**Ellen Mahony, M.D., Inc. PHONE: (203)-221-0102 FAX: (203)-221-1121 (11/2020)**

Patient Information as of \_\_\_\_/\_\_\_\_/\_\_\_\_ (enter today’s date)

(Please Print Legibly & Fill In or Correct All Fields)

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient’s Name** |  |  |  |
|  | First | Middle | Last |
| Address |  |  |  |  |
|  | Street & Apt # | City | State | Zip |
| Home Phone |  | Cell Phone |  | Other Phone  |  |
| Any restrictions for contacting you? |  No  Yes | E-mail |  |
| **Preferred Contact #**  |  |
| Age |  | Birthdate |  / /  | SS# |  - -  | Gender |  Female  Male  |
| Marital Status |  Single |  Married to: |  |  Other: |  |
| **Patient’s Employer** |  | Occupation |  |
| Work Phone |  | Ext: |  | Is it okay to call you at work? |  Yes  No |
| Address |  |  |  |  |  |  |
|  | Street & Suite # | City | State | Zip |
| **How did you hear about *Ellen Mahony, MD, Inc.*?** | **(Please be specific)** |  |
|  Website \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Event \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Radio \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Magazine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Friend/Family \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor**­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Newsletter \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Seminar \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CareCredit  Newspaper  Allergan  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Was a female surgeon a factor in your decision today?  Yes  No  |
|  |  |  |  |  |
| **Emergency Contact** |  | Relationship to Patient |  |
| Home Phone |  | Work Phone |  | Other Phone |  |

**Area of Interest** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you now or have you ever been treated for a condition involving:**

**** Heart/Lungs **** Asthma/Bronchitis **** Sinus Trouble **** Psychiatric Care

**** High Cholesterol **** Nervous System **** Muscle or Joints **** Depression

**** Diabetes **** Liver Disease **** Anemia **** Obesity

**** Immune System Disorder **** Gastrointestinal Tract **** Cancer **** Skin

**** Blood Clotting Disorder **** Excessive Bleeding/Bruising **** High Blood Pressure **** Drug Abuse

**** Check here if none apply **** Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergic to Medications?** **** Yes **** No **** Penicillin **** Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Foods? **** Yes **** No Type \_\_\_\_\_\_\_\_\_\_\_

 Latex? **** Yes **** No Adhesives? **** Yes **** No Please list any other allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any: Aspirin? **** Yes **** No Blood Thinning Agents? **** Yes **** No Cortisone/Steroids? **** Yes **** No

Do you smoke? **** Yes **** No How Much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drink Alcohol? **** Yes **** No How Much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height \_\_\_\_\_\_\_\_\_Weight **­­­­­­­­­­**\_\_\_\_\_\_\_\_Date of Last Physical \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you consider yourself to be in good health? **** Yes **** No

Family Medical History ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized or had any surgical operations?**** Yes **** No Cosmetic Surgery?**** Yes **** No

 If so, please list Month/Year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any problems with anesthesia?**** Yes **** No If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications that you are presently taking, including Vitamins, Herbal Supplements and over the counter drugs *(please include dosage):*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please list your Pharmacy name and address:***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEMALE PATIENTS ONLY**

 Are you pregnant? **** Yes **** No # Pregnancies \_\_\_\_\_\_\_ # Children \_\_\_\_\_\_ Method of Birth Control \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Problems w/ Breasts? **** Yes **** No If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_ Last Mammogram \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

 Menstruating? **** Yes **** No Menopausal? **** Yes **** No Last Pap smear \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Bra Size \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you plan to cover the costs of this procedure? Own Funds? **** Yes **** No Credit Card? **** Yes **** No

 Care Credit? **** Yes **** No Insurance?**** Yes **** No

Would you like to find out more about our finance plans? **** Yes **** No

Have you ever been involved in a malpractice lawsuit? **** Yes **** No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND RENDER CARE.**

I have answered the above questions concerning my health to the best of my knowledge. I hereby authorize Ellen A. Mahony, MD., permission to examine me and to render appropriate care at this time. Additional consents may be required as is appropriate for specific procedures. In addition, I hereby authorize release of any pertinent information to my insurance company for the purpose of obtaining insurance coverage for a procedure or to another medical practitioner or facility for the purpose of completing the medical record.

**SIGNED** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE** \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

**24 HOUR CANCELLATION POLICY**

We will confirm your appointment 24-48 hours prior to your scheduled time. ***We kindly ask for at least 24 hours notice if you need to cancel/change your appointment time.***  Failure to show for your Injectable/Office appointment or, if notification is not received in a timely manner, will result in a $62.50 cancellation fee charged to the credit card on your file. Failure to show for your Procedure appointment or, if notification is not received in a timely manner, will result in 20% of the total cost of services for that day as a cancellation fee charged to the credit card on your file.

Cardholder Name: First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Type: \_\_\_\_\_Visa \_\_\_\_\_Master Card

Credit Card Number: \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

Card Identification Number (last 3 digits on the back of the credit card): \_\_\_\_\_\_­­­­­\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_

 (Street) (Apt#) (City) (State) (Zip code)

**OFFICE APPOINTMENT CHANGES**

Appointment days/times are not guaranteed and may need to be rescheduled. As a surgical practice, we work collaboratively with surgical facilities and our patients. From time to time, unexpected events occur necessitating a last-minute adjustment. When, and if, we need to change your appointment, we will make every effort to provide an alternate day/time that works for you. Thank you in advance for your understanding.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Print Your Name Here

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Signature Date

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**ACKNOWLEDGEMENT OF NON-REFUNDABLE SURGICAL FEE**

I acknowledge that on choosing to book a surgical date, I will be required to pay a 20% non-refundable booking fee as a deposit. Care Credit may not be used for the deposit.

Refunds related to cancellations are as follow:

Any surgery cancelled within 21 -14 days of your surgery will result in forfeiture of 25% of your surgical balance.

 Any surgery cancelled within 14 days of the surgical date will result in forfeiture of all surgical fees.

Any cancelation due to either with-holding medical information or providing incomplete medical information will not be rescheduled or refunded.

Rescheduling of surgery is at the discretion of Dr. Mahony and will require a new payment process and signed Payment Policy. The rescheduling fee is $500.00.

Surgical/procedural refunds are not provided once surgery/services have been received.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

**I acknowledge that I have received a copy of the office’s Notice of Privacy Practices.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Your Name Here

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

|  |
| --- |
| HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices*This form does not constitute legal advice and covers only federal, not state, law.* |