SYLVAN BARTLETT, M.D.
1330 East 8th Street, Suite 400
Odessa, TX 79761
(432) 582-2344

Method of Payment

Date: _____

Patient Name: _____

I will be paying for the consultation with:

Cash: _____

Credit/Debit Card: _____

Insurance: _____

Check: _____

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Date: _____ Referred By: _____

Last Name: _____First Name: _____ M.I._____

DOB: _____ Social Security#: _____ DL#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Date of Injury/Illness: _____ Work Related? Yes No

Email Address: _____

Sex: Male Female Marital Status: Single Married Widow Divorced

Employer: _____ Job Title: _____

Street Address: _____ State: _____ Zip: _____

Supervisor/Safety Person: _____ Contact Number: _____

Primary Insurance: _____

Group #: _____ Member ID: _____

Claims Address: _____ Phone: _____

Secondary Insurance: _____

Group #: _____ Member ID: _____

Claims Address: _____ Phone: _____

Emergency Contact Person: _____ Relation: _____

Home Phone: _____ Cell Phone: _____

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS INFORMATION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BEUSED AND DISCLODED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY!

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "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.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of your office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or to treat you.

Payment: We submit a request for payment to your health insurance company. Your health insurance company request information from us regarding the care given. We provide to them about you and the care given. Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We obtain services from our insures or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentials, medical review, legal services, and insurance. We will share information about you with such insures or other business associates as necessary to obtain these services.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing except to the extent that your physician or practice has taken action in reliance on the use or disclosure indicated in the authorization.

You have the right to inspect and copy your protected health information. Under federal law however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action, or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

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You have the right to request restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this notice of privacy practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You have the right to use another healthcare professional.

You have the right to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have a right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contract of your complaint. **We will not retaliate against you for filling a complaint.**
This notice was published and becomes effective on/or before April 14, 2003.
We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA compliance officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this notice of our privacy practices.

Print Name: _____

Signature: _____

Date: _____

I authorize the following individual(s) to know of my confidential medical information.

_____ _____

_____ _____

Print Name: _____ Signature: _____ Date: _____

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IMPORTANT INSURANCE INFORMATION

Insurance processing can sometimes be confusing. We are providing this information in an effort to assist you in understanding our verification process.

When the need for surgery is determined by the physician the patient's chart and procedure information will go to the insurance department. The insurance department will then verify your benefits. We confirm that the procedure code the physician will be using is covered by your plan. If it is not covered we will notify you immediately.

If pre-certification and/or pre-determination is required we can often provide the required information over the telephone, however, on occasion we will have to mail or fax this information to them.

When your insurance provider responds to the above questions our insurance specialist will calculate the estimated amount due from you based on your co-payment and deductible. Note: This is an estimated amount, the actual amount may vary.

Completion of this verification procedure could take from two to four weeks and even longer in some cases. We will notify you before scheduling your surgery with the estimated amount of your out-of-pocket expense for the surgery or procedure.

Payment of your estimated amount will be due before your surgery, to be paid at your pre-operative visit. We accept personal check, VISA, Master Card, Care Credit, as well as cash.

It is important that you note that your insurance provider will not promise payment for any procedure. Payment for these benefits is subject to eligibility at the time of service and all contract limitation on your policy. Should your insurance provider elect not to cover this surgery or procedure you will be responsible for any charges incurred upon our receipt of insurance denial.

If you have any questions please call your insurance company. I have read and understood the above and agreed to meet my financial obligations.

Print: _____ Sign: _____ Date: _____

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AUTHORIZATION OF INFORMATION REALEASE:

I hereby authorize Dr. Sylvan Bartlett to release complete information acquired in the course of my examination for treatment. I realize my insurance company or other physicians treating me may sometimes need this information.

Signature: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment directly to Dr. Sylvan Bartlett for the surgical and/or medical benefits, otherwise payable to me for his services described.

Signature: _____

AUTHORIAZATION FOR PAYMENT:

I hereby promise to pay Dr. Sylvan Bartlett for any professional services rendered which are not covered by my insurance of any balance due after insurance payment has been made.
Signature: _____

AUTHORIZATION FOR TREATMENT:

I hereby request and authorize treatment form Dr. Sylvan Bartlett and/ or associates or assistants of his choice and am hereby responsible for payment of this account regardless of insurance.

Signature: _____

AUTHORIZATION FOR PHOTOS/VIDEOS

I do_____ do not_____ consent to the use of any photographs and/ or video of me taken by Sylvan Bartlett, M.D. or their authorized agents, for the purposes of promotion or publication. Although the photographs and accompanying material will not contain my name or any other identifying information, I am aware that I may or may not be identified by the photographs themselves. I agree that all such materials and any and all reproductions thereof shall remain the property of Sylvan Bartlett, M.D.

Signature: _____

Date: _____ Witness: _____

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OFFICE POLICIES

1. A surgical deposit of $250.00 is due at the time your surgery is scheduled. This surgery deposit is refundable only at the physician's discretion.

2. All Surgical fees for cosmetic procedures are due and payable by cash or certified check a minimum of 10 days before surgery or at your pre-operative visit.

3. No alcohol for two weeks prior and for two weeks after surgery.

4. If you are over the age of 40 years, an EKG and a chest x-ray is required. If you are under treatment for a medical condition (such as diabetes, hypertension, etc.), you will need to be cleared by your treating physician. If your physician does not think need a chest x-ray or EKG, then you do not need one.

5. Females over 40 years of age who are scheduled for breast surgery are requested to obtain a mammogram if they have not had one.

6. Do not take anything that will decrease your bloods ability to clot. This includes fish oil, vitamin E, herbals, non-steroidal anti-inflammatory drugs, aspirin, and any aspirin containing medications. You should not take these for 14 days before and after surgery!

Patient Signature: _____ Witness: _____

Date: _____ Time: _____

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REVIEW OF SYSTEMS

Allergies to anything (drugs, Food, latex, act): _____
_____
_____

Current Medications: _____
_____
_____

Circle all that apply:

GENERAL: Abnormal fatigue, Weight loss, Weight Gain, Sleeping problems

EARS: Hearing loss, Noises in the ear, Each ache, Itching in ears, Tinnitus, Dizziness, Popping, Fullness, Pressure, Frequent infections #_____ per year, Discharge, Your own voice sounds like you are in a barrel, Difficulty understanding others speech when in a noisy environment, Lesions of the external ear, Deformities of the external ear

NOSE: Nasal obstruction, History of trauma, Deformity of nose, Sinus infections, Discharge form nose, Nose bleeds, Nasal itching, Lesions of skin of nose

MOUTH and THROAT: Frequent sore throats, Itching of palate and/or throat, Difficulty swallowing, lump sensation, Laryngitis, Needs to clear mucous in morning, Mouth ulcers, Swelling of lips, Swelling of tongue, Scratchy or burning sensation.

RESPIRATORY SYSTEM: Emphysema, Pneumonia, Bronchitis, Asthma, Cough, Shortness of breath, COPD, Bronchitis/smoker, Tuberculosis

BREAST: Pain, Discharge, Masses, Fibrocystic changes, Biopsies, Surgeries_____
Family history of breast cancer (list i.e. mother, grandmother) _____

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HEART: Heart condition, Angina, History of heart attack, High or low blood pressure, Irregular heartbeat, Chest pain, Swelling or edema of hands or feet, Heart murmur, Valve disease, Angiogram, Stress test, Have been seen by a cardiologist.
Are you on any heart medications? _____

STOMACH and BOWEL: Unexplained weight loss or gain, Reflux (GURD), Nausea and vomiting, Diarrhea or constipation, Liver problems, Hernia, Belching, Bloating, Heartburn, Relating foods, Cramping, Bad breath, Excessive gas, Poor appetite, Irritable bowel syndrome

URINARY: Urinary infections/ Frequent yeast infections, Kidney disease, Problems urinating, Prostate problems,
Are you pregnant/ do you think your pregnant? Y N
Date of last menstrual cycle: _____

SKIN: Hives reaction to cosmetics, Blisters, Athletes foot, Rashes, Eczema, Swelling, Itching, skin malignancies, pigment problems

MUSCLE and SKELETAL SYSTEM: Back or Neck Problems, Arthritis, Muscle, Weakness, Numbness, Paralysis, Prosthesis devices (i.e. pins, screws) Joint pain, Muscle pain, Restless legs, Chronic Fatigue, weakness and/ or pain in hands, Limitation in motion in joints, Sensitive pressure points.

OTHER: Cancers (types) _____, Blood (bleeding disorders), blood transfusion, thyroid disease, recent cold, flu, Diabetes,
Communicable disease (i.e. HIV Hepatitis) _____
Do you have a pacemaker? Y N
Do you have implant if so what type_____
Do you have a stent? Y N

LIST ANY OPERATIONS WITH
DATES:_____
_____
_____
_____

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LIST OTHER ILLNESSES: _____
_____
_____
_____

ANY PROBLEMS WITH ANESTHESIA: _____
_____
_____

MEDICAL HISTORY (LIST DIAGNOSED MEDICAL PROBLEMS):_____ _____
_____
_____

SOCIAL HISTORY:

Is anyone hurting you at home? Y N
Do you smoke or chew tobacco regularly? Y N
If yes, how many packs per day? _____ How long? _____
Do you consume alcohol regularly? Y N
If yes, how much? Weekly_____ Monthly_____ Socially_____
Do you have a history of drug abuse? Y N
If yes, what type? _____

Can you read and write? English ☐ Spanish☐ Other: _____

FAMILY HISOTY: Please check this section carefully, circling all people with this disease

HEART DISEASE: Mother Father Brother Sister Aunt Uncle Grandmother Grandfather
STROKE: Mother Father Brother Sister Aunt Uncle Grandmother Grandfather
EMPHYSEMA: Mother Father Brother Sister Aunt Uncle Grandmother Grandfather
ASTHMA: Mother Father Brother Sister Aunt Uncle Grandmother Grandfather
DIABETES: Mother Father Brother Sister Aunt Uncle Grandmother Grandfather
Insulin Control Diet Control Oral Medication
HIGH BLOOD PRESSURE: Mother Father Brother Sister Aunt Uncle Grandmother Grandfather
CANCER: Mother Father Brother Sister Aunt Uncle Grandmother Grandfather
What type: _____

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DENTAL HISTORY:

Do you or have you had Temporomandibular Joint Disorder (TMJ)? Y N

Do you have on going dental problems? Y N

Do you have dentures? Y N ☐ Full ☐ Partial

Have you had labs or x-rays done? Please list what, where and approximate date: _____

_____

_____

Have you had cosmetic surgery in the past? Y N

If yes, what procedure and by what doctors and approximate date?

_____

_____

_____

_____

Have you had a consult with other cosmetic surgeons about the areas you want done with us today? Y N

Patient Signature: _____

Date: _____

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ATTENTION ALL PATIENTS

Please be aware that we need you to be off all common blood thinners including aspirin, Advil, and all types of non-steroid anti-inflammatory drugs, both prescription and non-prescription. Also stop all herbal medications as well as fish oil and vitamin E. You should be off these for two weeks before and after surgery.

AN EXCEPTION TO THIS

If your physician has placed you on aspirin or any of the above mentioned drugs for a medical treatment, please do not stop taking them without clearing this with your physician and Dr. Bartlett.

Do not do anything that will increase your cardiac output (i.e. running, straining, etc.) for two weeks after surgery. If you do you could develop a late bleeding complication.

ALCOHOL

Consumption of alcoholic beverages within two weeks before and after surgery could also put you at risk for bleeding complications.

SMOKING

Smoking decreases the circulation to tissue and decreases tissues ability to pull oxygen away from blood. Stop smoking for two weeks before and after surgery!

ARNICA MONTANA

An herbal, Arnica Montana, when taken orally has been shown to decrease bruising. Pineapple has the same chemical and eating it has shown to do the same.

I have read and understood the above information.

Patient: _____ Date: _____ Time: _____

Witness: _____ Date: _____ Time: _____

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ANTI- INFLAMMATORY AGENTS
PROHIBITED 2 WEEKS PRIOR AND 2 WEEKS AFTER SURGERY

Very Important

Bleeding is the most frequent complications following surgery. There are many across the counter medications as well as prescription medications and herbal medications that affect the activity of your platelets. It takes approximately 2 weeks for the platelets to obtain a normal activity after you discontinue these medications: this is why there is a need to be off these products for TWO WEEKS BEFORE and AFTER surgery.

AN EXCEPTION

If you're physician has placed you on aspirin or any medication to thin your blood because of medical reasons, please do not stop taking them without clearing it with your physician and notify Dr. Bartlett if you cannot safely stop them.

The following is just a **PARTIAL LIST** of those medications, vitamins, and herbal remedies that affect your body's ability to clot blood.

Aspirin (Anacin, Ascriptin, **Bayer**, Bufferin, Ecotrin, **Excedrin**)
Choline and magnesium salicylates (CMT, Tricosal, Trilisate)
Choline salicylate (Arthropan)
Celecoxib (Celebrex)
Diclofenac potassium (Cataflam)
Diclofenac sodium (Voltaren, Voltaren XR)
Diclofenac sodium with misoprostol (Arthrotec)
Diflunisal (Dolobid)
Etodolac (Lodine, Lodine XL)
Fenoprofen calcium (Nalfon)
Flurbiprofen (Ansaid)
Ibuprofen (**Advil**, **Motrin**, Motrin IB, Nuprin)
Indomethacin (Indocin, Indocin SR)
Ketoprofen (Actron, Orudis, Orudis KT, Oruvail)
Magnesium salicylate (Arthritab, Bayer Select, Doan's Pills, Magan, Mobidin, Mobogesic)
Meclofenamate sodium (Meclomen)
Mefenamic acid (Ponstel)
Meloxicam (Mobic)
Nabumetone (Relafen)
Naproxen (Naprosyn, Naprelan*)
Naproxen sodium (**Aleve**, Anaprox)
Oxaprozin (Daypro)
Piroxicam (Feldene)
Rofecoxib (Vioxx)

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Salsalate (Amigesic, Anaflex 750, Disalcid, Marthritic, Mono-Gesic, Salflex, Salsitab)
Sodium salicylate (various generics)
Sulindac (Clinoril)
Tolmetin sodium (Tolectin)
Valdecoxib (Bextra)

Note: Some products, such as Excedrin, are combination drugs (Excedrin is acetaminophen, aspirin, and caffeine).

Note that **acetaminophen** (Paracetamol; Tylenol) is not on this list. Acetaminophen belongs to a class of drugs called analgesics (pain relievers) and antipyretics (fever reducers). The exact mechanism of action of acetaminophen is not known. Acetaminophen relieves pain by elevating the pain threshold, that is, by requiring a greater amount of pain to develop before it is felt by a person. It reduces fever through its action on the heat-regulating center of the brain. Specifically, it tells the center to lower the body's temperature when the temperature is elevated. Acetaminophen relieves pain in mild arthritis but has no effect on the underlying inflammation, redness and swelling of the joint.

Paracetamol, unlike other common analgesics such as aspirin and ibuprofen, has no anti-inflammatory properties, and so it is not a member of the class of drugs known as non-steroidal anti-inflammatory drugs or NSAIDs.

Additional list of medications that affect blood clotting (some of the medications listed may be duplicated from list above:

- **Antiplatelet Medication:** Anagrelide (Agrylin®), aspirin (any brand, all doses), cilostazol (Pletal®), clopidogrel (Plavix®), dipyradamole (Persantine®), dipyridamole/aspirin (Aggrenox®), enteric-coated aspirin (Ecotrin®), ticlopidine (Ticlid®)
- **Anticoagulant Medication:** Anisindione (Miradon®), Arixtra, enoxaparin (Lovenox®) injection, Fragmin, heparin injection, Pradaxa, pentosan polysulfate (Elmiron®), warfarin (Coumadin®), Xerelto
- **Nonsteroidal Anti-Inflammatory Drugs:** Celebrex, diclofenac (Voltaren®, Cataflam®), diflunisal (Dolobid®), etodolac (Lodine®), fenoprofen (Nalfon®), flurbiprogen (Ansaid®), ibuprofen (Motrin®, Advil®, Nuprin®, Rufen®), indomethacin (Indocin®), ketoprofen (Orudis®, Actron®), ketorlac (Toradol®), meclofenamate (Meclomen®), meloxican (Mobic®), nabumeton (Relafen®), naproxen (Naprosyn®, Naprelan®, Aleve®), oxaprozin (Daypro®), piroxicam (Feldene®), salsalate (Salflex®, Disalcid®), sulindac (Clinoril®), sulfinpyrazone tolmetin (Tolectin®), trilisate (salicylate combination)
- **Herbs/Vitamins:** Ajoene birch bark, cayenne, Chinese black tree fungus, cumin, evening primrose oil, feverfew, garlic, ginger, ginkgo biloba, ginseng, grape seed extract, milk thistle, Omega 3 fatty acids, onion extract, St. John’s wort, tumeric, vitamins C and E

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List of Common Herbs and Vitamins

*Please discuss all herbal products, vitamins, over the counter, previous medications, and current medications with Dr. Bartlett.

Aloe Vera (Internal)	Asian Ginseng
Bayberry	Black Cohosh
Blue Cohosh	Bromelain
Caldendula	California Poppy
Cascara	Castor Bean
Cats Claw	Cayenne Pepper
Chamomile	Cinchona Bark
Dong Quai	Dandelion
Evening Primrose	Fenugreek
Feverfew	Figwart
Garlic	Ginger
Gingko Biloba	Ginseng
Guggul	Hawthorn
Hops Horse Chestnut	Horsetail
Kavakava	Lemon Balm
Licorice Root	Ma Huang
Niacin	Passion Flower
Sagrada	St. John's Wort
Valerian	Vitamin E
Willow Bark	Yohimbe

*****The above list includes common medications but is not a complete list.

*Please check with Dr. Bartlett if in doubt.

Patient: _____ Patient: _____
(Print) (Signature)

Date: _____

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IMPORTANT

PLEASE BE ADVISED THAT THERE MAY BE ADDITIONAL CHARGES FOR ANY LABS OR RADIOLOGY EXPENSES THAT ARE NOT PROVIDED IN THE OFFICE SUCH AS X-RAYS AND MAMMOGRAMS.

TESTS ORDERED AT THE DOCTOR'S DESCRETION.

Patient Print: _____

Patient Signature: _____

Date: _____