Integrated Dermatology of Glens Falls

REGISTRATION INFORMATION

PATIENT INFORMATION					**DATE:**
LAST NAME	FIRST NAME	MI	BIRTHDATE		SOCIAL SECURITY #
HOME ADDRESS	CITY		STATE	ZIP	SEX: ☐ MALE ☐ FEMALE
SPOUSE'S NAME	HOME #			WORK #	
EMAIL ADDRESS	MOBILE #			MARTIAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPERATED ☐ WIDOWED	
RESPONSIBLE PARTY INFORMATION (If other than self)					
LAST NAME	FIRST NAME	MI			HOME #
ADDRESS	CITY		STATE	ZIP	SOCIAL SECURITY #
EMPLOYER	OCCUPATION				WORK #
EMPLOYER'S ADDRESS	CITY		STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY ☐ SPOUSE ☐ SON ☐ DAUGHTER

EMPLOYMENT INFORMATION			
PATIENT'S EMPLOYER OR SCHOOL NAME IF STUDENT		OCCUPATION	EMPLOYMENT OR STUDENT STATUS:
PATIENT'S EMPLOYER OR SCHOOL ADDRESS			☐ FULL-TIME ☐ PART-TIME ☐ SELF EMPLOYED
CITY	STATE	ZIP	☐ NOT EMPLOYED ☐ ACTIVE MILITARY ☐ RETIRED

EMERGENCY INFORMATION				
NAME	RELATIONSHIP			HOME #
ADDRESS	CITY	STATE	ZIP	WORK #

INSURANCE INFORMATION ☐ PPO ☐ POS ☐ MEDICARE ☐ HMO CO-PAY $				
PRIMARY INSURANCE	SOCIAL SECURITY #	CARDHOLDER		DATE OF BIRTH
GROUP NUMBER		IDENTIFICATION NUMBER		EFFECTIVE DATE
ADDRESS	CITY	STATE	ZIP	PHONE NUMBER
SECONDARY INSURANCE		CARDHOLDER		DATE OF BIRTH
GROUP NUMBER		IDENTIFICATION NUMBER		EFFECTIVE DATE
ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

TRICARE INSURANCE INFORMATION-To be completed by TriCare patients only.		
SPONSORS NAME	DATE OF BIRTH	SOCIAL SECURITY #

PHARMACY INFORMATION-Must provide complete address information to ensure your prescriptions are sent to the correct pharmacy.			
PHARMACY NAME	PHARMACY PHONE NUMBER		
ADDRESS	CITY	STATE	ZIP

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HEALTH QUESTIONNAIRE

Date: _____

Name:_____ **Age:**_____ **Date of Birth:** _____

Referred By: _____

Primary Care Physician: Dr._____ **Phone:**_____

Reason for Visit (One or Two Main Problems to Address Today): _____

_____

Duration of Problem: _____

Treatment:_____

Aggravating factors: _____

Current Medications (please include OTC, herbs, vitamins, supplements): _____

_____

_____

Allergies to Medication: ☐**None** ☐ _____

Other Allergies: ☐**None** ☐**Latex** ☐**Bandages/Adhesive**

☐**Topical Antibiotic (Neosporin or other)** _____

Have you ever had any bad reaction to local anesthesia? ☐**No** ☐**Yes** ☐**Never had anesthesia**

FOR WOMEN ONLY:

Are you currently pregnant, trying to become pregnant, or are you nursing? _____

Are you on a contraceptive, if so what form? _____

SKIN CONDITIONS:

Have you ever had skin cancer? ☐**No** ☐**Yes**

If Yes, ☐**Basal Cell Cancer** ☐**Squamous Cell Cancer** ☐**Melanoma**

Where?_____ **When?** _____

Treatment? _____

Has anyone if your family ever had skin cancer? ☐**No** ☐**Yes**

If Yes, ☐**Basal Cell Cancer** ☐**Squamous Cell Cancer** ☐**Melanoma**

Who? _____

Integrated Dermatology of Glens Falls

Do you have a history of any skin problems or diseases? ☐No ☐Yes

If Yes, ☐Psoriasis ☐Eczema ☐Keloid ☐Other _____

SUN EXPOSURE:

When you are exposed to the sun do you:

- ☐ always burn
- ☐ usually burn, tan minimally
- ☐ sometimes mild burn, tan uniformly
- ☐ rarely burn, always tan well
- ☐ very rarely burn, tan very easily
- ☐ never burn, tan very easily

Where did you grow up? _____

Did you have: ☐ sunburns every summer in childhood

- ☐ at least one blistering sunburn, how many _____
- ☐ ever use a tanning bed, how many times/how often _____
- ☐ regular sunscreen use, SPF _____

PAST SURGERIES (Type and Date): _____

_____

_____

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS:

Allergic/Immunologic: ☐Normal ☐Seasonal allergies ☐Immunosuppression ☐Autoimmune problem

Constitutional: ☐Normal ☐Weight loss/weight gain ☐Fever/Nightsweats ☐Fainting

Cancer: Type _____

Cardiovascular: ☐Normal ☐Artificial Heart Valve ☐Pacemaker ☐Implanted Defibrillator ☐Irregular Heartbeat ☐Chest Pain/Heart attack ☐Mitral Valve Prolapse ☐Other _____

