DR. MATTHEW
GOODWIN
PLASTIC SURGERY

PATIENT INTAKE INFORMATION

LAST NAME _____ FIRST NAME _____ MIDDLE INITAIL _____

ADDRESS _____ CITY _____ ZIP CODE _____

DATE OF BIRTH _____ AGE_____ MARITAL STATUS _____ SS# _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMERGENCY CONTACT NAME _____ PHONE _____

YOUR EMAIL ADDRESS _____

REASON FOR VISIT _____ REFERRING DOCTOR _____

PHARMACY NAME, PHONE AND ADDRESS _____

MEDICAL HISTORY

HEIGHT _____ WEIGHT _____ RACE _____ ETHNICITY _____

PREVIOUS SURGERY _____

HOSPITALIZATIONS _____

Have you had skin or wound healing problems? (Please Describe) _____

Do your scars tend to hypertrophy or keloid? (Please Describe) _____

DO YOU HAVE: Allergies ___ Anemia ___ Angina ___ Anxiety ___ Arthritis ___ Asthma ___
Atrial Fibrillation/Arrhythmia ___ Benign Prostatic Hypertrophy ___ Blood Clots ___ Cancer type _____
Cerebrovascular accident ___ COPD ___ Coronary Artery Disease ___ Crohn's Disease/Colitis ___
Depression ___ Diabetes ___Gallbladder Disease ___GERD ___ Hepatitis C ___Hyperlipidemia ___
Hypertension ___ IBS ___Liver Disease ___ Migraine Headaches ___Myocardia Infarction/Heart Attack ___
Osteoarthritis ___Osteoporosis ___ Peptic Ulcer Disease ___Renal Disease ___Seizure Disorder ___
Other _____

Have you ever had radiation therapy/treatment? If so, when? _____

Have you ever had a blood transfusion? _____

Have you ever been diagnosed or treated for a psychiatric condition? If so, and when?
_____

MEDICATIONS: Please list ALL (including over the counter) medications that you are currently taking with dosage information: _____

_____

MEDICATION ALLERGIES: _____

FAMILY AND SOCIAL HISTORY

Have you or a family member ever had complications from anesthesia?_____

Have you or a family member ever had a serious illness? _____

Mother: Alive or Deceased? _____ **Father:** Alive or Deceased? _____

If alive, age: _____ **If alive, age:** _____

If deceased, cause of death/age: _____ **If deceased, cause of death/age:** _____

Siblings: Brother/s _____ Sister/s _____

Children: Son/s _____ Daughter/s _____

What is your approximate daily intake of the following:

Tobacco _____ **Alcohol** _____

Do you use recreational drugs? If so, please list _____

Smokeable or inhalable tobacco, marijuana, or other: _____

BREAST SURGERY PATIENTS (Reconstructive and Cosmetic)

What breast surgery are you interested in having? _____

Have you had any breast surgery or procedure(s) prior? (please describe) _____

_____

What brassiere size do you currently wear? _____

What size would you like to have? _____

Have you had any breast problem? Which breast? _____

Lumps/masses: Yes or No

Nipple discharge: Yes or No

Skin or nipple retraction: Yes or No

Size change: Yes or No

Neck or back pain: Yes or No

Bra strap pain: Yes or No

Irritation to skin under breast: Yes or No Other _____

When was your last mammogram? _____

Were there any abnormalities? _____

Have you had any other breast diagnostic tests (ultrasound, MRI, biopsy)? _____

Do you have any family history of breast cancer? (Who and age of diagnosis) _____

_____

Review of System

Patient Name_____ D.O.B_____

General
Have you gained or lost weight recently? Yes or No
How many pounds? _____
Have you ever had fever, chills or sweats? Yes or No

Eyes
Double vision: Yes or No
Have you ever lost vision? Yes or No
Blurred vision: Yes or No

Neurological
Trouble sleeping: Yes or No
Headaches: Yes or No
Seizures: Yes or No

Endocrine
Tired/Sluggish: Yes or No
Too hot/cold: Yes or No
Excessive thirst: Yes or No

Gastrointestinal
Indigestion: Yes or No
Abdominal pain: Yes or No
Heartburn: Yes or No
Nausea: Yes or No
Vomiting: Yes or No

Cardiovascular
Varicose veins: Yes or No
High blood pressure: Yes or No
Chest pain: Yes or No

Integumentary
Nipple Discharge: Yes or No
Persistent Itching: Yes or No
Skin Rash: Yes or No

Musculoskeletal:
Joint Pain: Yes or No
Swelling in your joints: Yes or No
Arthritis: Yes or No

ENT
Ear infection: Yes or No
Sinus problem: Yes or No
Sore throat/hoarse: Yes or No

Genitourinary
Painful/Frequent urination: Yes or No
Vaginal discharge/itching: Yes or No
Irregular menstruation: Yes or No
Blood in urine: Yes or No
Pain during/after sex: Yes or No

Respiratory
Frequent Cough: Yes or No
Shortness of breath: Yes or No
Wheezing

Hematologic/Lymphatic
Blood clotting problem: Yes or No
Anemia: Yes or No
Swollen glands: Yes or No

Psychiatric
Are you unhappy with your life?
Do you feel severely depressed?
Have you considered suicide?

Health Education
Blood pressure screening
Diabetes screening
Family planning/safe sex teaching
Healthy weight education
Hepatitis Vaccination
Influenza Vaccination
Lipid screening
Pneumovax vaccination
Smoking cessation

Cancer Self-Management

Breast self-exam	PAP testing
Colonoscopy	PSA testing
Mammogram	Skin exam

Dr. Matthew Goodwin MD FACS

Financial Policy

Thank you for selecting Dr. Goodwin for your plastic surgery. The following financial policies are regarding Dr. Goodwin's reconstructive practice which typically are insurance related. Please see the financial policies for Inspire Cosmetic Surgery and Med Spa for the cosmetic portion of his practice.

Dr. Goodwin's reconstructive practice encompasses the breadth of plastic surgery with a focus on breast reconstruction and skin cancer reconstruction.

Payment

In order to prevent any misunderstanding over the responsibility of payment for medical and surgical services provided to our patients, we supply you with the following information: The patient, guarantor, or the person bringing the patient (if the patient is a minor), is responsible for payment of services provided at the time of the office visit, test or procedure. We accept cash, personal checks (NSF charge: $25), and credit cards (American Express, Discover, VISA, & MasterCard). In the case of divorced parents, the parent bringing the child to the office is responsible for payment at the time of service. A copy of the bill, which is furnished at each visit, contains all the information necessary for you to submit to your insurance carrier.

Insurance

Dr. Goodwin's reconstructive practice participates in many insurance carriers. Please verify with his office your insurance status so that we can minimize any disruptions in your care. We require a copy of your insurance card and payment of your deductible or copayment at the time of service. We cannot waive co-payments, deductibles, or co-insurance amounts.

Most insurance programs require pre-authorization which means they must approve the surgical plan submitted by Dr. Goodwin prior to surgery. If surgical authorization is denied, IT IS THE PATIENT'S RESPONSIBILITY TO APPEAL. We are happy to provide medical records but will not undertake the appeal process for you. Furthermore, PRE-AUTHORIZATION DOES NOT GUARANTEE PAYMENT OF SURGERY COSTS. If payment is denied at any point prior to or after surgery, the patient or guarantor is responsible for payment of the full balance.

The benefits paid by insurance companies for plastic surgery vary greatly from carrier to carrier and plan to plan. Therefore, we make every effort to determine in advance if insurance coverage exists and then, ascertain the projected insurance payment and the required co-payment. As stated above, the patient, guarantor, or guardian is ultimately responsible for the account balance.

Medicare

Office visits to a doctor are covered under Part B of the Medicare program. Medicare pays 80% of their allowable charges after you pay the annual deductible for the calendar year. You are fully responsible for any non-covered services. As a courtesy, if you have supplemental insurance, we will be glad to file this for you.

Medicaid and other non-covered insurance programs

Our practice does not accept Medicaid and various other insurance/managed care policies. On a case by case basis, we may able to provide services. This will need to be discussed with the practice administration. If you do not have health insurance coverage or request a service that is not covered by your health plan, we require payment in full at the time service is rendered.

Referrals

If a referral from your primary care physician is required by your insurance plan it is your responsibility to bring this referral with you and present it at the registration desk at the time of your visit. You will be asked for your insurance card and driver's license at the registration desk for identification purposes.

FMLA, Medical Records, and other Forms/Paperwork

We understand that employers and various programs require paperwork to be filled out by the health care provider for the patient. These can be time consuming and therefore, a fee will be collected for providing them. $15 for FMLA forms. $15 for medical records. Other non-insurance related forms $15.

Office Visit No-Show and Late Policies

Consultation time slots are precious and missed visits affect our practice by consuming time for other patients. Please make sure to give sufficient notice for cancellation. Patients failing to provide at least 24-hour notice for cancellation or missed appointment will be charged $50 for rescheduling. Patients with multiple missed appointments without sufficient notice will be discharged.

Dr. Goodwin tries his best to be on time for his appointments. When he is late, it is usually because he is seeing or treating another patient. When patients arrive late, they can throw off the schedule completely and decreases quality of care. If the schedule is light, we will work to fit you in; however, if arriving more than 15 minutes late from their scheduled appointment, patients will likely need to reschedule.

Missing, Inaccurate, or Incomplete Billing Information

Please notify our office of any changes to your health plan or billing information. Failure to notify us of changes may result in your remaining balance on your account. The practice is not responsible for billing errors, lack of coverage, or payment due that is a result of missing, inaccurate, or incomplete information that has been provided by the patient, including information on secondary or third-party coverage.

Revision Surgery, Complications, and Uncovered Services

We hope and anticipate no complications will arise and revision are not necessary, but this cannot be guaranteed. Dr. Goodwin works to avoid complications, but on occasion they do arise and if additional treatment is required, your insurance will be billed for services rendered. You may also incur additional balances depending on your health plan/benefits contract. On occasion patients have consultations for conditions that are reconstructive but the treatments are not covered by insurance. Those consultations will still be billed to the health plan, as well as any copays or deductibles. Follow-up visits that are related to insurance based treatments will also be billed.

Surgical First-Assistant

Dr. Goodwin often requires the assistance of a surgical first-assistant in extensive or complex surgeries. These may not be covered by your insurance plan and there could be an additional cost. We will provide you some more information to this regard.

Please contact our office if you have any questions or concerns. Thank you.

Signature	Printed Name	Date

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.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health can act as each of the above business types. This medical information is used by the Department of Health in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department of Health for purposes of treatment, payment, and health care operations. *Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department of Health may use or disclose your health information for case management and services. The Department of Health clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided you.*

Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by the department's divisions, bureaus, and offices.
- Investigations and audits by the state's Inspector General and Auditor General, and the legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes, including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulation of health professionals.
- District medical examiner investigations;

- Research approved by the department.
- Court orders, warrants, or subpoenas;
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by the department will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. These uses and disclosures may be for marketing and for research purposes, certain uses and disclosure of psychotherapist notes, and the sale of protected health information resulting in remuneration to the Department of Health.

INDIVIDUAL RIGHTS

You have the right to request the Department of Health to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The department is not required to agree to any restriction. However, in situations where you or someone on your behalf pays for an item or service in full, and you request information concerning said item or service not be disclosed to an insurer, the Department will agree to the requested restriction.

You have the right to be assured that your information will be kept confidential. The Department of Health will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the department.
- Is not protected health information.
- Is by law not available for your inspection.
- Is accurate and complete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department will respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures the Department of Health may have made of your protected health information. This summary does not include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures to health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to April 14, 2003.

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6 year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

The Department of Health may mail or call you with health care appointment reminders.

Department of Health Duties

The Department of Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. The department has the responsibility to notify you following a breach of your unsecured protected health information.

As part of the department's legal duties this Notice of Privacy Practices must be given to you. The department is required to follow the terms of the Notice of Privacy Practices currently in effect.

The Department of Health may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Department of Health website at www.myflorida.com and will be available by email and at all Department of Health buildings. Also available are additional documents that further explain your rights to inspect and copy and amend your protected health information.

Complaints

If you believe your privacy health rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775.

The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department of Health will not retaliate against you for filing a complaint.

For Further Information

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.

Effective Date

This Notice of Privacy Practices is effective beginning July 1, 2013, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

References

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register* 65, no. 250 (December 28, 2000).
"Standards for the Privacy of Individually Identifiable Health Information; Final Rule" 45 CFR Part 160 through 164. *Federal Register*, Volume 67 (August 14, 2002).
HHS, Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information and Nondiscrimination Act; Other Modifications to the HIPAA Rules, 78 Fed. Reg. 5566 (Jan. 25, 2013).

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

INSURANCE AUTHORIZATION AND ASSIGNMENT. I hereby authorize Genesis Aesthetic Surgery, LLC to furnish information to my Insurance Carrier concerning illness and treatments and hereby Genesis Aesthetic Surgery, LLC payments for medical services rendered to myself or dependents. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.**

Signature x_____ **Date:** _____

NOTICE OF PRIVACY ACKNOWLEDGEMENT

- I acknowledge that the Notice of Privacy Practices is available.
- I acknowledge that due to the current HIPAA laws my doctor is required to obtain a written consent to disclose any Private Health Information in the presence of anyone other than myself.

Please check the corresponding Line:

_____ **I ALLOW** Genesis Aesthetic Surgery, LLC to discuss details of my medical records/financial records with _____

(Please print name of authorized family member or friend)

Relation (of authorized person) to patient _____

_____ **I DO NOT ALLOW** Genesis Aesthetic Surgery, LLC to discuss details of my medical records/financial records with anyone else but me.

_____ _____

Patient's Signature **Patient's Name**

_____

Consent to Leave Voicemail Messages Containing Medical Information

Patient's Name: _____

Date of Birth: _____

Genesis Aesthetic Surgery, LLC will not leave voicemails containing your medical information without your consent. Complete this form if you wish for Genesis Aesthetic Surgery's staff to leave voicemails containing your medical information.

By signing this form, you consent to Genesis Aesthetic Surgery, LLC leaving voicemails containing your medical information on the phone number(s) listed below. This information may include, but is not limited to, demographic information (patient name, date of birth, address, etc.) billing information, and medical information (appointment dates, medications, test results, etc.).

I, the undersigned, consent to voicemails containing my medical information at the following phone number(s):

Primary Phone: _____

Alternate Phone (Optional): _____

I understand that I have the right to revoke this consent at any time by sending a written request to Genesis Aesthetic Surgery, LLC. My decision to revoke this consent does not apply to information disclosed in a voicemail prior to the date of revocation.

By my signature below, I certify that I have read and understood the items on this form, that I have given truthful information about my identity, and that I am either the patient or the patient's legally authorized representative.

Patient's Signature or legal Guardian (If patient<18 yrs) _____

Patient's Name(print) _____

Date: _____

E-mail Consent Form

Patient Name _____ Date _____

Patient E-mail address _____ Patient phone number _____

The LLC and its Staff Members shall be referred to throughout this consent form as "Provider".

1. **RISK OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER:**

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail communication. These include, but not limited to, the following risks:

a. E-mails can be circulated, forward, and stored in numerous paper and electronic files.
b. E-mails can be immediately broadcast worldwide and be received by unintended recipients.
c. E-mail senders can easily type in the wrong email address.
d. E-mail is easier to falsify handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.
g. E-mail can be intercepted, altered, forward, or used without authorization or detection.
h. E-mail can be used to introduce viruses into the computer system.
i. E-mail can be used as evidence in court.

2. **CONDITIONS FOR THE USE OF E-MAIL:**

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of email for patient information. Consent to the use of e-mail includes agreement with the following conditions.

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patients medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those e-mails.
b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patients prior written consent, except as authorized or required by law.
c. The patient is responsible for protecting his/her password or other means of access to e-

E-mail Consent Form

mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.

d. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.

e. It is the patient's responsibility to follow-up and/or schedule an appointment.

3. PATIENT RESPONSIBILITIES AND INSTRUCTIONS:

To communicate by e-mail, the patient shall:

a. Limit or avoid using his/her employer's computer.

b. Inform Provider of changes in his/her e-mail address.

c. Confirm that he/she has received and read the e-mail from the Provider.

d. Put the patient's name in the body of the e-mail.

e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g. billing and questions).

f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.

g. Withdraw consent only by e-mail or written communication to Provider.

4. TERMINATION OF THE E-MAIL RELATIONSHIP

The Provider shall have the right to immediately terminate the e-mail relationship with you if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable.

E-mail Consent Form

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient Name (print) _____

Patient Signature _____ Date _____

HOLD HARMLESS

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the Internet to communicate with the Provider, and any breach by me of these restrictions and conditions.

Patient Name (print) _____

Patient Signature _____ Date _____