VER HALEN AESTHETICS
AND PLASTIC SURGERY

Appointment, Rescheduling & Cancellation Policies

We schedule our patient's surgery days and times according to the areas being done. This allows us to better estimate how long each procedure will take in order to schedule efficiently. When we have reschedules and/or cancellations, it causes our schedule flow to run inefficiently. We do understand that everyone's time is quite valuable. In an effort to keep our schedules running smoothly, we have implemented the policies below.

Late Policy: All patients are expected to arrive I hour before their scheduled procedure time. If you are late for your scheduled time, there will be a $50 fee for every 15-minutes you are late. If you are 30-minutes late, your appointment may need to be rescheduled to another date and time and you will be charged a **$500 rescheduling fee**. Traffic, weather, car delays and other issues cannot be foreseen so it is very important to plan ahead with the expectation of arriving well in advance of your scheduled appointment time.

Rescheduling Policy: We charge a **$500 rescheduling fee** any time a procedure is rescheduled.

Cancellation Policy: In the event a procedure is cancelled for any reason, you will forfeit your deposit(s), and any processing fees associated with your deposit(s). All remaining money will be refunded back to you via a check.

In the event you need to reschedule or cancel, please call our office at 817-484-0169 as soon as possible. Please leave your name, phone number and detailed message so we may return your call.

NOTE: Your deposit(s), and any processing fees, are Non-refundable.

By placing my signature below, I certify that I have read and understand the contents of this form.

If you do not sign up for a procedure, these policies will be on file for you in the event you later decide to schedule a procedure after your consultation date.

Patient Name (printed): _____ Signature: _____ Date: _____

PATIENT MEDICAL HISTORY FORM

Last Name: _____ First Name: _____ Sex: F M

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____

Email: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____ Waist: _____ Pant Size: _____ Shirt Size: _____

Person to Contact in Case of Emergency and telephone number _____

Family Physician: _____ Phone: _____

Referred By: _____

Please answer the following by circling YES or NO:

High Blood Pressure:	YES	NO	Skin Disease:	YES	NO
Bleeding Disorder:	YES	NO	Thyroid Disease:	YES	NO
Anemia:	YES	NO	Lung Disease:	YES	NO
Liver Disease:	YES	NO	Tuberculosis:	YES	NO
Heart Disease:	YES	NO	Hepatitis:	YES	NO
Psychiatric Illness:	YES	NO	Diabetes:	YES	NO
HIV:	YES	NO	Shortness of Breath:	YES	NO
Herpes I or II:	YES	NO	Keloid Scarring:	YES	NO
Blood Clots.	YES	NO	Kidney Disease:	YES	NO
History of Seizures:	YES	NO	Dizziness/Fainting	YES	NO
Asthma:	YES	NO	Vascular Disease:	YES	NO

Hernia/Umbilical: YES -I currently have one/have history of having one NO

Have you ever had Lipo Suction? YES or NO What Areas? _____ Month and Year _____

Have you had Gastric Bypass, Sleeve, Lapband, or other Weight Loss Surgeries? YES or NO Month and Year _____

Have you ever lost over 50lbs? YES or NO **How much weight have you lost**? _____ Month and Year _____

Please list any other medical history the doctor should be aware of:

_____

Have you recently been under the care of a physician for any reason? YES NO

If "YES," please explain: _____

(For Women) Are you or could you be pregnant? YES NO Last menstrual period: ___/___/___

(For Women) Are you breast feeding? YES NO

MEDICATIONS:

Please list medications you currently take, including appetite suppressants, vitamins, herbal supplements, or any homeopathic medication:

_____

Have you taken Accutane or anticoagulants in the last 6 months? YES NO

Do you have any ALLERGIES and/or SENSITIVITIES? (please indicate by checking YES or NO):

Penicillin:	YES	NO	Aspirin:	YES	NO	Lidocaine:	YES	NO
Sulfa:	YES	NO	Xylocaine:	YES	NO	Codeine:	YES	NO
Latex:	YES	NO	Shellfish:	YES	NO	Iodine:	YES	NO

Any Other: _____

Cigarette Smoking: YES NO How long since last use? _____

Alcohol Use: YES NO Drug Use: YES NO

Do you take Vitamin E? YES NO

Please list all previous surgeries, as well as cosmetic:

_____ Date: _____

_____ Date: _____

Any complications or problems during or following the above procedures? YES NO

Which body area/areas would you like treated? _____

Signature: _____ Date: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABQUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

West Houston Aesthetics and Plastic Surgery PLLC/(Ver Halen Aesthetics and Plastic Surgery) is required by law to maintain the privacy of Protected Health Information (PHI) and to provide you with notice of our legal duties and privacy practices with respect to PHI. PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This Notice of Privacy Practices ("Notice") describes how we may use and disclose PHI to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to your PHI. We are required to provide this notice to you by the Health Insurance Portability and Accountability Act ("HIPAA").

West Houston Aesthetics and Plastic Surgery PLLC/(Ver Halen Aesthetics and Plastic Surgery) is required to follow the terms of this Notice. We will not use or disclose your PHI without your written authorization, except as described or otherwise permitted by this Notice. We reserve the right to change our practices and this Notice and to make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised
Notice to you.

Examples of How We Use and Disclose Protected Health Information About You

Treatment. We may use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment. We may use your health information for various payment purposes. Example: We may contact your insurer or other health care payer to determine whether it will pay for your medications.

Health Care Operations. We may use your health information for certain operational, administrative and quality assurance activities. This information will be used in an effort to continually improve the quality and effectiveness of service we provide.

Special Uses. We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We are permitted to use or disclose your PHI for the following purposes. However, West Houston Aesthetics and Plastic Surgery PLLC/(Ver Halen Aesthetics and Plastic Surgery) may never have reason to make some of these disclosures. To Communicate with Individuals Involved in:

Your Care or Payment for Your Care. We may disclose to family member, other relative, close personal friend or any other person you identify. PHI directly relevant to that person's involvement in your care or payment related to your care.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation other similar programs established by law.

Public Health. As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement. We may disclose your PHI for law enforcement purposes as required by law or in response to a subpoena or court order. We may also disclose your PHI when required to do so by federal, state, or
local law.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI for approved medical research.

Notification. We may use or disclose your PHI to notify or assist in notifying a family member, personal representative, or another person responsible for your care, regarding your location and general condition.

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions. If you are a member of the armed forces, we may release PHI about you as required by military commend authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority and to correctional institutions or for national security purposes.

Other Uses and Disclosures of PHI. We will obtain your written authorization before using or disclosing your PHI for purposes other than those provided for above (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written
revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Obtain a paper copy of tile Notice upon request. You may request a copy of our current Notice at any time. Even if you have agreed to receive the Notice electronically, you are still entitled to a paper copy.

Request a restriction on certain uses and disclosures of PHI. You have the right to request additional restrictions on our use or disclosure of your PHI by sending a written request. We are not required to agree to those restrictions. We cannot agree to restrictions on uses or disclosures that are legally required, or which are necessary to administer our business.

Inspect and obtain a copy of PHI. In most cases, you have the right to access and copy the PHI that we maintain about you. To inspect or copy your PHI you must send a written request. We may charge you a fee for the costs of copying, mailing and supplies that are necessary. We may deny your request to inspect and copy in certain limited circumstances.

Request an amendment of PHI. If you feel that PHI we maintain about you is incomplete or incorrect, you may request that we amend it. To request an amendment, you must send a written request. You must include a reason that supports your request. In certain cases, we may deny your request for amendment.

Accounting of disclosures. You have the right to receive an accounting of the disclosures we have made of your PHI for reasons other than treatment, payment, or health care operations.

For More Information or To Report a Problem. If you have questions, requests or complaints, or are concerned that we have violated your privacy rights please contact:

Director of Patient Operations
7167 Colleyville Blvd, Suite 103
Colleyville, Texas 76034

If you believe your privacy rights have been violated, you can file a complaint with the Secretary of Health and Human Services.

I _____

hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed _____

Date _____

If not signed, reason why acknowledgement was not obtained

_____

_____

Staff Witness seeking acknowledgement:

_____

Date _____

VA
VER HALEN AESTHETICS
AND PLASTIC SURGERY

ARBITRATION AGREEMENT

PATIENT NAME: _____

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____ Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

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We are now in a new era of Health Care Reform - intended to help patients. Sadly, these reforms do not include any "Lawsuit Reforms" that would dramatically reduce costs for patients and also promote a better environment for patients and their physicians. In a recent nationwide poll[1] 83% of the nation's electorate wanted Congress to address the medical malpractice system as part of the Health Care Reform plan. We wish Congress had taken action implementing reforms that both doctors and patients could support. And the majority of patients agree. Congress missed the opportunity. Because of that we have taken action with the single goal of enhancing the relationship between patients and the physician.

We take great pride in our reputation for providing the highest levels of quality medical care to our patients. However, we realize there are times when some patients will not be satisfied with the outcomes of their treatments. We also recognize that in these instances, a patient has every right to pursue legal action if he/she feels we have been negligent in some way. We respect every patient's right to do so.

While some healthcare legal claims are justified, there are also frivolous legal claims filed in our country—claims that are driving up insurance rates and impacting court decisions for the patients who truly deserve compensation. We believe that an agreement early in the treatment process regarding the use of board-certified experts will help expedite resolution of concerns.

OUR COMMITMENT TO YOU

We commit to using only American Board of Medical Specialties (ABMS) board-certified expert medical witness(es) in any legal situation, who follow the code of ethics of our national specialty society. These steps ensure that expert medical witnesses we use have passed examinations, demonstrated expertise in their field and adhere to a solid code of ethics.

We demonstrate this commitment to you with our signature on this form.

WHAT WE ARE ASKING YOU TO DO

We are asking you or any representative to commit to this process also, by using only board-certified physician(s) as expert medical witness(es) if you are dissatisfied with your medical care and decide on legal action.

We hope, and believe, you will never have to consider this again. But if you do, we will honor this commitment to you.

Note[1] Poll conducted by ***Clarus Research Group*** (www.ClarusRG.com), a nonpartisan survey research firm based in Washington, DC.

PLEASE READ CAREFULLY

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean _____. (***insert name of patient or guardian)***

"Physician" shall be understood to mean Dr. Jon Ver Halen and Associated Physicians, West Houston Aesthetic and Plastic Surgery / Ver Halen Aesthetic and Plastic Surgery / Tri-Cities Medical Management.

I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the Physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Society of Plastic Surgeons.

I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the American Society of Plastic Surgeons and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and Patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief. In further consideration patient/guardian agrees to refrain from directly or indirectly publishing or airing commentary upon physician and his practice, background, expertise and/or treatment - the sole exceptions being communication to a confidential medical-peer review body; to another healthcare provider; to a licensed attorney; to a governmental agency; in the context of a legal proceeding; or unless mandated by law. Publishing is intended to include attribution by name, by pseudonym, or anonymously. In addition, patient/guardian will not denigrate, defame, disparage, or cast aspersions upon the physician; and will use all reasonable efforts to prevent any member of her immediate family or acquaintance(s) from engaging in any such activity. If patient/ guardian violates this term of Confidentiality, physician shall be entitled to recovery of damages.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

_____	_____
Physician	Patient/Guardian
_____	_____
Effective from Date of Treatment:	Date of Signature