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HEALTH SOLUTIONS, PLLC

NEW PATIENT INFORMATION
HAIR RESTORATION THERAPY

PERSONAL INFORMATION				
Name (Last, First, Middle)		Nickname	Date of Birth	Age
Maiden Name	Sex: ☐ Female ☐ Male	Spouse/Parent/Guardian (if under age 18)		
Address				
City, State, Zip code		Patient E-Mail		
Home Phone	Work Phone	Cell Phone		
EMERGENCY CONTACT				
Emergency Contact Person	Phone	Relationship		
EMPLOYMENT INFORMATION				
Employer		Occupation		
Business Address		City, State, Zip Code		
GENERAL INFORMATION				
How did you hear about our practice?		Who referred you to our practice?		
Patient's Signature		Date		

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HAIR EVALUATION QUESTIONNAIRE

Name: _____ Date: _____

What type of hair loss are you experiencing?
(check all that apply)

- ☐ Thinning
- ☐ Shedding
- ☐ Breakage
- ☐ Other _____

How long have you been experiencing hair loss?

Since your hair loss started, is it currently:

- ☐ Getting worse
- ☐ Staying the same/stable
- ☐ Getting better

Areas affected by hair loss:

- ☐ Scalp
- ☐ Brows
- ☐ Lashes
- ☐ Other _____

Do you have a family history of hair loss? (e.g., siblings, parents, grandparents, aunts/uncles etc.)
Please describe:

_____

Do you have discrete bald patches on your scalp or is your loss more generalized?

- ☐ Patches
- ☐ Generalized

Do you experience any other symptoms in your scalp?

- ☐ Itching
- ☐ Burning
- ☐ Pain
- ☐ Flaking
- ☐ Other _____

Do you currently wear or have you ever worn:

- ☐ Hair prosthesis such as a wig or hair piece
- ☐ Hair extensions
- ☐ Weaves
- ☐ Dreadlocks or twists

Please describe your hair styling regimen:

- ☐ Shampoo — How often _____
- ☐ Blow-dry — How often _____
- ☐ Color — How often _____
- ☐ Heat styling — How often _____
- ☐ Chemicals* — How often _____

*Chemical relaxing or straightening treatments

What have you used to try to stop hair loss or regain hair?

_____

Have you ever been diagnosed with any of the following?

- ☐ Lupus or autoimmune disease
- ☐ Thyroid disease
- ☐ Anemia
- ☐ Lichen panus
- ☐ Polycystic ovarian syndrome
- ☐ Acne
- ☐ Excess body or facial hair

Female patients:

- ☐ Are you pre-menopausal
  - ☐ If yes, regular 28-day menstrual cycles
- ☐ Do you use contraception
  - ☐ If yes, what method _____
- ☐ Are you post-menopausal
  - ☐ Are you on hormones

☐ **Yes** ☐ **No** **Are you taking medicines or supplements?**

If yes, please describe or attach list:

☐ **Yes** ☐ **No** **Are you a vegetarian or do you adhere to a special diet?**

If yes, please describe:

☐ **Yes** ☐ **No** **Have you experienced a major emotional or physical event in the past six to twelve Months (e.g., health issues, hospitalization, stressful or emotional life events):**

If yes, please describe:

☐ **Yes** ☐ **No** **Have you recently had your blood work checked?**

If yes, please bring your results with you to your appointment or have them faxed to our office prior to your appointment.

☐ **Yes** ☐ **No** **Have you ever had a scalp biopsy?**

If yes, please bring your results with you to your appointment or have them faxed to our office prior to your appointment.

Please let us know anything else about your hair that you would like to discuss or let us know about:

HIPAA NOTICE OF PRIVACY PRACTICE

FORWARD HEALTH SOLUTIONS, PLLC

General: The Health Insurance Portability and Accountability Act of 1996 (HIPAA), set rules that regulate how a person's personal health information can be disclosed to others.

Protected Health Information: This includes oral or recorded information created or received by the healthcare provider, health plan, employers, or others concerning physical or mental health provisions or payment for healthcare.

How your medical information will be used and disclosed: We will use your protected health information as part of patient care. For example, your protected health information may be used by the healthcare professional treating you, by the business office processing your payment for services rendered, or by our staff reviewing the quality and appropriateness of the care received.

We may also use and/or disclose your medical information:

- when required to determine our compliance with relevant laws;
- for public health concerns, such as reportable infections, diseases and injuries.
- in the course of certain judicial or administrative proceedings;
- for law enforcement purposes and /or other specialized governmental functions;
- to a coroner, medical examiner, or funeral director.
- to prevent or lessen a *serious* threat to the health and safety of yourself and others;
- as authorized by laws related to Workers Compensation programs;
- to another provider to whom we refer you to for further care;
- to family members or any other person you specify here:
  _____ (please print) and initial _____

Your rights regarding your protected personally identifiable information include:

- the right to request restrictions on certain uses and disclosures;
- the right to receive communication from us in a confidential manner;
- the right to inspect and copy your medical information;
- the right to request an amendment to your medical information;
- the right to receive an accounting of the disclosures for up to six years prior to your request;
- the right to request a copy of this notice;
- the right to complain to Forward Health Solutions, PLLC and the U.S. Department of Health Human Services.

Disclaimer: Forward Health Solutions, PLLC strives to respect and maintain our patients' privacy. A new law with legal terms and unmanageable expectations will not suddenly make any healthcare facility perfect. We will continue to make every effort to provide the best quality healthcare to you and your family in a manner that protects your privacy. Further, we will never intentionally breach your confidence by disclosing **private** information without your consent. However, if you feel you have **serious** privacy issues or concerns, you may want to consider using another facility. It is impossible to soundproof our office or guarantee that someone will not overhear a conversation, see your name somewhere, or even meet you in our lobby.

Please speak with any staff member if you have any questions regarding this policy. If you feel your privacy rights have been violated, please contact our Privacy Officer: Joanne Barthel, Forward Health Solutions, PLLC, 140 Mayfair Road, Suite 1500, Hattiesburg, MS 39402, (601) 450-2077

Patient Name (Print): _____ Patient Signature _____ Date _____

Witness _____ Date _____

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OFFICE POLICY

Patient Name: _____ DOB _____

PLEASE INITIAL EACH ITEM BELOW

___ **Primary Care and Emergencies**

- We do not assume treatment of chronic medical illnesses or general medical care (including pap smears, mammograms, and digital rectal exams).
- We do not prescribe refills of your routine medication prescribed by other physicians.

___ **Lab Work**

- We offer lab work at a significantly-reduced cost compared to many outside clinics. If you choose to have us do your lab work, allow 5-7 business days prior to your appointment. Payment is due at the time your blood is drawn.
- If you choose to obtain your lab work from an outside lab**,** you agree that you will have your blood draw 10-12 business days prior to your appointment. If you have an appointment and we do not receive all your labs or you do not bring the labs in with you, may need to schedule an additional appointment to review the labs we did not receive.

___ **Payment**

- **Agreement to Pay**: I understand and agree that I am responsible for payment of my account ***at the time of service,*** including my appointment and any services or supplements provided to me.
- We accept cash, personal checks, debit cards, VISA and MasterCard. Should your check be returned for non-sufficient funds, you will be charged $25 charge NSF fee and you will need to pay with cash or a credit card. Patients are responsible for all costs associated with collections on their accounts.
- **Insurance Patients**: We ***DO NOT*** accept any insurance, nor do we submit claims for you. We would be happy to provide you with an itemized invoice you may submit them to your insurance company. Note: Not all insurance companies will reimburse you for our services.
- **Medicare Patients:** ***We are an opt-out provider and you cannot bill Medicare*** for your visits or services provided by Forward Health Solutions.

___ **Appointment No-Shows, Cancellation and Late Fees**

- Appointments: Your appointment time is scheduled just for you. We do not double or overbook other patients into your appointment time. ***I also agree that if I do not cancel my appointment 24 hours prior to my appointment time, or on Friday morning prior to my Monday appointment time, I will be charged $100 for the missed appointment.***
- Late Fees: If you will be unavoidably late for your appointment, please let us know. If you arrive more than 15 minutes late, you may be required to reschedule.

___ **Medication Refills**

- Prescription refills should be requested at appointments, whenever possible.
- Refill requests should be made at least 2 business days prior to taking your last dose.

___ **Confidentiality**

- Your medical information is strictly confidential. We will not release it to anyone, including family members, without your written consent. However, if you wish, a family member may accompany you to your appointments without a written consent.
- If you want a copy of your records sent to another physician, we will require a written authorization from you.

___ **Employee Work Environment**

- Forward Health Solutions is committed to providing a work environment for our employees that is free of harassment of any nature, including sexual harassment or harassment based on such factors as race, color, religion, national origin, age, sex, marital status, and disability. Any patient who harasses a staff member or any other patients will be dismissed as a patient.

By signing this form, I acknowledge that I have read and agree to abide by the above office policy. I also understand that if I abuse or do not follow these policies, I may be discharged from the clinic.

Patient Name (Print): _____ Patient Signature _____ Date _____

Witness _____ Date _____

Rev. 4-8-15

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Medicare Private Contract

This agreement is between Rebecca Boyd, D.O., and Tomia Carter, CFNP, whose principal place of business is 140 Mayfair Road, Suite 1500, Hattiesburg, Mississippi 39402

and

Beneficiary: _____ DOB: _____

Who resides at: _____

And is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Beneficiary or his/her legal representative that Physician has opted out of the Medicare program effective October 1, 2010. The physician is not excluded from participating in Medicare Part B under (1128) 1128, (1156) 1156, or (1892) 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following by placing initials before each statement:

_____ Beneficiary or his/her legal representative accepts full responsibility for payment of the physician's charges for all services furnished by the physician.

_____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

_____ Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare.

_____ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

_____ Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from the physician and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

_____ Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and other supplements plans may elect not to , make payments for items and services not paid for by Medicare.

_____ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health situation.

_____ Beneficiary or his/her legal representative acknowledges that a copy of this contract has been available to him.

Date: _____ By:_____Beneficiary or his/her legal representative

140 Mayfair Drive Suite 1500 ▪ Hattiesburg, MS 39402
601-450-2077 Office ▪ 601-450-2079 Fax