Initial History and Physical Exam

Patient Name:		T	oday's Date:_		
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Patient to Complete:					
Medical Conditions/Fam No Medical Conditions	illy Medical E	listory (P=Patient F=Family)			
Acid Reflux	P_F_ P_F_	Fungal Infection	PF	PCOS	I F
Acne	P_F_	Hashimoto Thyroid Discase Heart Arrhythmia	PF_	Precancerous Skin Lesions	F
Actinic Keratosis	P_F	Herpes Simplex	P_F_	Psoriasis Raised Moles	F
ADD/ADHD	PF	High Blood Pressure	P_F_	Raised Moles Rheumatold Arthritis	I
Alopecia	PF	High Cholesterol	P_F_	Rosacea	F
ALS/Lou Gehrig's Disease	PF	HIV/AIDS	P_F_	Sarcoldorle	T
Anxiety	PF_	Hormone Imbalance	P_[/	Seasonal Allergies	F
Asthma	PF_	Hyperthyroidism	P_F_	Selzures	F
Bell's Palsy	P_F	Hypothyroldism	PF	Sexual Dysfunction	P
Blood Clotting Disorder	PF_	Impetigo	P_F_	Shingles	F
Lancer	PF_	Keloid Scarring	P_F_	Sjogren's Syndrome	Р
Cellac Disease	PF	Keratosis Pilaris	PF	Smoke	P
Charcot Marie Tooth Dx	PF	Lambert-Eaton Syndrome	PF	Stroke	P
Cold Sores/Fever Blisters Congestive Heart Failure	PF	Lupus/Scleroderma	. P_F_	Urinary Incontinence	P
COPD	P_F_	Melanoma/Skin Cancer	PF	Varicose Veins	P
Depression	P_F_	Melasma	P_F_	Vasculitis	P.
Diabetes	PPP	Migraines	P_F_	Vitiligo	P
Digestive Problems	PF_	Multiple Scierosis Muscle Weakness/Tremors	P_F_	Warts .	P.
Eczenia	P_F_	Muscular Dystrophy	P_F_	Other:	
rectile Dysfunction	P_F_	Myasthenia Gravis	PF		_
atigue	P_F_	Parkinson's Disease	PF_		
ibromyalgla	P_F_	Peripheral Neuropathy	PF_	· · · · · · · · · · · · · · · · · · ·	
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General Well-Belng: N Y Gastrointestinal: N Y Skin: N-Y Activity Change Y Y Heartburn Y Y Color change Y Y Appetute Change Churl Y Y Nanueea Y Y Color change Y Y Pale Partburn Y Y Constituting Y Y Abdominal pain Y Y Change Spots Y Y Fell Parting Y Y Constituting Y Y Constituting Y Y Constituting Y Y Constituting Y Y Change Spots Y Y Change Spots Y Y Change Spots Y Y Constituting Y Y Change Spots Y Y Constituting Y Y Change Spots Y Y Constituting Y Y Constitution Y Y Constituting Y Y Constitutin	REVIEW OF SYSTEMS									
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weight Change		Y	Y						Y	Υ.
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ethnicity	Υ.	Υ	NEUROLOGIC	,			. \()/
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Warm, dry, and intact	ν.	ν.	No signs of	resp distress	Υ	Υ.	
SKIN:			RESPIRATOR				
Appears stated age	Y.	Υ	n manyin				3/1, 1/5
Well-developed	Y.	λ.	Thyroid gla	nd w/o mass	Υ	Ϋ́	
No acute distress	Y	Υ.	Trachea mi	dline	Υ	Υ.)
	Y'	Υ		adenopathy	Y	Υ.	() ()
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Alert & Oriented	N						} (
	N						

11. Metician will fill out. A.

DIAGNOSIS & TREATMENT PLAN FOR AESTHETIC PROCEDURES

L JSCITON BBL PER PROTOCOL	
Pigmented Lesions	
Lentigines	Vascular Leslons
Becker Nervus	Port·Wine Stain
Keratosis	Hemangloma
Cafe-au-lalt macules	Leg Velns
l-lyperplgmentation	Leg Telanglectaslas
	Anglomas
Skin Treatments	
Rosacea/Telanglectasla	DIVA per protocol
Age Spoty / Fall-well	SkIn Resurfacing
Age Spots/Telanglectasia Erythema of Rosacea	Urlnary Incontinence
Melasma	[]HALO BBL per protocol
Pollkoderma	Rhytlds
Acne	Dyschromla
Acrie	Pigmented Lesion
[]BOTOX COSMETIC UP TO 400 UNITS PER YEAR at 3 M	
Glabellar Lines	MONTH INTERVALS
Lateral Canthal Lines	
Forehead Lines	
Rhytlds	
UUVEDERM FAMILY OF FILLERS UP TO 20 ML/YEAR	
JUVEDERM ULTRA PLUS XC PER PROTOCOL	
Rhytlds	[]JUVEDERM ULTRA PLUS XC PER PROTOCOL
Perforal Rhytids	Rhytids
Volume Deficit	Perioral Rhytids
	Volume Deficit
JUVEDERM VOLLURE PER PROTOCOL	[]JUVEDERM VOLUMA PER PROTOCOL
Rhytlds	Rhytids
Perioral Rhytids	Perloral Rhytlds
Volume Deficit	Volume Deflct
1 IPLATELET PIGUE PLAGATA ANTONIO	
PLATELET RICH PLASMA W/SKINPEN PER PROTOCOL Rhytids Static	[]FRACTIONAL RF MICRONEEDLING PER PROTOCOL
nivids Static	Skin Laxity
Rhytids w/ movement	Scarring
Skin Rejuvenation	Rhytlds Static
Acne Scarring	Rhytids w/ movement
CRYOCLEAR PER PROTOCOL	
Skin Tags	SKINPEN MICRONEEDLING PER PROTOCOL
	Acne Scarring
Sun Spots	
Age Spots/Telanglectasla	
I VI PEEL PER PROTOCOL	
Rhytids Static	VI PEEL PRECISION PLUS PER PROTOCOL
Rosacea	Rhytlds Statlc
그 나는 하는 사람들은 사람들이 아니는 아니는 이 아니라 이 경기에 가장 하는데 하는데 하는데 하는데 하는데 이 사람들이 아니는데 하는데 하는데 하는데 하는데 하는데 하는데 하는데 하는데 하는데 하	Rosacea
Skin Rejuvenation	Skin Rejuvenation
	Flyperpigmentation
[]DERMAPLANING PER PROTOCOL	Melasma
Complexion – Dull	
Rhytlds Static	

The aesthetician will yill out. Ap

TREATMENT NOTES:	
	The House was a second
Items listed in subparagraphs (A) – (J) of paragraph 2 of Texas MedicalPatient history and physical exam completed via telemedicine	Board rule 193.17 completed
Technician Signature:	Date:
Nurse Practitioner Signature:	Date:
Medical Director Signature:	Date:
MD, FACS	

The aesthetician will fill out + D1.

Motes, progress notes, H+P notes from Dictation in EHR:

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TEXAS HEALTH CARE, P.L.L.C. 923 PENNSYLVANIA AVE. FORT WORTH, TEXAS 76104 MEDICATION/HERB LIST

DR	UG	
ALL	ERG	ES:

PHARMACY:

FOOD ALLERGIES:

PHARMACY PHONE NUMBER:

Medication/Herb	Dosage	Frequency
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* CASC CON Messages		
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Texas Health Care, P.L.L.C.

HIPAA Authorization for Release of Patient Health Information

In general, HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

Print Name		and the state of t	Flightly data
	are (must be an addit 18yr	s or older)	Date
Patient Signata	ure (Must be an adult 18yr	o an ald	Particular state of a state of a state of small sta
. CJ No	o .	•	
□ Ye	es .		
Do you have a	n advanced directive (Livi	ng Will)?	
	AX	DYANCED DIRECTIVE	
Luci 14	U		
physician(s).			
physiciands	and pharmacist(s) regardi	ng my use of medications prescribed b	v mv other
I hereby give	my physician permission	to discuss all diagnostic and treatment	details with mer ath
	les .		
services.	a addition the your office or a	a facility on my behalf, to conduct benef	it verification
I consent and	d authorize your office on	fadility on was half to	
LJ C	Julier:		
L 1	rly parents.		
Lad I	viy children:		
L ,	My spouse:		
	Telephone Answering Mac	nine/Voice Mail	
L (only mysen		
I consent an	d authorize the release of	ABNORMAL test results to the followin	g;
. 0	Other:	ABNORMAL test results to the followin	THE SECTION OF THE PARTY OF THE
	My parents:		THE PERSON NAMED IN COLUMN ASSESSMENT ASSESS
	My children:	ommey voice Mail	
	My spouse:		
	Telephone Answering Ma	chine/Voice Mail	
	Only Myself	isometwhal test results to the following:	
I consent an	nd authorize the release of	NORMAL test results to the following:	A to traduct reconstruct a product
רז	Othor		
	may be sent to my home a	e by phone, a written communication	
. п	When unable to save doct	or with call back number only	
	OK to leave messa	ge with detailed information	
	Work Telephones		
(man)	O Leave name and d	octor with call back number only	
	OK to leave a mess	age with detailed information	
	nome or cell Phone:		
I wish to b	e contacted in the following	g manner (check all that apply):	

THC99P22Q REVISED 09/2016

Toxas Health Care, P.L.L.C. 923 PENNSYLVANIA AVE. FORT WORTH, TEXAS 76104

PAYMENT POLICY

Thank you for choosing Texas Health Care, the office of Dr. Yadro Duclc, Dr. Jesse Smith, Dr. Andrew Vories, Dr. Ricardo Cristobal, Amanda Hudson, RN, MSN, FNP, Lauren LeBlanc, RN, ACNP, Amy Williamson, RN, ACNP, Dr. Lindi Berry, Dr. Amy Zahn, Dr. Stevie Daniel and Katrina Jensen, M.A., CCC-SLP. We are committed to providing you with quality and affordable health care. Some of our patients have had questions regarding patient and insurance responsibility for services rendered; due to this we have developed this payment policy. Please read it, ask us any questions you may have and sign in the space provided. A copy will be provided to you upon request.

- 1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan that we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- 2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Fallure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit
- 3. Non-covered services. Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. Medicare beneficiaries are required to notify our office if enrolled in home health care or a skilled nursing unit. If our office is not notified, you may be liable for services rendered.
- 4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- **5. Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims pald. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
- **6. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.
- **7. Nonpayment.** If your account balance is past due, you will receive a letter requesting that you pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
- **8. Missed appointments.** Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. If you are unable to keep your scheduled appointment, please give a 24-hour notice to avoid being charged. We reserve the right to charge for missed or untimely canceled appointments. Excessive abuse of scheduled appointments may result in discharge from practice.

I have read and understand	the	payment	policy	and	agree	60	abide	by	it's	guidalines:
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Signature of Patient or Responsible Party	Date

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