HOPKINS
PLASTIC SURGERY

3450 W. Wheatland Rd., Suite 425, Dallas, TX 75237
(Physician Office Building II)
P (972) 298-6641 F (972) 298-2749

Welcome to our practice. We appreciate your selection of our office to serve your medical and cosmetic needs. Our goal is to provide you with exceptional and individualized care through the wide array of plastic and reconstructive procedures that Dr. Hopkins performs.

A native of Fort Worth, TX, Dr. Hopkins began his medical career in 1987 when he received his D.D.S. from the University of Texas Health Science Center in San Antonio and then specialized in Oral and Maxillofacial Surgery at the Washington Hospital Center in Washington, D.C. He then attended Medical School at the University of Alabama in Birmingham, graduating in 1993.

He completed six years of specialized training in Plastic and Reconstructive Surgery at Providence Hospital in Southfield Michigan, and Hand, Upper Extremity & Microsurgery at Baptist Hospital in Oklahoma City, OK. Dr. Hopkins has been in private practice here in Dallas since1999.

Dr. Hopkins is a member of the American Medical Association, Texas Medical Association, Dallas County Medical Society, and the American Society of Plastic Surgeons. He is currently on staff at Methodist Charlton Medical Center, Methodist Dallas Medical Center, and Methodist Mansfield Medical Center.

Dr. Hopkins is triple board certified, with board certifications from the American Board of Plastic Surgery in both Plastic and Reconstructive Surgery and Hand Surgery, as well as the American Board of Oral and Maxillofacial Surgery.

Our entire staff operates as a team. We take great pride in each staff member's training and capabilities, and we hope you share our confidence in our ability to serve you fully.

Our office is open Monday through Friday from 8:15 a.m. to 3:00 p.m. Patients are seen by scheduled appointments only. We ask that you arrive approximately 15 minutes prior to your appointment, and you may be asked to reschedule your appointment if you are more than 5 minutes late. We understand that appointments may need to be changed, so we ask that you kindly call 24 hours in advance if you cannot keep your scheduled appointment.

We have attached our patient registration forms and request that you complete them prior to your scheduled appointment. Along with your registration forms, we ask that you bring your picture ID, insurance card(s), and a list of any medications you are currently taking.

Please don't hesitate to contact our office with any questions prior to your appointment. We look forward to meeting you!

Sincerely,

Kara Everly
Practice Coordinator

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____Home ____Cell Phone/Teléfono_____ Date/Fecha _____

Patient Name/Nombre _____ SS # _____

Address/Direccion _____

City, State, Zip/Cuidada, Codigo, Postal _____

Sex ____M ____F Age _____ Edad Date of Birth _____ Feche de naciemiento ____ Married ____ Single ____ Minor Casado(a)

Email _____ Correo Electronico Preferred Communication ___ Home ___ Work ___Cell___Email

In case of an emergency, who may we contact? _____ Persona en caso de un emergenia?

Emergency contact phone/Numero de telefono emergencia _____

Pharmacy Name and Location _____ **(Farmacia)**

Insurance Information/Seguro Medico

____ **Self- Pay**

____ **Primary Insurance** _____ Phone _____

Subscriber ID _____ Subscriber Group _____

____ **Secondary Insurance** _____ Phone _____

Subscriber ID _____ Subscriber Group _____

____ **Workers Compensation Insurance** _____ Phone _____

Claim Number _____ Adjuster's Name _____

Employer _____ Employer's Phone _____

Assignment and Release/Asignacion y Lanzamiento

I certify that I, and/or my dependent(s) have insurance coverage with the above listed carrier(s) and assign directly to Dr. Hopkins all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above referenced doctor, may use my health care information and may disclose such information to the above referenced insurance carrier(s) and their agents for the purpose of obtaining payment for services and determine insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

_____ _____

Firma/Signature of patient, parent, guardian or personal representative Date/Fecha

_____ _____

Imprimir nombre/Print name of patient, guardian, representative Date/Fecha

Jeffrey D. Hopkins, M.D. Medical History Page 2

Patient Name: **DOB:**

Family History - Has any blood relative ever had the following?

	Y	N		Y	N		Y	N
Breast Cancer			High Blood Pressure			Kidney Disease		
Melanoma			Heart Disease			Depression		
Stroke			Diabetes			Blood Clots		

Past Medical History - Have you ever had the following?

	Y	N		Y	N		Y	N
Heart Disease			Asthma			Thyroid Disease		
Arthritis			AIDS or HIV			Bleeding Tendency		
Anemia			Mitral Valve Prolapse			Stroke		
Diabetes			High Blood Pressure			Hepatitis		
Cancer (Type)			Stomach Ulcer			Blood Clots/DVT/PE		
Glaucoma			Kidney Disease					

Do your CURRENTLY have any of the following?

Constitutional	Y	N
Fever		
Chills		
Malaise		
Weight Changes		
Increase/Decreased Appetite		
Night Sweats		

Skin		
Rash		
Itching		
Color Change		
Excessive sweating		
Abnormal nail/hair growth		
Texture Change		

Head		
Headaches		
Dizziness		
Syncope		
History of severe head injury		

Eyes		
Blurring		
Diplopia		
Photophobia-sensitivity to light		
Pain		
Visual acuity problems		
Recent changes in vision		

Ears		
Hearing Loss		
Pain		
Discharge		
Tinnitus		
Vertigo		

Nose		
Obstruction		
Nose Bleeds		
Sinus pain		
Chnges of smell		
Frequent colds		
Postnasal discharge		

Throat and Mouth	Y	N
Hoarseness		
Change in voice		
Bleeding/Swollen Gums		
Recent tooth extraction		
Frequent sore throat		
Soreness of tongue		
Mouth ulcers		
Disturbance of taste		

Respiratory		
Painful respiration		
Shortness of breath		
Cyanosis		
Night Sweats		
Exposure to TB		
Wheezing		
Date and results of last chest x-ray		

Cardiovascular		
Chest Pain		
Palpitations		
Hypertension		
Shortness of breath		
Leg Pain/Swelling		
Night waking due to breathing		

Gastrointestinal		
Heartburn		
Nausea		
Hemorrhoids		
Hepatitis		
Difficulty swallowing		
Jaundice		
History of Ulcers, Polyps, Tumors		

Musculoskeletal		
Joint Stiffness		
Joint Pain		
Swelling/Redness		
Difficulty moving limb		

Genitourinary	Y	N
Dysuria		
Urgency		
Frequency		
Nocturia		
STD		
Blood in urine		
Polyuria		
Hesitancy		
Dribbling		
Passage of stone		

Neurological		
Syncope		
Seizures		
Weakness/Paralysis		
Abnormal sensations		
Tremors		
Loss of Memory		

Endocrine		
Enlarged Thyroid		
Heat/Cold Intolerance		
Changes with hair		
Diabetes		
Polydipsia		

Hem/Onc/Lymph		
Anemia		
Thrombophlebitis		
Tendency to bruise		
History of transfusions		

Psychiatric		
Depression		
Mood Changes		
Suicidal thoughts		
Irritability		

Allergic/Immunologic		
Allergies		
Hives		
Asthma		
Allergic rhinitis		

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Medical History
Page 1

In this time of rapidly expanding medical knowledge and the increasing specialization associated therewith, there exists a very real risk of the specialist physician not being aware of the general health and medical background of the patients. On occasion, such information may critically affect what procedures we can safely undertake on you and under what circumstances. We therefore ask that you give us the following medical information.

