

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.

| | |
|---|--|
| Patient | |
| Name _____ Date of Birth ____/____/____ <small>first middle initial last</small> | |
| Nickname _____ SS# ____/____/____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Mailing Address: _____ <small>city state zip</small> | |
| Primary Phone: _____ <small>(please choose ONE of the following)</small> <input type="checkbox"/> OK to call, leaving detailed message if no answer <input type="checkbox"/> OK to call, leaving message with call-back number only if no answer <input type="checkbox"/> OK to call, but leave no message if no answer | Work Phone: _____ <small>(please choose ONE of the following)</small> <input type="checkbox"/> OK to call, leaving detailed message if no answer <input type="checkbox"/> OK to call, leaving message with call-back number only if no answer <input type="checkbox"/> OK to call, but leave no message if no answer |
| Other Phone: _____ <small>(please choose ONE of the following)</small> <input type="checkbox"/> OK to call, leaving detailed message if no answer <input type="checkbox"/> OK to call, leaving message with call-back number only if no answer <input type="checkbox"/> OK to call, but leave no message if no answer | Who should we contact in the event of an emergency? Name _____ Phone(s) _____ Relationship to Patient _____ |
| May we discuss your condition with a member of your household? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, with whom? _____ Relationship to Patient _____ | |
| Were you referred to us by another doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, by whom? _____ | |
| Ethnicity: <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Prefer not to answer | |
| Race: <input type="checkbox"/> Caucasian or European American <input type="checkbox"/> African American <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Native Alaskan or Native American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Prefer not to answer | |
| Preferred Language: _____ | |
| Insurance <i>(Please present insurance card(s) and a photo ID to receptionist for scanning.)</i> | |
| Do you have Primary Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: Insurance Name _____ Policy Holder's Name _____ Date of Birth _____ Relationship to Patient _____ | |
| Do you have Secondary Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: Insurance Name _____ Policy Holder's Name _____ Date of Birth _____ Relationship to Patient _____ | |
| Please complete the following if the patient is a minor or disabled. <i>(The person accompanying the patient today is considered the "Responsible Party".)</i> | |
| Responsible Party Name _____ Date of Birth ____/____/____ SS# ____/____/____ | |
| Mailing Address: _____ <small>city state zip</small> | |
| Assignment and Release <i>I authorize the release of any information to my referring physician. I hereby authorize Alaska Center for Dermatology to furnish my information to insurance carriers upon their written request and hereby assign to Alaska Center for Dermatology all payments for medical services rendered to the above patient.</i> | |
| _____ Patient Signature (or Responsible Party) | _____ Date |

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Dermatology Intake Form - New

Patient Name _____ Date of Birth _____

Occupation _____ Preferred Pharmacy & Location _____

Medication/Allergies

Do you take any prescription or non-prescription medication? Yes No

If Yes, please list:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please list all allergies to medication: No Known Drug Allergies

1. _____ 2. _____ 3. _____

| Skin | Yes | No |
|--|--------------------------|---|
| Do you have a personal history of melanoma? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had skin cancer? | <input type="checkbox"/> | <input type="checkbox"/> If Yes, what type? _____ |
| Has anyone in your family had skin cancer? | <input type="checkbox"/> | <input type="checkbox"/> If Yes, what type? _____ |
| Do you have a history of any specific skin diseases? | <input type="checkbox"/> | <input type="checkbox"/> If Yes, please list: _____ |
| Do you have problems with healing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you develop keloids after surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you bleed easily? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you develop skin rashes in reaction to <input type="checkbox"/> Medications? <input type="checkbox"/> Food? <input type="checkbox"/> Environment? | | |
| If Yes, please explain: _____ | | |

Medical History

Do you have now or have you ever had:

Asthma COPD Tuberculosis High blood pressure Heart attack Irregular heartbeat Stroke
 Diabetes Arthritis Hyperthyroid Hypothyroid Artificial Joints Hepatitis B/C HIV/AIDS

History of Cancer? Yes No If Yes, what type and where: _____

If Yes, what was your treatment: _____

Do you have a pacemaker? Yes No If Yes, does it have a defibrillator? _____

List any surgeries you have had in the last six months: _____

Social History

Smoking Status:

- Never smoked
- Current every day smoker
- Current some day smoker
- Former Smoker

Women:

- Are you pregnant or trying to conceive? Yes No
- If you are currently pregnant, what is your due date? _____
- Are you currently breastfeeding? Yes No

Signature _____ Date _____

(Patient, Or Guardian if Minor)

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Payment for Services (Medicare)

Patient Name _____ **DOB** _____

Because we are a contracted Medicare provider we obtain the following information for billing purposes.

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

Patient Responsibility

- Insurance coverage is not a guarantee of payment.
- 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.
- If we do not receive your payment in full within ninety days from the date of the first statement, your account may be turned over to a third-party collection agency.
- If a payment in check form is returned to us because of insufficient funds, you will be charged a \$25.00 fee.
- We accept cash, checks, and all major credit cards. Payment in full at the time of service may be required in the following circumstances:
 - All cosmetic services
 - Any procedures or treatments we believe are not covered by Medicare

Laboratory Services

We use a laboratory of our choice for pathology services, and they will bill you separately for those services.

I request that payment of authorized Medicare benefits be made 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. 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 charges. This authorization is not limited in time.

Patient Signature

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: