ALDONA J. SPIEGEL, MD

PLASTIC SURGEON & BREAST DESIGNER

Restore New Patient History Form

Date:_____Patient Name: _____

Age: _____ Birthdate: _____ Weight _____ Height _____ Bra Size _____
Email Address: _____
Emergency Contact:_____Phone:_____
Primary Care Doctor:_____Phone:_____
Address:_____
General Surgeon:_____Phone:_____
Oncologist: _____Phone: _____

Tell us how you found Dr. Spiegel:
Bing□ Facebook□ Google□ Google+□ Healthgrades□ Pinterest□ RateMDs□ RealSelf□ Twitter□
Vimeo□ Vitals□ Yelp□ YouTube□ Other (specify)_____
Family/Friend: _____
Referred by: _____ Phone: _____
Address: _____

Reason for visit: _____

History of Present Illness:
When did the condition first occur? _____
How was it diagnosed? ☐Self ☐Mammogram ☐Physician
What side is/was the tumor on? ☐RIGHT ☐LEFT ☐BOTH
What was the size of the tumor? _____
Number of lymph nodes removed?_____Number of nodes positive: _____
Have you had BRCA testing? ☐Yes ☐No ☐Positive ☐Negative
What type of tumor (if known)? ☐DCIS ☐Invasive Ductal ☐Lobular
If known, is the tumor? **ER** positive/negative **PR** positive/negative **HER2** positive/negative
Date of mastectomy (if applicable)_____Surgeon_____
Date of lumpectomy (if applicable)_____Surgeon_____
Date of reconstruction (if applicable)_____Surgeon_____
Describe any other treatment you have had so far (including reconstruction if any):
_____
_____

Radiation Therapy:
Duration: from_____to_____Quantity_____

Chemotherapy:
Duration: from _____to_____Medication_____

Past Medical History:

Have you ever been diagnosed with the following?

	No	Yes		No	Yes		No	Yes
High Blood Pressure	☐	☐	Thyroid Disease	☐	☐	Glaucoma	☐	☐
Diabetes	☐	☐	Kidney disease	☐	☐	Lymphedema	☐	☐
Asthma	☐	☐	Arthritis	☐	☐	Tuberculosis	☐	☐
Depression	☐	☐	Shingles	☐	☐	Stomach Ulcer	☐	☐
Anxiety	☐	☐	Stroke	☐	☐	Mitral Valve Prolapse	☐	☐
Blood Clots	☐	☐	Hepatitis	☐	☐	Seizures	☐	☐
Anemia	☐	☐	Multiple Sclerosis	☐	☐	Fibromyalgia	☐	☐
HIV	☐	☐						

If yes to any of the above, please state if the condition is stable and being treated:

_____

_____

_____

Have you or any of your relatives been diagnosed with blood disorders? ☐ **No** ☐ **Yes**

If so, please list _____

List any major illnesses and dates:

Date	Illness
_____	_____
_____	_____
_____	_____
_____	_____

Past Surgical History:

List all of your previous surgeries and dates

Date	Procedure
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever had a liposuction procedure? ☐ No ☐ Yes

If yes, what part of the body? ☐ Abdomen ☐ Thighs ☐ Buttock ☐ Back ☐ Other _____

Family History: List any blood relative diagnosed with cancer

Type of Cancer:	Relationship and age diagnosed if known
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications: (please include aspirin, ibuprofen, birth control pills etc. and dosage)

Pharmacy Name:_____ Pharmacy Phone: _____

Address:_____

Medication	Dosage and frequency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you currently using any birth control? ☐ No ☐Yes

Please list (oral contraceptive, nuvaring, IUD, etc) _____

Please list any supplements you are taking _____

DRUG ALLERGIES: ☐No ☐Yes

If yes, please list:

Drug:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

Social History:

Smoking (type & amount per day)_____if former smoker, quit date: _____

Alcohol (type and amount per week) _____

Jehovah's Witness? ☐No ☐Yes Marital Status: _____

Occupation:_____Spouse Occupation: _____

Number of Children:_____Number of pregnancies: _____

Age menstruation began:_____ Date of last mammogram _____

Have you noticed any new breast lump or nipple discharge? ☐No ☐Yes

Do you do regular breast self-examinations? ☐No ☐Yes

Did you breast feed? ☐No ☐Yes

Interests/Hobbies: _____

Physical Activity Level:

How often do you exercise? _____

If yes, what type of exercises do you perform? _____

What type of activities do you enjoy? _____

Does your work require any physical activity? ☐ No ☐ Yes

Do you have back pain? ☐ No ☐ Yes

Review of Systems:
Do you have now or have you had within the past year?

	No	Yes		No	Yes		No	Yes
Weight Increase	☐	☐	Swollen feet/ankles	☐	☐	Seizures	☐	☐
Weight Decrease	☐	☐	Skin rash	☐	☐	Joint or muscle pain	☐	☐
Chronic cough	☐	☐	Chronic diarrhea	☐	☐	Swollen lymph nodes	☐	☐
Chest pain	☐	☐	Jaundice	☐	☐	Easy bleeding/bruising	☐	☐
Rapid heartbeat	☐	☐	Depression	☐	☐	Dry eyes	☐	☐
Abdominal Pain	☐	☐	Heartburn	☐	☐	Urinary Symptoms	☐	☐

If yes to any of the above, please describe _____

_____

_____

Additional Information: _____

_____

_____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

x _____ _____

Signature of Patient Date

ALDONA J. SPIEGEL, MD
PLASTIC SURGEON & BREAST DESIGNER

Smoking, Second-Hand Exposure, Nicotine Products (Patch, Gum, Nasal Spray)

Patients who are currently smoking tobacco products or use nicotine products such as patches, gum or nasal spray are at a greater risk for significant surgical complications of skin necrosis and delayed healing. Individuals exposed to second-hand smoke are also at potential risk for similar complication attributable to nicotine exposure. Additionally, smoking may have a significant negative effect on anesthesia and recovery from anesthesia, with coughing and possibly increased bleeding. Individuals who are not exposed to tobacco smoke or nicotine containing products have a significantly lower risk of this type of complication.

Please indicate your current status regarding the items below:

☐ I am a non-smoker and do not use nicotine products. I understand the risk of second-hand smoke exposure causing surgical complications.

☐ I am a smoker or use tobacco and nicotine products. I understand the risk of surgical complication due to smoking or the use of nicotine products. I have been informed that **I MUST NOT SMOKE, MUST NOT USE ANY NICOTINE PRODUCTS AND AVOID SECOND-HAND SMOKE 3 months prior to** and **3 months after my surgery.** I understand that a nicotine test may be performed prior to my surgery. If positive, surgery will be cancelled and/or rescheduled.

☐ I take Wellbutrin or Chantix.

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____	_____	_____
Patient Signature	Date	Aldona J. Spiegel, MD

6560 Fannin, Suite 2200, Houston, TX, 77030
Phone: 713-441-6102
Fax: 713-790-2085

Updated Aug 2019

ALDONA J. SPIEGEL, MD
PLASTIC SURGEON & BREAST DESIGNER

Photo Consent

I,_____, hereby consent to the use of photographs taken of me by the office of Aldona J. Spiegel, M.D. at The Methodist Hospital, Institute for Reconstructive Surgery for the purpose of education, training and surgical planning. I understand the photographs will be taken from the neck down and I will not be identified by name.

(Please initial your acknowledgement and the statements you approve)

____I hereby release Aldona J. Spiegel MD, her personnel, The Methodist Hospital, The Institute for Reconstructive Surgery and any other persons participating in my care or dealing with the photographs from any and all liability which may or could arise from the taking or use of such photographs.

____I authorize the use of my photographs for the clinical chart.

____I authorize the use of my photographs in Dr. Aldona J. Spiegel's Internet photo gallery.

____I authorize the use of my photographs in Dr. Aldona J. Spiegel's Office Photo Album.

____I authorize the use of my photographs in affiliated products website (i.e. Mentor Direct) for physician and patient education.

____I authorize the use of my photographs to be used in medical journals, book chapters, and educational presentations.

____I authorize the use of my photographs on social media.

____I authorize the use of my video on Dr. Aldona J. Spiegel's website.

____I authorize the use of my video on social media.

_____ _____
Patient Name (Print) DOB

_____ _____
Patient Signature Date

___ _____
Consent Reviewed With

*We need written notice to retract your consent for any digital usage and future print.

6560 Fannin, Suite 2200, Houston, TX 77030
Phone: (713) 441-6102
Fax: (713) 790-2085

Updated August 2019

HOUSTON Methodist LEADING MEDICINE

INSTITUTE FOR RECONSTRUCTIVE SURGERY
TMHPO PATIENT PROVIDER EMAIL AGREEMENT

Email offers an easy and convenient way for patients and physicians to communicate. However, there are distinct differences between communications via e-mail as opposed to calling or coming in to the office. REMEMBER, there is no person on the other side of the email- just a computer. You cannot tell when your message will be read, or even if your doctor is in the office or on vacation. Never the less, we believe that the ease of communication email affords is a benefit to patient care. Below are our rules for contacting us using email.

- **E-mail is NEVER appropriate for urgent or emergency problems. If you have an urgent or emergent problem, please call 911 or go to the closest Emergency Department for immediate treatment.**
- **E-mail is NOT confidential. My staff may read your emails to handle routine, non-clinical matters. Also, you should also know that if sending e-mails from work, your employer has a legal right to read your e-mail.**
- **E-mail is NOT a substitute for seeing your physician. If you think that you may need to be seen, please call and make an appointment.**
- **E-mail will become a part of your medical record; a copy WILL be placed in your chart.**
- **E-mail is great for asking those straight forward questions that do not require in depth discussion. Appropriate uses of e-mail include prescription refill request, referral and appointment, scheduling requests and billing insurance questions.**
- **E-mails should NOT be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.**
- **Please identify the nature of your request in the subject line of your message.**

****Finally, either one of us can revoke permission to use the e-mail system at any time. ****

☐ *I DO want to communicate with my physician electronically. I have read the above information and understand the limitations of security on information transmitted. I understand that my physician may not be able to communicate with me electronically about my specific condition if I live outside of the state in which my doctor is licensed.*

Date: _____
Patient Name: _____
Patient Signature: _____
Email Address: _____
State of Residence: _____

INSTITUTE FOR RECONSTRUCTIVE SURGERY
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

You have been given the Notice of Privacy Practices for TMH Physician Organization and its Physicians. This Notice describes your legal rights regarding your health information and will inform you of the legal duties and privacy practices of TMH Physician Organization and its Physicians with respect to health information created for services generated by TMH Physician Organization and its Physicians. If you receive services by your physician or other health care provider at a different location, you may want to ask about that office or clinic's health information privacy policies and notices because they could be different.

Your name and signature below indicate that you have been provided with a copy of this Notice of Privacy Practices.

If you have a question regarding any of the information set forth in this Notice of Privacy Practices, please do not hesitate to call TMH Physician Organization's Business Practices Officer at 713.383.5125.

Patient Name: _____

_____ _____
Signature of Patient or Patient's Qualified Personal Representative — Date

_____
Printed Name of Qualified Personal Representative

_____
Legal Authority to Act on Behalf of the Patient

For Staff Use Only

Date Acknowledgment noted in HIS/patient management system: _____

Comments if Notice not provided or Acknowledgment not obtained:

_____

_____

Processed by: _____

HOUSTON Methodist
SPECIALTY PHYSICIAN GROUP

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I. PATIENT INFORMATION

Patient Name:		Date of Birth:
Patient Mailing Address:		
City/State		Zip Code:
Work #:	Home #:	Cell #:

II. INFORMATION TO BE DISCLOSED

I authorize_____to disclose my health information as follows, for service dates: _____:

- ☐ All paper chart records
- ☐ Entire medical record/outpatient clinical record
- ☐ History and physical(s)
- ☐ Operative report(s)
- ☐ Discharge summary(ies)
- ☐ Films and pictures
- ☐ All electronic medical records
- ☐ Laboratory results
- ☐ Radiology and imaging reports
- ☐ Pathology slides, blocks or reports
- ☐ Other test results: _____
- ☐ Other:_____

I understand that information used or disclosed pursuant to this authorization form may include information relating to Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

III. INFORMATION IS TO BE DISCLOSED TO/FROM:

Disclose to:	Disclose from:

IV. PURPOSE OF USE OR DISCLOSURE: _____

V. I authorize the disclosure of health information as described above. I understand:

- This authorization is valid for 180 days unless otherwise stated here _____ _____
- A photocopy or fax of this authorization is as valid as the original.
- I may revoke this authorization at any time by submitting a revocation in writing to Aldona J. Spiegel, MD.
- If I revoke this authorization, the revocation will not apply to information that has already been released in good faith before the revocation was received.
- Treatment or payment may not be conditioned on my completion of this authorization form.
- Information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by the federal privacy laws.

_____ _____

Signature of Patient or Qualified Personal Representative* **Date**

*If signed by a Qualified Personal Representative, the following must be completed:

Printed name of Qualified Personal Representative _____

Legal Documentation showing Authority to Act on Behalf of the Patient _____ _____

(Example: Guardian of Patient, Executor of Estate)

ALDONA J. SPIEGEL, MD
PLASTIC SURGEON & BREAST DESIGNER

Financial Policies

Please review and sign this document regarding our current office financial policies.

We ask that our patients please understand that the following policies are set forth by The Methodist Physician Organization and not the office, doctor or staff.

If you have any questions about financial or billing issues, please direct these to the insurance coordinator at 713-441-1667.