Age: _____ Height: _____ Weight: _____ Occupation: _____

Reason for seeing a plastic surgeon: _____

Please check any other areas of interest: ☐Breast Lift/Reduction ☐ Breast Augmentation ☐ Tummy Tuck ☐Face Lift ☐ Eyelid Surgery ☐Injectable – Botox/Juvederm

Please list any medication you are currently taking, including non-prescription drugs, vitamins, and/or herbals:

1. _____ Dosage: _____ 2. _____ Dosage: _____
3. _____ Dosage: _____ 4. _____ Dosage: _____
5. _____ Dosage: _____ 6. _____ Dosage: _____

Please list all drug allergies and reactions:

1. _____ Reaction _____ 2. _____ Reaction _____
3. _____ Reaction _____ 4. _____ Reaction _____

Please check if you have ever used: ☐ LSD ☐ Cocaine ☐ Marijuana ☐ None ☐ Other _____

Are you or have you ever been a smoker? ☐Yes ☐ No If you quit, how long ago? _____

How much are/were you smoking? _____

How much alcohol do you drink? _____ Type? _____

Is there any possibility that you may be pregnant? ☐Yes ☐No Number of pregnancies _____ Number of children _____

Have you or any member of your family ever had an unusual reaction to anesthesia? (Ex. Muscle weekness, jaundice, breathing problems or unexpected fevers) ☐ Yes ☐No If yes, what? _____

Have you ever seen a cardiologist? ☐Yes ☐No Cardiologist Name: _____

Date of your last EKG: _____

Have you ever had a mammogram? ☐ Yes ☐No Date and Results _____

Please list all the surgeries you have had (include plastic or cosmetic) or any major illnesses or hospital admissions with dates:

1. _____ Date _____ 2. _____ Date _____
3. _____ Date _____ 4. _____ Date _____

Who is your primary care physician (PCP)? _____ Phone: _____

Who may we thank for referring you, if other than your PCP? _____

I verify that the above information is true and accurate to the best of my knowledge.

_____ _____
Signature Date

_____
Print Name

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PRACTICE POLICIES

1. Dr. Hopkins sees patients by appointment only on Monday and Tuesday and again on Friday morning. You may reach our office staff during the following times:

Monday - Friday 8:00 a.m. to 3:00 p.m. ~ Closed from Noon - 1:00 p.m. for lunch

2. All patients to our office are asked to ***arrive 15 minutes prior*** to your scheduled time to complete or review any necessary paperwork and other administrative matters. **Late patients will be rescheduled.**

3. Our office does make courtesy calls to remind you of your appointment. We also provide you with an appointment card as well as offering you an option for Auto-Remind (email, text, voice). *Please take note that we do charge a no-show fee for all missed appointments. Please plan accordingly.*

4. Three consecutive no shows, cancellations or rescheduled appointments will result in termination of care due to non-compliance. ***Two rescheduled or cancelled surgeries will also result in a termination of care due to non-compliance.***
_____ **Patient Initials**

5. We require a minimum 24-hour rescheduling or cancellation notice. We do enforce a $50.00 administrative no show fee that must be paid prior to rescheduling your next appointment. Major hospital surgeries and minor office procedures covered by insurance that are cancelled with 3 days or less notice will be charged an administrative fee of $250.00.

6. The best time to get a prescription refill is at your appointment. When this is not possible, we ask that you contact your pharmacy and have them fax refill requests during business hours to (972) 298-2749. Please allow 3 business days to process these requests.

7. Non-Emergency prescription refill requests outside of business hours may incur a $75.00 administrative fee on your account. Please **DO NOT** call Dr. Hopkins after hours for a prescription refill or any other non-emergent issue. If Dr. Hopkins is called, for non-emergent issues or prescription refills, the administrative fee will be required to be paid prior to your refill being sent or your next office visit. If you have a medical emergency outside of our business hours listed above, please call 911 or visit your nearest emergency room.

8. Patients are responsible for notifying us of any changes to insurance coverage, home address and/or phone number as well as new medications or other matters affecting your treatment plan.

9. Certain health insurance plans require a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist and this is the patient's responsibility. Failure to follow your plan requirements may result in lower or no payment and the balance in full will be due by the patient.

10. Under the full consent of the patient, clinical photographs may be taken by the physician or staff. The photographs shall be used for medical, scientific, marketing or educational purposes and shall remain the property of Jeffrey D. Hopkins, D.D.S., M.D.

11. Dr. Hopkins makes every effort to keep on schedule; however, as a surgeon treating emergencies this is not always possible. We know your schedule is busy and we greatly appreciate your understanding if he is running behind schedule.

12. Practice and Financial Policies may be amended by this practice as needed.

_____ _____

Patient or Guardian Signature Date

*Adult signing for minor patient agrees to the above notice of Practice Policies

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FINANCIAL POLICY

We are dedicated to providing the best possible care for you,
and we want you to completely understand our financial policies.

1. Knowing your insurance benefits is your responsibility, and your policy is a contract between you and the insurance company. As a courtesy, claims will be filed based on the information you provide to us.

2. Insurance coverage may change at any given time and the patient is expected to provide a valid insurance card at each appointment. It is your responsibility to notify us of any changes which may affect outstanding claims. We also request notification of new phone numbers or home address.

3. Patients with insurance are expected to pay any co-payments, deductibles, co-insurance amounts and non-covered services at the time the service is rendered.

4. Cosmetic consultations are $100.00 and must be paid at the time of scheduling. If you miss your appointment and wish to reschedule, you will be required to pay another consultation fee. Cosmetic surgical procedures will require a 20% deposit at the time of scheduling and is refundable until 30 days prior to the scheduled surgery date. Cosmetic and surgical procedures not covered by insurance are expected to be paid in full two weeks prior to the scheduled surgery date. _____ (initial required).

5. The financial responsibility of the patient may change depending on how the insurance company processes the claim. A statement will be sent with the balance due and it is payable upon receipt.

6. Questions regarding coverage or disputes on processed claims should be directed to the insurance carrier at the customer service number listed on your card.

7. We require a minimum 24-hour rescheduling or cancellation notice *We do enforce a $50.00 administrative no show fee* for all medical appointments, that must be paid prior to rescheduling your next appointment. **ALL major hospital surgeries and minor office procedures require a $500 security deposit to secure the surgical date. This security deposit is NON-REFUNDABLE if you cancel your surgery within 10 days of the scheduled surgery.** _____ (initial required).

8. **Dr. Hopkins charges a $75 fee to complete disability forms, employment fitness for duty or FMLA forms.** These forms should be completed by the patients' PCP. If records are needed, they may be requested by the disability office and/or the employer. The patient is also welcome to sign a medical records release form to be sent to another party.

9. Workers' Compensation claims will become the full responsibility of the patient in the event the claim is denied. It is the patient's responsibility to provide the office with this information. Appointments will be rescheduled if the patient does not have this information or the patient can pay a self-pay office visit fee. We do not participate in third party liability insurance claims (auto, homeowner, etc.).

10. In the event your account becomes past due a late charge may be assessed and added to the balance. If no payment has been made after receiving your third statement, your account will be submitted for collection, and any costs, lawyer fees or other expenses will become your responsibility and added to your account. Non-compliance of our financial policy could result in termination of care.

11. Our office accepts cash, VISA, MasterCard, Discover, and American Express. Financing is available through Alphaeon and Care Credit and is based on their approval of your online application.

I have read and understand the above financial policy and hereby authorize the submission of medical claims to my insurance carrier for the purpose of payment. I assign all insurance payments to Jeffrey D. Hopkins, D.D.S., M.D. Inc. and agree to accept full financial responsibility of any amount not covered or paid by my insurance.

_____ _____

Patient or Guardian Signature Date

*Adult signing for minor patient agrees to this policy and accepts financial responsibility of the account.

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Jeffrey D. Hopkins, M.D.
3450 W. Wheatland Rd., Ste. 425, Dallas, TX 75237
P (972) 298-6641 F (972) 298-2749

RE: **Financial Preparedness for Surgery**

This letter is given to all patients being seen in our office for a surgical consultation with Dr. Hopkins.

It is very important to us that all our patients fully understand their financial obligations, along with our payment and cancellation policies prior to undergoing surgery with J Hopkins Plastic Surgery. When you schedule surgery, we must reserve time in the operating room at the chosen facility. At these facilities, Dr. Hopkins have secured operating room time, involving surgical nurses, technicians, and anesthesiologists to be available. Both facilities hold Dr. Hopkins accountable if this time is not used. Furthermore, we must turn down every other patient who wants surgery on the day and the time we have reserved on your behalf. The foregoing policy also holds for procedures done in our office: Based on both the financial and time commitments Dr. Hopkins must make, we ask that you be definite about your desire for surgery, and certain you have the funds available before scheduling your surgery.

After your consultation, our office will seek an authorization for surgery from your insurance provider. This can take up to three weeks. Once received, our team will obtain information regarding your benefit coverage which includes deductibles, coinsurance and/or any copay due. Any patient out-of-pocket (OOP) responsibility must be paid prior to surgery. This will be an **estimated** fee only. The Surgical Deposit Agreement is outlined below. When you feel you understand the contents of this form, and agree to the terms, please sign and date on the line indicated below.

- Once my surgery is scheduled with Dr. Hopkins, and the operating room/office procedure room is reserved at a specific time for me, and is no longer available to other patients. Therefore, I agree to submit a $500 refundable surgical deposit, plus 50% of the surgical fee (if applicable) at the time I request my surgery to be scheduled.

- The remaining surgical fee (if applicable) must be paid for no less than **TWO** weeks prior to the date of your surgery. The operating room and anesthesia fees will be billed directly to you, the patient. Each facility has specific payment policies that will be defined during the surgery scheduling process.

Please note, we ONLY obtain benefits for Dr. Hopkins services. We ***do not*** obtain benefits for the hospital, anesthesiologist, laboratory and/or radiology fees. You must anticipate paying an OOP fee to the hospital on the day of your pre-operative appointment. The hospital *will not know* what your OOP fee is until you are scheduled for surgery.

We **require** patients to contact the financial services department at MCMC or MDMC after we have scheduled your future surgery. The contact information will be provided to you at the time you are notified of the approval,but it is also listed below for your future reference. We also **require** that you contact your health insurance to discuss your benefits such as deductibles, copays or coinsurance the patient **is responsible for**.

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Some surgery procedures are covered under an insurance global period, which means that your post-operative care is covered under your surgical payment for a certain number of days after surgery (10/30/60/90 days). However, if there is a balance after your claim pays, you **will be required to pay** it prior to future appointments. If you need assistance with this, please visit our website @ www.drjhopkins.com for links to Care Credit and/or Alphaeon Credit.

Cancellation and Rescheduling Policy:

- Cancellation at least **30 Days** prior to surgery date – Full Refund of Deposit
- Cancellation **less than 30 Days** prior to surgery date – Forfeiture of Deposit
- Cancellation 2 days or less prior to surgery – Forfeiture of 50% of the Surgeon's Fee
- Rescheduling your surgery more than once – Rescheduling Fee of $300

There will be no funds held back in the event of rescheduling or cancellation by us, or in the event of a documentable medical reason with a treating doctor's statement.

*MCMC- Methodist Charlton Medical Center Financial Services- 214-945-5516

*MDMC- Methodist Dallas Medical Center Financial Services- 214-947-3422

I UNDERSTAND AND AGREE TO THE ABOVE TERMS Please sign and return. Thank you.

Signature: _____ Date: _____

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Advanced Directive

An advance directive is a legal document that says how you want to be cared for if you are unable to make decisions. You can include what medical treatments you would want and who you would trust to make decisions for you.

An advance directive can also include other legal documents. A living will is a list of treatment preferences. It can be used to indicate whether you would want cardiopulmonary resuscitation (CPR), tube feedings, a breathing machine, or certain medicines, like antibiotics.

The durable power of attorney for health care document identifies the person you would want to make medical decisions for you. This person is also called a proxy. Your proxy should be familiar with your values and wishes.

Advanced directives consist of the following legal forms:

- Directive to Physician and Family Surrogate
- Medical Power of Attorney
- Out-of-Hospital Do-Not-Resuscitate Order (DNR)
- Declaration of Mental Health Treatment

_____**Yes, I have an advanced directive.**
(please provide our office with a copy of your advanced directive)

_____**No, I do not have an advanced directive.**

_____ _____
Patient Signature Date

_____ _____
Guardian or Personal Representative Date

_____
Relationship to patient

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HIPAA PRIVACY NOTICE

Our practice is dedicated to maintaining the privacy of your individually **Protected Health Information (PHI).** In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you.

We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice. Your PHI may be used for your medical treatment and may be used in the Healthcare Operations of our business. Examples of this may be filing a claim to your insurance company, sharing your health information with others you authorize or with other professionals who are treating you.

You have many rights under HIPAA and our complete policy explains those rights in detail. Examples of those rights include the following:

- You have the right to restrict certain uses of your PHI.
- You have the right to inspect and copy your PHI.
- You have the right to receive an accounting of disclosures of PHI.
- You have the right to receive a paper copy of our complete Notice of Privacy Practices

I have read and understand this modified version of Jeffrey D. Hopkins, D.D.S., M.D.'s HIPAA notice. I am also aware a complete version of this notice is available and a copy is available upon my request.

_____ _____

Patient or Guardian Signature Date

HEALTH INFORMATION CONTACT AGREEMENT

Please contact me with my health information (test results, etc.) as follows:

- Home Number_____
- Work Number_____
- Cell Number _____

May leave messages on my home answering machine: ☐ Yes ☐ No
May leave messages on my work voice mail: ☐ Yes ☐ No

Messages concerning my medical care may be left with: _____

_____ _____

Patient or Guardian Signature Date

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PLASTIC SURGERY

Plastic Surgeon's warning to all patients who smoke:

As a smoker, or if you are exposed to second hand smoke, you can potentially develop complications such as poor wound healing, infection and bad scarring after surgery. Wounds will not heal without a good blood supply and circulating oxygen. Smoking reduces the blood flow to the wound by constricting small blood vessels; it reduces the ability of hemoglobin to move oxygen to the wound; and it reduces the amount of oxygen delivered to the wound. Smoking increases the risk of surgical wound infections.

Smoking poses problems for hand surgeries. Reduced blood flow is of specific concern in the hand, largely because there are so many tiny blood vessels in these extremities. Smoking a single cigarette can reduce blood flow to the fingers by more than 40 percent for up to an hour.

If you are having a breast lift or reduction and you smoke, your nipples could turn black and fall off. If you are having a tummy tuck and you smoke, you may get an infection resulting in a big gross open wound that will take three months to heal. If you are having a facelift and you smoke, the skin of your cheek could turn black and slough off, leaving exposed fat.

Smokers undergoing plastic, hand or wound surgery are at greater risk of an unsuccessful surgical out-come.

Quitting Smoking Before Surgery

In order to heal well after surgery, you should quit smoking.

- If you are unable to quit smoking cold turkey, start nicotine replacement therapy as soon as possible. You can buy nicotine gum, nicotine lozenges and nicotine patches at your local pharmacy. Additional smoking cessation medications need a prescription from your primary care physician.

- Quitting smoking at least ***four weeks before and for eight weeks after*** surgery will help surgical wounds heal with markedly decreased risk of post-surgical complications.

- Wound dressings, clothing, furniture and wallpaper absorb cigarette smoke. If you live in a home where there is smoke (secondary hand smoke), your wound healing may potentially be compromised.

_____ _____

Patient Signature Date