SHELL COSMETIC SURGERY CENTER
DAN H. SHELL III, M.D.

PATIENT INFORMATION **CHART#:** _____

LAST NAME: _____ FIRST NAME: _____ MI: ____ TODAY'S DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

BIRTHDATE: _____ AGE: _____ SOCIAL SECURITY NO: _____

HOME PHONE: _____ CELL: _____ WORK: _____

EMAIL: _____ SEX (PLEASE CIRCLE): MALE FEMALE

MARITAL STATUS (PLEASE CIRCLE) : SINGLE MARRIED WIDOWED DIVORCED

EMPLOYER: _____ OCCUPATION: _____

PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN YOURSELF:

NAME: _____ RELATIONSHIP: _____ BIRTHDATE: _____

ADDRESS: _____ PHONE #: _____ SS#: _____

REASON FOR VISIT: _____ **HOW WERE YOU REFERRED TO OUR OFFICE?**

(PLEASE CIRCLE): INTERNET INSURANCE FRIEND/RELATIVE PHYSICIAN ATTORNEY OTHER

NAME OF HOW/WHO REFERRED YOU: _____

MEDICAL INSURANCE INFORMATION (LIST ALL COVERAGE/POLICIES EVEN IF PROCEDURE IS COSMETIC)

PRIMARY: _____ POLICY HOLDER: _____ BIRTHDATE: _____

ID# _____ GROUP #: _____

SECONDARY: _____ POLICY HOLDER: _____

ID#: _____ GROUP#: _____

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Dan H. Shell, III, M.D., PLLC to release information requested by my insurance company or workman's compensation carrier. I also authorize Dan H. Shell, III, M.D., PLLC to release information to any hospital or physician to which I may be referred by this office. In addition, I also give authorization to request and obtain my medical records from my insurance company, workman's compensation carrier, hospitals, and/or physicians who have treated me. I hereby authorize assignment and payment directly to Dan H. Shell, III, M.D., PLLC from major medical benefits or legal settlements and/or judgments due me. I hereby agree to pay all charges that exceed or that are not covered by insurance. I understand I will be responsible for any fees attached to this account to recover any uncollected balances.

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____

** The patient must sign ALL forms unless they are a minor or they have a legal Power of Attorney (a copy must be given to our office)

SHELL COSMETIC SURGERY CENTER

PATIENT HEALTH QUESTIONNAIRE

NAME: _____ **DATE:** _____

Race: _____ **Ethnicity:** _____ **Language:** _____

Height: _____ **Current Weight:** _____ **Max Weight:** _____

Do you smoke? ☐ YES ☐ NO **Amount Smoked Daily:** _____ **Former Smoker?** ☐ YES ☐ NO

Drug Allergies: _____ **Latex product sensitivity or allergy:** ☐ YES ☐ NO

Employer: _____ **Are you required to lift over 10lbs at work?** ☐ YES ☐ NO

DO YOU HAVE OR HAVE A HISTORY OF THE FOLLOWING: (PLEASE CIRCLE)

Cancer	Blood Clot	Fainting	Lung issues
Diabetes	Blood Pressure (High/ Low)	Hepatitis	Shortness of breath
Stroke	Seizures	Asthma	Trouble with anesthesia
Heart Disease/Issues	Paralysis	Poor scarring / keloids	Shingles
Anemia	Bleeding Issues	Sickle Cell Disease	Sinus Problems
Arthritis	HIV	Back pain/injury	Mental Illness
Pacemaker	Tuberculosis	Drug Abuse	Headaches/Migraines
Kidney Issues	Slow to heal after cuts	Thyroid Disease	Acute Infections

Please list any other medical condition(s) that you may have/had not listed above: _____

_____

Are you taking any blood thinner medication, such as Aspirin, Plavix, Warfarin, Herbal etc? ☐ YES ☐ NO

Please list ALL medications that you currently take: _____ _____

_____ _____ _____ _____

Please list any surgeries that you have had:

_____ _____ _____

_____ _____ _____

Have you consulted with another plastic surgeon regarding your concerns? ☐ YES ☐ NO

If so, please give his/her name and location: _____

****FOR FEMALE PATIENTS ONLY**: (Complete only if applicable to reason for visit)**

Date of last mammogram _____ **Date of last menstrual period:** _____ **Bra Size:** _____

Children ☐ YES ☐ NO C-Section: ☐ YES ☐ NO Family history of breast cancer: ☐ YES ☐ NO

Relation to family member: _____ **If you have children, how many?** ____ **How old is your youngest child?** ____

DISCLOSURE AUTHORIZATION FORM

Protected health information is about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services ("PHI"). As required by the Health Insurance Portability and Accountability Act of 1966 ("HIPPA"), Dr. Dan Shell III, Shell Cosmetic Surgery Center has provided a Notice of Privacy Practices describing how it may be used to disclose PHI. It is important to understand that any uses or disclosures outside those circumstances described in the notice will be made **only with your written authorization including most disclosures to family members or friends.** This means we will not disclose information to a person despite their relationship with you unless you have specifically authorized them to receive such information. Therefore, this authorization must be completed to identify those individuals who will be permitted to receive information about your medical care.

AUTHORIZATION

I authorize the Practice to disclose my PHI to those individuals listed below (specify name, relationship and contact information if applicable)

Name	Relationship	Contact Number

The PHI is being disclosed for the following purpose (write "at my request" if there is no specific purpose or you do not wish to specify the purpose:_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practice's Privacy Officer. I understand that a revocation is not effective to the extent that the practice has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim.

I understand, that except as otherwise provided in this authorization, the Practice may use or disclose my PHI in accordance with Practice's Notice of Privacy Practices.

I understand that if I submit any type of FMLA or disability paperwork for completion, I am authorizing Dr. Dan H. Shell, III, M.D and/or his staff to release medical information, medical records, diagnosis or reason for visit to my employer and/or insurance company for purpose of completion of FMLA or disability paperwork.

I understand that PHI disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act or other applicable laws or regulations

_____ _____

PATIENT SIGNATURE (REPRESENTATIVE) **DATE**

_____ _____

PRINTED NAME **PERSONAL REPRESENTATIVE'S AUTHORITY**

REQUEST FOR CONFIDENTIAL COMMUNICATION VIA EMAIL/MAIL

PATIENT: _____ DOB: _____

EMAIL: _____

PHONE: _____

I understand that under the Health Insurance Portability and Accountability Act of 1996, I have the right to make reasonable requests to receive confidential communications of my protected health information from Dr. Dan H. Shell III, Shell Cosmetic Surgery Center by alternative means. By completing and signing this form, I am requesting and agreeing to the practice communicating with me via email at the address above.

I acknowledge and agree to the following:

*I have read and reviewed the "Important Information about Email" notice, had the opportunity to ask questions, have had such questions answered to my satisfaction, and understand the information within the notice.
* I consent to the practice communicating with me via email despite the possibility that my email system may not be encrypted or secured. I understand that there are no assurances of confidentiality.
*The email address above is accurate. It is my responsibility to update the practice of any change.
*I may withdraw this consent at any time by delivering written notice to the practice.

PLEASE CIRCLE THE WAYS THAT YOU CONSENT TO US COMMUNICATING WITH YOU:

METHOD	OK TO LEAVE VOICEMAIL	OK TO LEAVE MESSAGE WITH ANOTHER PERSON	PREFERRED CONTACT METHOD (Check One)
Call Home Phone	YES / NO	YES / NO	
Call Cell Phone	YES / NO	YES / NO	
Call Work Phone	YES / NO	YES / NO	

Email Preference:

Email Appointment Reminders: _____YES _____ NO

Email Medical Information/Communication with Staff: _____YES _____ NO

Email Office Specials/News: _____YES _____ NO

Send Regular Mail: _____YES _____ NO

_____ _____

PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE) DATE

_____

PRINT NAME

DAN H. SHELL III, M.D.
1068 CRESTHAVEN ROAD #200
MEMPHIS, TN 38119
(901) 761-4844 PHONE/(901) 761-6929 FAX

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changes at any time. I may obtain a revised copy of the notice by calling (901) 761-4844 or by requesting one at the following office:

Dan H. Shell III, M.D.
1068 Crestahven Road # 200
Memphis, TN 38119

_____ _____
Date Signature of Patient

_____
Print or Type Name

*As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

_____ _____
Date Signature

_____
Relationship to Patient

FINANCIAL POLICIES

1. We participate with most insurance plans, however, **it is the patient's responsibility to make sure that we are in network and participate with their insurance plan and to.**

2. If your insurance plan requires authorization, you are responsible for obtaining the referral and must have a valid referral at the time of your visit, or you will be responsible for payment in full.

3. Co-pays, deductibles and coinsurance are due **prior** to being seen by the doctor. Once your insurance company has processed your claim, we will bill you for any portion that the insurance company indicates is the "patient responsibility". You have (30) days to remit payment in full to the office. If you are unable to pay your balance in full, please speak with our billing department to set up payment arrangements. We ask that you remember that the ultimate responsibility for full payment for our services rest with the adult patient or guarantor (inclusive of any collection fees)

4. We will verify your benefits with your insurance company on all surgical procedures. If you have an unmet deductible or owe for co-insurance or out of pocket expenses, we will collect a surgery deposit before your surgery date. Deposits will be required on ALL scheduled cosmetic procedures.

5. If there is an error in your insurance information that you have provided to our office, we are authorized to change or correct the insurance information by a verbal authorization in person or on the phone.

6. If you do not provide correct insurance information including all insurance policies, you may be responsible for the entire bill.

7. There is a $25.00 fee **PER SET** for completion of any type of FMLA or disability paperwork that you request our office to complete on your behalf. We have **(5)** working business days to complete any type of paperwork once the fee is paid. Please note that FMLA does not cover elective cosmetic procedures.

8. There will be a processing fee of $35.00 on all returned checks

I understand that my services deemed medically necessary by my physician may be "non-covered" or considered "not medically necessary" by my insurance carrier. Many insurance carriers will not pre-authorize a physician to perform a particular procedure in advance but rather will determine medical necessity after the procedure is performed. Shell Cosmetic Surgery Center will assist you in every way possible to obtain payment for services rendered (in good faith). In the event that the insurance company denies payment based on this "lack of medical necessity." I understand that I am ultimately responsible for payment of all services rendered.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I AUTHORIZE Dan H. Shell, III, M.D. to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered for me or my dependents. I understand that I am responsible for any amount not covered by insurance.

MEDICARE – MEDICAID CERTIFICATION

I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carries any information needed for this or a Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Dan H. Shell, III, M.D. for services rendered to me.

PATIENT SIGNATURE: _____ **DATE:** _____

DAN H. SHELL III, M.D.
1068 CRESTHAVEN ROAD #200
MEMPHIS, TN 38119
(901) 761-4844 PHONE/(901) 761-6929 FAX

OPIOID AND CONTROLLED SUBSTANCES AGREEMENT AND INFORMED CONSENT

Opioid medications are used generally in the treatment of benign or malignant pain conditions. The following agreement and explanation of issues relates to treatment of painful disorders through the use of opioid medications and/or other controlled substances.

SIDE EFFECTS AND RISKS

Because theses medications are potentially dangerous, as are all medications, the side effects will be discussed with you at the beginning of the treatment and periodically thereafter. Side effects/risks include but are not limited to the following:

* Allergic reactions
* Somnolence
* Dizziness
* Nausea
* Urinary retention
* Hormonal imbalance
* Itching
* Tolerance
* Death
* Sedation
* Respiratory depression (slow breathing)
* Confusion
* Vomiting
* Suppression of menstrual cycle
* Constipation
* Physical dependence
* Addiction

CAUTION

Opioid medications may cause drowsiness. Alcoholic beverages should be avoided or be used with extreme caution and sparingly after approval from your physician while taking these medications. You should not drive a car or operate dangerous machinery while taking opioid medication.

Usually, most side effects of opioid use disappear over time and with continued use, except for constipation. Bowel maintenance should be addressed seriously and treated, if necessary. If the decision is to discontinue long term use of opioid therapy, a weaning manner rather than abrupt discontinuation of treatment should be exercised to prevent withdrawal symptoms.

INITIAL_____

PATIENT NAME: _____ **CHART#:** _____

I, _____, have agreed to use the following medications as part of my treatment for post surgical pain. I understand that these medications may not eliminate my pain but may reduce it and improve what I am able to do each day.

1. I understand that I have the following responsibilities:

   - I will take the medications at the dose and frequency prescribed.
   - I will not increase or change how I take my medications without the approval of this healthcare provider **(Dr. Dan H. Shell III)**.
   - I will arrange for refills at the prescribed interval **ONLY** during regular office hours. I will not ask for refills earlier than agreed, after hours, on holidays or weekends.
   - I will obtain all refills for these medications only at my designated pharmacy which is **PHARMACY NAME:** _____ and **PHARMACY PHONE NUMBER:** _____, with full consent for my provider and pharmacist to exchange information in writing or verbally.
   - I will not request any pain medications or controlled substances from other providers and will inform Dr. Shell of all medications that I am taking.
   - I will inform other health care providers that I am taking these pain medications and of the existence of this agreement. In the event of an emergency, I will provide this same information to the emergency department providers. I will inform this provider of any emergency room (ER) visit within (48) hours of discharge from ER.
   - I will protect my prescriptions and medications and will keep them safe and secure. I understand that lost or misplaced prescriptions **WILL NOT** be replaced.
   - I will keep medications only for my own use and will not sell, lend, share, or give any of my medication to others. Failure to uphold this term may constitute a criminal offense. I will keep all medications away from children.
   - I agree to comply with all components of my overall treatment plan including medical, psychological, or psychiatric assessments recommended by my provider.
   - I will actively participate in any program designed to improve function, including social, physical, psychological, and daily or work activities.

2. I will not use illegal or street drugs or another person's prescription medication. I will use no alcohol or other sedating agents or medications without discussing it with this provider (Dr. Dan H. Shell III). If I have an addiction problem with drugs or alcohol and my provider asks me to enter a program to address the issue, I agree to follow through. If in treatment, I will request that a copy of the program's initial evaluation and treatment recommendations be sent to this provider, and will not expect refills until that is received. I will also request written monthly updates to be sent to verify my continuing treatment.

INITIAL_____

3. I will consent to drug screening which may include the following:

    - Provide a urine or blood sample to conduct a laboratory test to check to see what drugs I have been taking.
    - Provide prescription containers and remaining drug doses to determine if medications are being taken as prescribed.

4. I understand that my provider is required by law to check the state prescription monitoring database for controlled substances I may have received from other prescribers.

5. I will keep all my scheduled appointments. If I need to cancel an appointment, I will do so a minimum of 24 hours before it is scheduled.

6. I understand that this provider may stop prescribing the medication if:

    - I do not show any improvement in pain or my activity has not improved;
    - I develop rapid tolerance or loss of improvement
    - I develop significant side effects from the medication; and/or;
    - My behavior is inconsistent with the responsibilities outlined above, which may also result in being prevented from receiving further care from this provider.

PLEASE NOTE: As of 1/16/2018 many insurance companies are limiting the number of opioid prescriptions filled as well as the quantity. They (insurance companies) are only allowing for a **MAXIMUM of a (5) day supply** of opioid pain medications. All narcotic pain medications written are monitored by the DEA/Federal Government due to the increase in opioid addiction. **After your initial prescription or (5) day post op supply unless there are *extenuating circumstances* you will be prescribed or advised to take Ibuprofen or extra strength Tylenol which can be purchase at your local pharmacy.**

PATIENT SIGNATURE: _____ **DATE:** _____

WITNESS SIGNATURE: _____ **DATE:** _____