PREMIER PLASTIC SURGERY
OF
TEXAS

Cosmetic, Plastic & Reconstructive Surgery
Peripheral Nerve Surgery

Dear New Patient:

Welcome to my practice. My staff and I look forward to meeting you at the consultation you have scheduled on:

Date: _____ Time: _____

Enclosed you will find patient information forms to be completed prior to your consultation. **If a REFERRAL from your insurance company is required, please contact your primary care physician. All appointments without the proper information required will be rescheduled.** Please be sure to complete your health survey as accurately as possible. This is very important for patients who will require surgery. All medications listed must have names spelled correctly, strength or dosage listed, and times taken per day. Surgeries must be listed as well, with specific type and time frame if not exact dates. If you wish to complete the paperwork at our office, please arrive 15 to 20 minutes prior to your scheduled appointment time. You are encouraged to bring any questions, references, or photographs that you feel you wish to share while discussing your appearance goals.

During your consultation, you will meet with me and with other members of my staff. We are all here to educate and guide you through your choices. Prior to your consultation, please have all medical records pertaining to your current medical problem sent to us by your referring physician. If there is a large volume of records, please be considerate of the physician's time and drop them off 2-3 weeks before your consultation for review. If you require more time or have additional questions, a second consultation may be scheduled. Please keep in mind that there will be a charge of **$40** for completion of forms.

A minimum of 24hours is required for any cancelled or rescheduled appointments. Patients arriving 15 minutes later than the listed arrival time above will be rescheduled. Patients arriving 20 minutes late are considered "no-show" and will be charged the late fee of **$50.** If you "no-show" for three appointments, written notice will be sent terminating you as a new patient.

I want to thank you for choosing my practice. I am dedicated to the highest standards of patient safety. Your safety requires that patient and surgeon work as partners to understand and fulfill your goals. My staff and I look forward to meeting you.

Yours truly,
Patty Young M.D.

Patty Young, MD
4104 West 15th Street, Suite 200, Plano, TX 75093
Phone: (972) 398-1131 Fax: (972) 398-0199
www.pattyyoungmd.com

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ATTENTION NEW PATIENTS:

Please bring all your medication bottles with you to your appointment. We must have the correct information on file with regards to the drugs name, dosage and frequency taken.

We thank you in advance for your cooperation in this matter.

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PATIENT HEALTH SURVEY

Date _____

Name _____
Age _____ Sex _____ Height _____ Weight _____

Reason for office visit:

_____

_____

List all doctors involved in your care. Include full name, specialty, address, phone number:

Referring physician: _____

Personal physician: _____

_____

_____

_____

_____

Medical History

Check those that apply

Cardiovascular

____ High blood pressure
____ Heart attack
____ Coronary artery disease
____ Irregular heart beats
____ Heart murmur
____ Heart failure
____ High cholesterol
____ Vascular Disease
____ Blood Clots

Urinary / GI

____ Kidney stones
____ Problem voiding
____ Kidney disease
____ GERD
____ Ulcer
____ Hepatitis
____ Pancreatitis
____ Colitis
____ GI Bleed

Neurologic

____ Stroke
____ Head Injury
____ Headaches
____ Depression
____ Anxiety
____ Chronic pain
____ Bell's Palsy
____ Herpes/Cold sores
____ Nerve compression

Pulmonary

____ Asthma
____ Hay Fever
____ Bronchitis
____ Pneumonia
____ COPD
____ Restrictive lung disease
____ Sleep Apnea

Endocrine/Heme

____ Hypothyroidism
____ Hyperthyroidism
____ Diabetes
____ Autoimmune disease
____ Sickle Cell / Trait
____ Anemia
____ HIV+

Musculoskeletal

____ Arthritis / DJD
____ Rheumatoid arthritis
____ Spine – herniated disc
____ Spine – arthritis/DJD
____ Paralysis
____ Fibromyalgia
____ Broken bones

Head and Neck

____ Dry Eyes
____ Glaucoma

Cancer

Type _____
Chemotherapy: Yes No Radiation: Yes No
Left or Right or Both Breast

Other Illnesses Not Listed: _____

Surgical History MUST complete this section

Year **Operation**

Have you ever had a problem with anesthesia? Yes No
If yes, what occurred? _____
Has a family member or relative had a problem with anesthesia? Yes No What? _____
Have you been told you need to take an antibiotic before surgery? Yes No Why? _____
Have you have rheumatic fever? Yes No
Do you have any metal implanted? Yes No If yes, where? _____

Allergies to Medications

Medications; include dosage, directions for use, purpose of medicine

MUST complete the following for medications for surgery…..
Pharmacy Name _____ **Phone #** _____
Pharmacy Complete Address _____

Herbal supplements and vitamins; include dosage and directions for use:

Social History

Please circle: Married Partner Single Divorced Separated Widowed
Children? Yes No
Occupation? _____
If medical problem is work related please explain: _____

Do you currently smoke? If yes, how much and how long have you smoked? Yes No

If you quit smoking; how long ago? _____
Do you drink alcohol? Yes No
How often do you drink? _____
Do you use street drugs or illegal drugs? Yes No What? _____
Have you ever been treated for drug use? Yes No
Have you ever been treated for alcohol use? Yes No

Family History **MUST** complete section below, please.

Illness	What family member has what disease
Heart disease	
Vascular disease	
Lung disease	
Diabetes	
Cancer	
Bleeding problems	
Blood clotting problems	
Other	

System Review check those that apply

___ Chest pains
___ Abnormal heart beats
___ Swelling of legs/feet
___ Leg cramps w/ walking
___ Sinus problems
___ Shortness of breath
___ Coughing
___ Fainting/blackouts

___ Easily bruise
___ Heartburn
___ Diarrhea
___ Constipation
___ Urine incontinence
___ Stool incontinence
___ Weight gain ___lbs
___ Weight loss ___lbs

___ Insomnia
___ Dizziness
___ Hearing loss
___ Ringing in ears
___ Vision loss
___ Muscle pain
___ Back pain
___ Neck pain

___ Numbness/Tingling
___ Coordination Prob.
___ Weakness
___ Joint stiffness
___ Fever
___ Blood transfusion
___ Poor healing
___ Ugly scarring

General Information Sheet

(Please Print Clearly) **Today's Date** _____

PATIENT:

Name _____

What would you like to be called _____

Address _____ City _____ State ___ Zip _____

DOB _____ Age _____ Male _____ Female _____ Ht _____ Wt _____

Home phone _____ Work phone _____ SS# _____-_____-_____

Cell phone _____ Email address _____

Employer _____ Occupation _____

Employer's address _____

Spouse's Name _____ SS# _____-_____-_____

DOB _____ Spouse's Employer _____

Employer's Address _____

Phone number _____ Occupation _____

RESPONSIBLE PARTY (if minor under the age of 18):

Name _____ Relation to Patient _____

DOB _____ SS# _____-_____-_____ Insured ID# _____ GP# _____

Home address _____

Home phone _____ Work phone _____

Employer name _____ Address _____

EMERGENCY CONTACT: (someone not living in your home with different number)

Name _____ Relation to Patient _____

Phone number _____

REFERRAL INFORMATION: (please tell us who referred you to our practice):

Physician Referral _____ Phone number _____

Physician address _____

Patient Referral _____

Other _____

Reason for Visit Today:

_____

Due to Injury? Y or N Date of Injury _____ On the job injury? _____ Auto Accident _____

INSURANCE INFORMATION:

Primary Insurance Information

Name of Insured Party/Policy Holder _____ Relation to Patient _____

DOB Insured Party _____ SS# Insured Party _____-_____-_____

Insured ID#/Policy # _____ Grp# _____

Name of Primary Insurance Carrier _____ Phone Number _____

Mailing Address _____

Employer Name _____

Employer Address _____

Secondary Insurance Information

Name of Insured Party/Policy Holder _____ Relation to Patient _____

DOB Insured Party _____ SS# Insured Party _____-_____-_____

Insured ID#/Policy # _____ Grp# _____

Name of Secondary Insurance Carrier _____ Phone Number _____

Mailing Address _____

Employer Name _____

Employer Address _____

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OFFICE POLICIES

-Our office hours are Monday through Friday, 9:00 am to 5:00 pm. We close the office from 12:00 to 1:00 for lunch. If you have an emergency, you can call 911 or go to the nearest emergency room.
-On occasion, our office may close early for meetings, seminars, training, etc. In this case, you may leave a message with the answering service and your call will be answered the following business day.
-All telephone calls will be answered as soon as possible, although every effort will be made to return calls within 24 hours. If you feel need immediate attention, please notify the receptionist when you call the office. Calls are returned in the order in which they are received and in order of urgency.
-It is our goal to schedule everyone as soon as possible for diagnostic testing, physical therapy, and surgeries. However, all are subject to insurance approval. Unfortunately, this process takes time. Please be aware that scheduling can take up to 2 weeks.
-Prescription refills will be called in as soon as possible. If you are taking prescription medication previously prescribed by another physician, you will need to contact the prescribing doctor for the refill.
-All forms to be completed by our office, i.e. Disability, FMLA, etc., must be given to our office with ample time to complete. Please allow 10 business days to complete the forms. Please keep in mind that there will be a charge of **$40** for completion of the forms.
-On occasion, the physician may be called away from the office for an emergency. This is the nature of a surgeon's practice. In this case, your appointment will have to be rescheduled. We will make every effort to notify you as soon as possible when this situation arises.
-Please contact us within 24hours of needing to cancel or reschedule. If you arrive 15 minutes late for your appointment, you will be rescheduled.
-Patients more than 20 minutes late will be considered "no-show" and will be charged a late fee of **$50**.
-If you need to cancel a procedure, and do not provide 24hour notice, you will be charged a cancellation fee of **$75.**
-Patients canceling a surgery will need to notify the office within 2 weeks of scheduled surgery or will be charged a cancellation fee of **$250.**
-In addition, if you "no-show" for three appointments, written notice will be sent terminating you as a new patient.

-A return check fee of $30.00 will be collected with any insufficient notice of returned check deposited.

I have read and understand the above office policies.

Signature Date

Lorna Woodford,LSA,CSFA

L&E First ASSISTANTS ,INC

Dear New Patient,

Use of a surgical first assistant is beneficial in many surgeries. The surgical assistant is an important part of the surgical team, as their care contributes to the decreased anesthesia time and decreased overall operative time. Dr. Young is one of several surgeons who utilize the service of L&E First Assistants, Inc. for this purpose. Please also be aware that in most cases the surgery may not proceed as scheduled when an assistant is necessary but not agreed upon by patient or pre-payment not received .
L&E First Assistants will bill separately for our services and will contact you directly to discuss payment. Payment is required prior to the surgical procedure. We will file a claim with your insurance company. Many times, our bill is fully applied to the insurance deductible. Our fee is $100.00 per hour as the minimal rate for insurance cases. The estimated length of the surgery is determined by your surgeon. Please be assured that you will not be charged any additional fee in the event that your insurance company does not pay. If, however, your insurance does pay the ENTIRE billed charges, you will receive a FULL REFUND for your original payment.
Cosmetic patients rates are $125.00 an hour.

Please complete the following information:

Patient name: _____

Name on credit card_____

Credit card #_____EXP_____CVV_____

Phone: Cell_____ Home:_____Work:_____

Email address:_____
By providing your signature you agree to the above terms and agree to the physician's office providing us with your insurance information.

Patient Signature:_____ Date:_____

7228 Wild Valley Dr, Dallas, TX 75231 Phone: 972-365-8729 Fax: 214-348-2708
Email: dallasdoone@sbcglobal.net

On-Point Services
where efficiency, excellence, and a positive environment meet

Dear Patient,

Dr. Young uses On-Point Services LLC for surgical assistance in the operating room. She has requested an On-Point Services Assistant to assist on your procedure. We would like to acquaint you with who we are and with the professional services we provide to you in the operating room. First Assistants are highly skilled allied health professionals trained in specific surgery specialties.

When scheduling a surgery with a hospital or surgery center (Facility), your surgeon may determine that surgical assistant services are medically necessary for that procedure to provide you with the most optimal surgical care and outcome. Surgical assistant's scope of practice is performed strictly under the direct supervision of the surgeon and defined by the rules and regulations of the Texas Medical Board.

A deposit is collected one week before your procedure to reserve you and your surgeon a Licensed Surgical Assist with On-Point Services LLC. **Please, be aware that in some cases the surgery may not proceed as scheduled when an assistant is necessary, but not agreed upon by the patient.** For any questions or concerns, please reach out to us via email, on-pointcare@on-pointservices.org or by phone at (214) 783.2244.

An On-Point Services representative will reach out to you prior to your procedure to answer any question you may have and will give instructions on how to make your deposit.

I, the patient, have read, understand and give consent to On-Point Services LLC and to its providers, to assist with my procedure as requested by my surgeon. I understand I will be responsible for submitting my deposit before my surgery date.

Name:_____ Date:_____

Signature:_____ Date of Surgery:_____

Patty Young, M.D.
Premier Plastic Surgery of Texas
Cosmetic, Plastic & Reconstructive Surgery
Peripheral Nerve Surgery

Our Promise to You

The practice of medicine and surgery is not an exact science, although good results are expected, there cannot be any guarantee or warranty, expressed or implied, by anyone as to the results that may be obtained. On occasion, surgical revision may be indicated following the original surgery.

If the revision is planned and performed within one year of the original surgery, and if insurance does not cover the revision, there will be a reduced fee extended to you. If insurance does pay for the revision, we will collect your copay and/or coinsurance prior to services being rendered. Please note, the usual/planned charges from the surgical facility/hospital, first assist, and the anesthesiologist will be the patient's responsibility.

_____

Signature

_____

Printed Name

_____

Date

Premier Plastic Surgery of Texas
4104 West 15th Street, Suite 200
Plano, Texas 75093

phone: 972-398-1131
fax: 972-398-0199
email: info@ppsoftx.com

Patty Young, M.D.
Premier Plastic Surgery of Texas
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Peripheral Nerve Surgery

Patty K. Young, M.D and Premier Plastic Surgery of Texas: Invested in Your Care

Facility Relationships

Dr. Patty Young has a financial interest in medical facilities in the area. These facilities and Dr. Young are committed to providing excellent medical care to our patients in a safe, high quality, caring environment. Her financial interest in these facilities often provides the doctor a voice in administrative, clinical and operational policies. This involvement helps ensure the highest level of patient care and customer service. Patients of Dr. Patty Young always have the option of utilizing an alternate health care facility or provider. Please ask one of our representatives for a list of alternate facilities should you desire. Dr. Young would welcome any questions regarding this aspect of her patient's care.

The facility with which Dr. Young and/or Premier Plastic Surgery have a financial interest is the Surgery Center of Plano.

Your signature below acknowledges receipt and understanding of the above disclosure.

_____

Signature

_____

Printed Name

_____

Date

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Plano, Texas 75093

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email: info@ppsoftx.com
Instagram @pattyyoungmd

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I, _____ (printed name of the patient) _____ (DOB of patient)
give permission for Premier Plastic Surgery of Texas and Patty Young, MD to send via facsimile or mail my medical records to other physicians who request them.

I also authorize medical records including all operative notes, pathology reports, diagnostic testing, x-ray reports with interpretation, progress reports, patient demographics, etc... to be released to

Patty Young, MD
Premier Plastic Surgery of Texas
4104 West 15th Street
Suite 200
Plano, Texas 75093
p. 972-398-1131
f. 972-398-0199

_____

Signature of Patient or Legal Guardian

_____

Printed Name of Signee Above

_____

Date

Premier Plastic Surgery of Texas
4104 West 15th Street, Suite 200
Plano, Texas 75093

Members

phone: 972-398-1131
fax: 972-398-0199
email: info@ppsoftx.com
Instagram @pattyyoungmd

Patty Young, M.D. & Premier Plastic Surgery of Texas

Cosmetic, Plastic & Reconstructive Surgery
Peripheral Nerve Surgery

Photographic Release and Consent

I, _____ agree that Patty K. Young, MD, Premier Plastic Surgery of Texas (PPSofTX), or designated representatives of the practice may take and use preoperative and postoperative photographs of my person for confidential clinical records purposes and that such photographs shall remain the property of Patty K. Young, MD and Premier Plastic Surgery of Texas.

Patient Signature	**Date**

I fully specifically grant my permission for the use of photographs, videotapes or case information for the following additional purposes as indicated by my initials below. As a result of this use, I understand that these photographs, videotapes or case information may appear in other related, updated or reprinted formats at any concurrent or future occasion. I understand that such consent is strictly on a voluntary basis. I understand a copy of this consent may be supplied with the images to any third party wherein they may be published or presented. I understand that some photographs may, by their representation, make me identifiable in appearance to others. I authorize Patty K. Young, MD and Premier Plastic Surgery of Texas to use my photographs, videotapes and case information in the following educational and scientific settings that I have initialed:

Please initial by each item:	
Patty K. Young, MD/PPSofTX office patient education material	
Patty K. Young, MD/PPSofTX file of preoperative and postoperative patient photographs available to prospective patients for viewing in the office	
Newspaper and magazine articles in which Patty K. Young, MD/PPSofTX participates	
Television programs in which my Patty K. Young, MD/PPSofTX participates	
Patty K. Young, MD/PPSofTX personal website or webpage	
Lecture(s) and multimedia presentations given by Patty K. Young, MD/PPSofTX for the general public	
Videos for social media purposes used by Patty K. Young, MD/PPSofTX	
Photographs for social media purposes used by Patty K. Young, MD/PPSofTX	

I also authorize Patty K. Young, MD and Premier Plastic Surgery of Texas (ie., my plastic surgeon) professional associations, the not-for-profit American Society for Aesthetic Plastic Surgery, to use my photographs and case information in fulfilling its mission of public education, in the settings that I have initialed:

Patient education brochures for purchase	
Patient education video tapes for purchase	
Lectures and slide presentations for purchase	
Television programs about plastic surgery	
Patty K. Young, MD/PPSofTX personal website or webpage	
Case studies presented on the Society's website at www.surgery.org	

Signature of Patient or Personal Representative	Date
Relationship of Personal Representative	
Printed Name of Patient if Personal Representative	Date
Signature of Practice Representative	Date

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