Malcolm Rude, M.D., P.A.

Plastic & Reconstructive Surgery

PERSONAL DATA:

Full name: _____ Name you like to be called: _____

Address: _____City: _____ State: _____ Zip: _____

Social Security Number: _____Date of birth: _____ Age: _____ Sex: _____

Home phone: _____ Work phone: _____ Mobile phone: _____

E-mail address: _____

Race : _____ Ethnicity : _____ Language: _____

EMPLOYER INFORMATION:

Occupation: _____ Company or School: _____

Employer's address: _____Phone number: _____

RESPONSIBLE PARTY: (If under 18 yrs. Old)

Name: _____Relation to patient: _____

Address: _____City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Mobile phone: _____

EMERGENCY CONTACT:

Name: _____Relation to patient: _____

Home phone: _____ Cell phone: _____

REFERRAL INFORMATION:

Physician referral: _____ Patient referral: _____ Other: _____

Primary Care Physician: _____

WOULD YOU LIKE US TO SHARE YOUR MEDICAL INFORMATION? yes no

WITH WHOM: Family _____ Physician _____ Other _____]

PAST MEDICAL HISTORY: (Check box of any medical conditions you have ever had)

- ☐ NO PERTINENT MEDICAL HISTORY
- ☐ High blood pressure
- ☐ Heart attack or congestive heart failure
- ☐ Heart murmur or heart valve disorder
- ☐ Asthma, bronchitis or COPD
- ☐ Stroke or paralysis
- ☐ Diabetes
- ☐ Thyroid disorder
- ☐ Arthritis or degenerative joint disease
- ☐ History of blood clots in the veins of your legs
- ☐ Any other medical problems (Be specific): _____
- ☐ Stomach ulcer or gastritis
- ☐ Hepatitis or other liver disorder
- ☐ Kidney disease or failure
- ☐ Autoimmune disease
- ☐ Anemia or any other blood disorder
- ☐ Transfusion of blood or blood products
- ☐ History of any psychiatric disorder
- ☐ Glaucoma or other eye disorder
- ☐ Seizure disorder
- ☐ Cancer (What type? _____)

OFFICE USE ONLY:

Ht: _____ Wt: _____ BP: _____/_____ P: _____

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PAST SURGICAL HISTORY: (List all previous operations by date and any associated problems with the surgery or anesthetic)

SURGERY	*DATE*	*PROBLEMS WITH SURGERY OR ANESTHETIC*

MEDICATIONS: (**All** prescription and over-the-counter medications)

☐ Please Check if NO Medications

MEDICATION	*DOSE / FREQUENCY*

ALLERGIES: (Reaction to any drug or anesthetic)

☐ Please Check if No Known Drug

MEDICATION	*REACTION*

PATIENT SOCIAL HISTORY: (please circle)

Marital status: *S M D W*

Number of children: *0 1 2 3 4 (or more)*

PATIENT ALCOHOL HISTORY: (please circle)

denies alcohol use *admits alcohol socially*

admits alcohol daily *admits to history of alcoholism*

PATIENT SMOKING HISTORY: (please circle)

DENIES: *denies tobacco use*

PACKS PER DAY: *< 1 per day* *1 per day* *2+ per day*

LENGTH: *for < 5 years* *for 5-10 years* *for 10-15 years* *for 15-20 years* *for 20+ years*

QUIT: *quit < 1 year ago* *quit 1-5 years ago* *quit 5-10 years ago* *quit 10+ years ago*

FAMILY HISTORY: (Any history of the following conditions in a blood relative? Which family members?)

Autoimmune Disorder	Y	_____	Bleeding Disorder	Y	_____
Cancer (type)	Y	_____	Colon Cancer	Y	_____
Diabetes	Y	_____	Glaucoma	Y	_____
High Blood Pressure	Y	_____	High Cholesterol	Y	_____
Liver Disease	Y	_____	Lung Disease	Y	_____
Malignant Melanoma	Y	_____	Obesity	Y	_____
Premature Heart Disease	Y	_____	Skin Cancer	Y	_____
Stroke	Y	_____	Thyroid Disease	Y	_____

No Relevant Family History

Unknown/Adopted

REVIEW OF SYSTEMS: (Check box of any symptoms you recently experienced or are currently experiencing)

- ☐ NO PERTINENT SYMPTOMS
- ☐ Recent weight loss or easy fatigability
- ☐ Fever, chills or night sweats
- ☐ Change in vision or temporary loss of vision
- ☐ Excessive tearing or excessively dry eyes
- ☐ Irregular heart rate or palpitations
- ☐ Tightness, pressure or pain in your chest
- ☐ Swelling of your feet or ankles
- ☐ A recent cold, flu or pneumonia
- ☐ Wheezing or shortness of breath
- ☐ Heartburn or reflux
- ☐ Frequent loose stools or constipation
- ☐ Blood in your stool or urine
- ☐ Pain or burning when you urinate
- ☐ Pain in your extremities or major joints
- ☐ Slow wound healing or excessive scaring
- ☐ Change in size or color of a mole or other growth
- ☐ New lumps or discomfort in your breast
- ☐ Dizziness, light-headedness or faintness
- ☐ Weakness in any extremity
- ☐ Any unusual stress in your life at this time
- ☐ Any chance that you may be pregnant
- ☐ Excessive or prolonged bleeding when cut
- ☐ Any known deficiency of your immune system
- ☐ Allergy or reaction to Latex

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Insurance Authorization

All Patients – Signature on File

I request that payment of authorized benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services. I understand that I am financially responsible for all fees and charges not paid by my insurance company and that they are due and payable within 45 days of service unless other arrangements have been made with the office. I further understand that should Malcolm Rude M.D., P.A. have to refer my account for outside collections that I am responsible for all fees incurred by the agency or attorney/legal fees.

Beneficiary Signature _____ Date _____

Medicare Patients Only – Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

Malcolm Rude, M.D., P.A.

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Malcolm Rude M.D., P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Malcolm Rude M.D., P.A. I understand that diagnosis or treatment of me by Dr. Malcolm Rude may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Malcolm Rude M.D., P.A. is not required to agree to the restrictions that I may request. However, if Malcolm Rude M.D., P.A. agrees to a restriction that I request, the restriction is binding on Malcolm Rude M.D., P.A. and Dr. Malcolm Rude.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Malcolm Rude or Malcolm Rude M.D., P.A. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Malcolm Rude M.D., P.A.’s Notice of Privacy Practices prior to signing this document. The Malcolm Rude M.D., P.A.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Malcolm Rude M.D., P.A. This Notice of Privacy Practices also describes my rights and the Malcolm Rude M.D., P.A.'s duties with respect to my protected health information.

Malcolm Rude M.D., P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Malcolm Rude M.D., P.A.’s website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative	Date
Print Name of Patient or Personal Representative	Description of Personal Representative’s Authority

Malcolm Rude, M.D., P.A.

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I consent to the taking of photographs by Dr. Rude or his designee of me or parts of my body in connection with the plastic surgery procedures(s) to be performed by Dr. Rude.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Rude.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because all parties acting under Dr. Rude's license and authority are not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA and may be redisclosed by parties acting under Dr. Rude's license and authority.

I release and discharge Dr. Rude, and all parties acting under his license and authority from all rights that I may have in the photographs and from any claim that I may have relating to the photographs.

As a patient you will have access to your photos as they will be a part of your medical record.

This is NOT releasing your photos to be used in advertisement. This form allows Dr. Rude to have the photos as a part of the medical record. There is a separate form to release your photos to be used or published in any print, visual or electronic media, including advertisements.

Patient X_____ Date _____

WITNESS/PHYSICIAN: _____

I have read the above Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

Parent/Guardian _____ *Date* _____

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Brazos Valley Plastic Surgery
Communication via Texts and Emails

Some of our patients wish to communicate with Dr. Rude and his associates using emails or mobile phone to mobile phone communication including texting. While our practice does permit the use of emailing/texting, the patient should be warned that this method of communication is not a secure means of communication and may be inappropriately accessed by others. Some issues for the patient to consider include the following: 1) Messages may be misdirected to the wrong recipient; 2) Messages may be accessed by unauthorized individuals while in storage or while in transmission; 3) Inappropriate access of protected health information by unauthorized individuals may result in that information becoming public and even posted on-line including on social media, or sold on the "dark side" of the internet contributing to identify theft. 4) Messages may not be received and reviewed in a timely manner and should not to be used for urgent care issues.
Brazos Valley Plastic Surgery makes every effort to avoid sending any protected health information in an unsecure fashion. Our preference is to not do any sensitive communication by this method.
As an alternative to emailing or texting, you may also communicate with Dr. Rude and associates (including after office hours and for acute medical issues) by calling our office phone line: **979-776-8825**. We also encourage our patients to communicate with us by using our patient portal for non-urgent matters. If you need assistance with signing up for the patient portal, please contact our office.
If you wish to proceed with utilizing emailing or texting with Dr. Rude and associates, we ask that you initial the appropriate spaces below and sign and date the authorization.

Authorization to Communicate via Texts and/or Emails:
By initialing below, I give permission to send and/or receive text messages with Dr. Rude and associates
Patient's Initials:_____

This authorization remains valid for (please check one)

( ) ____ years from the date of signature; or

( ) for my lifetime.

My Rights
I may refuse to sign this authorization. I am not obligated to use texting. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
I may revoke this authorization at any time, but I must do so in writing and submit it to the following address 2809 Earl Rudder Freeway South, Suite 101 College Station, TX 77845 My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
I have a right to receive a copy of this authorization. Information disclosed pursuant to this authorization could be re-disclosed by an unauthorized recipient.
Signature:

Date: _____ Time: _____a.m./p.m.

Signature: _____ Circle one: Patient Legal Representative