

Today's Date: _____

PATIENT INFORMATION

Patient's Last Name: _____ First: _____ M.I. _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (_____) _____ Cell: (_____) _____ Work: (_____) _____
Date of Birth: ____/____/____ Age: _____ Sex: _____ SSN: _____
Driver's License #: _____ Marital Status: _____
Email Address of Patient or Responsible Party: _____

RESPONSIBLE PARTY (If Different from Patient)

Last Name: _____ First: _____ M.I. _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (_____) _____ Cell: (_____) _____ Work: (_____) _____
Date of Birth: ____/____/____ Sex: _____ Driver's License #: _____

POLICY HOLDER INFORMATION (If Different from Patient)

Policy Holder Name: _____ Date of Birth: ____/____/____
SSN: _____ Employer: _____ Phone: (_____) _____
Relationship to the Patient: _____

How Did You Hear About Us? (Please Check One)

Family _____ Friend _____ Doctor _____ Insurance _____ Facebook _____ Website _____
Other: _____
Referring Physician: _____ Phone: (_____) _____

Do We Have Permission to: (Please Circle One)

Leave messages on your home/cell answering machine?	Y or N
Leave messages at your place of employment?	Y or N
Leave messages regarding biopsy or lab results?	Y or N
Discuss your medical condition with any member(s) of your household?	Y or N
If Yes, Whom? _____ Relationship: _____	
In case of emergency, who should be notified? _____	
Relationship: _____ Phone: (_____) _____	

I hereby consent to treatment by Dermatology & Skin Cancer Surgery Center for the care of the patient indicated on this form. I authorize the release of medical information to my primary care, referring physician or other specialist and as necessary to process insurance claims or assist in the patient's treatment. I also authorize payment of medical benefits to the provider.

Signature of Patient OR Responsible Party _____

(PLEASE COMPLETE BACKSIDE)

PREFERRED DERMATOLOGY

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.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without authorization.

- ◆ **Treatment:** We may disclose your protected health information to you and to our staff or to other health care providers to manage the care you need. This includes information released to pharmacies to fill prescriptions, to a diagnostic center to assist with your diagnosis, or to a hospital should you need to be admitted. If necessary to ensure you get proper care, we may also discuss the minimum necessary with friends/family members, involved in your care, unless you request otherwise.
- ◆ **Payment:** We may send information to you or to your health plan to receive payment for the services rendered. We may discuss the minimum necessary with friends/family members, involved in your payment, unless you request otherwise.
- ◆ **Health operations:** We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- ◆ We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain lawsuits and law enforcement.

Your authorization is required to disclose your protected health information; disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning on the date we receive the written, signed, revocation. You have rights concerning your protected health information. Should you wish to amend your authorization, please inform our office so that we can provide the necessary form(s) for documenting your request.

- You have the right to access your records and/or to receive a copy of your records. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an

electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.

- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a specific individual does not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.
- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply; ask for a form to request the restriction or for additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request. Medical records will not be altered in a manner inconsistent with health care regulations, such as adding/omitting information to get a health plan to pay a claim.
- You have the right to a notice of disclosures. This informs you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.

If you have any questions about our privacy practices, please contact our Business Office. You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Fax number: 1-304-721-4078 Office for Civil Rights

<http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>

We are required to abide by the policies stated in this Notice of Privacy Practices, effective on the date of signature within.

Preferred Dermatology Partners

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- < Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- < Obtain payment from third-party payers
- < Conduct normal healthcare operations such as quality assessments and physician certifications

My signature services as my acknowledgement that I have received, read, and understand the Notice of Privacy Practices and disclosures of my PHI. I understand this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name (written)

Relationship to Patient

Patient/ Guardian Signature

Date Signed

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Employee Name/Initials:	Reason:

PREFERRED DERMATOLOGY CONSENT NOTIFICATION

Consent to Photograph

1. I understand photographs, digital and/or other images may be made/recorded for identification, treatment and payment purposes.
2. I will specifically authorize in writing any other use or disclosure of my image or recording.

Consent to Treatment

1. I do hereby authorize the use and the administration of such drugs, anesthetics and other treatments, including the performance of skin biopsy, the use of cryosurgery with liquid nitrogen and the injection of intralesional cortisone, should any of these be deemed advisable, desirable or necessary for diagnostic, therapeutic or investigational purposes by any appropriately trained and/or licensed health care professional on the medical staff of Preferred Dermatology, for myself or my dependent.
2. I further consent to the examination for diagnostic or investigational purposes and disposal by authorities of the above-named medical facility or its designates herein, of any tissue or parts which may have been removed.
3. I understand that the skin biopsy involves removal of a piece of tissue and that such removal may result in a permanent scar or discoloration of the skin at the site of the biopsy. I further understand that more than one biopsy may occur during this visit.
4. I understand that all specimens removed are sent for analysis by a dermatopathologist and that the charges for dermatopathology will be billed to my insurance. However, I understand that in certain cases, I may be responsible for a portion or all of these charges.
5. I understand that the destruction of precancerous lesions, also known as actinic keratosis or solar keratosis, by liquid nitrogen may be deemed necessary by a member of the medical staff of Preferred Dermatology to prevent the risk of these lesions evolving into Squamous Cell Carcinoma.
6. I understand that the destruction of warts or molluscum by liquid nitrogen may be advised by a member of the medical staff of Preferred Dermatology, but these types of lesions are not cancerous and do not necessarily need to be treated. I am aware that these lesions may require more than a single treatment.
7. I understand that the injection of intralesional cortisone for the treatment of scars, cysts, acne and inflammatory conditions like psoriasis, atopic dermatitis and alopecia areata may be deemed necessary, advisable or desirable by a member of the medical staff of Preferred Dermatology.
8. I understand that any of the above procedures may have some unwanted side effects, which include, but are not limited to, permanent scarring, permanent discoloration of the skin at the site of treatment, atrophy (thinning or depression of the skin), infection, bleeding, nerve damage resulting in temporary or permanent numbness or temporary or permanent loss of function of certain muscles (paralysis).

9. I recognize the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.

Consent to Release of Information

1. I authorize Preferred Dermatology to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information may be released to any person or entity liable for payment on the patient's behalf to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
2. If I am covered by Medicare, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, laboratory reports, operative reports, physician progress notes, nurse's notes, and consultations.

Consent to Communicate via Phone, Text, or E-mail

1. I agree that when I provide my landline or cell phone number(s), I am giving express consent for Preferred Dermatology and its associates, assignees, successors, and agents, to contact me at these numbers, or at any number that is later acquired for me and to leave live or pre-recorded messages on voicemail or to text, regarding scheduling or scheduled appointments, my services, or my bill. For greater efficiency, calls or texts may be delivered by an auto-dialer. I realize by providing this consent I may receive future calls or text messages that deliver pre-recorded messages by or on behalf of Preferred Dermatology. Charges from your phone company may apply. Providing a telephone or cell number is not a condition of receiving services.
2. I may be contacted via voicemail, text, or email to remind me of an appointment, to obtain feedback on my experience with our healthcare team, to provide newsletters and marketing promotions, and to provide general health information. I consent to receiving healthcare communications at the phone number, or e-mail address provided. This request to receive emails and text messages applies to future communications, unless I request a change in writing.

Consent to Electronic Prescribing

1. I authorize Surescripts, an electronic prescribing network, to release my medication refill history to Preferred Dermatology for the purpose of ongoing treatment.

By signing below, I attest I have read and understand the Preferred Dermatology Consent Notification. I further attest that I have been given the opportunity to address any questions/concerns regarding my treatment plan, its attendant risks, benefits and alternatives have been explained to my satisfaction. I hereby authorize Preferred Dermatology to perform the procedures as deemed necessary in my treatment plan.

*Patient/Representative may revoke or modify this authorization.

**Revocation or modification of this authorization must be requested in writing.

Signature: _____ Date: _____

Written Name of Signer: _____

Relationship to Patient: ____ Self ____ Parent ____ Guardian/Representative

PREFERRED DERMATOLOGY FINANCIAL POLICY

Please remember that your health insurance is a contract between you and your insurance company. It is your responsibility to know your health plan benefits, including co-payment amounts, deductibles, co-insurance, and lab contracts. As a service to you, we will submit a claim to your insurance company for all applicable charges. You are responsible for any charges not covered by your insurance plan. Any amount not covered by the insured/patient's insurance is due within 30 days of the time of service. A photocopy of your ID and insurance card is needed by our billing department to assist you in filing your claim. It is the patient's responsibility to inform this office if your insurance requires pre-certification or preauthorization, prior to scheduling. The patient will be responsible for services denied by insurance due to "No Eligibility", "Non-Covered Service", "Preauthorization/Certification Not Obtained". Statements are generated after your insurance completes the processing of your claim.

