

MEDICAL HISTORY

Today's Date _____
 Name _____
 Date of Birth _____ Age _____ Weight _____ Height _____
 Street _____ City _____ State _____ Zip _____
 Phone: (H) _____ (W) _____ (Cell) _____ M ___ F ___ SS# _____
 Employer/Occupation _____ Language _____ Race _____ Ethnicity _____
 Spouse's Name _____ Occupation _____ Parent/Guardian (if under 18) _____
 Emergency Contact _____ Address/Phone _____
 (Other than Spouse) _____

Primary Physician _____ How did you hear about us? _____
 Referred by: Self / Friend Dr. _____

e-Mail _____ I authorize you to send me promotional emails and scheduling emails.
 Check here if you do not wish to receive emails.

Reason for visit? _____
 Location of problem _____
 How long has the problem been present? _____ Was there any previous treatment? Yes No
 • When? _____ Type? _____
 Was a biopsy done? No Yes Biopsy done by referring Dr. _____
 Other _____ Are you currently pregnant or breastfeeding? _____

ALLERGIES None List: _____

LIST ALL MEDICATIONS, VITAMINS, & HERBAL SUPPLEMENTS, AND MEDICAL ILLNESS ASSOCIATED WITH

Medication	Dosage (1mg)	When Taken (twice per day)	Medical Condition Associated with Rx (Afib)

Are you presently taking Plavix, Pradaxa, Coumadin, warfarin, Aggrenox, Xarelto, aspirin, fish oil, Vitamin E, garlic, ginkgo, ginger, or ginseng? _____

MEDICAL HISTORY

SYSTEM REVIEW: Check all that apply regarding your health and add any other important problems.

- | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| SKIN
<input type="checkbox"/> abnormal scarring
<input type="checkbox"/> poor healing
<input type="checkbox"/> other skin disorders | KIDNEY
<input type="checkbox"/> normal
<input type="checkbox"/> dialysis
<input type="checkbox"/> other kidney problems | CONSTITUTIONAL SYMP
<input type="checkbox"/> none
<input type="checkbox"/> weight loss
<input type="checkbox"/> fever
<input type="checkbox"/> other _____ | EYES/EARS/NOSE/THROAT
<input type="checkbox"/> normal
<input type="checkbox"/> glaucoma
<input type="checkbox"/> hearing aid
<input type="checkbox"/> plastic surgery | ORGAN TRANSPLANT
<input type="checkbox"/> YES
<input type="checkbox"/> NO
LIST: |
| RESPIRATORY
<input type="checkbox"/> normal
<input type="checkbox"/> asthma
<input type="checkbox"/> emphysema
<input type="checkbox"/> other lung problem(s)
<input type="checkbox"/> sleep apnea (If yes, do you wear CPAP? Yes / No) | GASTROINTESTINAL
<input type="checkbox"/> normal
<input type="checkbox"/> stomach ulcer
<input type="checkbox"/> colitis
<input type="checkbox"/> other GI problems | MUSCULOSKELETAL
<input type="checkbox"/> normal
<input type="checkbox"/> arthritis
<input type="checkbox"/> artificial joint
<input type="checkbox"/> other _____ | NEUROLOGICAL
<input type="checkbox"/> normal
<input type="checkbox"/> stroke
<input type="checkbox"/> seizures
<input type="checkbox"/> other _____ | PSYCHOLOGICAL
<input type="checkbox"/> depression
<input type="checkbox"/> anxiety
<input type="checkbox"/> bipolar |
| HEMATOLOGIC/LYMPH
<input type="checkbox"/> normal
<input type="checkbox"/> anemia
<input type="checkbox"/> bleeding problems
<input type="checkbox"/> enlarged lymph nodes
<input type="checkbox"/> transfusion | ENDOCRINE
<input type="checkbox"/> normal
<input type="checkbox"/> diabetes
<input type="checkbox"/> thyroid
<input type="checkbox"/> other _____

_____ | CARDIOVASCULAR
<input type="checkbox"/> normal
<input type="checkbox"/> chest pain
<input type="checkbox"/> artificial heart valve
<input type="checkbox"/> pacemaker/defibrillator
<input type="checkbox"/> high blood pressure
<input type="checkbox"/> mitral valve prolapse
<input type="checkbox"/> heart attack (when?) _____
<input type="checkbox"/> other _____ | INFECTIONS
<input type="checkbox"/> none
<input type="checkbox"/> hepatitis
<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> tuberculosis (T.B.)
<input type="checkbox"/> MRSA/Staph Infection | |

HISTORY OF SKIN CANCER

Do you have a history of: Melanoma? No Yes
 Basal/Squamous cell skin cancer? No Yes
 Have you had Mohs surgery in the past? No Yes
 Has anyone in your family had melanoma? No Yes If yes, please list who: _____
 Has anyone in your family had Pancreatic cancer? No Yes If yes, please list who: _____

List all prior surgeries:

Date	Surgery	Date	Surgery	Date	Surgery

Recent Hospitalizations (within last 12 months):

Date	Reason	Date	Reason

VACCINATIONS:

