JESSICA BELZ, M.D.
PLASTIC SURGERY

Name _____DOB _____ Age _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Ph: _____ Cell: _____Email: _____

Emergency Contact: _____ Phone: _____

*Relationship to the patient***:** _____

PHYSICIAN INFORMATION

Primary Care/Family Physician: _____Phone: _____

Referring Physician: _____ Phone: _____

How did you hear about us?

☐Physician referral ☐Former patient
☐Website/Internet ☐Friend
☐Hospital ☐Other: _____

Employer: _____Work phone: _____

Employer Address: _____

City: _____ State:_____ Zip Code: _____

Reason for today's visit _____

Please list any previous plastic surgeries: _____

_____

Skin care concerns:

- ☐ Aging & Texture: Fine lines, wrinkles, loss of firmness, elasticity, or uneven skin texture.
- ☐ Pigmentation: Sun damage, dark spots, age spots, or uneven skin tone.
- ☐ Sensitivities: Redness, rosacea, stinging, irritation, or allergies to products.

CURRENT MEDICAL CONDITIONS

To your knowledge, have you currently or in the past been diagnosed with any of the following?

Heart & Blood
- ☐ Anemia
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Blood Clots
- ☐ Blood Transfusion
- ☐ Bruise/Bleed Easily
- ☐ Irregular Heart Beats
- ☐ Pacemaker

Mental Health
- ☐ Anxiety
- ☐ Depression
- ☐ PTSD

Infectious Diseases
- ☐ AIDS
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Herpes

Digestive & Liver
- ☐ Liver Disease
- ☐ Ulcers

Raspatory
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Shortness of Breath

Neurological
- ☐ Stroke
- ☐ Seizures
- ☐ Fainting Spells
- ☐ Headaches/Migraines
- ☐ Head Injury

Autoimmune & Inflammatory
- ☐ Autoimmune Disease
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Psoriasis
- ☐ Multiple Sclerosis
- ☐ Crohn's Disease/Colitis

Cancer & Tumors
- ☐ Breast Cancer
- ☐ Other Cancer
  type: _____
- ☐ History of Radiation

Endocrine & Metabolic
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Obesity
- ☐ Weight Gain/Loss

Urinary & Kidney
- ☐ Kidney Stones
- ☐ Urinary Tract Infection

Skin
- ☐ Eczema
- ☐ Hives
- ☐ Skin Disease
- ☐ Rashes

Other Conditions:
_____
_____

SURGERIES/MAJOR HOSPITALIZATIONS

☐ If none, please check.

(please list all, including dates)

_____
_____
_____
_____

MEDICATIONS & DOSES

☐ If none, please check.

(please list all medications with dosages, including prescription & over-the-counter medications, vitamins and herbal supplements)

_____
_____
_____
_____

ALLERGIES

☐ **No known allergies** **Latex:** ☐YES ☐NO **Adhesive:** ☐YES ☐NO

List Allergies to Medication and reactions:

_____

_____

_____

FAMILY MEDICAL HISTORY

Have any family members suffered from any of the conditions listed below?

Condition	Relation to You *(please circle all who apply)*
☐Bleeding Disorder	
☐Blood Clots	
☐Breast Cancer	
☐Cancer (please specify what type)	
☐Diabetes	
☐Heart Disease/Stroke/Heart Attack	
☐High Blood Pressure	
☐Lung Disease/Asthma/Emphysema	
☐Mental Illness	
☐Other:	

SOCIAL HISTORY

Marital status *(please circle)*: Single Married Separated Divorced Widowed

Number of pregnancies: _____ Number of children: _____

Occupation: _____ Does your job require heavy lifting? _____

Do you consume alcohol? ☐YES ☐NO If yes, type and amount per week _____

Do you currently vape, smoke cigarettes or use tobacco products? ☐YES ☐NO

If current smoker, how many per day? _____How long have you smoked? _____

If you have smoked in the past, when did you quit? _____

Do you use THC, CBD, or Cannabis? ☐YES ☐NO

Have you ever used other IV or street drugs? _____

REVIEW OF SYSTEMS

*Do you **currently or in the last month had any of the following symptoms?** Circle all that apply.*

Weight Gain	Sinusitis	Chronic Diarrhea
Weight Loss	Shortness of Breath	Painful Urination
Headaches	Wheezing	Leakage of Urine
Depression	Chronic Cough	Leg Cramps
Fainting Spells	Chest Pain	Joint Pain
Blurred Vision	Heartburn	Backaches
Eye Pain	Breast Pain	Easy Bruising
Dry Eyes	Breast Lump	Insomnia
Double Vision	Nipple Discharge	
Difficulty Hearing	Abdominal Pain	
Nosebleed	Chronic Constipation	

FEMALE PATIENTS ONLY

Age period began _____ Age at first childbirth _____

Date of last period _____ Age of menopause _____

Are you pregnant?_____ Are you breastfeeding? _____

Date of last mammogram _____ Facility: _____

Do you have breast implants? ☐YES ☐NO Size/type? _____

Patient's Signature _____Date _____

The effort you have made to fill out this form is greatly appreciated. Thank you!

Initial **POLICIES AND CONSENTS**

_____ **CONSENT FOR GENERAL TREATMENT**

I request and authorize healthcare services provided by Dr. Jessica Belz and members of her clinical staff.

CONSENT FOR COMMUNICATION

_____ I agree to receive appointment reminders and other communications from Dr. Jessica Belz' office via text messaging, email, and/or phone. I acknowledge that communication via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in a text or email can be intercepted and read by other parties besides the person to whom it is addressed or intended. Please do not include personal identifying information such as your birth date, or personal medical information in any texts or emails you send to us.

NO REPRESENTATION OR GUARANTEES

_____ I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no oral or written representations or guarantees have been made to me as to the results of any diagnosis, treatment, and medical care that I (or the patient, if a minor) may receive as a patient of Dr. Jessica Belz.

RELEASE OF INFORMATION

_____ I hereby authorize Jessica M. Belz, M.D., PLLC, her agents, and employees to release copies of my medical records, including information from prior treating physicians, X-rays, reports, and information about substance abuse treatment, mental illness, HIV, AIDS, sexually transmitted infections or TB.

a) to any governmental agency, medical service organization, insurance company, auditing agency engaged by Jessica M. Belz, M.D., PLLC, or a third party payer, employer or physician for the purpose of processing any claims for benefits.
b) To any physician or health care facility to which I, the patient, may be referred to, for the purpose of continued patient care.
c) To the physician/facility who has referred me to Dr. Jessica Belz.

PAYMENT POLICY

_____ All professional services rendered are charged to the patient. The **patient** is responsible for all fees and **payment is expected when services are rendered.** FMLA and Disability forms will gladly be completed for an additional fee of $25. In the rare event of a complication, the **patient** is responsible for all fees related to said circumstances, including, but not limited to: anesthesia, facility, emergency room, laboratory, pathology, radiology, and other consultant fees.

I hereby certify that I have read this form, or it was read to me, and that I fully understand the contents of this form.

Patient Signature:_____ **Date:**_____

PATIENT PHOTOGRAPH CONSENT

Photographs are considered to be an integral part of your plastic surgical care. Photographs are required and nearly always taken prior to and after any procedure. Photographs may also be taken during procedures as deemed warranted. This is a generally accepted practice amongst plastic surgeons. Photographs are useful as a patient educational tool, are a critical part of surgical planning, and are a means to accurately assess results.

All photographs will be taken with as much discretion as possible. Care will be taken to assure they are as least identifiable as possible. Since the photos will concentrate on the area of concern, few will include the face. Your name will not be in the photograph. Your name will accompany the photos in storage. If the procedure includes the face, there will be **NO** ability to make the photos completely anonymous. Unique identifying, non-removable, body adornment such as tattoos or piercings may also preclude anonymity.

Photographs may be requested by insurance companies or others involved in your care. They may be sent through the mail, via the Internet or fax machine.

Except in an emergency, if a patient refuses to consent for photographs, Dr. Belz may choose not to proceed with the procedure.

_____**ALL MEDIA USE**, you allow your photos to be used for: Medical care and education, teaching other healthcare providers, practice materials (website, brochures, presentations) and Media such as social media, advertising, or publications. I hereby authorize Dr. Jessica Belz and/or her assistants to take, utilize, and store photographs of myself. I understand that copies of these photographs may be used for professional medical purposes deemed appropriate, including, but not limited to: any print or broadcast media, patient education, medical education, surgical planning, office photo albums, internet, practice website, television, advertising media, commercial media, social media, lay publication or during lectures to medical or lay groups. I release and discharge Dr. Belz and her staff from any and all claims or actions that I have or may have relating to such use and publications

_____**MEDICAL USE ONLY,** your photos will be used only for: your medical care purposes.
I hereby authorize Dr. Jessica Belz and/or her assistants to take, utilize, and store photographs of myself, solely for the purpose of medical care.

