# AUSTIN Plastic Surgery Center

## SERGIO PASQUALE MAGGI, MD, FACS

3410 Far West Blvd. Ste 110
512.345.3223
Austin, TX 78731
Fax 512.345.3228

www.DRMAGGI.com

## GENERAL PATIENT INFORMATION

NAME: ______________________________________________ DATE:_______________
HOW DO YOU PREFER TO BE ADDRESSED?: ___________________________________________

CELL #:_____________________________________ MAY WE LEAVE A MESSAGE: ________

WORK #:____________________________________ MAY WE LEAVE A MESSAGE: ________

HOME #:____________________________________ MAY WE LEAVE A MESSAGE: ________

E-MAIL: ____________________________________________________________________

WOULD YOU LIKE TO BE INCLUDED ON OUR E-MAIL LIST FOR UPDATES? YES _____ NO _____

HOME ADDRESS: ______________________________________________ APT: __________

CITY: ____________________________ ST: ________________ ZIP: __________________

DATE OF BIRTH: _______/_______/________ AGE: ________ SEX: _________

SOCIAL SECURITY NUMBER: ______-_______-________ MARITAL STATUS: S M D W

SPOUSE: __________________________________ CONTACT NUMBER: ________________

EMERGENCY CONTACT: ____________________________ NUMBER: _____________________

OCCUPATION: _________________________________________________________________

EMPLOYER: ___________________________________________________________________

NAME & PHONE NUMBER OF YOUR PRIMARY PHYSICIAN: __________________________________

_____________________________________________________________________________

HOW WERE YOU REFERRED TO OUR OFFICE? _____________________________________________
MAY WE THANK THEM? YES_____ NO_____

**I UNDERSTAND THAT I AM FINANICALLY RESPONSIBLE FOR ALL CHARGES. PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED WITH THE EXCEPTION OF SURGERY WHICH WILL BE DUE AT LEAST ONE WEEK PRIOR TO DATE OF SURGERY. WE ACCEPT CHECKS, MONEY ORDERS, VISA, MASTERCARD, AND AMERICAN EXPRESS. FOR FINANCING COMPANIES WE WORK WITH, PLEASE ASK YOUR PATIENT COORDINATOR.**

**SIGNED:** ____________________________________________ **DATE:** __________________

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## GENERAL HEALTH INFORMATION

**NAME:** ________________________________________ **DATE OF BIRTH:** ______________

PROCEDURES YOU WOULD LIKE TO DISCUSS: ________________________________________
______________________________________________________________________

ARE YOU IN GOOD GENERAL HEALTH? YES _____ NO _____ DATE OF LAST EXAM: ____________
CURRENT HEIGHT: __________ CURRENT WEIGHT:____________ GOAL WEIGHT: __________

PLEASE LIST **ALL MEDICATIONS** (INCLUDING ANY OVER THE COUNTER OR VITAMINS) THAT ARE TAKEN ON A DAILY, OR REGULAR BASIS: ____________________________________________
______________________________________________________________________
______________________________________________________________________

PLEASE LIST **ALL DRUG ALLERGIES** OR ANY ADVERSE DRUG REACTIONS: ____________________
______________________________________________________________________
______________________________________________________________________

DO YOU SMOKE OR USE ANY NICOTINE PRODUCT: YES ___ NO___ IF SO, HOW MUCH?: ____________
DO YOU DRINK ALCOHOL?: YES ____ NO ____ IF SO, HOW MUCH?: __________________________

HAVE YOU HAD ANY OPERATIONS OR BEEN HOSPITALIZED FOR ANY REASON? YES _____ NO _____
PLEASE LIST ALL DATES AND REASONS: ____________________________________________
______________________________________________________________________
______________________________________________________________________

PLEASE LIST ANY ILLNESS OR CONDITION THAT YOU ARE FOLLOWED BY A MD FOR: ______________
______________________________________________________________________
______________________________________________________________________

PLEASE LIST ANY DISEASES, ILLNESSES, OR CONDITIONS WHICH RUN IN YOUR FAMILY?: ____________
______________________________________________________________________
______________________________________________________________________

DO YOU TAKE ASPIRIN ON A REGULAR BASIS? YES______ NO______ HOW MUCH: ______________
DO YOU HAVE EXCESSIVE BLEEDING OR BRUISING? ______________________________________
ARE YOU CURRENTLY PREGNANT OR NURSING? _________________________________________

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## A Brief Note Before We Meet For Your Consultation Today:

We understand that all of our patients have many options and choices to choose from.

We are very grateful that you have given us today the opportunity to participate in your care. And we also thank you for taking the time to review and complete these forms.

We routinely follow-up with all of our consultations a few days afterwards to answer any additional questions that you may have, as well as to inquire on how your experience was with us today.

Patient satisfaction is one of our highest goals.

Sincerely yours,
Dr. Maggi and staff

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# OFFICE POLICY AND PROCEDURES

In order to provide you with the best possible service, I want to offer clear communication and clarification of office policies and procedures.

**APPOINTMENTS:**

My office staff answers the telephone from 8:30 a.m. to 5:00 p.m., Monday through Thursday with lunch from 1:00p.m. To 2:00p.m., and Friday from 9:00a.m. To 1:00 p.m. If no one is available please leave a message and someone will be in touch with you as soon as possible. Please arrive punctually for your appointment.

**EMERGENCIES:**

In case of an emergency after regular office hours, the Medical Exchange (458-1121) will assist you in reaching Dr. Maggi. If you do not reach the doctor within thirty minutes, or if the emergency is life threatening, you need to **go to an emergency room immediately!**

**CANCELLATION OF APPOINTMENTS:**

If you need to cancel or reschedule an appointment, please give us at least a 24-hour notice. This will protect my schedule and practice. Please understand that once you have scheduled an appointment, that time is reserved for you and requests from others are refused. Should you have a Monday appointment time that needs to be cancelled, please notify us by Friday.

**PAYMENTS FOR ELECTIVE/COSMETIC SURGERY:**

A five hundred dollar ($500.00) non-refundable deposit is due in order to schedule a surgery( this will block out the allotted time for the operating room) and the rest of the payment will be due no later than the scheduled date of the History and Physical exam (two weeks before your surgery).
**If you decide to cancel surgery, you must notify either the Office Manager or the Nurse who scheduled your surgery at least 2 weeks (14 days, including holidays and weekends) prior to your scheduled surgery date. If you cancel within One (1) week of surgery we will retain fifty percent of the full surgery fee. If you cancel the same day or week of surgery, the whole payment will be retained.** Your surgery fee is a one-time charge that includes all of your pre- and post-operative visits.

Surgery is not without risks, and the potential of complications. Your surgery fee does not include the possible cost(s) of any post-operative complications that may result- such as, medications, additional procedures, hospitalizations, anesthesia or other related charges (pathology, radiology, laboratory, etc.)

If a "touch-up" or revision surgery/procedure is necessary after your surgery, additional fees will apply. As with your initial surgery the fee may include fees for Dr. Maggi, facility fee, anesthesia fee, and other related charges.

**IF YOU UNDERSTAND AND AGREE TO FOLLOW THE ABOVE STATED POLICIES, PLEASE SIGN BELOW.**
**THANK YOU, SERGIO P. MAGGI, M.D.**

**PATIENT/PARENT/OTHER LEGALLY RESPONSIBLE PERSON SIGNATURE**_________________________
**WITNESS**____________________________
**DATE**______________________

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# Authorization for Release of Patient Photographs

I consent to the taking of photos, slides or video footage by Dr. Maggi or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Maggi. I further authorize Dr. Maggi or one of his/her associates to use these photos as they deem necessary for my treatment, or for use in advertisements or publications for Dr. Maggi or Austin Plastic Surgery Center (APSC).

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of APSC and may be retained by APSC or released by APSC for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, websites, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the images may portray features that will 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. Maggi.

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 have any affect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the 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 further understand that, because APSC 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.

I release and discharge Dr. Maggi, APSC, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs in any form or format.

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

______________________________ ______________________________

Signature Date

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# HIPAA ACKNOWLEDGEMENT

I, ____________________________________ acknowledge that I have read and received a copy of Austin Plastic Surgery Center's Notice of Privacy practices.

_________________________________ _______________

Patient's Name (Please Print) Date

_________________________________ _______________

Signature (Patient/Guardian) Date