henghold skin health & surgery group

PATIENT REGISTRATION **Today's Date:**

Name_____ S M W D Sep Date of Birth_____ Age____
Street_____ City_____ State_____ Zip_____
Phone: (H)_____ (W) _____ (Cell) _____ M___ F___ SS#_____
Employer/Occupation: _____ Language: _____ Race: _____ Ethnicity _____
Spouse's Name_____ Parent/Guardian (if under 18)_____
Emergency Contact: _____ Relationship: _____Phone #: _____
Have you seen our Billboard ____ Commercial on Channel 3 ____ WEAR Healthline on-line ____ Newspaper Ad/Article ____

INSURANCE & BILLING INFORMATION – If information is on the insurance card, you can skip

PRIMARY INSURANCE

Person Insured _____
Policy Holder Name _____
Policy Holder Date of Birth _____
Policy Holder Address_____
_____
Policy Holder Social Security # _____
Employer _____
Policy Number (ID#)_____
Group Number _____
If you have Medicare Part B, Are you disabled? ___Yes ___ No

SECONDARY INSURANCE

Person Insured _____
Policy Holder Name _____
Policy Holder Date of Birth _____
Policy Holder Address_____
_____
Policy Holder Social Security # _____
Employer _____
Policy Number (ID#)_____
Group Number _____

Email: _____@_____.____
I approve receiving emails from Henghold Skin Health & Surgery Group for: ☐Messages ☐Medical Info ☐Marketing Promotions

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize direct payment of surgical/medical benefits to Henghold Skin Health & Surgery Group for services rendered in person or under 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 Henghold Skin Health & Surgery Group 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: _____

PATIENT PORTAL CONSENT : 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 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 type of webpage that uses encryption to keep unauthorized persons from reading communications, information or attachments. Secure messages and information can only be ready 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 Risk : 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 but 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 verify 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 on-line communications between my provider 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 provider may impose to communicate with me via on-line communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

Date:_____ Signed:_____

Our Financial Policy: At Henghold Skin Health & Surgery Group 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 Discover, MasterCard® and Visa® for your charges.

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

henghold skin cancer & surgery group

MEDICAL HISTORY

Today's Date: _____ **Patient Name** _____

DOB: _____ **Height** _____ **Weight:** _____ **Age:** ____ **Sex** ☐M ☐F

Primary Care Physician: _____ **Referred By:** ☐Self/Friend ☐Dr. _____

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 **By whom 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? _____

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

SKIN
☐ abnormal scarring
☐ poor healing
☐ other skin disorders

KIDNEY
☐ normal
☐ dialysis
☐ other kidney problems

CONSTITUTIONAL SYMP
☐ none
☐ weight loss
☐ fever
☐ other _____

EYES/EARS/NOSE/THROAT
☐ normal
☐ glaucoma
☐ hearing aid
☐ plastic surgery

ORGAN TRANSPLANT
☐ YES
☐ NO
LIST:

RESPIRATORY
☐ normal
☐ asthma
☐ emphysema
☐ other lung problem(s)
☐ sleep apnea (If yes, do you wear CPAP? Yes / No

GASTROINTESTINAL
☐ normal
☐ stomach ulcer
☐ colitis
☐ other GI problems

MUSCULOSKELETAL
☐ normal
☐ arthritis
☐ artificial joint
☐ other _____

NEUROLOGICAL
☐ normal
☐ stroke
☐ seizures
☐ other _____

PSYCHOLOGICAL
☐ depression
☐ anxiety
☐ bipolar

HEMATOLOGIC/LYMPH
☐ normal
☐ anemia
☐ bleeding problems
☐ enlarged lymph nodes
☐ transfusion

ENDOCRINE
☐ normal
☐ diabetes
☐ thyroid
☐ other _____
_____
_____
_____

CARDIOVASCULAR
☐ normal
☐ chest pain
☐ artificial heart valve
☐ pacemaker/defibrillator
☐ high blood pressure
☐ mitral valve prolapse ☐ transplant
☐ heart attack (when?) _____
☐ other _____

INFECTIONS
☐ none
☐ hepatitis
☐ HIV/AIDS
☐ tuberculosis (T.B.)
☐ MRSA/Staph Infection

*** Continue on back of form

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

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**

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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 taken 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. These reminders may be communicated by using the following methods: text message, email and telephone.

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 or 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 questions and would like additional information, you may contact the Quality/Risk Management Department at 530 Fontaine Street, Pensacola, Florida 32503, 850-474-4775.
If you believe your privacy rights have been violated, you may file a complaint with the Henghold Skin Health & Surgery Group's Representative, Kelley Chester at 850-474-4775 or with the Secretary of Health and Human Services (HHS). You may contact HHS at www.medicare.gov/Ombudsman/activities.asp.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Name	/	relationship	Name	/	relationship
Name	/	relationship	Name	/	relationship

I have reviewed and understand my Privacy Rights. If I do not sign this consent, I may be declined treatment. With my consent, any physician or provider of Henghold Skin Health & Surgery Group may use and disclose my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO).

Name (Print)	Signature of Patient or Legal Guardian	Date