

DERM-CARE

Patient's Name: _____

Date of Birth: _____

Email Address: _____

Phone Number: _____

Primary Care Physician Name and Address:

Phone Number: _____ FAX: _____

Pharmacy Phone Number: _____ FAX: _____

Welcome to Derm-Care, P.C.

Thank you for selecting Derm-Care! We will strive to provide you with excellent progressive dermatologic care. Please fill out this form completely, and in ink. If you have any questions, please ask us, we will be happy to help.

Personal Information

Name _____ Birthdate _____ Soc. Sec. # _____ - ____ - ____
M F Occupation _____
Address _____
City, State, Zip _____
Referred By: _____

Contact Information

Home Phone _____ Cell Phone/Pager _____
Work Phone _____ EXT # _____
Email Address _____
Where do you prefer to receive calls? Home Work Cell
In the event of emergency, who should we contact?
Name _____ Relationship _____ Work# _____ Home# _____

Insurance Information

Insured's Name _____
Relation to Patient _____
Insured's Birthdate _____
Soc. Sec. # _____
Employer _____
Insurance Company _____
Group # _____
ID # _____
Copay Amount _____

Additional Insurance

Insured's Name _____
Relation to Patient _____
Insured's Birthdate _____
Soc. Sec. # _____
Employer _____
Insurance Company _____
Group # _____
ID # _____
Copay Amount _____

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent if minor

Date

THANK YOU FOR FILLING OUT THIS FORM. THE INFORMATION YOU HAVE PROVIDED WILL HELP US TO SERVE YOU MORE EFFECTIVELY AND EFFICIENTLY. IF YOU HAVE ANY QUESTIONS AT ANY TIME, PLEASE ASK-WE ARE HAPPY TO HELP.

DERM-CARE

NAME: _____ DATE of BIRTH: _____ DATE: _____

MEDICAL HISTORY:

MAIN REASON FOR VISIT: _____

HISTORY OF SKIN DISEASE/SKIN CANCER OR MELANOMA IN THE PAST:

MEDICAL PROBLEMS:

MEDICATIONS:

DRUG ALLERGIES:

NONE

HABITS:

TOBACCO
 ALCOHOL
 DRUGS

SURGERIES:

HAVE YOU BEEN DIAGNOSED OR TREATED FOR (CHECK)

HIGH BLOOD PRESSURE
 DIABETES
 HEART DISEASE
 ASTHMA
 LUNG DISEASE
 THYROID PROBLEMS
 KIDNEY PROBLEMS

SEIZURES/STROKE
 GLAUCOMA
 HEPATITIS
 HIV/AIDS
 COLD SORES
 ARTIFICIAL HEART VALVES
 ARTIFICIAL JOINTS

HAVE YOU HAD A PROBLEM WITH:

ANESTHETICS
 BLEEDING

HEALING
 SCARRING (KELOID)

SIGNATURE

DATE

REVIEWED WITH PATIENT _____ MD

NOTICE OF PRIVACY PRACTICES/ACKNOWLEDGEMENT

Derm-Care, P.C.
522 N New Ballas Rd.
Suite 180
Creve Coeur, MO. 63141
(314)991-8700

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. 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 my treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy* practices containing a more complete description of the uses and disclosures of my health information. I understand that 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 at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

HIPAA regulations require your permission for us to release any of your medical information. Please list below the name(s) and relation to you, of anyone that may receive your lab, pathology or other medical information from our office.

Name of other person we may give information to

Other persons relationship to you

I UNDERSTAND AND AGREE TO THE ABOVE

Signature of patient/parent Date

OFFICE USE ONLY

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

| | | |
|-------|-----------|---------|
| Date: | Initials: | Reason: |
|-------|-----------|---------|

Derm-Care P.C.
Elsa Gutierrez, M.D.
522 N. New Ballas Rd
Suite 180
St. Louis, MO 63141

FINANCIAL POLICY

***Non-Covered and Cosmetic Services**

Unfortunately, not all services are paid by your insurance company. In cases where the service has not been paid, you will be personally responsible for the bill. Cosmetic procedures are not covered. If the patient is a minor, the parent/legal guardian who brings the child to our office will be responsible for the payment.

***Co-Pays**

Insurance copayment is required at the time of each visit.

***Tests/Biopsies**

Your doctor may suggest that some "screening" tests be performed to allow a better evaluation of your health. These services may also be considered non-covered by your insurance company, and you will be responsible for payment. Any laboratory tests or biopsies are read by separate provider. You may receive a separate bill for these services.

***Returned Checks**

There is a **\$25** fee for any returned checks.

***Collection Fees**

If your account goes to our collection agency, you will be responsible for any fees charged, including any attorney, court costs, or other legal costs involved in the collection of the balance due.

***Missed Appointment Fees**

If you schedule an appointment and do not show for it or cancel within twenty four hours, a **\$25** fee will be charged.

Signature patient/responsible party

Date

Derm-Care, P.C.
NOTICE OF PRIVACY PRACTICES
(Medical)

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 & Accountability Act of 1996 ("HIPAA") is a federal program that requires 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, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

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

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

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

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

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. 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.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised copy of a revised Notice of Privacy Practices from this office.