD

is considered cosmetic in nature. By signing this form, I understand that insurance will not be billed for this procedure and that I am responsible for payment.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Members
AMERICAN SOCIETY OF PLASTIC SURGEONS

4415 MacCorkle Avenue, SE Charleston, WV 25304 Phone: (304) 925-8949 Fax: (304) 925-8953

W. Andrew Stewart, MD
Jeffrey N. Thaxton, MD
Plastic and Aesthetic Surgery

FINANCIAL POLICY

_____ I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy. I agree that this non credit card challenge agreement is irrevocable.

_____It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment. Services that are paid for with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Stewart & Thaxton PLLC., to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment.

_____Cash, cashier's check, Visa, MasterCard or CareCredit financing. If a Visa, MasterCard or CareCredit card is used, the account holder or other authorized signer must be present to make payment. Please be aware that debit cards, while bearing either the Visa or MasterCard logo, often have daily transaction limits. Please check with the issuer of your card regarding any limits or restrictions regarding the use of these cards for large dollar amount transactions.

_____Payment by personal check will not be accepted later than two weeks prior to the surgery date. We do not accept third party checks. All returned checks will be assessed for a $35.00 fee.

_____Cancellation Fees. We understand that unavoidable events can result in the need to cancel a procedure. However, operating room personnel are scheduled weeks in advance and must be compensated if a cancellation occurs. We appreciate your understanding that cancellation fees are necessary to compensate our personnel and are not meant to penalize you. If a scheduled procedure is cancelled by the patient within two weeks of the procedure, the deposit is non-refundable. If the procedure is scheduled within two weeks of the surgery date and subsequently cancelled, the cancellation fee of $1,000 will also apply. If the total of the procedure is less than $1,000, the entire fee is forfeited. Additionally, if payment of the deposit is made by Visa, MasterCard, or CareCredit card, the amount of the discount charged to our office will also be due and payable by the patient. (Example: Deposit of $1,000 paid via CareCredit card, with 5% discount fee charged by CareCredit. Additional $50 due by Patient to reschedule).

_____Cancellation fees will apply if the procedure is cancelled or postponed by the surgeon due to the patient failing to comply with the surgeons instructions prior to the surgery, including, but not limited to: not providing accurate medical history, failure to discontinue the use of certain prescription or over the counter medications prior to surgery, discontinuation of smoking or use of nicotine products, or situations where we deem it unsafe to operate after sedation.

_____If you wish to re-schedule your surgery, the amount of the cancellation fee, deducted from your original payment in addition to any Visa, MasterCard, or CareCredit discount, must be paid at the time of reschedule. Chronic cancellations will not be re-scheduled.

_____A deposit of $1000 is required at the time a cosmetic procedure is scheduled. If the total cost of a procedure is $1,000 or less, the entire amount is due at the time of scheduling. The remaining balance is due in full two weeks prior to the scheduled surgery date. Failure to do so will result in cancellation of the procedure and forfeiture of the deposit. Exceptions will be made only in cases where the surgery date is moved forward. If a procedure is scheduled within two weeks of the surgery date, payment in full will be due at that time.

I have read and understand the above policy.

Patient Signature Date

Witness Signature Date

925-8953

Members
AMERICAN SOCIETY OF PLASTIC SURGEONS

4415 MacCorkle Avenue, SE Charleston, WV 25304 Phone: (304) 925-8949 Fax: (304)

W. Andrew Stewart, MD
Jeffrey N. Thaxton, MD
Mountain State Plastic Surgeons

Plastic and Aesthetic Surgery

HIPAA Notice of Privacy Practices

W. Andrew Stewart, MD, FACS and Jeffrey N. Thaxton, MD
4415 MacCorkle Avenue, SE, Charleston, WV 25304 phone: 304-925-8949

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This **Notice of Privacy Practices** describes how we may use and disclose your protected heath information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physicians, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be proceed to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

We may use or disclose, as needed, your protected health information in order to support the busines

Healthcare Operations: s activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required By Law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Worker's Compensation, Inmates, Required Uses and Disclosures, Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under the federal law, however, you may not inspect or copy the following records, psychotherapy notes, information compiled in reasonable anticipation of, or us in, a civil,

criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to who you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and became effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Print Name: **Signature:** **Date:**