COVID-19 SAFE PRACTICE PROTOCOLS

SCREENING QUESTIONNAIRE

Please answer yes or no to the following questions about symptoms or other risk factors:

YES	NO	
☐	☐	Cough, sore throat, shortness of breath, fatigue
☐	☐	Fever > 100
☐	☐	Diarrhea
☐	☐	Loss of taste or smell
☐	☐	Dizziness or loss of balance
☐	☐	Have you tested positive for COVID-19
☐	☐	Traveled Internationally
☐	☐	Traveled domestically especially New York or New Orleans
☐	☐	Have anyone sick at home
☐	☐	Been Exposed to anyone with COVID-19

YES	NO	**Occupation**
☐	☐	Are you a first responder or work in a hospital or health care facility or grocery/ retail store
☐	☐	Have you been screening or treating patients for COVID-19

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SCRIPT

Patient Consent – COVID-19 Pandemic

I understand there is currently a COVID-19 (Coronavirus) pandemic. I understand that I am entering the office for a procedure, follow up appointment or consult. No one truly understands how many persons have been infected and are carriers of COVID-19. At this time, a vaccine is not available for COVID-19, so a 100% guaranteed COVID-19 safe environment is not possible. I understand your staff and office will be taking all efforts to prevent all patients from contracting the illness. But, even with diligent efforts, these efforts cannot prevent all cases and some patients are likely infected, but asymptomatic, before they even arrive at a health care facility. I understand the health care providers of this facility will do their best to prevent my acquiring or developing a COVID-19 infection. I understand, if in the face of the pandemic I do acquire such an infection, that the staff will reasonably work towards providing state of the art care.

_____ _____

Printed Patient Name **Signature of Patient/Personal Representative**

_____ _____

Relationship to Patient **Date**

_____ _____

Practice Representative Name **Signature of Practice Representative/Witness**

EID B. MUSTAFA, M.D.

PSC Plastic Surgery Center

1201 Brook Avenue
Wichita Falls, Texas 76301-5601
Phone (940) 322 1122 • Fax (940) 767 8918

Patient Information

Name (Last, First, MI) Date of Birth

Address

City State ZIP

Home Phone Cell Phone Social Security #

Race: ___Asian ___Black ___Caucasian ___Pacific Island ___American Indian
___Alaskan native ___Other ____Declined

Ethnicity: ___Hispanic ___ Non Hispanic ____Declined

Marital Status	Married	Single	Widowed	Separated	Divorced	Minor
Student Status	Full-Time	Part-Time	N/A			
Employment	Full-Time	Part-Time	Retired			

Patient's Employer

Employer's Address Phone

Emergency contact not living with you **Phone**

Spouse or Guardian Information

Name (Last, First, MI) Date of Birth

Social Security # Employer & Wk#

PLEASE BRING PHOTO ID AND INSURANCE CARD(S)

I understand that withholding information or giving false information is fraud. I certify the above information is correct to the best of my knowledge; I also understand that I am financially responsible for all charges subject to insurance coverage.

Patient's
Signature_____ Date_____

EID B. MUSTAFA, M.D.

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Phone (940) 322 1122 • Fax (940) 767 8918

Patient Name:					Date:	
Reason for visit:					Age:	
Referring Physician:					**Height:**	**Weight:**
Are you **allergic** to any **medicine or latex?** **Yes** **No** **If so please list them:**						
Please circle if you are taking:	Aspirin	Blood thinners	Diet Pills	Herbs	Garlic	Vitamin E

PLEASE INCLUDE A LEGIBLE, CURRENT MEDICATION LIST WITH STRENGTH, DOSAGE, AND HOW OFTEN TAKEN

Past Surgical History

Please list **ALL** surgical & invasive procedures you have ever had:

Past Medical History

Illness	Yes	No		Yes	No
Diabetes			Lung Disease		
High blood pressure			Hepatitis & type		
Heart Disease			Cancer & type		
Liver Disease			High Cholesterol		
Thyroid Disease			Mental illness		
Stroke or ministrokes			Bleeding disorders		
Deep vein thrombosis (blood clots)					

Please list any other:

Lifestyle	Yes	No	Amt.		Yes	No
Alcohol Use				Past or Current Drug Use		
Cigarettes				Sexually Transmitted Diseases		

Family History	Yes	No	Relation		Yes	No	Relation
Diabetes				High Blood pressure			
Heart Disease				Bleeding Disorder			
Other							

Patient Name________________Date of Birth________________

Medication	Strength	How Often?	Comments

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Dr. Eid B. Mustafa all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Dr. Eid B. Mustafa to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and laboratory in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and lab's expenses.

This lifetime assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Kell West Hospital

I am aware that Kell West Hospital is a physician-owned hospital and that Eid B. Mustafa, M.D. is a shareholder.

Signature:_____

Date:_____

Eid B Mustafa, M.D.
Attn: HIPAA Officer
1201 Brook Ave, Wichita Falls, TX 76301
940-322-1122

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received/been offered a copy this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and our Practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

I give permission for Eid B. Mustafa, M.D.,P.A.:

May leave a message regarding ☐ appointment and / or ☐ test results

☐ At_____ Home phone number and/or

☐ At_____ Cell phone number and/or

☐ May share medical information with:

1. Name:_____ Relationship:_____

   Phone#:_____

2. Name:_____Relationship:_____

   Phone#_____

I assume responsibility to inform the practice of any changes in the above information

Print Patient's Name: _____Date:_____

Patient's Date of Birth:_____ Relationship to patient:_____

Signature:_____ Today's Date:_____