- **In Network Coverage:** For insurance companies that we are contracted with, we will determine your co-payments (co-pays), co-insurance, and deductibles at the time of the visit. Co-payments and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are DUE AT THE TIME OF SERVICE. Preferred Dermatology is a specialist clinic, and your co-pay will be subject to the "specialty" co-pay amounts, as assigned by your insurance plan.
- **Out of Network Coverage:** If we are not participating in your plan, we will collect payment, in full, at the time of the visit. Co-payments and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are DUE AT THE TIME OF SERVICE. We are happy to assist you in filing a claim for reimbursement to your insurance company.
- **Co-payments, deductibles, and fees:** Co-payments and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are DUE AT THE TIME OF SERVICE. Failure to produce payment may result in your appointment being rescheduled. Recent shifts in the healthcare industry have resulted in insurance companies increasingly transferring costs to patients.
- **Payment Methods:** Preferred Dermatology happily accepts Debit Cards, HSA/FSA cards, Care Credit, Cherry Funding, Aspire, Personal Checks, Money Orders, Credit Cards (Visa, Mastercard, and Discover).
We no longer accept cash or American Express.
- **Credit Card Surcharges:** Preferred Dermatology adds a small surcharge to each credit card purchase, which will not exceed the amount of the fee charged by the credit card vendor. This applies only to Visa, Mastercard, and Discover purchases. No fee will be added to debit cards, HSA/FSA, Care Credit, Cherry Funding, Aspire, or Check/Money Order.

- **NSF (Non-Sufficient Funds):** Should your payment result in an NSF return, we will apply an additional \$25.00 NSF fee to your account, as these fees are charged to the provider for returned payments.
- **Collections Accounts:** We make every attempt to reach you regarding any outstanding balances left after your insurance by sending multiple texts, paper statements, and phone calls. It is the patient's responsibility to make sure your phone number and/or mailing address is current with our office. If we are unable to collect on your past due amounts, we will turn your account over to an outside collection agency. Your account will incur an additional fee of 30% of your outstanding balance. Failure to rectify your balance will result in cancellation of future visits.
- **Self-Pay Patients:** Self-pay or uninsured patients are responsible for payment at the time of service. The fee schedule is based on prevailing market rates.
- **Non-Covered Services:** Cosmetic services cannot be submitted to insurance and payment in full is due at the time of service.
- **Credit Card on File Policy:** We will keep your credit / debit / HSA card on file after the services are provided. Due to the high number of deductible plans, and higher patient coinsurance benefits, this has become a common practice. Please keep in mind, we will not charge your card if there is no balance.

***Once your credit card information is entered, it is encrypted and cannot be viewed or accessed by our organization.*

By signing the agreement, you understand that once your health plan has paid their portion, that you will receive an Explanation of Benefits (EOB). The health plan EOB will provide details of how the claim was processed, including what was paid to the provider and any balance allocated to the patient. Preferred Dermatology may charge my credit card, the amount due, once the EOB is received and posted. If the charge exceeds \$100 you will receive a courtesy call or email prior to authorizing the card on file. Circumstances when your card would be charged include but are not limited to missed co-payments, deductibles and co-insurance, and non-covered services and/or denial of services. If the credit card we have on file changes or expires, please notify us immediately by calling our office. If your credit card is denied for any reason, we reserve the right to charge an additional \$25 declined card fee. We will contact you if this occurs.

- **Medicare Patients:** All co-payments are due at the time of service. Medicare has an annual deductible, which will also be collected, if it has not been met, at the time of your service. We will bill Medicare, as well as any secondary or tertiary insurance plans. We must have your signature on file, to do so. The patient will be responsible for any balance not paid by Medicare and/or secondary/tertiary insurances.
- **Referrals:** Your insurance plan may require a referral to be completed before seeing a specialist. It is your responsibility to obtain the proper referral. If you don't have a referral at the time of your appointment, your appointment may be rescheduled until a referral is provided.

- **Pathology/Laboratory Services:** During your visit, if we collect a specimen or send anything to the lab, the testing is performed and finalized after you leave. The lab/pathologist reviews the sample and creates a confirmed lab/path report outlining the services rendered. These charges are then entered into your account. These charges, while they appear later, are still related to your dermatology visit.

Preferred Dermatology sometimes uses a third party for our laboratory work and pathology services. In those instances, you/your insurance will receive an additional bill from ProPath.

- **Missed Appointments:** Please provide at least 24-hour notice to cancel an office appointment. Should you fail to keep your appointment or cancel in less than 24-hours, we may charge a \$30 no-show fee.

Please provide at least 48-hour notice to cancel a surgery appointment. Should you fail to keep your surgery appointment or cancel in less than 48 hours, we may charge a \$70 no-show fee.

After TWO consecutive missed appointments, you may be dismissed from the practice.

- **Prescription Policy:** Please call for refills during regular office hours and leave the patient's name, DOB, phone number, medication, and the pharmacy requested. Please allow 48 business hours to complete the request. Some prescriptions may be delayed due to completing a PRIOR AUTHORIZATION form required by your insurance company. For oral medications, biologics, and some topical medications, the patient may need to be evaluated before the prescription can be refilled. We cannot refill a prescription if the patient has not been evaluated within 12 months.

