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 Heath 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, pathologist, anesthesiologist and other individuals to coordinate different aspects of the patients 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 tho 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 patients' 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 heath information.

PATIENTS 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 no 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 ma charge a reasonable fee for such copies.

Right to Amend: You have the right o a written request to amend medical information that he or she believes is inaccurate or incomplete. Dr. Padgett may deny the request fi 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., mail, email, text or at work).

The 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 o obtain a copy of your medical records. You must request the copy in writing with your signature authorizing Dr. Padgett to release your medical records. You must also provide address as to where medical records 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 on of them of which she is part owner. If your surgery is scheduled there please provide her with a 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 tie. 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 use and disclosure of my personal health information for the purposed of treatment, payment and health care operations. My signature below which 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 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 preoperative photographs. I authorize such photographs to be used for presentations for teaching purposes before medical groups and for any other purpose which may 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.

Patient Signature: ____ Date: _____________________________

(Parent Signature if Patient is a Minor): ____

I give Dr. Padgett permission to use my photos via internet. (No face or name will be provided) Yes or No

Dr. Jeanette Padgett, Board Certified by the American Board of Plastic Surgery Date: ________________

Name:____ Age:________________

Address:____________________________________ *City:*______________ *State:*________ *Zip:*____________

Home Phone:________________________ Work:_____________________ Cell:_________________________

SSN#: ___________________________ Date of Birth: ________________ Marital Status: S M D W Sex: M or F

Employer: ______________________________________
Email:____

Spouses Name (or Parents Name if Minor): ____

Home Phone: __________________________ Work: _____________________ Cell: ______________________

Spouses or Parent SSN#: ____________________________ Spouses or Parent Date of Birth: _________________

Spouses or Parent 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 WITH INSURANCE. ALL PROCEDURES PERFORMED BY DR. PADGETT ARE CONCIDERED COSMETIC AND SELF PAY.

I understand that the procedure for which I am consulting with Dr. Padgett is cosmetic. I understand that Dr. Padgett is no a provider for my insurance plan and I understand that I am fully responsible for full payment of my procedure prior to surgery.

Patient Signature: ____ Date: ______________________________

Referred by: _________________________________ May we send a thank you? ________________________

How did you hear about Dr. Padgett? (Please Circle)

Our Website Doctor Facebook Twitter Relative Internet Real Self Friend 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, Skincare, Ears, Implant Removal, Facelift, Botox, Breast Reduction, Juvéderm, Other _________________________________

Health Questionnaire Date: ____________________

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

____

Have you consulted any other doctors including plastic surgeons about this? Yes or No (Please List Names)

____

Are you being treated or medicated for any health conditions: Yes or No (If yes please explain)

____

Height _________________ Weight _________________

Do you smoke cigarettes? Yes or No

Have you smoked in the past? Yes or No

How many packs daily? ____________

When did you quit? ____________________

How many years have you smoked or did smoke? ____________

Do you use recreation drugs? Yes or No

Do you drink alcohol? Yes or No (If yes, how much) _______________________

Any addiction to pain medication? Yes or No

Do you use any form of Nicotine (Vape, Patch, Dip) Yes or No

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

Are you Allergic to Latex? Yes or No

Have you ever had MRSA? Yes or No

Are you on Birth Control? Yes or No

Are you on Estrogen? Yes or No

Have you ever had a change in body temperature with surgery? Yes or No

Please list any medications you are currently taking, please include all over the counter medication, vitamins and supplements:____

____

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

Diabetes	Yes	No	High Blood Pressure	Yes	No
Joints	Yes	No	Low Blood Pressure	Yes	No
Bladder/Kidney	Yes	No	Heart Problems	Yes	No
Bleeding/Clotting	Yes	No	Lung Problems	Yes	No
Cancer	Yes	No	Stomach	Yes	No
Hepatitis	Yes	No	Skin	Yes	No
Blood transfusion	Yes	No	Ear/Nose/Throat	Yes	No
Sleep Apnea	Yes	No	OB/GYN	Yes	No
Do you use a CPAP	Yes	No	Thyroid	Yes	No

If you answered yes to any of the above do you still have that disease or any residual of it? Yes or No

If yes, please
explain:____

What diseases run in your family?

____

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

____

____

____

____

Who is your family doctor? ____________________________ Phone:

____

Address: __________________________________ City: ______________ State: ______________ Zip:

____

Has our office ever treated any member of your family? Yes or No (If yes whom)

____

Breast Questionnaire

What is your particular breast problem?

____

What size bra do you wear? _____________ Padded or Unpadded

How many children do you have? _______ Ages: ____

Did you breast feed? Yes or No Bottle feed? Yes or No By Choice? Yes or No

Did your breast change during pregnancy? Yes or No (if yes explain)

____

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

____

Have you ever had implants placed? Yes or No

If yes: Approximate Date _________________________ Type and Size of Implants

____

Name of Surgeon ________________________________ Address and
Location______________________________

Has anyone in your family had any breast disease, tumors, or cancer of the breast? Yes or No

If yes, what type? Benign or Malignant
describe:____

If yes, what is the relationship to you? ___________________

What size bra would you like to have? ________________

Do you need a lift? Yes or 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 or No

I, ____ am giving consent for the below mentioned person/persons to obtain medical care for myself in my absence. I understand I am fully responsible for all medical expenses incurred with said medical treatments.

Mark Yes or No on all that apply and the person in which may have access to your information

Access to all medical records	Access to all financial records	Designated Person	Relationship to you

- All medical records would include making appointments, picking up prescriptions, release of records, etc.
- By signing, I acknowledge that I have read and received a copy of Notice of Privacy, Practice/Patient Rights and Responsibilities as required by HIPPA.

I understand that if I want to make any changes to the information listed above, I must contact Dr. Jeanette Padgetts office to revoke this for in its entirety or complete a new form.

Patients Signature: _______________________________________ Date: _____________________________

Witness: ____ Date: _____________________________

In Case of Emergency, I can be reached at: ____

I, ___________________________ do not wish to allow anyone other than myself to have access to my medical records and/or financial records for any reason.