Michael H. Hennessey, M.D. F.A.C.O.G., Kelsie Yang, PA-C, Megan Dixon Sherman, PA-C

Patient Health Questionnaire (PHQ-9)

Patient Name: ________________________ **Date:** ____________

1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Including HIV, STD, and AIDS related information

Patient Name:____ Date:____________

SSN:____________________________ DOB:____________ Phone:____________________

I hereby authorize (Physician Name, Complete Address, and Phone Number):

____

____

____

To release information from medical records for treatment during the period from ____________________ to ______________. Please include all portions of the medical records including laboratory and radiology studies. The above records will include any information regarding HIV, STD, and AIDS related testing or treatment, drug, and/or alcohol abuse, and psychiatric treatment to be released to Hennessey OBGYN : 907 Mar Walt Drive Suite 2024, Fort Walton Beach, FL, 32547 OR 4554 Highway 20 East, Niceville, FL 32578.

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for this purpose.

____ ____________________

Patient's Signature OR Legally Authorized Representative Date

If the patient is a minor and/or incapacitated, authorization must be signed by the parent of legal guardian. If the patient is deceased, authorization must be signed by the next of kin or executor or proof of same.

____ ____________________

Witness Date

907 Mar Walt Drive Suite 2024
Fort Walton Beach, FL 32547
Phone: (850) 243-2229
Fax: (850) 862-0124

Michael H. Hennessey, M.D. F.A.C.O.G., Kelsie Yang, PA-C, Megan Dixon Sherman, PA-C

TEXT MESSAGES/VOICE If I am unreachable, Hennessey OBGYN physicians or staff ☐ **may** ☐ **may NOT** leave voice messages or send text messages.

PERSONAL RELEASE OF INFORMATION -As part of the HIPPA Privacy guidelines, we are NOT allowed to discuss your PHI (personal health information) with anyone such as your spouse, parents or friend without your written permission. You may elect to allow Hennessey OBGYN providers or staff to release or discuss your protected health information.

☐ **ALLOW**- Release information to person(s) below ☐ **DO NOT RELEASE MY INFORMATION**

YOU MUST LIST FULL NAMES OF EACH PERSON(S)

Name:____DOB:__________________

Name:____DOB:__________________

CONSENT TO CONTACT - We offer a Patient Portal to all of our patients. This allows you to access your patient chart, results of labs, tests and procedures. You can also send us questions, requests refills and check appointments through the portal. Please provide your email if you wish to have access the patient portal. **Initial:**________

Email:____

CANCELLATIONS AND MISSED APPOINTMENTS - Office appointments canceled with less than 24 hour notification and patients who do not show up for their appointment will be subjected to a **$25.00** fee for an office appointment and a **$100.00** fee for a procedure. Patients who No-Show (2) or more times in a 12 month period may be dismissed from the practice and will be denied future appointments. We do understand that special, unavoidable circumstances may cause you to cancel within 24 hours. Fees may be waived with Management's approval.

Initial:________

ELECTRONIC PRESCRIPTIONS CONSENT - Our office uses electronic prescriptions. Your provider will send your prescription to the pharmacy electronically, expediting the processing of your medications and reducing the chance for errors. This also allows us to obtain the medications that have been prescribed to you over the past 13 months.

Accepts ☐ **Declines** ☐

What **PHARMACY** do you use?____

What **LAB** do you use? ____

FLORIDA SHOTS PROGRAM - I authorize Hennessey OBGYN to access my immunization record through the Florida Shots program.

Initial: ________

PRIVACY POLICY NOTICE - I have received the NOTICE OF PRIVACY PRACTICES from Hennessey OBGYN.

Initial: ________

LIFETIME INSURANCE AGREEMENT & AUTHORIZATION - I authorize payment directly to Henessey OBGYN, benefits otherwise payable to me by my insurance company. I do hereby assign Hennessey OBGYN, any benefits, payments, or proceeds from any insurance company who is or may be liable at any time for all or part of my charges on this account to the extent necessary to such charges in full. If my insurance does **NOT** pay the physician directly, I agree to Hennessey OBGYN amounts equal to all health insurance benefits, which I receive for medical care, immediately upon receipt of such payments. I authorize Hennessey OBGYN to release my insurance carrier or its representative any information needed from my medical records concerning the examination and treatment rendered to me that is neccesary to process the insurance claim.

Initial: ________

FINANCIAL RESPONSIBILITY - I acknowledge I am responsible for **ALL** charges and/or services, which were provided by Hennessey OBGYN whether incurred in the past or future, including any amount not paid or covered by my insurance. I understand Hennessey OBGYN will **NOT** take responsbility for negotiating the settlement of disputed insurance claims. I agree to pay the charges for care provided to me within (30) days of the first monthly statement. Amounts beyond this time may be assessed a penalty and may be applied to the balance, unless other agreements have been made through the billing department.

Initial:________

Patient's Name (Please Print): ____

Patient's Signature:______________________________________Date:__________________

Michael H. Hennessey, M.D., Kelsie Yang, PA-C, Megan Dixon Sherman, PA-C

RECEIPT OF NOTICE TO OBSTETRIC PATIENTS

I have been given information in the **form of a brochure** prepared by the Florida Birth Related Neurological Injury Compensation Association (NICA), pursuant to Section 766.316, Florida Statues, by Hennessey OBGYN (Dr. Michael H. Hennessey), participating physician in the program, where certain limited compensation is available in the event certain types of qualifying neurological injuries may occur during labor, delivery and/or resuscitation. For specifics on the program, I understand I can contact Florida Birth-Related Neurological Injury Compensation Association, Post Office Box 14567, Tallahassee, Florida 32317-4567, Phone # (800) 398-2129.

I specifically acknowledge that I have received a copy of the brochure prepared by NICA.

Dated this_________________ day of _________________,20_______.

____
Print Name

____
Patient Signature

____
Social Security Number

____
Witness

907 Mar Walt Drive, Suite 2024
Fort Walton Beach, Fl 32547

Michael H. Hennessey, M.D., Kelsie Yang, PA-C, Megan Dixon Sherman, PA-C

RECEIPT OF NOTICE TO OBSTETRIC PATIENTS

I have been furnished information on prenatal and carrier screening options offered by **Hennessey OBGYN (Dr. Michael H. Hennessey. Kelsie Yang, PA-C, and Megan Dixon Sherman, PA-C)** This information includes prenatal screening for chromosome abnormalities: Panorama screening, First Trimester Screening, and Second Trimester Screening. I have also received information on the Horizon carrier screening option that can be done before or anytime during pregnancy and includes: cystic fibrosis, SMA (spinal muscular atrophy), and Fragile X Syndrome.

Dated this ______________________day of ________________________, 20_____.

____
Print Name

____
Patient Signature

____
Social Security Number

____
Witness

907 Mar Walt Drive, Suite 2024
Fort Walton Beach, FL 32547
Phone Number: (850) 243-2229
Fax Number: (850) 862-0124

4554 East Highway 20
Niceville, FL 32578
Phone Number: (850) 279-6267
Fax Number: (850) 279-6385

HENNESSEY
Obstetrics & Gynecology

Michael H. Hennessey, M.D., Kelsie Yang, PA-C, Megan Dixon Sherman, PA-C

PLEASE KEEP FOR YOUR RECORDS

SCREENING FOR CHROMOSOME ABNORMALITIES

Down syndrome is a condition which involves mental retardation, facial differences, and sometimes other birth defects. This condition is caused by an extra chromosome number 21.Trisomy 18 and Trisomy 13 are two conditions which involve extra chromosomes and are usually more severe than Down syndrome.

There are several tests available to pregnant mothers that determine the **chances** that their baby will have one of these conditions. These tests are only **screens** which means the results will not tell "for sure" but will only identify pregnancies that are at a higher chance for these conditions. The patients that are at a higher risk will be offered further testing such as amniocentesis.

These tests are **OPTIONAL** since some women may not want to know if their baby is at a high risk for these conditions.

Panorama Screening:

- Identifies the following: Down syndrome (Trisomy 21), Trisomy 18, Trisomy 13, sex chromosome abnormalities, tripoidy, vanishing twin, complete molar pregnancy, 22q11.2 deletion syndromes and additional microdeletion syndromes
- Done after 10th week of pregnancy
- Involves only a blood test on the mother at a Pro-Health Fort Walton Beach location-11 Racetrack Rd Suite D-1 phone: 850-243-2900
- Results available in about 10 business days
- There is an option to find out gender; however, there is **NO** guarantee that gender will be determined

First Trimester Screening:

- Done between about 11 and 14 weeks of pregnancy
- Involves a special type of ultrasound examination to measure an area behind the baby's neck (called an NT) and a blood test on the mother
- Done at the Regional Perinatal Center (RPC) at Sacred Heart Hospital, where they have the special certification needed to do the NT ultrasound
- Results available by telephone in about 1 week
- Earlier and higher detection rate for Down syndrome and Trisomy 18 and 13 than the quad screen test
- May help determining the importance of some ultrasound findings (markers) that are often seen later in pregnancy that may increase the suspicion for chromosome problems
- Need a follow-up blood test (called AFP) between 15-20 weeks of pregnancy to screen for Spina Bifida (open spine defect)

Second Trimester Screening:

- Done between 15 and 20 weeks of pregnancy
- Involves only a blood test on the mother
- Results available in about 1 week, also screens for Spina Bifida
- Regardless of other optional screens, we **REQUIRE** the Spina Bifida test to be performed

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PLEASE KEEP FOR YOUR RECORDS

CARRIER SCREENING FOR CHROMOSOME ABNORMALITIES

(page 1)

Cystic Fibrosis is a genetic disease which can affect a couple's child. Certain races are more common to have this genetic disorder; for example: Ashkenazi Jewish, non-Hispanic Caucasian, Hispanic American, African American, and Asian American. People can carry the gene (autosomal recessive), and not know that they have it. If both you and your partner carry the gene your child will be affected 25% of the time.

Cystic Fibrosis is a progressive, multi system disease which affects the lungs, intestines, pancreatic and reproductive systems. These children suffer from chronic coughs, wheezing, failure to thrive, loose stools, and digestive difficulties. The average survival is 30 years, with the cause of death usually being respiratory failure.

Spinal muscular atrophy (SMA) is a genetic disease that results in progressive muscle weakness and paralysis. The condition occurs in 1 in 10,000 live births and affects both males and females.

There are three types of SMA. The most severe type is usually diagnosed within the first few months of life. Affected children have severe muscle weakness and typically do not survive past the age of two. The other two types of SMA, which are less common than the severe type, involve a lesser degree of muscle weakness. Most affected individuals need to use wheelchairs or need assistance with walking. Life expectancy for the less severe types ranges from teenage years to adulthood. Those with the mildest form of SMA are expected to have a normal lifespan.

Fragile X Syndrome (FXS) is a genetic condition that causes intellectual disability, behavioral and learning challenges and various physical characteristics. Though FXS occurs in both genders, males are more frequently affected than females, and generally with greater severity. Life expectancy is not affected in people with FXS because there are usually no life threatening health concerns associated with the condition.

We have the ability to identify the genetic defects in you and your baby's father through a blood test. Your insurance company; however, may NOT cover the cost of this test and it can be quite costly. If you want the test to be performed you should check with your insurance carrier about the cost. If you do not want the test to be performed, it will in no way hamper our ability to adequately take care of your pregnancy.

Horizon Carrier Screening:

- Can be done any time before or during pregnancy and only involves only a blood test on the mother at Pro-Health Fort Walton Beach Location 11 Racetrack Rd Suite D-1 phone: 850-243-2900
- Results available in about 10 business days
- Includes screening for up to 274 autosomal recessive andX-linked conditions, screening for 500+ mutations of Cystic Fibrosis, Duchenne muscular dystrophy screening, enhanced (2+) SMA and Automatic AGG interruption testing for Fragile X syndrome.