Patient Financial Responsibility

- Please bring your insurance card with you at the time of your appointment.
- Please notify our office if your insurance changes.
- Co-payments are collected at the time of your visit.
- If your insurance requires you to obtain a referral to see a specialist and you do not have one on the date of service, please be aware that your insurance company will hold you responsible for payment of services rendered.
- Please note you will be responsible for any co-insurance, deductibles or non-covered services not paid by your insurance.
- Your co-insurance (out of pocket) for surgical procedures must be paid in full 3 weeks prior to the date of surgery, otherwise we will need to reschedule your procedure.
- Houston Methodist Hospital will usually expect your deductible to be paid in full on the date of surgery, therefore, we suggest you contact your insurance company to find out the amount that your are responsible for inpatient or outpatient hospital charges.
- For patients who do not have insurance coverage, we will require that payment be made in full at the time of service or three weeks prior to any scheduled surgery.

I assign my insurance benefits be made on my behalf directly to Institute for Reconstructive Surgery for services rendered.

Print Name _____

Signature _____ Date _____

Print Guardian Name (If minor) _____

Guardian Signature (If minor) _____

ALDONA J. SPIEGEL, MD
PLASTIC SURGEON & BREAST DESIGNER

Office Policy for Insured Patients

Many insurance carriers require pre-certification of particular procedures. Within the same insurance company the plans differ depending upon what type of contract your employer has negotiated. We are more than willing to follow any and all necessary guidelines to ensure that your encounter with the Institute for Reconstructive Surgery is reimbursed properly, but you must inform us of those guidelines. If you do not inform us of any special requirements in your contract and we subsequently order services, such as lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility. This will hold true for any Managed Care contract as well as any group/individual policies which may cover you and your dependents.

Please be advised that prior authorization or pre-determination is required prior to your scheduled surgical date. If your insurance does not provide authorization prior to the surgical date, your surgery may be postponed. Any non-covered services will be the patient's financial responsibility and payment will be required three weeks prior to the date of service.

With your cooperation and assistance, you should be able to receive all of the benefits offered to you. If you have any insurance related questions or concerns, please feel free to call our billing specialist at 713-441-1667.

I have read and understand the office policy stated above and agree to accept responsibility as described.

_____
Printed Name

_____ _____
Signature Date

Updated Aug 2019

ALDONA J. SPIEGEL, MD
PLASTIC SURGEON & BREAST DESIGNER

Insurance Coverage - Women's Health and Cancer Rights Act of 1998

On October 21, 1998, the Women's Health and Cancer Rights Act of 1998 became effective as part of the 1999 Omnibus consolidated and Emergency Supplemental Appropriation Act. This new federal law requires group health plans and individual health policies that provide coverage for mastectomies to also provide coverage for breast reconstruction in connection with such mastectomy. In accordance with the Women's Health and Cancer Rights Act of 1998, members receiving mastectomy-related services are entitled to the following benefits:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas

ALDONA J. SPIEGEL, MD
PLASTIC SURGEON & BREAST DESIGNER

Dear Patient:

As you go through the reconstruction process for breast cancer, we want you to know that we are as interested in your emotional well-being as we are in your physical health. We offer a support group made up of women, just like yourself who have gone through what you may be experiencing. The group is called "Pink Sisters". The women who make up this group have experienced the same fear, uncertainty, isolation and resentment that you may experience. They have dedicated themselves to "be there" for you if you need extra support or just someone to talk with.

At any time you can call Ann Watkins, our Pink Sister Liaison, at 713-906-5415 or E-mail her at duwatann@aol.com, to find out when the next meeting is planned, or just to talk to another survivor like yourself.

So that you can talk personally with someone and get that extra support you may need, we have a "Match Me" system to connect you with a former patient who has the same diagnosis, has gone through the same procedure or even someone who may have a similar life situation. If you would like to be matched with a Pink Sister please complete the consent form, and return to the office.

Sincerely,

Aldona J. Spiegel, MD

ALDONA J. SPIEGEL, MD
PLASTIC SURGEON & BREAST DESIGNER

Pink Sister Match Consent

Name	
City/State	
Phone#	
Email	
Diagnosis	
BRCA Positive ?	YES □ NO □
Procedure	
Occupation	
Interests	
Notes	

Please check applicable boxes:

	I would like to be matched with a Pink Sister and consent to be contacted by my Pink Sister match to share information and experiences.
	I would like to receive email communications about upcoming events, blogs, etc.
	I would like to participate and help with event planning, meetings, etc.

I,_____, give consent to the Pink Sisters Support Group to contact me as indicated above. I understand that my last name will not be revealed to my match. Furthermore, I understand that any procedure information provided by a Pink Sister is only representative of their personal experience and any medical information provided will be provided by Dr. Spiegel and/or appropriate staff members of the Center for Breast Restoration.

Signature	
Date	