Corpus Christi Institute of Cosmetic and Plastic Surgery

Vijay K. Bindingnavele M.D., F.A.C.S.
Cassidy D. Hinojosa, M.D.
5642 Esplanade Drive, Corpus Christi, Texas 78414
Phone 361-888-7417 – Fax 361-651-1489

PATIENT INFORMATION					
Patient Name (First Middle Last)				Social Security Number:	
Mailing Address				Driver's License #	
City			State		ZIP + 4 digits
Home Phone	Cell Phone	Date of birth	Age	Sex: ☐ Male ☐ Female	
Email ADDRESS:	EMPLOYER: OCCUPATION:				Language Spoken:
PRIMARY CARD HOLDERS INFORMATION					
Name: Last: First: MI:				Date of Birth:	
Employer Name & Address & Occupation				Work Phone:	
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated				Social Security Number:	
EMERGENCY CONTACT (in case of an emergency)					
Emergency Contact Name:				Phone/ Relationship	
Emergency Contact Name:				Phone/ Relationship	
OTHER INFORMATION					
ALLERGIES:					
Referring Doctor:		Family Doctor:			
Pharmacy		Pharmacy Phone #:			
Reason for Today's Visit:					

AUTHORIZATION FOR MEDICAL TREATMENT: I hereby authorize Dr. Vijay Bindingnavele to provide medical, surgical and/or hospitalization care/treatment on myself or my dependent.

Signature of Patient: ____ Date: ___________

AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION: I hereby authorize Vijay Bindingnavele MD PA to obtain any medical information of records which will aid in the treatment or diagnosis of my illness. I also authorize Vijay Bindingnavele, MD PA to release any information acquired in the course of my examination or treatment to other physicians or to insurance companies.

I give permission for Vijay Bindingnavele, MD PA to discuss my personal health information with the following people:

___________________________________ ____

Print Name & Relationship Patient Signature Date

Corpus Christi Institute of Cosmetic and Plastic Surgery

Financial Responsibility and Insurance Coverage

Primary Insurance Information:
Insurance Company:
Secondary Insurance Information:
Insurance Company:
Tertiary Insurance Information:
Insurance Company:

Assignment of Insurance: I hereby authorize payment directly to Vijay Bindingnavele, MD PA for Surgical and/or Medical Benefits, if any, and otherwise payable to me for these services. I understand I am financially responsible for any charges not covered by this assignment.

Financial Responsibility Statement: By signing this form, I understand that I am responsible for payment of any co-pays, deductibles and/or co-insurances deemed my responsibility by my insurance coverage. Vijay Bindingnavele, MD PA will file insurance as a courtesy to our patients. In the event of a surgical procedure, I understand that I am to pay these fees prior to my surgery. In the event that I am unable to pay this amount in full, I agree to pay half the amount upfront and continue making payments monthly until the balance is paid in full. It is the patient's responsibility to update Vijay Bindingnavele, MD PA when there are any insurance changes, failure to do so will result in the patient being billed for 100% of the service charge.

No Insurance Coverage Policy: By signing this form, I understand that I am responsible for all service rendered. I also understand that since I have no insurance coverage I have been given a discount on my services. I understand that if I fail to make payment in a timely manner, I will be referred to a collection agency and the balance will be reported on my credit report.

Minor Patients: The adults accompanying a minor and the parents (or guardians if the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan.

Patient Information: (Please Circle One)

Race-

American Indian or Alaskan Native	Asian	African American	Hispanic or Latin American
Native Hawaiian or Pacific Islander	White	Other	Prefer not to disclose

Ethnicity- Hispanic or Not Hispanic

By signing below, I acknowledge all the information on this page is correct. In consideration for the services rendered, or to be rendered, I hereby accept financial responsibility for this account.

Signature of Patient or Responsible Party Date

Corpus Christi Institute of Cosmetic and Plastic Surgery

SURGICAL HISTORY AND PHYSICAL

To be completed by patient Today's Date ____________________

Name ____ Age ________ Date of Birth _____________________

Reason for Visit ____

Please list any allergies to medications (include Iodine, Tape or Latex) __________________________________

____

List your current medications (include weight loss medications and herbal/mineral supplements)

Medication	Frequency	Reason	Medication	Frequency	Reason

List any major illness and year of diagnosis	List past surgical procedures and year performed

Tobacco: □ Yes □ No Amount _______________ **Alcohol**: □ Yes □ No Amount ______________

Family Medical History ____

____

____

I □ **do** □ **do not** consent to my photo(s) being taken pre- and post-operatively. Please note that photos must be taken prior to surgery for certain surgical procedures.

____

Patient Signature Date

Corpus Christi Institute of Cosmetic and Plastic Surgery

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I acknowledge that I have received and had an opportunity to read the privacy practices of the office of Vijay Bindingnavele, MD PA. In reading this information I understand my rights as a patient. This practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I also understand that uses and disclosures may be permitted without prior consent in the event of an emergency.

If it is necessary for Dr. Vijay Bindingnavele or his staff to notify me of personal health information, I wish to be contacted in the following manner (check all that applies):

Home Telephone ___________________________

- □ O.K. to leave message with detailed information
- □ Leave message with call back number only

Written Communication

- □ O.K. to mail to my home address
- □ O.K. to fax to this number ___________________________

Cellular Telephone ___________________________

- □ O.K. to leave message with detailed information
- □ Leave message with call back number only

Email ____

Personal health or financial information may be released to the following people (example: spouse, child)

____

It is understood that I also authorize the collection and release of personal information to third parties in the event of any financial dispute regarding the procedure or treatment in question.

Note: In the event that patient health is compromised, it may be necessary for Dr. Vijay Bindingnavele or his staff to communicate with a patient via certified mail without the patient's consent.

____

Signature of Patient Date

Please let the receptionist know if you would like a copy of our privacy practices

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

Corpus Christi Institute of Cosmetic and Plastic Surgery

Vijay K. Bindingnavele M.D., F.A.C.S.
Cassidy D. Hinojosa, M.D.
5642 Esplanade Drive, Corpus Christi, Texas 78414
Phone 361-888-7417 – Fax 361-651-1489

Name: ____
Address: ____
(STREET ADDRESS, CITY, STATE AND ZIP CODE)

I consent to the taking of photograph(s) and/ or by Dr. Vijay Bindingnavele or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Vijay Bindingnavele.

I provide this authorization as a voluntary contribution in the interest of public education. I understand that such photograph(s) and/or video images shall become the property of Dr. Vijay Bindingnavele for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals, textbooks, television, newspaper, magazine article, social media sites (Facebook, Instagram, Snapchat, etc.), and/ or Corpus Christi Institute of Cosmetic and Plastic Surgery publications (newsletters, flyers, brochures, World Wide Web page, etc.); 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. Vijay Bindingnavele.

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 effect on any actions taken prior to my revocation.

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 release and discharge Dr. Vijay Bindingnavele and all parties acting under his 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.

I certify that I have read the above Authorization and Release and fully understand its terms.
Signature: ______________________________ Date: ______________

I have read the above Authorization and Release, I am the parent, guardian, or conservator of ______________________________, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.
Signature: ______________________________ Date: ______________

Corpus Christi Institute of Cosmetic and Plastic Surgery

Cassidy D. Hinojosa, M.D.
5642 Esplanade Drive, Corpus Christi, Texas 78414
Phone 361-888-7417 – Fax 361-651-1489

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

____
Patient Signature

____
Witness Signature

____
Date