The Dermatology Clinic

PATIENT INITIAL EVALUATION INFORMATION **(YOUTH)** **DATE**_____
(Or Non Guarantor)

Patient Name_____ Date of Birth____/___/____
First Middle Last Month Day Year

Mailing Address_____
Street City State Zip

Home Phone_____Work Phone_____Cell Phone_____

*****The Dermatology Clinic sends all appointment reminders via text*****

May we leave a voicemail message should we need to contact you for any reason? YES NO

List names of persons (with relationship i.e., grandparent) and contact numbers with whom your medical information may be shared:

_____

Email Address_____
(You may leave blank if you do not desire to be contacted by email)

Please circle the following email communication you would like to receive from us:

Information on upcoming events Medical dermatology news Cosmetic specials

Preferred language: _____English OR other_____ Gender: Male_____ Female_____

Race_____ Ethnicity *(i.e. French)* _____

Occupation_____Company/School_____City/State_____

Emergency Contact_____
Name Telephone Number Relationship

The Dermatology Clinic

Last name, First (of patient)

INSURANCE INFORMATION

Do you have health insurance? Yes____ No____

Primary Insurance Company_____

Name of Policy Holder_____

Relationship to Patient_____

Policy Holder's Date of Birth_____

Policy Holder's SS#_____

Secondary Insurance Company_____

Name of Policy Holder_____

Relationship to Patient_____

Policy Holder's Date of Birth_____

Policy Holder's SS#_____

Policy Holder's address (if different from patient)_____

Patient's SS#_____

****PLEASE PRESENT INSURANCE CARDS AND PHOTO ID TO THE RECEPTIONIST****

Authorization, Release & Agreement To Pay For Services Rendered

As a responsible party, I authorize the healthcare providers at The Dermatology Clinic to perform diagnostic procedures and treatments as may be necessary for proper medical care.

I understand that in certain circumstances, biopsies or other skin tests may be sent to an outside facility for diagnostic purposes and that I am responsible for any charges incurred. All attempts will be made by The Dermatology Clinic to send your biopsies to labs within your insurance network. I understand that separate charges will be filed from the outside laboratory.

I understand that it is my right to inquire about my insurance coverage of potential services at any time during treatment at The Dermatology Clinic and that the medical providers encourage all patients to be familiar with their policies, deductibles, and benefits prior to their evaluation. Any questions or concerns should be directed to The Dermatology Clinic Insurance Department.

Medicare: I hereby request that payment of authorized Medicare benefits to or on my behalf for services furnished in or by The Dermatology Clinic, shall be made to the clinic and I specifically assign such benefits to the clinic. I hereby certify that all information given by me in connection with applying for benefits under Title XVIII of the Social Security Act is true, correct and complete in all respects. I understand that payment for *certain services not deemed medically necessary* are not authorized under the Medicare/Medicaid Program and that I shall be responsible for such charges unless other third party coverage is available.

Insurance: I hereby assign The Dermatology Clinic all rights, benefits, and interest under any insurance policy, health plan, or third party payer liable to me, in consideration for services rendered by the physician. I hereby authorize payment to The Dermatology Clinic by any insurance policy, health plan or third party payer for treatment received at the clinic. Secondary third payer insurance claims (i.e. cancer policy) will not be automatically filed by The Dermatology Clinic; however, we will be happy to assist you with such policies when applicable.

Last name, First (of patient)

Authorization, Release & Agreement To Pay For Services Rendered (cont'd.)

Financial Responsibility: I understand that I am financially responsible to the clinic for all charges not covered or paid by insurance. I also understand and agree that all deductibles, coinsurance, non-covered charges, and other items not paid by insurance, health plan or other third party payers are due and payable at time of service. I understand that following collection of insurance payment after filing on my behalf, I will receive a statement from The Dermatology Clinic for either the remainder of amount on my deductible or non-covered services and that payment is expected. I understand that The Dermatology Clinic has a billing policy of mailed statements and that past-due accounts will be given to a reputable collection agency if statements go unanswered. I agree that in the case of default of payment, if this account is placed in the hands of a collection agency or attorney for collection or suit, all collection fees, finance charges, attorney fees, costs and other expenses will be paid by me.

Non-Certification: I hereby agree that as the policyholder/beneficiary of insurance, health plan or other third party payer, I am responsible for assuring certification is obtained from the insurance company, third party administrator or health plan for the procedure date. If certification is not obtained, I further agree that in the event the insurance health plan or other third party payer denies either all or part of the payment on the account, I will pay the account in full upon demand from the clinic.

Consent for Release of Health Information for Billing and Payment Purposes: I consent to the release of health information (medical records, medical results, and any and all other health information) by the clinic or any physician involved in patient's care for the purpose of billing, claims management, medical data processing, reimbursement, certification to any insurance company, third party payer, health plan or government agency necessary for the billing and payment of patient's account.