Pneumonia: No Yes Date: _____ Influenza: No Yes Date: _____

SOCIAL HISTORY

Occupation: _____ Marital Status: S M D W

Spouse Name: _____

Tobacco: No Yes If yes, Pks/Day: _____ Former Smoker No Yes Yrs tobacco free: _____

Previous sunlight exposure or sunburns: mild moderate extensive

Average alcohol intake in a week: _____

Primary Pharmacy: _____

Address Street: _____ City: _____ Phone: _____

Do you have an Advance Directive? No Yes If No, would you like information? No Yes



PATIENT REGISTRATION

Today's Date: _____

Name _____ S M W D Sep Date of Birth _____ Age _____
 Street _____ City _____ State _____ Zip _____
 Phone: (H) _____ (W) _____ (Cell) _____ e-Mail: _____ M F SS# _____
 Employer/Occupation: _____ Language: _____ Race: _____ Ethnicity _____
 Spouse's Name _____ Occupation _____ Parent/Guardian (if under 18) _____
 Emergency Contact _____ Address/Phone _____
 (Other than spouse) _____
 Primary Physician _____ Referred by _____
 How did you hear about us? _____

INSURANCE & BILLING INFORMATION

PRIMARY INSURANCE

Person Insured _____
 Policy Holder Name _____
 Policy Holder Date of Birth _____
 Policy Holder Address _____

 Policy Holder's Social Security# _____
 Insurance Company _____
 Insurance Co. Address _____
 Street _____
 City/State/Zip _____
 Policy Number (ID#) _____
 Group Number _____

SECONDARY INSURANCE

Person Insured _____
 Policy Holder Name _____
 Policy Holder Date of Birth _____
 Policy Holder Address _____

 Policy Holder's Social Security# _____
 Insurance Company _____
 Insurance Co. Address _____
 Street _____
 City/State/Zip _____
 Policy Number (ID#) _____
 Group Number _____

If you have Medicare Part B: 1. Are you disabled? ___ Yes ___ No 2. Are you or your spouse employed: ___ Yes ___ No

PAYMENT POLICY

This practice is a participating provider for AETNA PPO, BCBS AL PPC and PMD, TRICARE, Medicare, BCBS FL PPO, UnitedHealthcare PPO, Cigna PPO, Mailhandlers/PHCS and other insurance companies. If you have one of these insurances, you will be responsible for the deductible co-pays. We are a provider for certain HMO plans; however, prior authorization is required.

If you do not have one of the above plans, all charges are payable at the time services are rendered. We will file an insurance claim for your reimbursement or provide you with a copy to file. For surgical fees, please consult with the front office regarding payment.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to William B. Henghold, MD, Elias E. Ayli, DO, Adam A. Ingraffea, MD, J. Paul Fairchild, MD, Sean N. Branch, DO, Beverly Quenneville, PA-C, Patrizia Lewis, AGNP-C, Kelly Stubblefield, FNP-BC, and/or Jeanette Batchelor, PA-C for services rendered in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Date: _____ Signed: _____

AUTHORIZATION TO RELEASE INFORMATION INCLUDING ELECTRONIC TRANSFER AND PERMISSION TO TREAT

I hereby authorize William B. Henghold, MD, Elias E. Ayli, DO, Adam A. Ingraffea, MD, J. Paul Fairchild, MD, Sean N. Branch, DO, Beverly Quenneville, PA-C, Patrizia Lewis, AGNP-C, Kelly Stubblefield, FNP-BC, and/or Jeanette Batchelor, PA-C to release any medical information that may be necessary in processing applications for insurance benefits. I also authorize the release of any medical information that may be necessary for treatment, diagnosis and/or coordination of care between Henghold Skin Health and Surgery Group or any physician taking call for them to include e-prescribe.

Date: _____ Signed: _____

AUTHORIZATION TO REFILE INSURANCE CLAIMS

I hereby authorize Henghold Skin Health & Surgery Group to refile insurance claims on my behalf.

Date: _____ Signed: _____

I approve receiving emails from Henghold Skin Health & Surgery Group for : Messages Medical Info Marketing Promotions



**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

With my consent, **Dr. William B. Henghold, Dr. Elias E. Ayli, Dr. Adam A. Ingraffea, Dr. Sean N. Branch, Beverly Quenneville, PA-C, Patrizia Lewis AGNP-C, Jeanette Batchelor, PA-C, Kelly Stubblefield, FNP-BC, Dr. J. Paul Fairchild and staff** may use and disclose my protected health information (PHI) to carry out Treatment, Payment and Healthcare Operations (TPO). Please refer to Henghold Skin Health & Surgery Group **NOTICE OF PRIVACY PRACTICES** for a more complete description of such uses and disclosures.

I have the right to review the NOTICE OF PRIVACY PRACTICES prior to signing this consent. Henghold Skin Health & Surgery Group (the Practice) reserves the right to revise the Notice of Privacy Practices at anytime. A revised copy may be obtained from Henghold Skin Health & Surgery Group Privacy Officer.

With my consent, the above-mentioned doctors and staff may call my home or other designated location and leave a message on voice mail or in person regarding any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items, account balances, and any call pertaining to my healthcare.

