Alaska Center for Dermatology, P. C.

3841 Piper Street | Suite T4-020 | Anchorage, AK 99508 | telephone 907.646.8500 | fax 907.646.9760

Patient Registration Form

Please print all information clearly. Today's Date ________________

Patient

Name ____ Date of Birth ____________________
first / middle initial / last

Prefers to be called *(if applicable)* ________________________ SS# ___________________________ Sex ☐M ☐F

Mailing Address____
street, apt # / box # / city / state / zip

Marital Status __________________________ Spouse *(if applicable)* ______________________________________

Are you employed? ☐Y ☐N Employer ______________________________ Occupation ____________________

Please let us know how we may contact you *(check all that apply)*:

☐ Home Phone _________________________
- ☐ OK to call, leaving detailed message if no answer
- ☐ OK to call, leaving message with call-back number only if no answer
- ☐ OK to call, but leave no message if no answer

☐ Work Phone ______________________________
- ☐ OK to call, leaving detailed message if no answer
- ☐ OK to call, leaving message with call-back number only if no answer
- ☐ OK to call, but leave no message if no answer

☐ Cell/Alt. Phone ________________________
- ☐ OK to call, leaving detailed message if no answer
- ☐ OK to call, leaving message with call-back number only if no answer
- ☐ OK to call, but leave no message if no answer

☐ Written Communication
- ☐ OK to mail to home address
- ☐ OK to fax to this number ______________________________

May we discuss your condition with a member of your household? ☐Y ☐N

If so, with whom? ____________________________________ Relationship to patient ______________________

Who should we contact in case of emergency? ____

Phone ______________________________________ Relationship to patient ___________________________

Were you referred to us by another Health Care Provider? ☐Y ☐N If so, by whom?________________________________

Responsible Party *(Parent or Legal Guardian, for patients under the age of 18)*

Name ____ Date of Birth ____________________
first / middle initial / last

Mailing Address____
street, apt # / box # / city / state / zip

Home phone_________________________ SS# ___________________ Relationship to Patient __________________

Insurance *(Please present insurance card(s) and a photo ID to receptionist for scanning.)*

Primary ____ Secondary______________________________________

Name of Insured *(if different from patient)* _______________________ Name of Insured *(if different from patient)* _______________________

Relationship to Patient ______________________________ Relationship to Patient ______________________________

Primary's DOB___________________________________ Secondary's DOB ___________________________________

Assignment and Release

I authorize the release of any information to my primary care or referring physician. I hereby authorize Alaska Center for Dermatology to furnish my information to insurance carriers and hereby assign to Alaska Center for Dermatology all payments for medical services rendered to me and my dependents.

____ ____________________

Patient Signature (or Responsible Party) **Date**

Dermatology Medical History

Patient Name____ **Date**____________________

Reason for today's visit: ____

List all medications you are currently taking (including prescriptions, over-the-counter medications, vitamins, and herbs)

1. ______________________ 2. ______________________ 3. ______________________
4. ______________________ 5. ______________________ 6. ______________________

Do you take aspirin on a daily basis? ☐ YES ☐ NO If yes, explain reason: ____________________________________

Are you allergic to any medications? ☐ YES ☐ NO If yes, please list:

1. ______________________ 2. ______________________ 3. ______________________

Have you ever had dental anesthesia (Novocaine)? ☐ YES ☐ NO Have you ever had any negative reactions to it? ☐ YES ☐ NO

Does your dentist require you to take antibiotics prior to procedures or exams? ☐ YES ☐ NO

Do you have now, or have you ever had diseases or conditions of:

Lungs	**YES**	**NO**	**Cardiovascular**	**YES**	**NO**	**Other Systemic**	**YES**	**NO**
Bronchitis	☐	☐	High Blood Pressure	☐	☐	Diabetes	☐	☐
Emphysema	☐	☐	Chest Pain	☐	☐	Thyroid	☐	☐
Asthma	☐	☐	Heart Attack	☐	☐	Kidney	☐	☐
Chronic Cough	☐	☐	Irregular Heartbeat	☐	☐	Bladder	☐	☐
Shortness of Breath	☐	☐	CHF	☐	☐	Gastrointestinal	☐	☐
Wheezing	☐	☐	Blood Clot	☐	☐	Stomach Absorptive Disorder	☐	☐
Tuberculosis	☐	☐	Pacemaker	☐	☐	Arthritis/Joint Deformity	☐	☐
			Defibrillator	☐	☐	Convulsions/Epilepsy/Seizures	☐	☐
						Stroke	☐	☐
						Fainting	☐	☐
						Multiple Sclerosis	☐	☐
						Hepatitis A	☐	☐
						Hepatitis B	☐	☐
						Hepatitis C	☐	☐

List any other diseases or conditions:

____

____

List any surgical procedures you have had in the last 6 months:

____

____

Skin	**YES**	**NO**	
Have you ever had skin cancer?	☐	☐	
Has anyone in your family had skin cancer?	☐	☐	
Do you have a history of any specific skin diseases?	☐	☐	If yes, please list: ______________________
Do you have problems with healing?	☐	☐	
Do you develop keloids (scars) after surgery?	☐	☐	
Do you bleed easily?	☐	☐	

Do you develop skin rashes in reaction to ☐ Medications? ☐ Food? ☐ Environment? If yes, please explain: ______________________