Ears/Eyes/Nose: ☐Normal ☐Glaucoma ☐Glasses/Contacts ☐Other _____

Endocrine: ☐Normal ☐Diabetes ☐Thyroid Disease ☐Other _____

Gastrointestinal: ☐Normal ☐Reflux ☐Liver Problem ☐Nausea ☐Diarrhea ☐Other _____

Genital/Urinary: ☐Normal ☐Enlarged Prostate ☐Prostate Cancer

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Hematologic: ☐Normal ☐Anemia ☐Bleeding Problems ☐Other _____

Infections: ☐Normal ☐HIV ☐Hepatitis ☐Tuberculosis/+PPD Skin Test

☐Other _____

Musculoskeletal: ☐Normal ☐Arthritis ☐Artificial Joint ☐Other _____

Neurological: ☐Normal ☐Stroke ☐Seizures/Epilepsy ☐Multiple Sclerosis

☐Other _____

Respiratory: ☐Normal ☐Asthma ☐Emphysema ☐Other _____

Psychiatric: ☐Normal ☐Depression ☐Anxiety Attacks ☐Other _____

Others: ☐Kidney Problems ☐Cold Sores ☐Varicose Veins

☐Require Antibiotics Prior to Dentistry

Any other medical problems: _____

FAMILY HISTORY: ☐Eczema ☐Psoriasis ☐Other _____

SOCIAL HISTORY:

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow/Widower

Occupation: _____

Smoking: ☐No ☐Former ☐Yes, packs/day

_____ **Alcohol:** ☐No ☐Yes, how much/often

_____

By signing, I am acknowledging that I have disclosed all of my health information known to me at this time, and all of my other personal information is accurate. I understand that it is my obligation and responsibility to notify Integrated Dermatology of Glens Falls of any changes in my medical information during the course of my medical treatment.

❖ **SIGNATURE** _____ **Date** _____

INTEGRATED DERMATOLOGY OF GLENS FALLS FINANCIAL POLICY

Patient Name:_____DOB:___ /___ /____

If you are covered by an insurance company with which we are contracted (participating provider), we will bill your insurance company for all covered charges. We will only file your first two insurances. If you have a third coverage it is your responsibility to file and pay any amount due on your account. Insurance companies we are contracted with included, but are not limited to; Medicare - government and individual policies, Medicaid - under the age of 15/with referral, Cigna, United Healthcare, BCBS, Aetna, Tricare - Standard, Prime (with referral) and Tricare for life. If you are a VA, Tricare or Medicare patient, it is required, for billing purposes, to provide our facility with your or your sponsors full SSN. Failure to do so will result in non-payment from your insurance company. If this information is not given you will be considered self-pay.

Please be sure to confirm that we are under your insurance before coming in. If we are not contracted with your insurance company, you will be considered self-pay.In the event that you, as the patient, and we, as the physician, are not aware of a charge that is not covered by your plan(s) you will be billed for the remaining balance once we obtain a denial from your insurance company.

Unpaid charges billed to your insurance will appear on your statement indicating they are pending a response from the insurance company. If a charge has been pending with your insurance for over 60 days please contact your insurance company. If the charge remains unpaid it may become your financial responsibility.

If your health insurance requires an authorization or referral it is your responsibility to ensure it is obtained before services are received. You are also responsible for the renewal of any old or out dated authorizations/referrals.

Payments for amounts due must be paid at the time of service. Examples of amounts due include: deductibles, co-payments, co-insurance, services not covered by your insurance company, cosmeticprocedures and amounts for self-pay patients. If you are unable to pay the amount due in full it is your responsibility to contact us to discuss making other payment arrangements before being seen.

All payments can be made by cash, check, money order, Visa, MasterCard, Discover or American Express.

Failure to pay a balance due in a timely fashion may result in your inability to receive services from Integrated Dermatology of Glens Falls until the account is paid in full or payment arrangements have been made.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred at Integrated Dermatology of Glens Falls.

_____ /____/_____

Patient or guardian signature Date

INTEGRATED DERMATOLOGY OF GLENS FALLS

CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____

Address: _____

_____

Date of Birth: _____

RECEIVE Records

From: _____

_____

_____

Phone: _____ Fax: _____

I hereby consent and authorize you to release copies of my medical record, including current and previous medical records from other practices and hospitals, and/or clinics, which are part of my medical records. PLEASE NOTE: this authorization includes consent for the release of alcohol, drug, psychiatric and psychological information: and any information relation to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results. I agree that a copy of this release shall be as valid as this original release. Please send copies of all requested information as soon as possible to the address listed below:

SEND Records

To: _____

_____

_____

Phone: _____ Fax: _____

___ SEND ALL OF MY MEDICAL RECORDS

___ SEND RECORDS FROM (DATE)_____TO (DATE) _____

___ SEND MY RECORDS PERTAINING TO _____

Patient's Signature: _____

Date: _____

Witness: _____

Integrated Dermatology of Glens Falls

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 READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or informationabout treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

Integrated Dermatology of Glens Falls

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alterative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of June 1st 2015 and it is our intention to abide by the terms of the Noticeof Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain.We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with our office and with the State of Virginia. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.