With my consent, the Practice may mail or e-mail to my home or other designated locations any items that assist the Practice in carrying out TPO, such as appointment reminder cards, patient statements and other healthcare information including electronic prescriptions to designated pharmacies.

I have the right to request the Practice restrict how it uses or discloses my PHI. However, the Practice is not required to agree to my requested restrictions.

By signing this form, I am consenting to Henghold Skin Health & Surgery Group and staff to use and disclose my PROTECTED HEALTH INFORMATION to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures per my prior consent.

If I do not sign this consent, I may be declined treatment. I understand that this Consent expires after one year.

Please allow the following person(s) to obtain my personal healthcare information. (If none, please write NONE)

Do you have a **Medical Power of Attorney?** This is someone who makes medical decisions for you.

Yes _____ No _____

If so, Name _____ Please send in legal documents.

Signature of Patient or Legal Guardian

Date

HIPAA Patient Consent: 2016-06-09blw



FINANCIAL POLICY

Our Financial Policy: At Henghold Surgery Center our policy is to provide exceptional health care services. In many cases, we have agreements with insurance companies and other payors. When we have such agreements, we bill in accordance with the terms of the contracts. We assure you that the charges accurately reflect the complexity of care rendered and the skill and expertise required for your case.

Credit Card Policy: In your interest, we are pleased to accept MasterCard®, Visa® and CareCredit® for your charges.

Insurance Usual and Customary: We are providers for many insurance companies; therefore, we adjust our charges down to their allowed amount.

Our Policy: Our policy requires payment of co-payments, co-insurance, and any deductibles at the time of service. If there is any patient balance owed after all insurance companies have made their payments, we will bill you for that amount. All insurance information must be given to the office prior to your appointment or you could be responsible for the entire amount for the office visit and/or procedures.

Patient Responsibilities: 1) I understand that my insurance coverage is based on a legal contract between myself and my insurance company. 2) I understand that I (as "Patient") am responsible for understanding and reading the conditions, coverage, terms, and limitations of my insurance policy. 3) I understand that the legal contract of my insurance policy requires me to be responsible for payment of valid and legitimate fees and charges as follows: All outstanding deductibles, co-payments, non-covered procedures and services that are performed, and outstanding valid charges and fees after insurance companies have made their payments and we have made contractual adjustments.

HMO and PPO Members: If you are a member of an HMO or PPO in which we participate, your co-payments, co-insurance, or deductible is required at the time of service. You are also responsible to see that we have a current referral on hand if your insurance carrier requires one. If we do not have this referral at the time of the visit, your appointment will be rescheduled.

Patient Name (Print)

Patient Signature

Date

Financial Policy – ASC,2016-06-09blw



henghold[™]
surgery
center

○ 850-474-4775 · T 800-243-7546 · F 850-484-8223
A 530 Fontaine Street · Pensacola, Florida 32503

■ henghold.com



PATIENT PORTAL CONSENT FORM

Henghold Skin Health & Surgery Group offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the Web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

DATE

PATIENT SIGNATURE



henghold™ skin health & surgery group

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our facility uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of our facility.

How We May Use or Disclose Your Health Information

For Treatment. We may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, therapist, nurse, or other person providing health services to you, will record information in your record related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions take by them in the course of your treatment and note how you respond.

For Payment. We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations. We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- evaluate the performance of our staff;
- assess the quality of care and outcomes in your cases and similar cases;
- learn how to improve our facilities and services; and
- determine how to continually improve the quality and effectiveness of the health care we provide.

Appointments. We may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Required by law. We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence; and
- to assist law enforcement officials in their law enforcement duties;

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedents. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.



Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions. Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

Workers' Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

Other uses. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent our facility has taken action in reliance on such.

Your Health Information Rights

You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 C.F.R. §164.522; however, our facility is not required to agree to a requested restriction;
- obtain a paper copy of the notice of information practices upon request;
- inspect and obtain a copy of your health record as provided for in 45 C.F.R. §164.524;
- request that your health record be amended as provided in 45 C.F.R. §164.526;
- request communications of your health information by alternative means or at alternative locations; and
- receive an accounting of disclosures made of your health information as provided by 45 C.F.R. §164.528.
- restrict information from your payor. If you do so, you must inform us ahead of time and pay for that portion in full.

Concerns/Complaints

You may complain to our facility and/or to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a concern. To register a concern with our facility, please contact the Administrator or complete and return a Patient Concern Form to our facility.

Our Obligations

Our facility is required by law to:

- maintain the privacy of protected health information;
- provide you with this notice of its legal duties and privacy practices with respect to your health information;
- abide by the terms of this notice;
- notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- notify you if your protected health information is breached.
- provide you with access to your electronic protected health information in the electronic form and format you request within 30 days of your request. You may be charged reasonable fees for labor and supplies.
- accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations; and

We reserve the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made publicly available and posted at the facility.

Contact Information

If you have any questions or complaints, please contact: **Office Manager**



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of Notice of Privacy Practices.

Name (Print) Signature Date

Office Use Only

Date acknowledgement received: _____

-OR-

Reason acknowledgement was not obtained:

