

A to Z Dermatology
In Case of Emergency

Name of friend or relative not residing with you _____

Relationship to patient _____ Address _____

Day telephone # () _____ Evening telephone # () _____

Pharmacy Information

Pharmacy Name _____

Address _____

Telephone # () _____ Fax # () _____

How did you hear about A to Z Dermatology?

___ Newspaper ___ Physician ___ Yellow pages ___ Website
___ Direct Mail ___ Friend ___ Relative ___ Insurance

Release of information and assignment of benefits

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Responsible Party Signature _____ **Date** _____

Payment Policy

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies in this office. Payment is required for all service at the time they are rendered unless you are in a prepaid plan in which we participate. We accept payment in the form of cash, check or credit card. In the event of hospitalization or major procedures, our office may fill with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any un-met deductible, non-covered services and co-payments. Please note that the patient is responsible for any/all charges not paid by their insurance company. Prior authorization does not guarantee payment of claims. *If you must cancel or reschedule an appointment please do so at least 24 hours before the scheduled appointment time to avoid a possible late/cancellation fee that are not covered by the insurance.* Your signature below signifies your understanding and willingness to comply with these policies.

Patient signature _____ **Date** _____

A to Z Dermatology **Medical Questionnaire**

Patients Name _____ **Date of Birth** _____ **Date** _____

Do you have or have you ever had any of the following?

- | | | |
|-----|-----|--|
| Yes | No | |
| ___ | ___ | Skin Cancer/Melanoma |
| ___ | ___ | Acne/ Accutane |
| ___ | ___ | Cold sores |
| ___ | ___ | Keloids/Bad scars |
| ___ | ___ | Eczema/ Skin rashes |
| ___ | ___ | Difficulty with wound healing |
| ___ | ___ | Difficulty with skin infections |
| ___ | ___ | Psoriasis |
| ___ | ___ | Asthma/ Hay fever / Hives / Sinus Problems |
| ___ | ___ | Rheumatic fever |
| ___ | ___ | Heart disease |
| ___ | ___ | High blood pressure |
| ___ | ___ | Heart murmur/ Mitral valve prolapsed |
| ___ | ___ | Artificial join, heart valve, or prosthesis |
| ___ | ___ | Heart burn/ Ulcers/ Gastritis/ Reflux |
| ___ | ___ | Kidney Disease |
| ___ | ___ | Glaucoma |
| ___ | ___ | Diabetes |
| ___ | ___ | Tuberculosis |
| ___ | ___ | Blood-bourne infections |
| ___ | ___ | Autoimmune disease (lupus, rheumatoid Arthritis) |
| ___ | ___ | Blood transfusions |
| | | Dates _____ |
| ___ | ___ | Hepatitis-B or C (please circle) |
| ___ | ___ | Surgery/hospitalizations |
| | | Operation _____ |
| | | Date _____ |
| | | Hospital _____ |
| ___ | ___ | Other |

Are you allergic to any medications? _____

Please list _____

Are you currently taking any medications or vitamin/mineral supplements? _____

Please list _____

Other questions:

- | | | |
|--|-----|-----|
| | Yes | No |
| Are you in good health? | ___ | ___ |
| Do you smoke? | ___ | ___ |
| Do you sunbathe or use tanning booths? | ___ | ___ |
| Do you need antibiotics before surgery or dental work? | ___ | ___ |
| Do you bleed easily for a long time after a cut or extraction? | ___ | ___ |

Are you now under a physician's care?

If yes, for what conditions? _____

Primary Care Physician

Have any blood relatives ever had any of the following?

- | | | |
|-----|-----|---------------------|
| ___ | ___ | Skin Cancer |
| ___ | ___ | Melanoma |
| ___ | ___ | Abnormal moles |
| ___ | ___ | Asthma/ Hay fever |
| ___ | ___ | Eczema/ Skin rashes |
| ___ | ___ | Diabetes |
| ___ | ___ | Psoriasis |
| ___ | ___ | Other skin disease |

Females Only

- | | | |
|----------------------------------|-----|-----|
| Are you pregnant? | ___ | ___ |
| Are you nursing? | ___ | ___ |
| Do you take birth control pills? | ___ | ___ |
| Date of last menstrual period? | ___ | ___ |

A to Z Dermatology
Surgical Check List

Need prophylaxis medication prior to any surgical procedure

| Yes | No | |
|-----|-----|--|
| ___ | ___ | Prosthetic valve |
| ___ | ___ | History of bacterial endocarditis |
| ___ | ___ | Mitral valve prolapsed with regurgitation |
| ___ | ___ | Mitral valve prolapsed without regurgitation in MEN>45 years |
| ___ | ___ | Any valve dysfunction |
| ___ | ___ | Cardiac malformation |
| ___ | ___ | Hypertrophic cardiomyopathy |
| ___ | ___ | Orthopedic prosthese |
| ___ | ___ | CNS shunts |
| ___ | ___ | Shunt/ Fistula with nearby inflamed or infected tissue |

Not allergic to PCN

Amoxicillin 500 mg take 4 pills 2 hours prior to surgical procedure then one pill twice a day for one week, Disp # 18.

PCN allergic (type 1 anaphylaxis reaction)

Clindamycin 600 mg PO 2 hours prior to surgical procedure
Azithromycin or Clarithromycin 500 mg PO

Name _____ Date _____

Signature _____

A to Z Dermatology
HIPAA: Notice of our Privacy Practices

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply)- Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information- This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction.

You have the right to request to receive confidential communications- You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information- If we deny your request for amendment, you will have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures- You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payments, and healthcare operations: required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request. You have the right to obtain a paper copy of this notice from us, even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make copies of our new notice if you wish to obtain one.

Complaints

You may complain to us or to the Secretary of Health and Human Service if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Acknowledgement Form

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____