



1000 N. Davis Drive, Suite B, Arlington, TX 76012  
12222 N. Central Expressway, Suite 250, Dallas, TX 75243  
Phone: (817) 342-0232 Fax: (817) 275-1401

[www.MyCompleteTransformation.com](http://www.MyCompleteTransformation.com) [www.AdvancedCosmeticSurg.com](http://www.AdvancedCosmeticSurg.com)

*New Patient Form*

Account#: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_ Sex: Male or Female ( Please circle)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Pharmacy Name/#: \_\_\_\_\_

SS#: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home #: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Email Address: \_\_\_\_\_

*Spouse Information*

Spouse's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Work/Cell#: \_\_\_\_\_

How were you referred? \_\_\_\_\_ Reason For Visit: \_\_\_\_\_

*Insurance Information*

Insurance Company: \_\_\_\_\_ Provider#: \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_

*Emergency Contact*

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_ Phone# 2 : \_\_\_\_\_

*Please List 2 Phone Numbers*

*Assignment of Benefits*

I authorize the release of any medical information about me to Dr. Clayton A. Frenzel, his assistants or insurance company that is needed in the course of examination or treatments. Benefits to be paid to Advanced Surgery. I understand there is a \$500.00 fee to schedule surgery. Payment for office visits is required at the time services are rendered. For all procedures, advanced payment is required two weeks prior to surgery. For all procedures less than \$500.00, payment must be at the time of treatment or before.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



**Patient Medical History:**

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Age: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs.

Sex:  Female  Male

What is the most you have ever weighed?: \_\_\_\_\_ lbs.

KNOWN ALLERGIES:  Latex  Adhesive Tape  Sulfa  Penicillin  Aspirin  Codeine

No Known Allergies  Other Medication Allergies: \_\_\_\_\_

**HISTORY OF SPECIFIC MEDICAL PROBLEMS:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> HIV             | <input type="checkbox"/> LIVER DISEASE            | <input type="checkbox"/> BLEEDING DISORDER      |
| <input type="checkbox"/> CANCER          | <input type="checkbox"/> HEPATITIS TYPE _____     | <input type="checkbox"/> GI PROBLEMS            |
| <input type="checkbox"/> ASTHMA          | <input type="checkbox"/> HEART DISEASE            | <input type="checkbox"/> UCLERS                 |
| <input type="checkbox"/> BRONCHITIS      | <input type="checkbox"/> CONGESTIVE HEART FAILURE | <input type="checkbox"/> ESCCESSIVE SCARRING    |
| <input type="checkbox"/> EMPHYSEMA       | <input type="checkbox"/> HEART ATTACK # _____     | <input type="checkbox"/> FEVER BLISTERS         |
| <input type="checkbox"/> COPD            | <input type="checkbox"/> HIGH BLOOD PRESSURE      | <input type="checkbox"/> PROSTATE PROBLEMS      |
| <input type="checkbox"/> SLEEP APNEA     | <input type="checkbox"/> STROKE # _____           | <input type="checkbox"/> KIDNEY/BLADDER/URINARY |
| <input type="checkbox"/> ENT PROBLEMS    | <input type="checkbox"/> CHEST PAIN               | <input type="checkbox"/> BACK/NECK PROBLEMS     |
| <input type="checkbox"/> HARD OF HEARING | <input type="checkbox"/> PACEMAKER                | <input type="checkbox"/> GLAUCOMA               |
| <input type="checkbox"/> SINUS PROBLEMS  | <input type="checkbox"/> PALPATIONS               | <input type="checkbox"/> RETINA PROBLEMS        |
| <input type="checkbox"/> HEART MURMUR    | <input type="checkbox"/> CATARACT                 | <input type="checkbox"/> HIGH CHOLESTEROL       |
| <input type="checkbox"/> ARTHRITIS       | <input type="checkbox"/> DIABETES                 | <input type="checkbox"/> DEPRESSION             |
| <input type="checkbox"/> SEIZURES        | <input type="checkbox"/> THYROID PROBLEMS         | <input type="checkbox"/> ANEXITY                |
| <input type="checkbox"/> ANEMIA          |   |   |

List any other problems or concerns: \_\_\_\_\_

Name of previous physician: \_\_\_\_\_ Last Exam Date: \_\_\_\_\_

**SOCIAL HISTORY:**

Do you drink alcohol?  Yes  No How many drinks per week? \_\_\_\_\_

Do you smoke?  Yes  No How many packs per day? \_\_\_\_\_ When did you quit? \_\_\_\_\_

**SURGICAL HISTORY: (list all prior surgeries and what year)**

\_\_\_\_\_  
\_\_\_\_\_

Complications with anesthesia?:  Yes  No If yes, what was the complication?

\_\_\_\_\_

**Medication History:** (please include Vitamins; Herbal Supplements)

Medication	Dosage	Reason	Prescribing Doctor

Please list any medications to which you are **allergic** to:

Medication	Reaction

Allergic to **Latex**? [ ] Yes [ ] No

Allergic to **Food**? [ ] Yes [ ] No

Please list all previous surgeries and hospitalization stays:

Year	Surgery	Hospitalization Stays

**Family History:**

Please check which, if any, of your family members had any of the following conditions: (mother, father, sibling, grandparent, aunt/uncle)

Anemia:	Stroke:
Sleep Apnea:	Obesity:
Kidney Disease:	Cancer:
Diabetes:	Gallstones:
Gout:	Heart Disease:
High Blood Pressure:	Blood Clots:
Bleeding Problems:	Obesity Related Issues:

**Additional Comments:**




Dr. Clayton A. Frenzel, P.A.

## PATIENT CONSENT TO TREATMENT

**PURPOSE:** As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy. This disclosure is not intended to alarm or frighten you, but rather to make you better informed so that you may give or withhold your consent to the proposed treatment.

**CONSENT TO TREATMENT:** I voluntarily request Dr. Clayton Frenzel, as my physician, and such associates, assistants, nurses and other health care providers as it may deem necessary or advisable, to treat my condition. I understand that it is my responsibility to actively participate in my care in order to maximize improvement in my condition.

I understand that I may undergo extensive diagnostic tests and examinations during my treatment with Dr. Clayton Frenzel. If I am unable or unwilling to undergo such testing, my treatment plan may be revised and my condition outcome may be affected. During the course of treatment, I may be required to make frequent follow-up visits to review diagnostic test results. Patients will be required to personally attend office visits for appropriate care and treatment of their condition.

I agree to keep my physician and authorized associates apprised of any changes in my medical condition. Certain diagnostic test, treatments and drug therapies can be dangerous under certain medical conditions or medication use. Pregnancy is one such medical consideration and females must be certain to acknowledge this condition prior to diagnostic imaging and initiation of any medication therapy. Female patients who become pregnant during the course of their treatment with Dr. Clayton Frenzel will notify their prescribing physician if they are on medication therapy.

*Furthermore, I understand that no warranty or guarantee will be made to me as to the result of any medication therapy, treatment or cure of my condition. I have the opportunity to ask questions about my condition and treatment, risks of non-treatment and the medication therapy, medical treatment(s) or diagnostic procedures(s) to be used to treat my condition, and the risks and hazards of such medication therapy, treatment(s) and procedure(s), and I believe I have sufficient information to give this informed consent. I hereby consent to treatment.*

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*



Dr. Clayton A. Frenzel, P.A.

**ACKNOWLEDGEMENT  
TO RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I understand that as part of my healthcare, Advanced Cosmetic Surgery ("PROVIDER") originates and maintains health records describing my health history, symptoms, examination and tests results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and in other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals and as required or permitted by law without my consent.

The PROVIDER'S *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this acknowledgment. I understand that the PROVIDER reserves the right to change the Notice of Privacy Practices.

I have been provided and have reviewed the PROVIDER'S *Notice of Privacy Practices* dated **March 25, 2011.**

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Print Name of Patient or Legal Representative

Date: \_\_\_\_\_

I give permission to Advanced Bariatric Surgery to release my private health information to the following person(s). Please print below.

\_\_\_\_\_

\_\_\_\_\_



Dr. Clayton A. Frenzel, P.A.

## **Notice of Privacy Practices**

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. Clayton A. Frenzel, P.A. has adopted the following privacy policies:

### **Uses and Disclosures**

***Treatment:*** Your health information may be used by staff members or disclosed to other health care professionals for the sole purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedure will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

***Payment:*** Your health information may be used to seek payment from your health plan or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

***Health care operations:*** Your health information may be used as necessary to support the day-to-day activities and management of Advanced Cosmetic Surgery. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

***Law enforcement:*** Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

***Public health reporting:*** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

***Other uses and disclosures require your authorization:*** Disclosure of your health information or its used for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a used or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of you decision.

### **Additional Uses of Information**

***Appointment reminders:*** Your health information will be used by our staff to send you appointment reminders by mail or to contact you by phone regarding appointment reminders.

***Information about treatments:*** Your health information may be used to send you information or the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

## Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your Protected Health Information
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your Protected Health Information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed; and
- The right to receive a printed copy of this notice.

## Advanced Cosmetic Surgery's Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

## Right to Review Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these provisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

## Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy. Protected Health Information should be submitted in writing. You may obtain a form to request access to your records by contacting: **Dr. Clayton A. Frenzel, P.A. , 1000 N. Davis Dr. Ste. B, Arlington, TX 76012 (817) 342-0232.**

## Complaints:

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: **Daphne Danns or Tami Holden, 1000 N. Davis Dr. Ste. B, Arlington, TX 76012 (817) 342-0232.**

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

**Effective Date:** This notice is effective on or after March 25, 2011.