Patient Attestation

- a) I understand that Preferred Dermatology may bill my health plan for the care I receive.
- b) I agree that payments from my health plan may go directly to Preferred Dermatology.
- c) I understand if my insurance sends me payment for these services, I am responsible for paying Preferred Dermatology.
- d) I understand that I must pay any co-payment, deductible, co-insurance, denied procedures or any other part of the claim that my health plan deems "patient responsibility".
- e) I understand I am required to pay for services, otherwise covered by my plan, but were unauthorized.
- f) I understand if I fail to get the proper referral, as required by my plan, I am responsible for paying for all services rendered.
- g) I understand if I choose not to use my health insurance for a visit, I am responsible for all services rendered.
- h) I understand I am responsible for all services rendered, if Preferred Dermatology is not in network with my health insurance.
- i) I understand I am financially responsible for all cosmetic services and/or products, which are not covered by insurance.
- j) I understand lab/pathology charges are added after my office visit.
- k) I understand Preferred Dermatology adds a credit card surcharge to Visa, Mastercard, and Discover purchases.
- l) I understand I may be turned over to a collection agency for lack of payment, and my account will be charged 30% of the outstanding balance.

By signing below, I attest I have read and understand the Preferred Dermatology Financial Policy. I further attest that I have been given the opportunity to address any questions I have as it relates to the policy within.

Signature: _____ Date: _____

Written Name of Signer: _____

Relationship to Patient: ____ Self ____ Parent ____ Guardian/Representative

HISTORY AND INTAKE FORM

Patient Name: _____ Patient DOB: _____

Today's Date: _____

Reason for Today's Visit: _____

Past Medical History: (Please circle all that apply)

Anxiety	Depression	High Blood Pressure	Lymphoma
Arthritis/Osteoarthritis	Diabetes	HIV/AIDS	Multiple Sclerosis
Asthma	End Stage Renal Disease	High Cholesterol	Rheumatoid Arthritis
Atrial Fibrillation	Fibromyalgia	Hyperthyroid	Seizures
Bone Marrow Transplant	GERD	Hypothyroid	Stroke
COPD	Hearing Loss	Leukemia	NONE
Coronary Artery Disease	Hepatitis	Lupus	

Cancer: _____

Other: _____

Past Surgical History: (Please circle all that apply)

Appendix Removed	Coronary Artery Bypass	Ovaries Removed
Bladder Removed	Mechanical Valve Replacement	Prostate Removed
Breast Biopsy (Right/Left)	Biological Valve Replacement	Spleen Removed
Lumpectomy (Right/Left)	Hip Replacement (Right/Left)	Testicles Removed
Mastectomy (Right/Left)	Knee Replacement (Right/Left)	Thyroid Removed
Breast Implants	Kidney Biopsy	Partial Hysterectomy
Colectomy	Kidney Stone Removal	Full Hysterectomy
Gallbladder Removed	Kidney Removed (Right/Left)	NONE

Organ Transplant: _____

Other: _____

Skin Disease History: (Please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Psoriasis
Asthma	Flaking or Itchy Scalp	Rosacea
Atypical Moles	Hay Fever	Shingles
Basal Cell Skin Cancer	Seasonal Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	NONE

Other: _____

Do you wear sunscreen? **YES NO** If yes, what SPF? _____

Do you or have you ever tanned in a tanning salon? **YES NO** When? _____

Do you have family history of Melanoma? **YES NO**

If yes, which relative(s)? _____

Do you have family history of Non-Melanoma Skin Cancer? **YES NO**

If yes, which 1st degree relative(s)? _____

(PLEASE COMPLETE BACKSIDE)

Medications & Dosages: (Please list all current medications and dosages)

Drug Allergies: (Please list all medication allergies)

Alerts: (Please circle all that apply)

Allergy to Adhesive	Artificial Heart Value	Pacemaker
Allergy to Lidocaine	Blood Thinners	Defibrillator
Allergy to Topical Antibiotics	MRSA	Other Electronic Implanted Device

Have you had a joint replacement within last 2 years? **YES NO**

Does epinephrine give you rapid heartbeat? **YES NO**

Do you require antibiotics prior to a surgical procedure? **YES NO**

Do you have a history of fainting? **YES NO**

Are you pregnant or currently trying to get pregnant? **YES NO**

Vaccine History: (Please circle all that apply)

Have you had the flu vaccine? **YES NO**

When? _____

Have you had the pneumonia vaccine? (65 or older) **YES NO**

Preferred Pharmacy Name: _____

Pharmacy Phone #: _____ City or Zip Code: _____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smoke Cigarettes

Smoke Electronic Cigarettes

Have Smoked in the past

Never Smoked

Alcohol Use:

3 or more drinks per day

1-2 drinks per day

Less than 1 drink per day

NONE

Occupation: _____ Hobbies: _____

Preferred Language: _____ Race: _____

Ethnic Group: _____

Details/Comments: _____
