LYOS
PLASTIC SURGERY & ASSOCIATES

HOW DID YOU HEAR ABOUT US? INTERNET / BILLBOARD / RADIO / MAGAZINE / SOCIALMEDIA / GOOGLE / YELP / REAL SELF / MAGAZINE / OTHER

_____

PLEASE ANSWER ALL QUESTIONS

PLEASE CIRCLE MALE / FEMALE

NAME_____ AGE_____ DOB_____
LAST FIRST MIDDLE INITAL

PATIENTS SOCIAL SECURITY #_____

PATIENT DL#_____

HOME ADDRESS_____ _____
STREET APT NUMBER

_____
CITY STATE ZIPCODE

HOME (____)_____ CELL(____)_____ WORK(____)_____

BEST CONTACT NUMBER (PLEASE CIRCLE ONE) HOME / WORK / CELL-PLEASE LIST

CELLULAR CARRIER_____

EMAIL_____

EMPLOYER_____ OCCUPATION_____

EMPLOYER ADDRESS_____ _____
STREET CITY STATE ZIPCODE

NAME OF RESPONSIBLE PARTY /
INSURANCE SUBSCRIBER **(IF OTHER THAN PATIENT)**_____

HOME ADDRESS_____ _____
STREET CITY STATE ZIPCODE

HOME (____)_____ CELL (____)_____

PLEASE LIST IF REFERRED BY: FRIEND / FAMILY / EMPLOYEE_____

PRIMARY PHYSICIAN_____

ADDRESS AND/OR PHONE #_____

PHARMACY PHONE #/ ST ADDRESS:_____

_____

REASON FOR CONSULTATION (LIST ALL)_____

STATEMENT OF FINANCIAL RESPONSIBILITY

The service(s) you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. If applicable and indicated, we will verify insurance coverage as a courtesy to you. However, you are ultimately responsible for payment of your bill in full.

_____ _____

PATENT/GUARDANTOR SIGNATURE DATE

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INSURANCE REIMBURSTMENT

This form must be complete in order to verify and bill your insurance carrier.

*** sections must be complete if you are not the subscriber**

NAME OF PRIMARY INSURANCE CO_____

POLICY_____ GROUP#_____

PATIENT STATUS (PLEASE CIRCLE ONE) SINGLE / MARRIED / OTHER

PATIENT EMPLOYMENT STATUS (PLEASE CIRCLE ONE) EMPLOYED / FULL-TIME STUDENT / PART-TIME STUDENT

NAME OF SUBSCRIBER (IF OTHER THAN PATIENT)_____

RELATIONSHIP TO PATIENT (PLEASE CIRCLE ONE) SPOUSE / PARENT/ CHILD / OTHER

SUBSCRIBER SOCIAL SECURITY # _____ SUBSCRIBERS DOB_____

SUBSCRIBERS EMPLOYER/SCHOOL NAME_____

POLICY #_____ GROUP #_____

NAME OF SUBSCRIBER (IF OTHER THAN PATIENT)_____

RELATIONSHIP TO PATIENT (PLEASE CIRCLE ONE) SPOUSE / PARENT / CHILD / OTHER

SUBSCRIBERS SOCIAL SECURITY #_____ SUBSCRIBERS DOB_____

SUBSCRIBERS EMPLOYER/SCHOOL NAME_____

PLEASE READ CAREFULLY: YOUR INSURANCE CARRIER MIGHT NOT FULLY REIMBURSE YOU FOR HOSPITAL ADMISSION OR SURGICAL PROCEDURES!

Most group insurance policies have just recently been amended to include preadmission certification requirements for hospital admissions and/or second surgical opinion requirements for selected surgical procedures. I understand that this is my responsibility to fulfill any preadmission or second opinion requirements contained in my insurance policy. I realize that failure to do so may result in a significant reduction in my insurance benefits. I, the undersigned, have read the above policy regarding my financial responsibility to Lyos Plastic Surgery & Associates, for providing services to me or the patient mentioned below. I certify that the information, to the best of my knowledge, true and accurate. I hereby assign to Lyos Plastic Surgery & Associates all payments to which I am entitled for medical and/or surgical expenses related to the services reported for my illness or injury. I understand that I am financially responsible to said provider for charges not covered by this assignment of benefits. A copy of this assignment is as valid as the original.

_____ _____

PATIENT (PRINT NAME) DATE

_____

PATIENT SIGNATURE

_____ _____

GUARANTOR/SUBSCRIBER if patient is a minor (PRINT NAME) DATE

_____

GUARANTOR/SUBSCRIBER SIGNATURE (if patient is a minor)

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Physician-Patient Medicare Opt-Out Contract

Patient Name:_____

"Physician" shall be understood to mean Andrew T Lyos, M.D., Lyos Plastic Surgery & Associates, Memorial Aesthetic Surgery Center and/or MD Aesthetica Medical Spa. This agreement is between "Physician and/or Provider", whose principal place of business is: 9230 Katy Freeway, Suite 420, Houston, TX 77055 and the "Patient" and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. Physician has informed Patient that Physician has opted out of the Medicare Program, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.
Physician agrees to provide general medical services to Patient. In exchange for the services, Patient agrees to make payments to Physician pursuant to the current Fee Schedule. (The Fee Schedule includes most, but not all, common services.)

Patient also agrees, understands, and expressly acknowledges the following:
Please sign below to acknowledge your agreement:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent heath care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he/she has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by Physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.

_____ _____
PATIENT NAME (PRINT) DATE

_____
PATIENT OR DESIGNATED REPRESENTITIVE SIGNATURE

_____ _____
PHYSICIAN SIGNATURE DATE

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PATIENT_____ DOB_____

EMAIL_____

SSN # _____ PHONE #(_____)_____

I understand that under the Health Insurance Portability and Accountability Act of 1996, I have the right to make reasonable requests to receive confidential communications of my protected health information from Lyos Plastic Surgery & Associates, Memorial Aesthetic Surgery Center and MD Aesthetica Medical Spa ("**Practice**") by alternative means or at alternative locations. By completing and signing this form, I am requesting Practice communicate with me via email at the address above.

I acknowledge and agree to the following:

- I have received and reviewed the "Important Information About Email" notice; had an opportunity to ask questions and have had such questions answered to my satisfaction; and understand the information contained within the notice.
- Despite the possibility that my email system may not be encrypted or secure and there are no assurances of confidentiality, I consent to the Practice communicating with me via email.
- The email address above is accurate and it is my responsibility to update the Practice of any changes.
- I may withdraw this consent at any time by delivering written notice to the Practice.

Please mark the ways that you consent to us communicating with you

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Perferred Contact Method(s)	Best Time to Call*
Call Work Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐	AM / PM / ANY
Call Cell Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐	AM / PM / ANY
Call Home Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐	AM / PM / ANY

Ok to send Emails?

Email Appointment Reminds ☐ Yes ☐ No

Email Medical Info/Communicate with Staff ☐ Yes ☐ No

Email Office Specials/News ☐ Yes ☐ No

Ok to Send Regular Emails? ☐ Yes ☐ No

Ok to Send Text Message For Appointment Reminders? ☐ Yes ☐ No

-IF YES, PLEASE LIST CELL PHONE CARRIER (e.g. AT&T): _____

Please list **Emergency Contact:**

Name	Relationship	Contact Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE) DATE

LYOS
PLASTIC SURGERY & ASSOCIATES

IMPORTANT INFORMATION ABOUT EMAIL
THIS NOTICE DESCRIBES THE RISKS ASSOCIATED WITH UNENCRYPTED EMAIL. PLEASE REVIEW IT CAREFULLY.

SECURITY RISKS

Most standard email providers such as Gmail, Yahoo, Hotmail, etc. do not provide a secured or encrypted means of communication. As a result, there is risk that any protected health information contained in an email may be disclosed to, or intercepted by, unauthorized third parties. Additionally, email messages accessible through personal computers, laptops, or phones have inherent privacy risks especially when the email account is provided by an employer, when the account is not password protected, or the account is shared. Use of more secure communications, such as phone, fax or mail is preferred and always an available alternative.

RESPONSIBILITY

When consenting to the use of email through such unsecured or unencrypted systems, you are accepting responsibility for any unauthorized access or disclosure to protected health information contained within the message. The Practice will not be responsible for unauthorized access of protected health information while in transmission and will not be responsible for safeguarding information once it is delivered. The Practice will take steps to ensure that any email with protected health information is protected prior to being sent to the requested address and will use the minimum necessary amount of protected health information when communicating with you.

ADDITIONAL INFORMATION

It is important to understand that emails will not be used to replace or facilitate communications between you and your physician and will not be considered private communications. There is no guarantee that the Practice will be actively monitoring the inbox so responses and replies sent to or received by you or the Practice may be hours or days apart. Email messages may be inadvertently missed or errors in transmissions may occur. The Practice will not be responsible for any issues caused by delays in communications. If you have an immediate need or an emergency situation, you must contact the Practice by telephone or dial 9-1-1 if applicable. Practice staff will be utilized to monitor the inbox in order to properly direct or respond to communications received. Therefore, any information considered sensitive should not be included in your communications.

At the Practice's discretion, any email message received or sent may become part of your medical record.

RETAIN FOR RECORDS

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DISCLOSURE AUTHORIZATION FORM FAMILY & FRIENDS

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 ("**PHI**"). As required by the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), Lyos Plastic Surgery & Associates has provided a Notice of Privacy Practices describing how it may use and disclose PHI. It is important to understand that any uses or disclosures outside those circumstances described in the notice will be made **only with your written authorization including most disclosures to family members or friends**. This means we will not disclose information to a person despite their relationship with you unless you have specifically authorized them to receive such information. Therefore, this authorization must be completed to identify those individuals who will be permitted to receive information about your medical care.

AUTHORIZATION

I authorize the Practice to disclose my PHI to those individuals listed below (specify name, relationship and contact information if applicable):

NAME	RELATIONSHIP	CONTACT NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____

The information that can be disclosesd to the above named individuals includes:

☐ All PHI

Only information relating to (*specify such as appointments, payment, etc.*):

Only information pertaining to the time period from:_____ To: _____

Other (*specify*):_____

This authorization will be in full force and effect for two years unless otherwise indicated below.

Expiration Date: _____

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The PHI is being disclosed for the following purpose (*write "at my request" if there is no specific purpose or you do not wish to specify the purpose*):

_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practice's Privacy Officer. I understand that a revocation is not effective to the extent that the Practice has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that, except as otherwise provided in this authorization, the Practice may use or disclose my PHI in accordance with Practice's Notice of Privacy Practices.

I understand that PHI disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act or other applicable laws or regulations.

I understand that the Practice will not condition my treatment, payment or eligibility for benefits on whether I provide authorization for the requested use or disclosure except:
(1) if my treatment is related to research, or
(2) Health care services are provided to me solely for the purpose of creating PHI for disclosure to a third party.

_____ _____
PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE) DATE

_____
PRINTED NAME

_____
PERSONAL REPRESENTATIVE'S AUTHORITY (IF APPLICABLE)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

LYOS
PLASTIC SURGERY & ASSOCIATES

I acknowledge and agree that I have been provided a copy of the Notice of Privacy Practices for Andrew T Lyos, M.D., Lyos Plastic Surgery & Associates, Memorial Aesthetic Surgery Center and/or MD Aesthetica Medical Spa that describes how my protected health information must be protected and my rights to access and control such information. I acknowledge and agree that I have reviewed the Notice of Privacy Practices in its entirety and been given the opportunity to ask any questions regarding the use or disclosure of my protected health information and my associated rights. I acknowledge and agree that I have had all my questions answered to my satisfaction.

_____ _____

PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE) DATE

_____

PRINTED NAME

_____

PRESONAL REPRESENTATIVE'S AUTHORITY (IF APPLICABLE)

FOR OFFICE USE ONLY
WE WILL MAKE A GOOD FAITH EFFORT TO OBTAIN A WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES PROVIDED TO EACH PATIENT. IF A PATIENT IS UNWILLING OR UNABLE TO SIGN THIS ACKNOWLEDGEMENT, THE GOOD FAITH EFFORTS TO OBTAIN SUCH ACKNOWLEDGEMENT AND REASON WHY THE ACKNOWLEDGEMENT WAS NOT OBTAINED MUST BE DOCUMENTED.
REASON:

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Patient's Name_____ Date of Birth_____

Photograph Consent and Release

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after treatment or surgery. The photographs will be taken by one of the members of Lyos Plastic Surgery & Associates medical staff. I hereby give my consent for Lyos Plastic Surgery & Associates and/or MD Aesthetica Medical Spa to use the photographs under one of the following circumstances.

Please initial one of the following:

_____ **Internet:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Lyos Plastic Surgery & Associates or MD Aesthetica Medical Spa, can be used on the company's website in order to inform the public about treatments and/or plastic surgery methods. Further, I release and discharge Lyos Plastic Surgery & Associates and/or MD Aesthetica Medical Spa, any employees of Lyos Plastic Surgery & Associates, and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am **not identified by name or any other identifying marks at any time during any use or publication of these materials by any party**.

_____ **All Media:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Lyos Plastic Surgery & Associates or MD Aesthetica Medical Spa, can be used in any print or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet, social media and television, in order to inform the public about treatments and plastic surgery methods. Further, I release and discharge Lyos Plastic Surgery & Associates and/or MD Aesthetica Medical Spa, any employees of Lyos Plastic Surgery & Associates, and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am **not identified by name at any time during any use or publication of these materials by any party.**

_____ **Medical Care Only:** Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Lyos Plastic Surgery & Associates and/or MD Aesthetica Medical Spa. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Lyos Plastic Surgery & Associates and/or MD Aesthetica Medical Spa.

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other photo consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

_____

Signature (Patient or Parent/Guardian if Patient is under 18) Dat

Name: _____ Date:_____

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Cosmetic Interests (Check all that apply):

- ☐ Botox Cosmetic
- ☐ Dark Spot Removal
- ☐ Crows Feet
- ☐ Skin Tightening
- ☐ Chemical Peels
- ☐ Laser Hair Reduction
- ☐ Unwanted Fat
- ☐ Facials
- ☐ Skincare Products
- ☐ Mole Removal
- ☐ Skin Resurfacing
- ☐ Skin Texture/Tone
- ☐ Anti-Aging
- ☐ Crepey Skin
- ☐ Forehead Wrinkles
- ☐ Smile Lines
- ☐ Lip Enhancement
- ☐ Spider Vein Removal
- ☐ Coolsculpt
- ☐ Cellulite
- ☐ Dark Circles Under Eyes
- o Other:

Surgery Interests (Check all that apply):

- ☐ Face Lift
- ☐ Breast Augmentation
- ☐ Rhinoplasty
- ☐ Tummy Tuck
- ☐ Liposuction
- ☐ Cellulite
- ☐ Facial Implants
- ☐ Droopy Eyelids
- ☐ Mommy Makeover
- o Other:

How did you hear about Dr. Lyos and MD Aesthetica?

- ☐ Physician
- ☐ Advertisement
- ☐ Friend or Family
- ☐ Yellow Pages
- ☐ Internet
- ☐ Other: _____

If someone referred you, please share his or her name so we can thank them:

_____

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HEALTH HISTORY FORM

Patient Name: _____ DOB: _____

Please answer all of the questions as accurately as possible. If you do not understand a question please ask for assistance.

Primary Care Doctor: _____

Smoker? If so type & amount per day _____ Alcohol (type and amount per week) _____

If former smoker, quit date: _____ Weight _____ Height _____

Drug/Food Allergies: _____

List previous surgeries or major illnesses and dates: _____

_____

_____

_____

List any medications you are taking including non-prescription drugs, vitamins, and herbals: _____

_____

FAMILY HISTORY

BREAST CANCER..... No Yes	HIGH BLOOD PRESSURE..... No Yes	KIDNEY DISEASE..... No Yes
MELANOMA..... No Yes	HEART DISEASE..... No Yes	DEPRESSION..... No Yes
STROKE..... No Yes	DIABETES..... No Yes	

PAST MEDICAL HISTORY

STAPH/SKIN INFECTIONS……No Yes	CANCER……No Yes	STOMACH ULCER……No Yes
HEART DISEASE……No Yes	GLAUCOMA……No Yes	KIDNEY DISEASE……No Yes
ARTHRITIS……No Yes	ASTHMA……No Yes	THYROID DISEASE……No Yes
RHEUMATIC FEVER……No Yes	AIDS or HIV+……No Yes	BLEEDING TENDENCY……No Yes
ANEMIA……No Yes	STROKE……No Yes	MITRAL VALVE PROLAPSED……No Yes
TUBERCULOSIS……No Yes	HEPATITIS……No Yes	HIGH BLOOD PRESSURE……No Yes
DIABETES……No Yes		

REVIEW OF SYSTEM

Do you currently have:

WEIGHT CHANGE..... No Yes	SWOLLEN FEET/ANKLES..... No Yes	SEIZURES..... No Yes
DRY EYES..... No Yes	SKIN RASH..... No Yes	JOINT OR MUSCLE PAIN..... No Yes
CHRONIC COUGH..... No Yes	CHRONIC DIARRHEA..... No Yes	SWOLLEN LYMPH NODES..... No Yes
CHEST PAIN..... No Yes	JAUNDICE..... No Yes	EASY BLEEDING..... No Yes
RAPID HEART BEAT..... No Yes	Depression..... No Yes	EASY BRUISING..... No Yes

WOMEN ONLY:

Age period began_____ Number of pregnancies _____ Did you breast feed? No Yes

Do you do regular breast self-examinations? no yes Breast lump or discharge? No Yes

Date of last mammogram_____