U.S. DERMATOLOGY partners

PATIENT INFORMATION

PATIENT DEMOGRAPHICS

<table>
<tr><td>First Name:</td><td colspan="3"></td><td>Middle Initial:</td><td></td></tr>
<tr><td>Last Name:</td><td colspan="3"></td><td>Nick Name:</td><td></td></tr>
<tr><td>Date of Birth:</td><td colspan="3"></td><td>Sex:</td><td></td></tr>
<tr><td>Marital:</td><td colspan="2">Married / Single / Divorced / Widowed</td><td colspan="2">Social Security Number:</td><td></td></tr>
<tr><td>Address:</td><td colspan="5"></td></tr>
<tr><td>City:</td><td></td><td>State:</td><td></td><td>Zip Code:</td><td></td></tr>
<tr><td>Home Phone:</td><td colspan="2">( )</td><td>Cell Phone:</td><td colspan="2">( )</td></tr>
<tr><td>Email:</td><td colspan="2"></td><td>Preferred Language:</td><td colspan="2"></td></tr>
<tr><td colspan="2">How did you hear about our office?</td><td colspan="4"></td></tr>
<tr><td colspan="2">Please check one of the following regarding communications by phone:</td><td colspan="4">☐ Leave a message with detailed information
☐ Leave a message with a call-back number only</td></tr>
</table>

PATIENT INSURANCE

Please bring the patient's current insurance card and a valid ID, to the front desk when checking in for the appointment. The patient's insurance and ID will be scanned into the system at that time.

NOTICE OF PRIVACY PRACTICES

I have been given a copy and have read the Notice of Privacy Practices which explains how my medical information will be used and disclosed. I authorize the release of my medical information necessary to evaluate and/or treat my condition, to process insurance claims on my behalf, and for other necessary health care operations of *U.S. Dermatology Partners*. I understand that I am entitled to receive a copy of the Notice of Privacy Practices.

CANCELLATION POLICY FOR APPOINTMENTS

It is my responsibility to call the office to cancel at least 24 hours prior to the scheduled appointment. *U.S. Dermatology Partners* reserves the right to charge a fee if the appointment is not cancelled at least 24 hours in advance. Additionally, the office reserves the right to reschedule appointments for which I am more than 15 minutes late. Special types of appointments require a deposit to reserve the appointment date. *U.S. Dermatology Partners* reserves the right to charge a fee or retain the deposit if the appointment is not cancelled at least 72 hours in advance.

COSMETIC SERVICES AND RETAIL SALES

Payment for cosmetic services is required in full prior to the provision of the service. Due to the nature of cosmetic products, exchanges/refunds may not be allowed.

FINANCIAL POLICIES

- I understand that I am financially responsible for charges for services rendered on my behalf or on behalf of my dependent, regardless if they are covered by my insurance company, Medicare and/or supplemental policy.
- Payment is required at the time services are rendered. *U.S. Dermatology Partners* is allowed by contract with your insurance company to collect the copayment and/or co-insurance and any unmet deductible at the time of service. The amount collected is ***estimated*** based on benefit information available. Specific policy information is often limited or unavailable until after a claim has been filed.
- Insurance coverage is not a guarantee of payment. I understand I am responsible for any remaining balance not covered by my insurance company, Medicare and/or supplemental policy. It is my responsibility to contact them if I have questions regarding my benefits and coverage.
- I understand that if I have a surgical procedure or biopsy performed that requires further examination by a Pathologist, there are three separate charges that will occur, as required by my health insurance plan: (1) a charge by my treating provider for collecting the specimen; (2) a charge by the Pathologist, a medical doctor, to examine the specimen; and (3) a charge by the laboratory preparing the specimen for the pathologist. I understand that I will be billed separately by my treating provider, the pathologist, and the laboratory.
- I understand that my insurance company, Medicare and/or supplemental policy may have a preferred lab for blood work. It is my responsibility to know which preferred lab I can use, and to inform my provider at the time of service.
- I understand that a fee may be assessed for returned checks.
- I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

By signing below, I certify that I have read the above information and my questions concerning these policies have been answered. My signature also certifies my understanding and agreement with the above information. The duration of this consent is indefinite and continues until revoked in writing.

Patient Printed Name:		Patient DOB:	
Parent/Legal Guardian Printed Name:		Relationship to Patient:	
Signature:		Date:	

PATIENT CONSENTS

CONSENT FOR TREATMENT

I authorize *U.S. Dermatology Partners,* its employees and agents, including physicians, physician assistants, and other employees, to provide any healthcare services that my provider deems necessary for diagnosis and/or treatment. The duration of this consent is indefinite and continues until revoked in writing. If a biopsy is performed, I authorize the Pathologist to send my specimen for a second opinion and/or obtain special tests, if medically necessary to ensure an accurate diagnosis. I understand that additional costs may result and that I will be responsible for any remaining balance that is not covered by my insurance company, Medicare and/or supplemental policy. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

CONSENT FOR PHOTOS

I understand that during the course of treatment, photographs may be taken for clinical and educational purposes. No audio taping, videotaping, or photography is allowed by non-staff members.

