

# AUSTIN Plastic Surgery Center

**SERGIO PASQUALE MAGGI, MD, FACS**

3410 Far West Blvd. Ste 110  
Austin, TX 78731

512.345.3223  
Fax 512.345.3228

www.DRMAGGI.com

## GENERAL PATIENT INFORMATION

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
LAST FIRST MI

HOW DO YOU PREFER TO BE ADDRESSED?: \_\_\_\_\_

CELL #: \_\_\_\_\_ MAY WE LEAVE A MESSAGE: \_\_\_\_\_

WORK #: \_\_\_\_\_ MAY WE LEAVE A MESSAGE: \_\_\_\_\_

HOME #: \_\_\_\_\_ MAY WE LEAVE A MESSAGE: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

WOULD YOU LIKE TO BE INCLUDED ON OUR E-MAIL LIST FOR UPDATES? YES \_\_\_\_\_ NO \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ APT: \_\_\_\_\_

CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_-\_\_\_\_-\_\_\_\_ MARITAL STATUS: S M D W

SPOUSE: \_\_\_\_\_ CONTACT NUMBER: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ NUMBER: \_\_\_\_\_

NAME & PHONE NUMBER OF YOUR PRIMARY PHYSICIAN: \_\_\_\_\_

HOW WERE YOU REFERRED TO OUR OFFICE? \_\_\_\_\_

MAY WE THANK THEM? YES \_\_\_\_\_ NO \_\_\_\_\_

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED WITH THE EXCEPTION OF SURGERY WHICH WILL BE DUE AT LEAST ONE WEEK PRIOR TO DATE OF SURGERY. WE ACCEPT CHECKS, MONEY ORDERS, VISA, MASTERCARD, AND AMERICAN EXPRESS. FOR FINANCING COMPANIES WE WORK WITH, PLEASE ASK YOUR PATIENT COORDINATOR.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

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## GENERAL HEALTH INFORMATION

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PROCEDURES YOU WOULD LIKE TO DISCUSS: \_\_\_\_\_  
\_\_\_\_\_

ARE YOU IN GOOD GENERAL HEALTH? YES \_\_\_\_\_ NO \_\_\_\_\_ DATE OF LAST EXAM: \_\_\_\_\_  
CURRENT HEIGHT: \_\_\_\_\_ CURRENT WEIGHT: \_\_\_\_\_ GOAL WEIGHT: \_\_\_\_\_

PLEASE LIST ALL MEDICATIONS (INCLUDING ANY OVER THE COUNTER OR VITAMINS) THAT  
ARE TAKEN ON A DAILY, OR REGULAR BASIS : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST ALL DRUG ALLERGIES OR ANY ADVERSE DRUG REACTIONS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DO YOU SMOKE OR USE ANY NICOTINE PRODUCT? YES \_\_\_ NO \_\_\_ IF SO, HOW MUCH?: \_\_\_\_\_  
DO YOU DRINK ALCOHOL?: YES \_\_\_ NO \_\_\_ IF SO, HOW MUCH?: \_\_\_\_\_

HAVE YOU HAD ANY OPERATIONS OR BEEN HOSPITALIZED FOR ANY REASON? YES \_\_\_\_\_ NO \_\_\_\_\_  
PLEASE LIST ALL DATES AND REASONS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST ANY ILLNESS OR CONDITION THAT YOU ARE FOLLOWED BY A MD FOR: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST ANY DISEASES, ILLNESSES, OR CONDITIONS WHICH RUN IN YOUR FAMILY?: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DO YOU TAKE ASPIRIN ON A REGULAR BASIS? YES \_\_\_\_\_ NO \_\_\_\_\_ HOW MUCH: \_\_\_\_\_

DO YOU HAVE EXCESSIVE BLEEDING OR BRUISING? \_\_\_\_\_

NUMBER OF CHILDREN AND AGES: \_\_\_\_\_

ARE YOU CURRENTLY PREGNANT OR NURSING? \_\_\_\_\_

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## A Brief Note Before We Meet For Your Consultation Today:

We understand that all of our patients have many options and choices to choose from.

We are very grateful that you have given us today the opportunity to participate in your care. And we also thank you for taking the time to review and complete these forms.

We routinely follow-up with all of our consultations a few days afterwards to answer any additional questions that you may have, as well as, to inquire on how your experience was with us today. If we could please get your consent on the best way to contact you.

Phone      Email      Text

---

Name

Date

Patient satisfaction is one of our highest goals.

Sincerely yours,  
Dr. Maggi, and staff.

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## OFFICE POLICY AND PROCEDURES

In order to provide you with the best possible service, I want to offer clear communication and clarification of office policies and procedures.

### APPOINTMENTS:

My office staff answers the telephone from 8:30 a.m. to 5:00 p.m., Monday through Thursday with lunch from 1:00p.m. To 2:00p.m., and Friday from 9:00a.m. To 1:00 p.m. If no one is available please leave a message and someone will be in touch with you as soon as possible. Please arrive punctually for your appointment.

### EMERGENCIES:

In case of an emergency after regular office hours, the Medical Exchange (458-1121) will assist you in reaching Dr. Maggi. If you do not reach the doctor within thirty minutes, or if the emergency is life threatening, you need to go to an emergency room immediately!

### CANCELLATION OF APPOINTMENTS:

If you need to cancel or reschedule an appointment, please give us at least a 24-hour notice. This will protect my schedule and practice. Please understand that once you have scheduled an appointment, that time is reserved for you and requests from others are refused. Should you have a Monday appointment time that needs to be cancelled, please notify us by Friday.

### PAYMENTS FOR ELECTIVE/COSMETIC SURGERY:

A one thousand dollar (\$1000) non-refundable deposit is due in order to schedule a surgery( this will block out the allotted time for the operating room) and the rest of the payment will be due no later than the scheduled date of the History and Physical exam (two weeks before your surgery).

If you decide to cancel surgery, you must notify either the Office Manager or the Nurse who scheduled your surgery at least 2 weeks (14 days, including holidays and weekends) prior to your scheduled surgery date. If you cancel within One (1) week of surgery we will retain fifty percent of the full surgery fee. If you cancel the same day or week of surgery, the whole payment will be retained. Your surgery fee is a one-time charge that includes all of your pre- and post-operative visits.

Surgery is not without risks, and the potential of complications. Your surgery fee does not include the possible cost(s) of any post-operative complications that may result- such as, medications, additional procedures, hospitalizations, anesthesia or other related charges (pathology, radiology, laboratory, etc.).

If a "touch-up" or revision surgery/procedure is necessary after your surgery, additional fees will apply. As with your initial surgery the fee may include fees for Dr. Maggi, facility fee, anesthesia fee, and other related charges.

**IF YOU UNDERSTAND AND AGREE TO FOLLOW THE ABOVE STATED POLICIES, PLEASE SIGN BELOW. THANK YOU, SERGIO P. MAGGI, M.D.**

PATIENT/PARENT/OTHER LEGALLY RESPONSIBLE PERSON SIGNATURE \_\_\_\_\_

WITNESS \_\_\_\_\_

DATE \_\_\_\_\_

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## Authorization for Release of Patient Photographs

I consent to the taking of photos, slides or video footage by Dr. Maggi or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Maggi. I further authorize Dr. Maggi or one of his/her associates to use these photos as they deem necessary for my treatment, or for use in advertisements or publications for Dr. Maggi or Austin Plastic Surgery Center (APSC).

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of APSC and may be retained by APSC or released by APSC for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, websites, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the images may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Maggi.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any affect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because APSC is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA.

I release and discharge Dr. Maggi, APSC, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs in any form or format.

I certify that I have read the above Authorization and Release and fully understand its terms.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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## HIPAA ACKNOWLEDGEMENT

I, \_\_\_\_\_ acknowledge that I have read, and received a copy of Austin Plastic Surgery Center's Notice of Privacy practices.

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (Patient/Guardian)

\_\_\_\_\_  
Date