

David H. Humphreys, M.D., F.A.C.S., P.A.
Plastic Surgery Center 5 Livingston Street, Asheville, NC 28801
(828)253-3866 FAX: (828)254-2423

Thank you for choosing our office. In order to serve you properly, PLEASE PRINT the following information.			
Name:		Age:	Date:
Address:		City/State/Zip:	
SSN:	Birthdate:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Home Ph:	Work Ph:	Cell Ph:	E-mail:
Spouse(parent if minor):		Spouse's Employer:	
Any restrictions for contacting you:			
Employer:		Employer's Address:	
Occupation:		Full/Part/Student/Retired/Other:	
Emergency Contact Name:			Relationship:
ER Contact Home Ph:		ER Contact Work Ph:	
How did you hear about us:			
For what reason are you seeking treatment:			
Are you/your family previous patients at the Plastic Surgery Center:			
If patient is a child, who may authorize treatment:			Relationship:
Person financially responsible for treatment if not Self:			
Address of person financially responsible:			Phone:
Primary Insurance:		Address:	
Policyholder:		Policy No:	Group No:
SS#:	Employer:		Employer Address:
Date of Birth:			
Secondary Ins:		Address:	
Policyholder: SS#:		Policy No:	Group No:
Date of Birth:			
		Employer:	Employer Address:
If Workers Compensation, treatment authorized by:			Claim #:
If you authorize release of your medical information to anyone besides your insurance carrier, please give the name:			
If you have a telephone answering machine at home, may we leave messages there: YES NO			
I authorize this office to release to the named insurance company any information necessary to expedite insurance payment: I understand that I am responsible for all charges, regardless of insurance coverage.			
Patient, Parent or Guardian Signature:			Date:

PLASTIC SURGERY CENTER

James M. McDonough, M.D. • David H. Humphreys, M.D. • Donald R. Conway, M.D.

5 Livingston Street at Victoria Road • Asheville • NC • 28801 • 828-254-4444 • Fax 828-254-2423

CONSENT TO TREAT AND AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION

I WISH to be treated by the above named physicians. While I am a patient, I permit my doctor(s) and their staff caring for me to treat me in ways they judge are beneficial to me. I understand this care may include tests, examinations, and medical treatment.

I AUTHORIZE the above named physicians to obtain or release any medical information necessary for treatment or for processing insurance claims for services provided.

I AGREE that this authorization shall be valid until rescinded in writing or replaced by one of another date.

SIGNED: _____

DATE: _____

ADDRESS: _____

AUTHORIZATION FOR PAYMENT OF BENEFITS

I AUTHORIZE that payment of medical benefits be made to the above named physicians on any claim submitted for service furnished me by that physician or organization.

I AGREE that this authorization shall be valid until rescinded in writing or replaced by one of another date.

SIGNED: _____

DATE: _____

Billing of insurance on your behalf is provided as a courtesy by the Plastic Surgery Center. You are responsible for payment of your charges regardless of insurance coverage. If you are a member of a managed care insurance program, you should verify with your insurance carrier that they will pay for services provided by this office.

*****DO NOT WRITE BELOW THIS LINE*****

PATIENT INFORMATION UPDATES

I have reviewed the patient information sheet. My (or the patient's) information remains current and accurate.

Signature or patient (or guardian) Date

I have reviewed the patient information sheet. My (or the patient's) information remains current and accurate.

Signature or patient (or guardian) Date

I have reviewed the patient information sheet. My (or the patient's) information remains current and accurate.

Signature or patient (or guardian) Date

I have reviewed the patient information sheet. My (or the patient's) information remains current and accurate.

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HEALTH HISTORY INTAKE FORM

Patient Name _____ **Birth Date:** _____

Please answer all of the questions as accurately as possible. If you do not understand the question, ask for assistance.

Chief Complaint(why are you here?): _____

Primary Care Doctor: _____ **Date last physical exam:** _____

Drug allergies: _____ **Latex...no yes / Betadine..no yes**

Anesthesia reaction/problems: _____ **Sleep Apneano yes -- if yes, do you use a CPAP** _____

List previous surgeries or major illnesses and dates: _____

List any medications you are taking, including non-prescription drugs, vitamins, and herbals:

Social History:

Smoking (type and amount per day) _____ Alcohol(type and amount per week) _____

If former smoker, date quit: _____ Weight _____ Height _____ BMI _____

Family History: Has any blood relative ever had the following:

Breast Cancer	no	yes	High Blood Pressure ...	no	yes	Kidney Disease	no	yes
Ovarian Cancer	no	yes	Heart Disease	no	yes	Depression	no	yes
Stroke	no	yes	Diabetes	no	yes	Melanoma	no	yes

Past Medical History: Have you ever had the following:

Heart Disease	no	yes	Diabetes	no	yes			
Chest Pain	no	yes	Cancer	no	yes	Stomach Ulcer	no	yes
Blood Clots	no	yes	Glaucoma	no	yes	Kidney Disease	no	yes
Arthritis	no	yes	Asthma	no	yes	Thyroid Disease	no	yes
Rheumatic Fever	no	yes	AIDS or HIV	no	yes	Bleeding Tendency	no	yes
Anemia	no	yes	Stroke	no	yes	Mitral Valve Prolapse .	no	yes
Tuberculosis	no	yes	Hepatitis	no	yes	High Blood Pressure ...	no	yes
Gastric Reflux	no	yes -- if yes --	are you on medication for this?(name) _____					

Review of Systems: Do you have now or have you had within the past year:

<u>Constitutional:</u>	<u>Skin:</u>	<u>Neurological:</u>
Weight Change	Skin rash	Seizures
no	no	no
yes	yes	yes
<u>EENT:</u>	<u>Gastrointestinal:</u>	<u>Musculoskeletal:</u>
Dry Eyes	Chronic Diarrhea	Joint or Muscle Pain ..
no	no	no
yes	yes	yes
<u>Respiratory:</u>	Jaundice	<u>Lymphatic:</u>
Chronic Cough	no	Swollen Lymph Nodes.
no	yes	no
yes	<u>Psychiatric:</u>	yes
<u>Cardiovascular:</u>	Depression	<u>Hematologic:</u>
Chest Pain	no	Easy Bleeding
no	yes	no
yes	<u>Genitourinary:</u>	Easy Bruising
Rapid Heart Beat	Kidney/	no
no	yes	yes
yes	Urinary Problems	no
no	no	yes

Women Only: Birth control pills no yes

Number of children: _____ Last menstrual period: _____

Date of last mammogram _____ Number of pregnancies: _____

Do you do regular breast self-examinations? no yes Did you breast feed? no yes

Breast lump or discharge no yes

I VERIFY THAT THIS HEALTH HISTORY IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X _____ Date _____

Signature of patient or guardian
 (above information is to be updated annually)

Plastic Surgery Center

David H. Humphreys, M.D.
5 Livingston Street ♦ Asheville NC 28801

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

Patient: _____ Date: _____

Dr. David H. Humphreys, may disclose protected health information in the form of photographs, films, and/or videos from the records of _____.

I understand that photographs are a necessary part of my medical record. Such photographs, slides, or videotapes may be published by David H. Humphreys, M.D., in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods. I understand that such uses may also include marketing on behalf of David H. Humphreys, M.D., for which he may receive direct or indirect remuneration.

**I agree and authorize the use of these images, without compensation to me, for the following specific purposes:
(Please initial in the boxed marked Yes or No for each item)**

Yes	No	Medium
		Office medical record. (Required)
		In office seminars for prospective patients.
		On our website for prospective patients.
		In print advertisements.
		In the office photo album for prospective patients.

Additional Comments:

I understand that the images will not be identified by name but that such photographs, videotapes, computer, and/or Internet images may reveal my identity (i.e. facial shots, distinctive body markings). I accept this loss of anonymity.

I understand that I have the right to revoke this authorization, *in writing*, at any time by sending such written notification to the practice at 5 Livingston Street, Asheville, NC, 28801.

I understand that a revocation is not effective to the extent that my physician has already disclosed the health information.

I understand that information released by this authorization may be disclosed by the recipient and may no longer be protected by federal and state law.

Patient Signature

Date

Witness Signature

Date

HIPAA Consent Form

Use and Disclosure of Your
Protected Health Information

Your protected health information will be used by Dr. David Humphreys or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the
Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Dr. David Humphreys may or may not agree to restrict the use or disclosure of your protected health information

If Dr. David Humphreys, agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent o the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to
Change Privacy Practices

Dr. David Humphreys reserves the right to modify the privacy practices outlined in the notice.

Signatures

I have reviewed this consent form and give my permission to Dr. David Humphreys to use and disclose my health information in accordance with it.

Name of patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative
(if patient is a minor or unable to consent)

Relationship to Patient