Effective Date: November 18, 2009

Privacy Notice

"THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCL0SED 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, pharmacists, hospital, ambulatory surgery center, pathologists, anesthesiologists 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 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 Health 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 and 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 make 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:** A 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 a reasonable period. Dr. Padgett may charge a reasonable fee for such listing.
***Right to Obtain a Paper Copy:** You have the right to obtain a copy of your medical record. You must request the copy in writing with your signature authorizing Dr. Padgett to release your 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 your 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 also understand that I may revoke this authorization at any time. I further understand that any such a 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 purposes 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. Jeanette Padgett is not required to accept my restriction request.

*I also hereby authorize for benefits to be paid directly to Dr. Padgett for medical services I receive from any of the physicians in this practice. I understand I will be responsible for any unpaid balance including charges for which a referral was not obtained.

*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 and lay 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 includes being put on the internet.

_____ Date: _____
Patients Signature: (parent if patient is a minor)

*** **I HAVE RECEIVED A COPY OF THE PRIVACY NOTICE (1st page)** ***

X_____

(PLEASE SIGN AND DATE)

Jeanette Padgett, M.D.
Board Certified by the American Board of Plastic Surgery **DATE:**_____

Patient Information

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

Address:_____
Street City State Zip

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

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

Patient's Employer: _____**EMAIL** :_____

Spouse's Name: _____
(Parent if patient is a minor)

Home Phone: _____ **Work Phone**: _____ **Cell Phone**: _____

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

Spouse's Employer: _____

Nearest Relative To Notify In Case of Emergency: _____

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

***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 procedure prior to surgery.

_____ _____
(patient or guardian signature) **(date)**

Referred by: _____ **May we send a thank you? _____ yes _____ no**

How did you hear about Dr. Padgett? (please circle

Gazette*** Our Website*** Network TV*** Doctor*** Yellow Pages*** Insurance Co. *** Attorney***

Love Your Look Website*** Radio*** Relative*** Newspaper*** OK Woman*** Other:_____

If Radio, what station? KJ103

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

Breast Implants Liposuction Tummy Tuck Breast Lift Eyelids Nose Scar revision Skin spots

Skin Care Explant Ears Facelift Collagen Chemical Peel Dermabrasion

Breast Reduction Other:_____

Jeanette Padgett, M.D.
Board Certified Plastic and Cosmetic Surgeon

Health Questionnaire

Patient name: _____

What is the specific problem for which you are seeking 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 ☐

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

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

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

High Blood Pressure	_____ yes _____ no	Low Blood Pressure	_____ yes _____ no
Heart Problems	_____ yes _____ no	Lung	_____ yes _____ no
Stomach	_____ yes _____ no	Skin	_____ yes _____ no
Ear/Nose/Throat	_____ yes _____ no	OB/GYN	_____ yes _____ no
Thyroid	_____ yes _____ no	Diabetes	_____ yes _____ no
Joints	_____ yes _____ no	Bladder/Kidney	_____ yes _____ no
Bleeding /Clotting	_____ yes _____ no	Cancer	_____ yes _____ no
Hepatitis	_____ 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 you family doctor? _____ Phone Number: _____
City: _____ State: _____

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

_____

Jeanette Padgett, M.D.
Board Certified Plastic and Cosmetic Surgeon

BREAST QUESTIONNAIRE

Patient Name: _____

* What is your particular breast problem? _____

* Does this run in the female members of your family? _____ yes _____ no

* 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 breasts change with pregnancy? _____yes _____ no If yes, please explain:_____

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

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* Have you ever had implants placed? _____ yes _____ no
* If yes: Approximate date: _____
Type and size: _____
Name of surgeon: _____
Address or Location: _____

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* Has anyone in your family had any breast disease, breast tumors, or cancer of the breast? _____ yes _____ no

* If yes, what type? Please circle benign malignant Please Describe:_____

* If yes, what is their relation to you? _____

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* 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 Television Brochures Friends and Family Books/Magazines

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* Please check the brochure you received from our office today:

_____ Saline Implant Brochure
_____ Silicone Implant Brochure
_____ Explant (Removal of breast implants)
_____ Mastopexy (Breast Lift)
_____ Breast Reduction
_____ Breast Augmentation
_____ Abdominoplasty
_____ Liposuction


MEDICAL
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