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,

J HOPKINS PLASTIC SURGERY

Home Cell Phone: ____ Date: _______/ ________/ ___________

Patient Name: ____ SS#: ________________________________

Address: ____

City, State. Zip: ____

Sex: M F Age: ________________ Date of Birth/: ______/ _______/ ________ Married Single Minor

Email: ____ Preferred Communication: Call Text Email

In case of an emergency, who may we contact? ____

Emergency Contact Phone: ____

Pharmacy Name and Location: ____

Insurance Information

Self-Pay
Primary Insurance: ____ Phone: ____________________________

Subscriber ID: ____ Subscriber Group: _________________________________

Secondary Insurance: ____ Phone: _________________________________

Subscriber ID: ____ Subscriber Group: ________________________________

Workers Compensation Insurance: ___________________________________ Phone: _____________________________

Claim Number: ____ Adjuster Name: ________________________________

Employer: ____ Employer's Phone: _____________________________

Assignment and Release

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 payments for service and determine insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

____ ___________________________________

Signature of patient, parent, guardian or personal representative Date

____ __________________________________

Print Name of above signature Date

Medical History

In this time of rapidly expanding medical knowledge and the increasing specialization associated, there exists a very real risk of the specialist physician's 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 medications you are currently taking, including non-prescription drugs, vitamins, and/or herbals.

Medication Name	Dosages	Medication Name	Dosages

Please list all drug allergies and reactions:

Medication Name	Reaction	Medication Name	Reaction

Please Check it 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 weakness, 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/ Results: ___________________________________

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

Type	Date	Type	Date

Who is your primary care physician (PCP): ___________________________________ Phone: __________________________________

Who my 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

Jeffery D. Hopkins, M.D. Medical History								
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
Anemia			Asthma			Thyroid Disease		
Arthritis			AIDS or HIV			Bleeding Tendency		
Cancer			High Blood Pressure			Stroke		
Diabetes			Mitral Valve Prolapse			Hepatitis		
Heart Disease			Stomach Ulcer			Blood Clots/DVT/PE		
Glaucoma			Kidney Disease					
Do you CURRENTLY have any of the following?								
Constitutional	Y	N	**Throat and Mouth**	Y	N	**Genitourinary**	Y	N
Fever			Hoarseness			Dysuria		
Chills			Change in voice			Urgency		
Malaise			Bleeding/Swollen Gums			Frequency		
Weight Changes			Recent Tooth extraction			Nocturia		
Increase/Decreased Appetite			Frequent sore throat			STD		
Night Sweats			Soreness of tongue			Blood in urine		
Skin			Mouth ulcers			Polyuria		
Rash			Disturbance of taste			Hesitancy		
Itching						Dribbling		
Color Change			**Respiratory**			Passage of stone		
Excessive Sweating			Painful respiration			**Neurological**		
Abnormal Nail/Hair growth			Shortness of breath			Loss of memory		
Texture Change			Cyanosis			Syncope		
Head			Night Sweats			Seizures		
Headaches			Exposure to TB			Weakness/Paralysis		
Dizziness			Wheezing			Abdominal sensations		
Syncope			Date/Results of last Chest X-ray			Tremors		
History of severe head injury						**Endocrine**		
Eyes			**Cardiovascular**			Enlarged Thyroid		
Blurring			Chest Pain			Heat/Cold Intolerance		
Diplopia			Palpitations			Changes with hair		
Photophobia-sensitivity to light			Hypertension			Diabetes		
Pain			Shortness of breath			Polydipsia		
Visual acuity problems			Leg pain/Swelling			**Hem/Onc/Lymh**		
Recent changes in vision			Night waking due to breathing			Anemia		
Ears			**Gastrointestinal**			Thrombophlebitis		
Hearing loss			Heartburn			Tendency to bruise		
Pain			Nausea			History of transfusions		
Discharge			Hemorrhoids			**Psychiatric**		
Tinnitus			Difficulty swallowing			Depression		
Vertigo			Jaundice			Mood Changes		
Nose			History of Ulcers,Polyps, Tumors			Suicidal thoughts		
Obstruction			**Musculoskeletal**			Irritability		
Nose Bleeds			Joint Stiffness			**Allergic/Immunologic**		
Sinus pain			Joint Pain			Asthma		
Changes of smell			Swelling/Redness			Allergies		
Frequent colds			Difficulty moving limbs			Hives		
Postnasal discharge			**Psychiatric**			Allergic rhinitis		
			Depression					
			Mood Changes					

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 instance that are cancelled with 3 days or less notice will he 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 Name / Patient or Guardian Signature Date

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

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 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.

5. The financial responsibility of the patient may change depending on how the insurance company processes the claim. A statement will it 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
8. procedures require a $500 security deposit to secure the surgical date. This security deposit is NON-REFUNDABLE if you cancel surgery within 10 days of the scheduled surgery. ____________________ (initial required).

9. *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.

10. 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.).

11. 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 e your responsibility and added to your account. Non-compliance of our financial policy could result in termination of care.

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

13. I have read and understand the above financial policy and hereby authorize the submission of medical claims to my insurance carrier for the 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 not covered or paid by my insurance.

___________________________/________________________________ ____________________________
Patient Name / Patient or Guardian Signature Date

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

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 has to secure 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, MDMC, Crescent RMC 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**.

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 7 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

______________________________ ______________________
Signature Date

____
Print Name

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

____
Print Name

____ ____________________
Guardian or personal representative Date

____
Relationship to patient

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

____

Print Name

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 or Guardian Signature Date

____

Print Name