MICHAEL DIAZ, M.D., F.A.C.S.
BOARD CERTIFIED PLASTIC SURGEON

936 Tommy Munro Dr. • Biloxi, MS 39532
Phone: 228-396-2663 • Fax: 228-396-2664

_____
Date

Reason for visit Today: (Please include topic, be as specific as possible)_____

_____

PERSONAL INFORMATION

Name: _____ Date of Birth: _____

Social Security #_____ Sex: Male / Female

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

Address: _____

City: _____ State: _____ Zip Code: _____

E-mail Address: _____

Employer: _____ Occupation: _____

Circle One:
Single / Married / Separated / Divorced / Widowed / Other

Insured ID Name: _____

Date of Birth: _____ Social Security #: _____

Spouse/Significant Other's Name: _____

Employer: _____ Occupation: _____

Work Phone: _____ Spouse Date of Birth: _____

Family Physician's Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Last Physical Exam: _____

Name of person to contact in case of an emergency:

Name: _____ Phone: _____ Relationship: _____

MEDICAL INFORMATION:
We are help to help you. Please answer as truthfully and completely as possible. Do you have or have you had:

Heart Disease	❒ Yes ❒ No	Bulimia or Anorexia	❒ Yes ❒ No
Autoimmune Disorder	❒ Yes ❒ No	Hormone Replacement Therapy	❒ Yes ❒ No
Asthma or COPD	❒ Yes ❒ No	Mental Illness	❒ Yes ❒ No
Lung Disease	❒ Yes ❒ No	Drug Dependency	❒ Yes ❒ No
CPAP Machine	❒ Yes ❒ No	Depression	❒ Yes ❒ No
Sleep Apnea	❒ Yes ❒ No	Environmental Allergies	❒ Yes ❒ No
Cancer	❒ Yes ❒ No	Serious Accident	❒ Yes ❒ No
High Blood Pressure	❒ Yes ❒ No	Thyroid Disease	❒ Yes ❒ No
Blood or Bleeding Disorder	❒ Yes ❒ No	Diabetes	❒ Yes ❒ No
Anemia	❒ Yes ❒ No	Problem with general anesthesia	❒ Yes ❒ No
Latex Allergies	❒ Yes ❒ No	Chronic Illness	❒ Yes ❒ No
Birth Control Pills	❒ Yes ❒ No	Previous/Current Serious Illness	❒ Yes ❒ No

Type: _____ Other: _____

If you answered **YES** to any of the above, please explain: _____

_____

_____

_____

_____

FAMILY HISTORY: Has any family member had any of the following?

		Affected Family Member	Notes
No Relevant Family History	❒ Yes ❒ No		
Unknown / Adopted	❒ Yes ❒ No		
Autoimmune Disorders	❒ Yes ❒ No		
Cancer	❒ Yes ❒ No		
Diabetes	❒ Yes ❒ No		
Heart Disease	❒ Yes ❒ No		
Hemophilia / Blood or Bleeding Disorder	❒ Yes ❒ No		
High Blood Pressure	❒ Yes ❒ No		
Lung or Respiratory Disease	❒ Yes ❒ No		
Problem with General Anesthesia	❒ Yes ❒ No		

Are you **ALLERGIC** to any medications? ❒ Yes ❒ No If **YES**, please list:

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Do you take anti-depressants? ❒ Yes ❒ No If **YES**, physician prescribing them: _____

Please list **ALL MEDICATIONS** you are taking & the physician prescribing them:

_____

_____

_____

_____

_____

_____

Please list **ALL** previous surgeries, **including** Cosmetic Procedures:

OPERATION **YEAR** **HOSPITAL/CITY** **SURGEON** **TYPE OF ANESTHESA**

_____
_____
_____
_____

If you have had any Cosmetic Procedures, were you happy with the outcome? ___ Yes ___No

CHILDBIRTH:

Number of pregnancies: _____ How much weight did you gain with each pregnancy? _____

Number of children: _____ Age(s) of children:_____ Did you breastfeed? __Yes __No

Have you Stopped Breastfeeding? ___ Yes ___No

LIFESTYLE:

Do you smoke (cigarettes, cigars or e-cigs)? ___Yes ___No Packs per day? _____

Number of years: _____ Have you quit smoking? ___Yes ___ No When? _____

How many drinks containing alcohol do you drink a week? _____

Do you take Aspirin, Ibuprofen, Advil, Aleve or Naproxen on a regular basis? ___Yes ___No

Have you taken diet pills/injections or been on a diet in the last 3 years? ___Yes ___No

Do you take Adipex (Phentermine)? ___Yes ___No Date last taken? _____

***You must stop taking Adipex/Phentermine at least 2 weeks prior to surgery.**

List **ALL OVER THE COUNTER MEDICATIONS, INCLUDING VITAMINS & HERBAL SUPPLEMENTS, which you take regularly:**_____
_____
_____

What is your height? _____ Weight? _____ Have you gained/lost weight recently? ___Yes ___ No

Do you exercise regularly? ___ Yes ___No Activity: _____ How often? _____

Do you wear glasses? __Yes __No Contact Lenses? __Yes __No Name of eye doctor: _____

Name of Pharmacy you use: _____ Location: _____

How did you hear about Dr. Diaz? _____ May we thank them for referral? __Yes __No

_____ _____

Patient Signature Date

Patient Consent Form

MICHAEL DIAZ, M.D., F.A.C.S.
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I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Release pertinent information to assist the practice with medical authorization and financial support if there's a challenge to payment. This can include health care expenses; which include medical insurance, banking, finance companies and credit card companies.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

AUTHORIZATION

I. **GENERAL CONSENT TO TREATMENT:** I AGREE AND CONSENT TO A PHYSICAL EXAMINATION BY **MICHAEL DIAZ, M.D.** FOR AESTHETIC AND GENERAL PLASTIC SURGERY CONSULTATION BY DR. MICHAEL DIAZ AND/OR HIS ASSOCIATES. I UNDERSTAND THAT ADDITIONAL DIAGNOSTIC PROCEDURES AND TREATMENT MAY BE RECOMMENDED BY THE PHYSICIAN AND WILL BE DISCUSSED WITH ME BEFORE BEING DONE. I ACKNOWLEDGE THAT THERE ARE NO GUARANTEES, EXPRESSED OR IMPLIED, AS TO THE RESULTS OF ANY PROCEDURES OR MEDICAL TREATMENT PERFORMED.

II. **RELEASE OF INFORMATION:** I AUTHORIZE PHYSICIANS PROVIDING SERVICES ON BEHALF OF THE PATIENT TO RELEASE ALL BILLING AND MEDICAL INFORMATION (INCLUDING INFORMATION CONCERNING SUBSTANCE ABUSE AND HIV STATUS, IF APPLICABLE) TO PHYSICIANS OR INSTITUTIONS PROVIDING FOLLOW-UP CARE, THE SOCIAL SECURITY ADMINISTRATION, MEDICARE, MEDICAID (OR THEIR VARIOUS INTERMEDIARIES), AND THE INSURANCE COMPANY, EMPLOYER, PERSON ACTING ON BEHALF OF A PREFERRED PROVIDER ARRANGEMENT OR THIRD PARTY NAMED ON THIS PATIENT INFORMATION FORM (OR ANY OF THEIR AGENTS OR REPRESENTATIVES), WHEN SUCH INFORMATION IS REQUIRED FOR PAYMENT, WORKERS' COMPENSATION, UTILIZATION REVIEW, OR COVERAGE DETERMINATION PURPOSES. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING AND DELIVERED TO THIS PHYSICIAN'S OFFICE.

III. **ASSIGNMENT OF INSURANCE OR THIRD PARTY COVERAGE:**

A. I AUTHORIZE ANY THIRD PARTY PAYOR TO PAY DIRECTLY TO THE PHYSICIAN PROVIDING SERVICES TO THE PATIENT, ALL BENEFITS DUE PAYABLE AS A RESULT OF SERVICES RENDERED.

B. I AUTHORIZE ASSIGNMENT TO THE PHYSICIAN WHO HAS PROVIDED SERVICES TO THE PATIENT THE INSURED'S RIGHTS TO PENALTIES AND ATTORNEY'S FEES IN THE EVENT THAT THE INSURER FAILS TO TIMELY PAY SUCH BENEFITS IN ACCORDANCE WITH MISSISSIPPI LAW.

IV. **ACKNOWLEDGEMENT OF RESPONSIBILITY TO PAY FOR SERVICES:**

I ACKNOWLEDGE AND AGREE THAT, EXCEPT AS PROVIDED BY LAW, AND IN CONSIDERATION OF THE SERVICES PROVIDED, I WILL PAY ANY CHARGES WHICH, FOR ANY REASON, ARE NOT PAID BY ANY THIRD PARTY PAYOR UNLESS THERE IS A SPECIFIC WRITTEN AGREEMENT BETWEEN THE PHYSICIAN AND THE PATIENT OR BETWEEN THE PHYSICIAN AND THE PAYOR. I ACKNOWLEDGE THAT THIS FEE IS INCURRED ON OPEN ACCOUNT FOR PROFESSIONAL MEDICAL SERVICES. I ACKNOWLEDGE THAT IF I FAIL TO PAY THE BALANCE DUE ON THIS OPEN ACCOUNT WITHIN THIRTY (30) DAYS AFTER WRITTEN DEMAND, AND IN THE EVENT JUDGEMENT IS RENDERED AGAINST ME, IN ADDITION TO THE PRINCIPAL BALANCE DUE, I SHALL BE LIABLE FOR REASONABLE ATTORNEY FEES, LEGAL INTEREST FROM DATE OF JUDICIAL DEMAND, UNTIL PAID, PLUS COSTS OF COURT.

V. **MEDICARE PATIENTS:**

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE PAYABLE TO **MICHAEL DIAZ, M.D.**, FOR ANY SERVICES FURNISHED ME BY DR. MICHAEL DIAZ AND/OR HIS ASSOCIATES. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE HEALTHCARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

_____ _____

DATE **SIGNATURE**

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Audio / Visual / Website Authorization for Healthcare Education

_____
Print Name

The undersigned does hereby authorize Dr. Michael Diaz, his agents or employees or other persons to photograph, make moving sound pictures, videotapes, disc, or audiotapes of the above-named patient while under the care of Dr. Michael Diaz, and agrees that Dr. Michael Diaz, his agents or employees or other persons may use negatives, discs, prints, videotapes, or audiotapes prepared therefrom for research, teaching, or publication, or other purposes including use on a website, for the education of patients and healthcare practitioners.

This consent is subject to revocation at any time except to the extent the action has been taken thereon.

Your healthcare (or payment for healthcare) will not be affected by whether or not you sign this authorization. Once your healthcare information is released, re-disclosure of your healthcare information by any recipient may no longer be protected by federal law.

_____ _____
Signature of Patient/Legal Guardian Printed Name Date

_____
Relationship (if not patient)

I hereby grant permission for the use of any of my medical records, including illustrations, photographs or other records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

_____ _____
Signature of Patient Signature of Witness

_____
Date

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Dear Valued Patient,

We here at Michael Diaz, MD, FACS have been asked to accept many different insurance policies. We accept their promise to pay when you present an insurance care, however, you will be ultimately responsible for any amount that your insurance company does not pay. Please note that it is your responsibility to know your insurance benefits.

The benefits offered by many insurance companies vary depending on which doctor you see, whether the insurance company is primary or secondary and/or various other combinations. You will be responsible for the balance if your insurance company does not pay.

We encourage you to verify coverage with your own insurance prior to being seen.

We do agree to bill your insurance for you only as a courtesy. If they do not pay within a reasonable period of time we will expect you to pay us and deal with the insurance company yourself.

I have read and agree and understand that I am ultimately liable for the services that I receive. If for any reason, my insurance does not pay for my services, I agree to pay Michael Diaz, MD directly and will not hold your staff, including receptionists, Doctor's, or telephone operators responsible for my insurance company not paying my bills.

CREDIT CARD PAID SERVICES:

Services that are performed that are paid with a credit card, debit card, or financing third party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Michael Diaz, MD, FACS to use and disclose my protected health information to any Credit Card Entity, Bank or Financing Company when they request such information to process an account and assist with payment. I agree that this non credit card challenge agreement is irrevocable.

Patient's Signature *Date Signed*