CONSENT FOR FILING INSURANCE CLAIMS

I understand that to file claims and release medical information to my insurance company, Medicare and/or supplemental policy, *U.S. Dermatology Partners* is required to keep my signature on file. I hereby authorize *U.S. Dermatology Partners* to receive benefits directly from my insurance company, Medicare and/or supplemental policy when an assigned claim is filed. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Sydrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I also authorize *U.S. Dermatology Partners* to appeal any denials to my insurance company, Medicare and/or supplemental policy, on my behalf and authorize the release of any medical information to my insurance company, Medicare and/or supplemental policy that is necessary for the processing of claims. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to *U.S. Dermatology Partners*. I further understand that should my account become delinquent, I shall pay the reasonable collection and attorneys fees of *U.S. Dermatology Partners*, if any.

CONSENT FOR ELECTRONIC PRESCRIPTION HISTORY

I understand that to offer the best patient care, *U.S. Dermatology Partners* will retrieve my prescription history that has been ordered and filled through an EHR system. I authorize *U.S. Dermatology Partners* to import the prescription history obtained through an EHR system into my electronic chart.

CONSENT FOR APPOINTMENT REMINDERS / THIRD PARTY COMMUNICATIONS

I authorize *U.S. Dermatology Partners* to send me appointment reminders via automated SMS text messages, phone calls, and emails. I understand that message/data rates may apply to messages sent by *U.S. Dermatology Partners* under my cell phone plan. I authorize *U.S. Dermatology Partners* and third-party collection agents to utilize all contact information I have provided in efforts to communicate regarding my account. I agree that affiliates may contact me through text messages, ring-less calls, and emails to provide me with my bill and to remind me to pay for services provided by *U.S. Dermatology Partners,* in compliance with federal and state laws. I understand that I am under no obligation to receive automated notifications and may opt-out of these communications at any time by following the prompts in the reminder. Further, I may revoke my consent to receive billing and payment communications by affiliates.

U.S. DERMATOLOGY partners

PHI COMMUNICATION PREFERENCES

I authorize *U.S. Dermatology Partners* to disclose any and all details of my medical diagnoses, treatment, and billing/claims information to the individuals, as indicated below. This authorization is voluntary, and I understand that I have the right to revoke this authorization by submitting a written request to the office. I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is released. I understand that the below list may not be exhaustive and that my **protected health information** (PHI) may be disclosed to additional individuals based on my written authorization or as indicated in our Notice of Privacy Practices. This authorization shall remain in effect indefinitely unless revoked in writing by me.

☐ **I elect not to authorize disclosure to any individuals at this time**

			Check all that apply	
First and Last Name:	**Relationship:**	**Telephone Number**	**Medical**	**Billing**
		( )		
		( )		
		( )		

Communication for benign (non-cancerous) test results	**Telephone Number**
I hereby allow all benign (non-cancerous) test results to be put in a voice message on the phone number indicated in the box.	( )

By signing below, I certify that I have read the above information and my questions concerning these policies have been answered. My signature also certifies my understanding and agreement with the above information. The duration of this consent is indefinite and continues until revoked in writing.

Patient Printed Name:		Patient DOB:	
Parent/Legal Guardian Printed Name:		Relationship to Patient:	
Signature:		Date:	

U.S. DERMATOLOGY partners

NOTICE OF PRIVACY PRACTICES

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your protected health information (PHI). By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights regarding your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

U.S. Dermatology Partners
5310 Harvest Hill Rd, Ste. 290, Dallas, TX 75230
compliance@usdermpartners.com

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:

1. Treatment. Our practice may use your PHI to treat you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us.

3. Health Care Operations. Our practice, and its affiliated entities and management company, may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment. We will notify you about your appointment utilizing an automated phone system, a personal call, text or by mail. This notification may involve leaving a message on an answering machine or other automated or electronic equipment for such purposes, which could (potentially) be received or intercepted by others.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

7. Health-Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

8. Release of Information to Family/Friends. Our practice will routinely disclose to your responsible party(ies) the PHI directly relevant to his/her involvement with your health care, PHI related to payment of your health care, and PHI used for notification purposes. Our practice may release your PHI to another responsible party(ies) you identify, that is involved in your care.

9. Marketing. We may contact you to give you information about products or services related to your treatment, or care. We will not otherwise use or disclose your medical information for marketing purposes, without your prior written authorization.

10. Sale of Health Information. We will not sell your health information without your prior written authorization.

11. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

12. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law.

13. Responding to Lawsuits. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

D. USE AND DISCLOSURE OF PHI IN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your protected health information:

1. Public Health Risk Reporting. Our practice may disclose your PHI to public health authorities that are authorized by law. For example, we are required to report certain communicable diseases to the state's public health department.

2. Law Enforcement. Your health information may be disclosed to law enforcement agencies, military, and national security without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

3. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs that provide benefits for work-related injuries or illnesses.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you. These include:

- The right to request restrictions on the use and disclosure of your protected health information, including to request that a health plan not be informed of treatment for which patient paid entirely out of pocket.
- The right to prohibit the sale of your protected health information, its use for marketing purposes, or participation in research.
- The right to request to receive confidential communications concerning your medical condition and treatment in a specific manner.
- The right to inspect and obtain copies of your protected health information.
- The right to request an amendment or corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed outside of our practice if not for treatment, payment, or health care operations.
- The right to file a complaint if you believe your privacy rights have been violated. Please file your complaint in writing. You will not be penalized for filing a complaint.
- The right to receive a printed copy of this notice.

All requests must be in writing and directed to U.S. Dermatology Partners, 5310 Harvest Hill Rd, Ste. 290, Dallas, TX 75230. Our practice may charge a fee for the costs associated with any request.

F. RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES.

Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

If you believe your privacy rights have been violated, you may complain to the secretary of the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or to the Compliance/Privacy Officer listed below. There will not be retaliation against you for filing a complaint. Again, if you have any questions regarding this notice or our health information privacy policies, please contact:

U.S. Dermatology Partners
5310 Harvest Hill Rd, Suite 290, Dallas, TX 75230
compliance@usdermpartners.com

U.S. DERMATOLOGY partners

Name: ______________________ Preferred Language: ____________ Date of Visit: __________

Date of Birth: __________ Place of Birth: ________________ Ethnic Group: ☐ Prefer not to specify ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ Prefer not to specify ☐ White ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Black or African American ☐ Other: ________________

PCP: ______________ Referred by: ____________ Occupation/Employer: ______________

Emergency Contact________________________ Phone____________________

Preferred Pharmacy: ______________ Pharmacy Phone or City/Zip:____________________

Please describe your skin problem(s) & reason for today's visit: ______________________

____

Area(s) involved: ________________ How long have you had the problem(s): __________

Please check appropriate box (Y/N) as each applies to your CURRENT OR PAST MEDICAL HISTORY:

*Artificial heart valve / Infection ☐Y ☐N
*Artificial joint (past 2 years) ☐Y ☐N
*Cold sores/herpes ☐Y ☐N
*Hepatitis, type: _______ ☐Y ☐N
*HIV/AIDS ☐Y ☐N
*Organ transplant: __________ ☐Y ☐N
*Pacemaker/Defibrillator ☐Y ☐N
*Staph bacterial infection ☐Y ☐N
*MRSA infection ☐Y ☐N
*Vasovagal reaction (fainting) ☐Y ☐N
*Premedication prior to procedures ☐Y ☐N
Antibiotic:____________
*Accutane use in the last 6 months ☐Y ☐N

Diabetes ☐Y ☐N
High blood pressure ☐Y ☐N
Dementia ☐Y ☐N
Autoimmune condition ☐Y ☐N Type: ________________
Cancer (other than skin) ☐Y ☐N Type: ________________
Radiation treatment ☐Y ☐N When & why: ______________

Hyperthyroid ☐Y ☐N
Hypothyroid ☐Y ☐N

SURGICAL PROCEDURES (within the past 2 years): __________

____

***Have you had MELANOMA SKIN CANCER?** ☐Y ☐N Location(s) & date(s):________________
Have you had BASAL CELL CARCINOMA? ☐Y ☐N Location(s)& date of most recent: ________
Have you had SQUAMOUS CELL CARCINOMA? ☐Y ☐N Location(s)& date of most recent: ________
Do you wear Sunscreen? ☐Y ☐N SPF ________
Has anyone in your FAMILY HAD MELANOMA? ☐Y ☐N Which relative(s): ______________

Are you ALLERGIC to:
*Adhesive ☐Y ☐N
*Epinephrine ☐Y ☐N
*Lidocaine ☐Y ☐N
*Antibiotic ointment ☐Y ☐N
*Latex ☐Y ☐N

ALLERGIES TO MEDICATIONS:
____
____
____

SOCIAL HISTORY:

Alcohol use:
☐ None
☐ < 1 drink a day
☐ 1-2 drinks daily
☐ 3 or more per day

Cigarette smoking:
☐ Never smoked
☐ Former smoker
☐ Currently smoke

List all CURRENT MEDICATIONS
(including chemotherapy, over-the-counter medications, vitamins, herbal supplements):

____

____

REVIEW OF SYSTEMS (*CURRENT* SYMPTOMS or CONDITIONS):

*Pregnant or planning ☐Y ☐N
*Currently breastfeeding ☐Y ☐N
*Recent biologic med. ☐Y ☐N
*Recent chemotherapy ☐Y ☐N
*Problems w/bleeding ☐Y ☐N
*Immunosuppression ☐Y ☐N

Abnormal blood counts ☐Y ☐N
Abnormal scarring ☐Y ☐N
Enlarged lymph nodes ☐Y ☐N
Fever or chills ☐Y ☐N
Recent Illness ☐Y ☐N
Describe:______________

Have you received the following vaccinations:
Flu (Oct – Mar only) ☐Y ☐N
Pneumonia (65+ years only) ☐Y ☐N
Shingles (50+ years only) ☐Y ☐N

Patient Signature______________________ **Date**________ **Dr Initials** ________ **Staff Initials**________ v.04.2019