SUMMER CLARK, M.D.
1611 Wallace Blvd.
AMARILLO, TX 79106
(806) 354-4900

Patient's Full Name:_____ Name Preferred to be Called: _____Sex: _____
Street Address:_____ Race:_____
City:_____ State: _____ Zip:____ Home Ph: (____)_____ Cell Ph: (____)_____
Birth Date: _____ Age: _____ Social Security No: _____
E-Mail Address:_____
Marital Status: (circle) M S W D Spouse's Name:_____
Spouse's Social Security No: _____ Spouse's Birth Date:_____

Responsible Party (if different than patient or spouse):_____
Address:_____City/State/Zip:_____
Social Security No:_____ Birth Date:_____ Relationship to patient:_____
Responsible Party Home Ph: (____)_____ Cell Ph: (____)_____

If Referred by Another Physician – Physician Name:_____
Address:_____City/State/Zip:_____
Phone: (____)_____
Primary Care Physician (if different from referring Physician):_____
Address:_____ City/State/Zip: _____Phone #_____

Primary Insurance Company
Name: _____
Address:_____
City/State/Zip:_____
ID Number:_____
Subscriber:_____
Subscriber Social Security No:_____
Subscriber DOB:_____

Secondary Insurance Company
Name:_____
Address:_____
City/State/Zip:_____
ID Number:_____
Subscriber:_____
Subscriber Social Security No:_____
Subscriber DOB:_____

Patient's Employer (or retired from):_____
Address:_____ City/State/Zip:_____
Work Ph: (____)_____

Spouse's (or Responsible Party's) Employer (or retired from):_____
Address:_____ City/State/Zip:_____
Work Ph: (____)_____

Emergency Contact:_____ Relationship:_____
Address:_____ City/State/Zip:_____
Phone: (____)_____ Cell Ph: (____)_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION BY PROFFER SURGICAL ASSOCIATES, LLP FOR ANY INSURANCE CLAIMS SUBMISSION AND AT THE DOCTOR'S DISCRETION, ASSIGN THE INSURANCE PAYMENT TO THEM FOR THESE SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES THAT ARE NOT COVERED.

PREFERRED PHARMACY_____
PHONE:_____

PATIENT OR RESPONSIBLE PARTY
SIGNATURE:_____DATE:_____

PROFFER

LOCAL Medical History

Todays Date: _____
Proposed Procedure: _____
Reviewed By: _____

Allergies (Food & Drugs)

Height: _____
Weight: _____

Previous Surgical History (Including Eye Surgeries & Eyelid Surgery)

Family History:

CHECK ALL THAT APPLY TO YOU NOW OR IN THE PAST

CARDIOVASCULAR

___ High Blood Pressure
___ Coronary Artery Disease
___ Heart Attack _____ Year
___ Angina / Chest Pain
___ Congestive Heart Failure
___ Coronary Artery Bypass Grafts
___ Angioplasty / Stents _____ Year
___ Irregular Heart Beat / Arrythmia
___ Heart Murmur / Valve Prolapse
___ Pacemaker / ICD
___ Difficulty Walking Up Stairs
___ Cardiologist _____
___ DVT (Blood Clots in Legs)

NEUROLOGIC

___ Anxiety / Depression
___ Mental Disorders
___ Epilepsy / Seizures
___ Multiple Sclerosis
___ Stroke / Paralysis
___ Polio
___ Migraines
___ Muscle Weakness
___ Spinal Cord Abnormality
___ Other Neuro Disease

KIDNEY

___ Kidney Failure
___ Frequent Infections
___ Other Kidney Disease

SKIN CANCER HISTORY

___ Basal Cell Carcinoma
___ Squamous Cell Carcinoma
___ Melanoma
___ Other
___ Have You Ever Been Treated with Mohs Surgery? _____

RESPIRATORY

___ Cough / Cold Last 2 Weeks
___ Asthma / Wheezing
___ Emphysema / COPD
___ Bronchitis
___ Sleep Apnea _____ CPAP Used
___ TB
___ Allergies / Sinus
___ Other Lung Disease
___ Blood Clots In Lungs

ENDOCRINE

___ Diabetes – Yr Dx. _____
___ Insulin: _____
___ Oral Meds
___ Thyroid Disease
___ Other Endocrine Disease
___ Steroid Medication In Past Year

SOCIAL

___ Tobacco Use
___ Have you EVER Smoked Yes No
___ Packs Per Day for _____ Years
____Quit ____ Years Ago
____ Alcohol ___ Yes ___ No
Amount_____
Have You Ever Used Street Drugs?
_____ Yes ___ No
_____ Regular Exercise Program

VACCINATIONS

☐ Flu ☐ Pneumonia

Date of Injections _____

GASTROINTESTINAL

___ Ulcer
___ Hiatal Hernia
___ Frequent Heart Burn
___ Acid Reflux
___ Other GI Disease
___ Hepatitis
___ Other Liver Disease

BLOOD

___ Bleeding Disorder
___ Sickle Cell
___ Hemophilia
___ Other Blood Disease
___ AIDS / HIV
___ Do You Take Aspirin Daily
___ Name Blood Thinners taken Daily _____

OTHER

___ Malignant Hyperthermia
___ Rheumatic Fever
___ Rheumatoid Arthritis / Lupus
___ Enlarged Prostate
___ TMJ
___ Cancer
___ Loose / Missing Teeth
___ Capped Teeth
___ Dentures / Partials
___ Recent Dental Work
___ Hearing Aid
___ Glaucoma
___ MRSA ___ Latex Allergy
*Other _____

Patient / Guardian Signature

X _____

Patient Sticker

Patient Name: _____

Patient Sticker

Please list ALL drug **ALLERGIES** and reactions

Medication	Reaction

Please list ALL medications, vitamins and over-the counter medications taken:

Medication	Dosage	Frequency Taken	Why Medication is Taken	Last Taken	FOR PHYSICIAN USE ONLY Discharge Order		
					Continue	Stop	Change

Continue on Back if Needed

Physician/Licensed Independent Practitioner _____ Date & Time _____

Patient/Other Signature _____ Date & Time _____

Discharge Staff Signature _____ Date & Time _____

Patient Sticker

Medication	Dosage	Frequency Taken	Why Medication is Taken	Last Taken	**FOR PHYSICIAN USE ONLY** Discharge Order		
					Continue	Stop	Change

Proffer Surgical Associates

ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgment.

I _____ have received a copy of this office's Notice of Privacy Practices. *You have the right to refuse to sign this document*

_____

(Please Print Name)

_____

(Signature)

Date: _____

I give permission to release medical information to the following persons:

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

_____ The patient or individual refused to sign this document

_____ Communications conflicts prohibited us from obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please specify) _____

_____

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I, the undersigned patient consent to the following, photographs and/or videos of me to be used by Proffer Surgical Associates.

I consent to such photographs, videos and any associated quotes by me being edited and published by my Doctor and/or any party acting under my Doctor's license and authority in any print or electronic form, including, but not limited to posts on social media, for the purpose of informing the medical profession or the general public about aesthetic procedure methods and results, surgical and non-surgical, and whether or not such settings are regarded as educational, scientific of commercial.

I expect to be recognized from my likeness or quotes.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will exist in perpetuity 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 my Doctor.

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 release and discharge my Doctor and all parties acting under my Doctor's license and authority from all rights that I may have in the photographs, videos or quotes and from my claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these material in any medium. I certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____

Patient Signature Witness / Physician

_____ _____

Printed Patient Name Date

I have read the above Authorization and Release. I am the parent, guardian or conservator of the patient, a minor. I am authorized to sign this consent on the patient's behalf.

_____ _____

Patient/Guardian/Conservator Signature Date

_____

Printed Patient/Guardian/Conservator Name

PROFFER
SURGICAL ASSOCIATES

Marketing Authorization Form

Patient Name: _____ Date: _____

1. Authorizing marketing communication from this practice means I may:
   a. Receive treatment communications concerning treatment alternatives or other health related products or services.
   b. Be contacted for appointment reminders or information about treatment alternatives or other health related benefits and services that may interest me.

- **I understand that I have the right to "opt out" of receiving such communications.**
- **I understand that this practice may receive remuneration for communications.**

Other communications for such purposes that do not involve financial remuneration are adequately captured in this practice's notice of privacy practices (NPP).

2. Marketing Authorization Options:

□ **I wish to receive Marketing Communications from this Practice Only.**
□ **I wish to receive Marketing Communications from this Practice, and this Practice's Business Associates.**
□ **I do <u>NOT</u> wish to receive any Marketing Communications.**

Patient Signature: _____

Communication that encourages you to use our services is considered marketing. If we intend to use, or sell PHI for personal gain or commercial advantage, we must **first obtain written authorization.** Authorization is required for all treatment and health care operations communications where the covered entity receives financial remuneration for making the communications for a third party whose product or service is being marketed. Such a policy will ensure that all such communications are treated as marketing communications, instead of requiring covered entities to have two processes in place based on whether the communication provided to individuals is for a treatment or a health care operations purpose. **We MAY receive financial remuneration from a third party due to marketing.**

HIPAA states the term "financial remuneration" does not include non-financial benefits, such as in-kind benefits, provided to a covered entity in exchange for making a communication about a product or service. Rather, financial remuneration includes only payments made in exchange for making such communications.

In addition, HIPAA emphasizes that the financial remuneration a covered entity receives from a third party must be for the purpose of making a communication and such communication must encourage individuals to purchase or use the third party's product or service. If the financial remuneration received by the covered entity is for any purpose other than for making the communication, then this marketing provision does not apply.