Social History	**YES**	**NO**	
Do you drink alcohol?	☐	☐	If yes, __________drinks per day *or* __________ per week
Do you use IV drugs?	☐	☐	If yes, what ________________how often ________
Do you smoke?	☐	☐	If yes, how much ______________________
Have you had or have you been exposed to HIV (AIDS)?	☐	☐	

Women	**YES**	**NO**		**YES**	**NO**
Are you pregnant?	☐	☐	Have you had a hysterectomy?	☐	☐
If yes, what is your due date? ______________			Have you had an oophorectomy?	☐	☐
Are you breast-feeding?	☐	☐	Have you had your tubes tied?	☐	☐

What is your occupation? ____

What are your hobbies? ____

Completed by: ☐ Patient ☐ Medical Assistant (initials) ___________

Patient Signature ____**Date**____________

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PAYMENT FOR SERVICES

(Medicare)

Name ____ DOB______________________

Because we are a contracted Medicare provider,
we must obtain the following information regarding your coverage for billing purposes.

	Yes	No
Do you qualify for Medicare because you are over the age of 65?	☐	☐
Do you or your spouse carry insurance through a current employer?	☐	☐
Do you qualify for Medicare due to a disability?	☐	☐
If yes, is your disability work-related?	☐	☐
Are you covered by the VA (Veteran's Administration)?	☐	☐
Are you covered by the Federal Black Lung Program?	☐	☐
Are you covered by the End Stage Renal Disease Program?	☐	☐

Please read, initial where indicated, and sign below.

PATIENT RESPONSIBILITY

- Insurance coverage is not a guarantee of payment. (________ *initial*)
- **The billing information you present must be accurate and current.** (________ *initial*)
- You will receive a statement for any allowed balance after all applicable insurances have been billed. That balance is due in full at that time. (_________ *initial*)

We accept cash, checks, and all major credit cards. If a payment in check form is returned to us because of insufficient funds, you will be charged a $25 fee. Payment ***in full*** at the time of service is required in the following circumstances:

- Cosmetic services are rendered.
- Procedures or treatments we believe are not covered by Medicare are rendered.

LABORATORY AND PATHOLOGY SERVICES

We use a laboratory of our choice for pathology services unless you request otherwise. We will share your insurance information with the laboratory so that they may file a claim with your carrier. The laboratory will then bill you for any remaining balance. You will need to contact the laboratory directly for any questions regarding their bill.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Alaska Center for Dermatology, P. C. for any services furnished to me by them. Regulations pertaining to Medicare assignment of benefits apply. I understand that my signature authorizes a request for payment and authorizes release of medical information necessary to pay the claim. I permit a copy of this authorization to be used in place of the original. I understand that my signature authorizes a request for payment and authorizes release of medical information necessary to pay the claim. I permit a copy of this authorization to be used in place of the original. By my signature below, I acknowledge that I have read and that I understand the above statements. I also understand that I am responsible for laboratory and pathology charges as well. This authorization is not limited in time.

____ ____________________
Patient Signature ***(as it appears on Medicare Card)*** **Date**

Alaska Center for Dermatology, P.C.

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 review it carefully.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

Ways in Which We May Use and Disclose Your Protected Health Information:

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician who we have requested to be involved in your care. For example – we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Payment. We will use and disclose your protected health information to obtain payment for the health care services we provide you. For example – we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations**.** We will use and disclose your protected health information to support the business activities of our practice. For example – we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

Other Ways We May Use and Disclose Your Protected Health Information:

Appointment Reminders**.** We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

Treatment Alternatives**.** We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

Others Involved in Your Care**.** We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

Research. We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required by Law**.** We will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Worker's Compensation. We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates. We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

***A Paper Copy of This Notice*.** You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our practice manager, Charity Austin at Alaska Center for Dermatology, 3841 Piper St St T4-020, Anchorage, AK 99508. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

Request Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and your reasoning that supports your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

- the information was not created by us, or the person who created it is no longer available to make the amendment;
- the information is not part of the record which you are permitted to inspect and copy;
- the information is not part of the designated record set kept by this practice; or if it is the opinion of the health care provider that
- the information is not accurate and complete.

Request Restrictions. You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. *For example* – you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our practice manager.

We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period of time greater than six years (our legal obligation to retain information).

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. *For example* – you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice manager or directly to the Secretary of Health and Human Services.

To file a complaint with our practice manager, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to Charity Austin at Alaska Center for Dermatology, 3841 Piper St Ste T4020, Anchorage, AK 99508. You should know that there would be no retaliation for your filing a complaint.

Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

For More Information

If you have questions or would like additional information, you may contact our practice manager at (907) 646-8500.

Effective Date: March 3, 2003

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ACKNOWLEDGEMENT OF
RECEIPT OF
NOTICE OF PRIVACY PRACTICES

Thank you for choosing the Alaska Center for Dermatology for your healthcare needs.

We are required by law to provide you with a copy of our **Notice of Privacy Practices**. To ensure that our records are accurate, please sign below to acknowledge that you have been provided with a copy of our notice and that you have been given an opportunity to review it.

____
Patient Name

____ ____________________
Patient Signature (or Legal Representative) Date

____ ____________________
Staff Member Signature Date

Comments: