Effective Date: March 30, 2015

Privacy Notice

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

Dr. Padgett is required by law to maintain a Privacy Notice and abide by the terms of the notice. The following is a list of how your Protected Health Information may be used by this office.

FOR TREATMENT: Dr. Padgett may disclose protected health information about a patient to nurses, lab technicians, pharmacist, hospital, ambulatory surgery center, pathologists, anesthesiologist and other individuals to coordinate different aspects of the patient's care.
FOR PAYMENT: Dr. Padgett may use or disclose protected health information to third party payers to receive payment for treatment.
FOR HEALTH CARE OPERATIONS: Dr. Padgett may disclose protected health information to others in connection with quality assurance reviews.
APPOINTMENT REMINDERS: Dr. Padgett may disclose protected health information in connection with contacting the patient to provide an appointment reminder.
INDIVIDUALS INVOLVED IN CARE OR PAYMENT FOR CARE: Dr. Padgett may disclose protected health information to friends or family members who are involved in the patient's medical care.
RESEARCH/MEDICAL LITERATURE: Dr. Padgett may use or disclose protected health information, subject to a valid authorization, in connection with a research study, journal article or educational program.
AS REQUIRED BY LAW OR TO AVERT A SERIOUS THREAT TO HEALTHE OR SAFETY: Dr. Padgett may be required by law to disclose protected health information.

PATIENT RIGHTS

RIGHT TO REQUEST RESTRICTIONS: You have the right to request restrictions on certain uses and disclosures of protected health information. However, Dr. Padgett is not required to agree to a requested restriction.
RIGHT TO INSPECT A COPY: You have the right to inspect and copy information that may be used to make treatment decisions. Dr. Padgett may charge a reasonable fee for such copies.
RIGHT TO AMEND: You have the right to are a written request to amend medical information that he or she believes is inaccurate or incomplete. Dr. Padgett may deny the request if he or she believes the information is accurate and complete.
RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS: Patient may request that Dr. Padgett only communicate with him or her in a certain manner (i.e., by mail or at work).
RIGHT TO AN ACCOUNTING OF DISCLOSURES: A patient has the right to request an accounting of all disclosures Dr. Padgett made of protected health information related to the patient over reasonable period. Dr. Padgett may charge a reasonable fee for such listings.
RIGHT TO OBTAIN A PAPER COPY: You have the right to obtain a copy of your medical records. You must request the copy in writing with your signature authorizing Dr. Padgett to release you medical record. You must also provide address as to where medical record may be sent. A reasonable fee may be charged including postage.

IF YOU WISH TO RECEIVE ADDITIONAL INFORMATION ABOUT ANY OF THE MATTERS IDENTIFIED IN THE PRIVACY NOTICE OR IF YOU BELIEVE YOU PRIVACY RIGHTS HAVE BEEN VIOLATED BY THE OFFICE, PLEASE CONTACT OUR OFFICE AT 405-755-5115

Authorization

Dr. Padgett operates at several different facilities, Oklahoma Surgicare being one of them, of which she is part owner. If your surgery is scheduled there please provide her with feedback on the quality of care you receive there.

I hereby authorize the use and disclosure of any information contained in my medical record to my insurance company, referring physician, and/or primary care doctor or to any other individual(s) Dr Padgett feels is indicated in the quality and continuance of care. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

I hereby consent to the use and disclosure of my personal health information for the purposed of treatment, payment and health care operations. My signature below indicates that I have been given an opportunity to ask questions before signing.

I understand that I may request restrictions on the uses and disclosures of my health information at any time by written request. I further understand that Dr. Jeannette Padgett is not required to accept my restrictions request.

I understand that after my initial surgery, if any surgical revisions are requested, there will be subsequent charges by the facility and anesthesiologist.

Print Name: _____ Date: _____
Signature: _____

RELEASE/CONSENT TO BE PHOTOGRAPHED

I HEREBY AUTHORIZE Dr. Padgett and her employees to take such photographs of me as may be deemed necessary. These include pre-operative and post-operative photographs. I authorize such photographs to be used for presentations for teaching purposes before medical groups, and for any other purpose which may be deemed appropriate in the interest of medical education, knowledge, or research. Although I give my permission to the publication of all details of the photographs concerning my case, I specifically understand that I will not be identified by name, nor will my face be displayed unless the surgery is specific for facial areas. This also includes being put on the internet.

_____ Date: _____
Patient signature: (parent if patient is a minor)

I HAVE RECEIVED A COPY OF THE PRIVACY NOTICE

Patient Signature: _____ Date: _____

Board Certified by the American Board of Plastic Surgery **Date:**

Name: _____ _____**Age:**_____
First Middle Last

Address: _____
Street **City** **State** **Zip**

Home phone: _____ **Work:** _____ **Cell:** _____

SS#_____ **Date of Birth:** _____ **Marital Status: S M D W** **Sex: M F**

Employer: _____ **Email:** _____
Is it ok to receive emails from Real Self about Dr. Padgett? ___ Yes ___ No

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Spouse's Name: _____
(Parents name if minor)

Home phone: _____ **Work:** _____ **Cell:** _____

Spouse's/parent SS#:_____ **Spouse's/parents Date of Birth:** _____

Spouse's/Parents Employer: _____

Nearest Relative To Notify In Case of Emergency: _____

Relationship to you: _____ **Home Phone:** _____ **Cell:** _____

DR PADGETT IS NOT CONTRACTED WITH ANY INSURANCE COMPANIES. SHE DOES NOT ACCEPT OR FILE INSURANCE. ALL PROCEDURES PERFORMED BY DR. PADGETT ARE CONSIDERED COSMETIC.

I UNDERSTAND THAT THE PROCEDURE FOR WHICH I AM CONSULTING WITH DR. PADGETT IS COSMETIC. I UNDERSTAND THAT DR. PADGETT IS NOT A PROVIDER FOR MY INSURANCE PLAN AND I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR FULL PAYMENT OF MY PROCEDURE PRIOR TO SURGERY.

_____ **Date:** _____
(Patient or guardian signature)

Referred by: _____ **May we send a thank you?** _____

HOW DID YOU HEAR ABOUT DR. PADGETT? (Please circle)
Our website Doctor Yellow pages Love Your Look Website Jakefm 929Now Relative Internet RealSelf Other: _____

I am consulting with Dr. Padgett for the following reason: (please circle all that apply):

Breast Implants, Liposuction, Tummy Tuck, Breast Lift, Eyelids, Scar Revision, Skin Care, Ears, Remove Implants, Facelift, Botox, Chemical Peel, Dermabrasion, Breast Reduction, Juvederm , Skinfinity, MicroPen, PRP Other:_____

Heath Questionnaire

What is the specific problem for which you are seeking a consultation? _____
_____

Have you consulted any other doctors including plastic surgeons about this? _____Yes _____No

Please list their names: _____

Are you being treated or medicated for any health condition? _____Yes _____NO if yes, explain briefly:
_____

Height_____ Weight_____

Do you smoke cigarettes? _____Yes _____NO
How many packs daily? _____
How many years have you smoked or did you smoke? _____
How much alcohol do you drink? _____

Have you smoked in the past? ____Yes ____NO
When did you quit? _____

Do you have any allergies to medication? Penicillin Codeine Other: _____
Sulfa None

Are you allergic to Latex? Yes or No

Have you ever had MRSA? Yes or No

Please list any medications you are currently taking, please include over the counter medications as well:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

To you knowledge, have you ever had any of the following conditions?

High blood Pressure	**Yes No**	**Thyroid**	**Yes No**
Low Blood Pressure	**Yes No**	**Diabetes**	**Yes No**
Heart problems	**Yes No**	**Joints**	**Yes No**
Lung	**Yes No**	**Bladder/Kidney**	**Yes No**
Stomach	**Yes No**	**Bleeding/Clotting**	**Yes No**
Skin	**Yes No**	**Cancer**	**Yes No**
Ear/Nose/Throat	**Yes No**	**Hepatitis**	**Ye No**
OB/GYN	**Yes No**	**Blood transfusion**	**Yes No**

If you answered yes to any of the above, do you still have that disease or any residual from it? _____ yes _____ no

If yes, please explain: _____

What diseases run in your family? _____

Please list all surgeries you have had in the past including approximate date: _____
_____

Who is your family doctor? _____ Phone number: _____
City: _____ State: _____

Has this office ever treated any member of your family? _____yes _____ no
If yes, whom: _____

Breast Questionnaire

What is your particular breast problem? _____

Does this run in the female members of the family? _____

What is your Height: _____ Weight: _____

What size bra do you wear? _____ Padded or Unpadded

How many children do you have? _____ Ages: _____

Did you breast feed? _____yes _____no Bottle feed? ____yes ____no By Choice? ____yes ____no

Did your breast change with pregnancy? _____ yes ____no if yes explain: _____

What year did you have your last mammogram? _____ At what facility? _____

Have you ever had implants placed? ____yes ____no

If yes: Approximate date: _____
Type and size: _____
Name of Surgeon: _____
Address or Location: _____

Has anyone in your family had any breast disease, tumors, or cancer of the breast? ____yes ____no

If yes, what type? Benign Malignant Please Describe:_____

If yes, what is their relationship to you? _____

What bra size would you like to have? _____

Do you need a breast lift? ____yes ____no

Prior to your visit today, have you researched the surgery which you are interested and feel you have some knowledge of the procedure and associated risks and complications? ____ yes ____no

Please circle all sources of information that apply: Internet Brochures Friends and Family Books/ Magazines

Please check the brochure you received from our office today:

Breast Augmentation ____ Breast Reduction ___ Abdominoplasty ___ Liposuction ___ Mastopexy ___ Eyelid ___ Botox____ Juvederm_____ Skinfinity_____ MicroPen_____ PRP_____ Dermamedics_____