_____ _____

Signature of Guarantor/Responsible Party Date

Address of Guarantor/Responsible Party_____

Notice of Privacy Practices/Written Acknowledgement Form

The Dermatology Clinic supports and fully participates in the H.I.P.A.A. program which protects your privacy as a patient. Please take a few moments to review H.I.P.A.A. guidelines which we take very seriously and then sign below to state that you have received the information.

The Dermatology Clinic is required to provide you with this information and request documentation that you received it from us. Thank you!

I have reviewed a copy of The Dermatology Clinic's Notice of Privacy Policies.

Name_____ Date _____

(Please print full name)

Signature_____

Last name, First (of patient)

The Dermatology Clinic

What is the primary reason for your visit today?_____

Have you ever had skin cancer before? YES NO If yes, what type?_____

Primary Care Physician_____ Phone Number_____

Did another healthcare provider refer you to this office? YES NO

If YES their name_____

Female Patients: Are you currently pregnant? YES NO Are you currently breastfeeding? YES NO

Name of your pharmacy and city/state:_____

CURRENT MEDICATIONS (*Please list*)

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____
Others_____

DRUG ALLERGIES

Name of Drug & reaction (rash, hives, nausea, etc.)

1._____
2._____
3._____
4._____

PAST SURGICAL PROCEDURES

Surgery *Hospital* *Date*

1._____
2._____
3._____
4._____

The Dermatology Clinic

Last name, First (of patient)

FAMILY HISTORY (*Please circle*)

Is there a family history of skin cancer? YES NO Type_____
Is there a family history of any skin disorder? YES NO Type_____
Is there any other important history? YES NO Explain _____

REVIEW OF SYSTEMS: ***Check your recent symptoms (in the last few weeks):***

___Abnormal Wound Healing	___Diarrhea	___Inability to Urinate	___Painful Urination
___Antibiotics prior to dentist	___Difficulty Hearing	___Incontinence	___Paralysis
___Changes in bowel habits	___Difficulty Sleeping	___Indigestion/Reflux	___Prolonged Bleeding
___Changes in menstrual cycle	___Dizziness	___Joint Pains	___Seizures
___Changes in vision	___Double vision	___Joint Swelling	___Shortness of Breath
___Chest pains	___Ear Pain	___Loss of Consciousness	___Skin Growths
___Chills	___Fainting	___Muscle Pains	___Ulcers (Skin)____(Stomach)___
___Chronic rashes	___Fatigue	___Nausea	___Vomiting
___Cough	___Fevers	___Night Sweats	___Weight Loss
___Depression	___Headache	___Numbness	
___Heart Palpitations	___Painful Bowel Movements		

The above mentioned symptoms are being managed/treated by_____.

PAST MEDICAL HISTORY: ***Check medical conditions you have been diagnosed with:***

___Allergies (seasonal)	___Gonorrhea	___ Keloids	___Rheumatic fever
___Anemia	___Heart arrhythmia	___ Kidney Problems	___Rheumatoid arthritis
___Arthritis	___Heart Attack	___ Lung disease	___Seizures
___Artificial Heart Valve	___Heart Disease	___ Lyme disease	___Stroke
___Asthma	___Heart defibrillator	___ Menstrual dysfunction	___Syphilis
___Autoimmune disorder	___Heart Failure	___ Miscarriage	___Thyroid abnormality
___Bleeding Disorder	___Heart Murmur	___ Mitral valve prolapsed	___Tuberculosis
___Diabetes	___Heart Surgery	___ Nerve damage	___Vascular Disease
___Emphysema	___Hepatitis	___ Pacemaker	___Visual Impairment
___Gastric Ulcer	___High Blood Pressure	___ Pneumonia	
___Gastrointestinal Disorder	___High Cholesterol	___ Psychiatric Condition	
___Glaucoma	___HIV/AIDS	___ Prostate Disease	

Do you have any disease, condition or problem not listed?_____

As part of the Affordable Care Act we are required to obtain the following information in order to ensure quality care

SMOKING STATUS/ EXPOSURE TO SMOKE:

___I do not smoke or chew tobacco.

OR

___ I am exposed to smoke
___I smoke and currently NOT trying to quit.
___I chew tobacco and currently NOT trying to quit
___I have been advised to quit using tobacco products
___I am a tobacco user currently undergoing counseling to quit.

___ Current every day smoker	___ Former smoker	___ Date Started_____
___ Current some day smoker	___ Never smoker	___ Date Ended_____
___ Unknown if ever smoked	___ Smoker, current status unknown	
___ Light tobacco smoker		

Patient is accompanied at today's visit by _____
Name Relationship

The Dermatology Clinic

CONSENT FOR TREATMENT OF MINOR

This section must be completed if the patient is under the age of eighteen:

It is usually best for the parent to be present during a visit to The Dermatology Clinic. Questions regarding medical history are an integral part of the evaluation, and parents are often the best historians for their child. A person is considered a minor in the state of Mississippi until the age of 18. Consent must be obtained by Dr. Hairston, Dr. Woodson, or NP Kala White to evaluate and treat minors.

Many times parents find themselves unable to accompany their minor child to appointments. We require that this form be completed to ensure that your child can receive medical treatment without your presence with your permission.

I authorize my child, _____, to receive medical treatment at The Dermatology Clinic in my absence if I am unable to attend the appointment and another adult accompanies them. Specifically, my child may be accompanied by the following specific persons:

1._____

2._____

3._____

□ I authorize that the above child may attend their evaluation without myself or another guardian. I understand that Dr. Hairston, Dr. Woodson, or NP Kala White may call me during the course of the evaluation/treatment.

***Please provide telephone number to contact you at the time(s) of your child's evaluation:*_____**

CHILD/PATIENT NAME_____

Parental Signature_____ Date_____

Printed Name of Parent_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND ABOUT HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The policy of The Dermatology Clinic is to protect the confidentiality, integrity and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use or disclosure of such information. We are required by law to maintain the privacy of your health information and provide you with this notice of our duties and obligations. This policy applies to patients who are current or former patients of The Dermatology Clinic.

Individually identifiable health and personal information are any information obtained by The Dermatology Clinic in connection with providing healthcare treatment, obtaining payment and related health care operations. This relates to past, present or future information that The Dermatology Clinic receives from you as our patient.

The Dermatology Clinic collects personal information in order to learn about your medical history, medical conditions, render treatment, and collect payment for our services. We gather this information from your patient forms, health questionnaires and other forms you will be asked to complete from time-to-time. In addition, we will assemble information based on our discussions and conversations with you, your personal representative and your family members. Your healthcare plan or insurance carrier may provide information to our office.

We will use this information to provide caring and quality medical care to you. Examples include diagnosis, treatment and communications such as follow up and appointment reminders, as well as treatment alternatives or other health-related benefits that may be of interest to you or your particular medical condition. As part of our standard treatment and healthcare operations, we may share information with a facility such as a hospital, laboratory, diagnostic service or healthcare provider to efficiently coordinate your treatment plan. We will obtain your authorization before using your information for marketing purposes. For contracted insurers, your information will be used for claims management and to obtain payment from your insurance carrier. We will exchange paper and electronic data with your insurance carrier for activities such as eligibility, benefit and coverage determinations, precertification, utilization review and related activities. For worker's compensation, information about a work-related condition can be exchanged with the employer.

Your information is maintained in our office in our computer system. The Dermatology Clinic limits the access to your protected health information to those employees and business associates who need to know that information. With some limitations, you have the right to inspect, amend, copy and receive an accounting of disclosures of your medical and billing records.

We do not disclose personal information to third parties unless one of the following exceptions applies:

- We receive explicit authorization from you to release individually identifiable information. This authorization must be in writing and give exact details regarding to whom the disclosure applies, the nature of the data to be released, the applicable dates and signed by the patient (or guardian). You may revoke this authorization by providing a written statement to The Dermatology Clinic Office Administrator.
- Federal, state or other applicable law requires us to share protected information or records. Your information may be disclosed to a health agency for purposes such as licensure, certification, audits, investigations and inspections. As required for law enforcement purposes or in response to a valid subpoena or court order, your information may be disclosed. Other disclosures could be required by law for military duty, national security activities or for coroners or funeral director to carry out their duties.

We are obligated to abide by the terms of this notice. We will contact you for permission to use and disclose your information for reasons not described in this Notice of Privacy Practices. We will notify you in the event you are affected by an unsecured breach of information. We reserve the right to change the terms of this Notice of Privacy Practice and to make new notice provisions effective for all health information that we maintain.

With some exceptions, you have right to inspect, review or obtain a copy of your health information. This request must be in writing and there may be a reasonable charge to provide you with a copy of your information. You also have the right to request your records be amended, to request special accommodations and restrictions of your health information, including to your health plan, and to receive an accounting of the disclosures of your information. You have the right to request to receive communications of your information in a special manner or location. The Dermatology Clinic is not obligated to agree to a requested restriction. We must receive a written request from you to administer these rights. Please speak to the receptionist for further information or to begin the process to exercise any of these rights.

If you have a complaint about the management of your health information or believe your privacy rights have been violated, please contact our Office Administrator, Becky Janssen, at 662-328-3375. You have the right to file a complaint with Office for Civil Rights and there will be no retaliation for filing a complaint.