Katherine D. Hein, M.D.

1 Washington Street, Suite 301, Wellesley MA 02481

PATIENT INFORMATION

PATIENT NAME, LAST	FIRST	INITIAL	SEX	DATE OF BIRTH	AGE

HOME ADDRESS	CITY	STATE	ZIP

PRIMARY PHONE	SECONDARY PHONE	PHARMACY	PHARMACY ADDRESS	PHARMACY PHONE

EMPLOYER	ADDRESS	CITY, STATE, ZIP

MARITAL STATUS SINGLE MARRIED DIVORCED OTHER	SPOUSE NAME & DATE OF BIRTH	EMAIL ADDRESS

REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN

ACCIDENT INFORMATION

CHIEF MEDICAL CONDITION/ COMPLAINT	

DATE OF ACCIDENT	MOTOR VEHICLE ☐	WORK RELATED ☐	OTHER ☐

INSURANCE INFORMATION (GIVE CARDS TO RECEPTIONIST FOR PHOTOCOPYING)

PRIMARY INSURANCE COMPANY	POLICY ID#	GROUP #

SUBCRIBER NAME	SUBSCRIBER DATE OF BIRTH	RELATIONSHIP TO PATIENT

SECONDARY INSURANCE COMPANY	POLICY ID#	GROUP #

SUBCRIBER NAME	SUBSCRIBER DATE OF BIRTH	RELATIONSHIP TO PATIENT

PLEASE TELL US HOW YOU HEARD ABOUT US	

WOULD YOU LIKE TO RECEIVE MAILINGS FOR PROMOTIONS AND SPECIAL OFFERS? YES __ NO __	WOULD YOU LIKE TO RECEIVE EMAILS FOR PROMOTIONS AND SPECIAL OFFERS? YES __ NO __

WOULD YOU BE INTERESTED IN LEARNING MORE ABOUT ANY OF THE FOLLOWING?
BOTOX __ RESTYLANE __ LASER HAIR REMOVAL __ SKIN CARE __ SKIN CARE PRODUCTS __ FACIAL __ MICRODERM ABRASION __ PEEL __ BREAST AUGMENTATION __ BREAST REDUCTION __ CO2 LASER RESURFACING (FULL FACE) __ LIPOSUCTION __ OTHER __

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the above named physician of medical/surgical benefits, if any, otherwise payable to me for his/her services.	PATIENT SIGNATURE (PARENT/GUARDIAN IF PATIENT IS A MINOR), DATE
I understand that in the event my insurance company requires that I obtain a referral from my primary care physicain to receive services from a specialist, and I don't obtain the referral, I will be responsible for the charges in full.	PATIENT SIGNATURE (PARENT/GUARDIAN IF PATIENT IS A MINOR), DATE

Katherine Hein, M.D., P.C.
Plastic & Reconstructive Surgery
HEALTH HISTORY FORM

Name: _____ Date of birth: _____ Date: _____

Referring Physician: _____ Primary Care Physician_____

Reason for today's visit: _____ Height_____ Weight_____

For Women if relevant:
Age at 1st period _____ Age at menopause_____ Bra size _____
Number pregnancies_____ Number live births _____

Medications	Medical History – include why you take each medicine listed	Surgical History - what was done and when

List of all allergies / what happens when you take this
_____
_____
_____

List all medical illnesses in your immediate Family:

Condition	Relationship
_____	_____
_____	_____
_____	_____

Do you:
Have problems with anesthesia yes___ no___ Explain:_____
Take aspirin regularly yes___ no___
Smoke yes___ no___ I quit _____ months /years ago I smoke ____ packs daily
Drink alcohol yes___ no___ Number of drinks per week_____
Have a special diet yes___ no___ Explain: _____
Use of recreational drugs yes___ no___ How often: _____

Review of Systems: Do you have any problems with the following? Please circle yes or no:

GENERAL/MS		HEENT		LUNGS	
Fever	yes ☐ no ☐	Eye pain	yes ☐ no ☐	Frequent cough	yes ☐ no ☐
Chills	yes ☐ no ☐	Blurred vision	yes ☐ no ☐	Wheezing	yes ☐ no ☐
Weakness	yes ☐ no ☐	Double vision	yes ☐ no ☐	Asthma	yes ☐ no ☐
Fatigue	yes ☐ no ☐	Dry eyes	yes ☐ no ☐	Pneumonia	yes ☐ no ☐
Muscle pain	yes ☐ no ☐	Difficulty hearing	yes ☐ no ☐	Shortness of breath	yes ☐ no ☐
Weight loss	yes ☐ no ☐	Sinus problems	yes ☐ no ☐		
		Sore throat	yes ☐ no ☐		
HEART		**ABDOMEN**		**GU**	
Circulation problems	yes ☐ no ☐	Nausea	yes ☐ no ☐	Urinary infections	yes ☐ no ☐
High blood pressure	yes ☐ no ☐	Stomach ulcers	yes ☐ no ☐	Blood in urine	yes ☐ no ☐
Irregular heartbeats	yes ☐ no ☐	Vomiting	yes ☐ no ☐	Urinary incontinence	yes ☐ no ☐
Chest pain	yes ☐ no ☐	Constipation	yes ☐ no ☐		
NEURO/PSYCH		**HEM/ENDOCRINE**		**SKIN/ALLERGIES**	
Depression	yes ☐ no ☐	Anemia	yes ☐ no ☐	Allergies	yes ☐ no ☐
Anxiety	yes ☐ no ☐	Bruising	yes ☐ no ☐	Skin rash	yes ☐ no ☐
Stress	yes ☐ no ☐	Bleeding disorder	yes ☐ no ☐	Boils	yes ☐ no ☐
Migraines	yes ☐ no ☐	Thyroid problems	yes ☐ no ☐	Persistent itch	yes ☐ no ☐
Neurological prob	yes ☐ no ☐	Diabetes	yes ☐ no ☐		

Signature: _____Date: _____

Katherine D. Hein, MD, PC
1 Washington Street, Suite 301
Wellesley MA 02481

Thank you for choosing Katherine Hein, MD as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.).

Co-pays:
The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards.

Insurance Claims:
Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

☐ have read and accepted the terms of the Privacy Policy.

_____
Print Name

_____ _____
Signature Date

NOTICE OF PRIVACY PRACTICES

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

Understanding Your Health Record/Information
Each time you visit this office a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and plan for future care. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a source of information for public health officials charged with improving the health of the nation

Understanding what is in your record and how your health information is used helps you to ensure its accuracy; be aware of who, what, when, where, and why others may access your health information; make better, more informed decisions when authorizing disclosures.

Your Health Information Rights
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request in writing a restriction on certain uses and disclosure of your information
- obtain a paper copy of the notice of privacy practices upon request
- inspect and obtain a copy of your health record upon written request
- amend your health record
- request in writing an account of disclosures of your health information
- request in writing that communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken up until the office has received written notification of such revocation

Our Responsibilities
This organization is required to:

- maintain the privacy of your health information
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations
- maintain de-identification practices which eliminate certain pieces of personal identification information from records that are electronically transmitted, while keeping the minimum information necessary in order to effectively communicate
- mitigate, to the extent practicable, any harmful effect that is known to the practice of a use or disclosure of confidential information in violation of its policies and procedures or the requirements of the rule or of any of its business associates

We reserve the right to change our practices and to make the new provisions effective for all protected health information that we maintain. Should our privacy practices change dramatically we will notify you accordingly.

For More Information or to Report a Problem
If you have any questions and/or would like additional information, you may contact the privacy policy officer, Lisa Shumski, at (508) 875-7777. If you believe that your privacy rights have been violated, you may file a complaint with the privacy policy officer or the Office of Civil Rights. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by the physician or physician assistant will be recorded in your chart and used to determine the course of treatment that should work best for you.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer which may include information that identifies you, as well as your diagnosis, treatment, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Medical professionals may use information in your chart to assess the care and outcomes in your case and others like it in order to continually improve the quality of the healthcare we provide.

Other Permitted or Required Uses and Disclosures

Business associates: There are some services provided in this practice through contacts with business associates. Examples include hospital-based procedures and all services provided at the hospitals with which this practice is affiliated including MetroWest Medical Center-Framingham Union Campus and Leonard Morse Campus, and Milford-Whitinsville Regional Hospital. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. In order to protect your health information, however, we require that these business associates appropriately safeguard your information.

Notification: We may use or disclose information regarding your location and general condition to a family member, personal representative, or another person responsible for your care.

Communication with family: Medical professionals may disclose to a family member, close friend or any other person whom you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: This practice may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Food and Drug Administration (FDA): We may disclose health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public heath authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Effective Date: April 14, 2003

Patient Signature_____ Date_____

Informed Consent

Telemedicine

INSTRUCTIONS

This document explains the purpose of telemedicine – also known as "telehealth" and referred herein, collectively, as "telemedicine" – and outlines the benefits and risks of telemedicine.

It is important that you read the whole document carefully. Please initial each page. Doing so means you have read the page. Signing the consent agreement means that you agree to a telemedicine session with your doctor or one of the doctor's assistants (i.e. nurse practitioner, physician assistant, etc.).

GENERAL INFORMATION

Telemedicine is the distribution of health-related services and information via electronic and telecommunication technologies, such as computers and mobile devices, to access and manage health care services remotely. Telemedicine may include technologies you use from home or that your doctor uses to improve or support health care services. Telemedicine allows out-of-office patient and clinician contact, care, advice, reminders, education, intervention, monitoring, and remote admissions. Examples of telemedicine include videoconferencing, teleconferencing, transmission of images, e-health including patient portals, and remote monitoring of vital signs.

ALTERNATIVE METHODS OF MEDICAL CARE BESIDES TELEMEDICINE

In-person care is an alternative method of medical care to telemedicine.

BENEFITS OF TELEMEDICINE

The benefits of telemedicine include the following:

- Make health care accessible to people who live in rural or isolated communities.
- Provide long distance clinical care.
- Make services more readily available or convenient for people with limited mobility, time or transportation options.
- Obtain expertise of specialists.
- Improve communication and coordination of care among members of a health care team and patient.
- Provide support for self-management of health care.
- Quick and efficient medical evaluation and management.

RISKS OF TELEMEDICINE

As with any medical care options, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and assistant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- Security protocols could fail, causing a potential breach of privacy and/or inadvertent disclosure of personal identifying information and/or protected health information;
- Lack of access to complete medical records may result in adverse drug interactions, allergic reactions or other judgment errors;
- Overuse of medical care;
- Unnecessary or overlapping care.

_____ **Patient Initials**

CONSENT FOR THE USE OF TELEMEDICINE

1. I understand that the purpose of telemedicine is to provide health care services.
2. I permit my doctor and the doctor's assistants to use telemedicine in my care.
3. I understand that telemedicine means using phone and/or video to communicate with my health care team instead of seeing my team in person (face-to-face).
4. I understand that reasonable efforts will be made to protect my privacy, though there may be risk of inadvertent disclosure of my personal identifying information and/or protected health information.
5. I understand that I can ask questions and discontinue the use of telemedicine at any time I choose.
6. I understand that telemedicine does not replace other types of medical assessment and care. If I am not improving and have serious health concerns, I will seek immediate medical attention at an emergency facility.
7. ALL OF MY QUESTIONS REGARDING TELEMEDICINE WERE ANSWERED, AND THE FOLLOWING WAS EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
    a. THE CONCEPT OF TELEMEDICINE
    b. RISKS AND BENEFITS OF THE USE OF TELEMEDICINE
    c. ALTERNATIVE METHODS OF MEDICAL CARE

I CONSENT TO THE USE OF TELEMEDICINE IN MY MEDICAL CARE AND THE ITEMS THAT ARE LISTED ABOVE (1-7). I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS.

_____

Patient or Person Authorized to Sign for Patient Date/Time

I have been offered a copy of this consent form (patient's initials) _____

_____ **Patient Initials**