I understand that I will not be entitled to monetary payment or any other consideration as a result of the use of these images and that these photographs will use discretion and be as confidential as possible.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

JESSICA BELZ, M.D.
PLASTIC SURGERY

NOTICE OF PRIVACY PRACTICES

Effective Date:04/01/2026

Jessica Blez, MD
207 W. Sunset Rd
San Antonio, TX 78209

Ph: 210-97-7100
Email: info@drjessicabelz.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND YOUR RIGHTS UNDER FEDERAL AND TEXAS LAW.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

We are required by law to protect your medical information in accordance with HIPAA and Texas law. We maintain safeguards to protect your privacy. We may use your information for the following purposes: 1) treatment, 2) payment and 3) health care operations.

- **Treatment** means providing or managing health care and related services by one or more health care providers. Examples would include information pertaining to consultation, examination, surgery, and other medical care. These are often requested by other health care providers involved with your care or entities involved in your care such as hospitals and surgery centers. They request this be sent through the mail, and/or via fax or internet (electronic). This information can also include photographs. When photographs are involved, no facial features are included unless the area of concern is located on the face. Mailings and/or appointment reminders sent to you or others may contain our business name, logo and/or doctor's name. We may send you e-mails confirming appointment and/or surgery times, and request results of needed labs, tests, procedures, or medical evaluations.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. Please be aware that although payments via check or credit card by you contain no health information, they will be deposited into an account readily identifiable by bank or card personnel as being associated with a "plastic surgeon's office."

- **Health care operations** include the business aspects of running our practice, such as conducting assessment and improvement activities, auditing functions, cost management analysis and customer service.

Under Texas law, most other disclosures require your written authorization. You may revoke such authorization in writing and we are required to abide by that written request, except to the extent that we have already taken actions relying on your authorization.

NOTICE OF PRIVACY PRACTICES – continued

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose personal health information, (PHI), including electronic, that identifies you without your written authorization. Individual authorization is required for uses such as psychotherapy notes, PHI for marketing, sale of PHI, or fundraising. This practice does not participate in any of these practices at this time.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer, Dr. Jessica Belz.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to family members, other relatives, close personal friends or any other person identified by you. It is our policy to be as discrete as possible at all times. We do, however, frequently need to relay information to friends and relatives pertaining to your care, such as your course during surgery or recovery. We may relay information to a significant other or answering machine about appointments or billing issues. If you do not want us to call a place of employment or home or leave messages, please notify us.

- The right to reasonable requests to receive confidential communication of protected health information, from us by alternative means or at alternative locations.

- The right to access your records within 15 days.

- The right to request corrections to your medical records.

- The right to request confidential communication.

- The right to obtain a paper copy of this notice from us on request.

- The right to be notified of any breach of unsecured protected health information, as required by law.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective of all protected information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Policy from this office.

You have recourse if you feel that your privacy protections have been violated. You have a right to file a formal complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of the policies and procedures of our office. We will not retaliate against you for filing a complaint.

JESSICA BELZ, M.D.
PLASTIC SURGERY

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT AND CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can be and will be used to:

- Conduct, plan and direct my treatment and follow up among the various health care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received and/or read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to abide by my requested restrictions, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient name: _____

Relationship to patient: _____

Patient signature: _____

OFFICE USE ONLY

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

Date: _____ Initials: _____ Reason: _____

NOTICE TO PATIENTS

Jessica M. Belz, M.D. practices medicine through her professional limited liability corporation known as Jessica M. Belz, M.D., PLLC.

Earl E. Ferguson, M.D. practices medicine through his professional association known as Earl E. Ferguson, M.D., PA.

Drs. Belz and Ferguson are not partners in the practice of medicine nor are their professional organizations. They have organized their practices as an office sharing arrangement. Accordingly, Dr. Belz has no interest in Dr. Ferguson's practice, nor does Dr. Ferguson have an interest in Dr. Belz' practice.

Both practices will abide by all laws, rules and regulations related to privacy rights of their respected patients.

Please address any issues related to the above notice to your physician.

Thank you.

I have been given the above notice related to the separate practices of Dr. Jessica M. Belz and Dr. Earl E. Ferguson.

_____ _____

Patient Signature Date