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

Patient Name _____ _____ _____ Date of Birth _____/_____/_____
first middle initial last

Nickname _____ SS# _____/_____/_____ Sex: ☐ M ☐ F

Email Address: _____

Mailing Address: _____ _____ _____ _____
city state zip

Which phone number would you like to designate as your **primary number**? ☐ Cell ☐ Home ☐ Work

Cell Phone	**Home Phone**	**Work Phone**
_____	_____	_____
Choose ONE of the following: ☐ Leave detailed message ☐ Leave message with call-back number only ☐ Leave no message	Choose ONE of the following: ☐ Leave detailed message ☐ Leave message with call-back number only ☐ Leave no message	Choose ONE of the following: ☐ Leave detailed message ☐ Leave message with call-back number only ☐ Leave no message

Emergency Contact Name _____

Phone(s) _____ Relationship to Patient _____

Do you authorize us to communicate with another individual, such as spouse or relative? If so, please indicate below.

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Primary Insurance	**Secondary Insurance**
Ins Co Name _____	Ins Co Name _____
Subscriber ID# _____	Subscriber ID# _____
Subscriber Name _____	Subscriber Name _____
Subscriber DOB _____ Relationship to Pt _____	Subscriber DOB _____ Relationship to Pt _____

Responsible Party for Minor *If patient is a minor, the parent accompanying them today is the Responsible Party. This information will also apply to patients who have a designated legal guardian. Responsible Party must sign Assignment and Release below.*

RP Name _____ Date of Birth ____/____/_____ SS# _____/_____/_____

Mailing Address: _____ _____ _____ _____
city state zip

Assignment and Release *I authorize the release of any information to my referring physician. I authorize Alaska Center for Dermatology to furnish my information to insurance carriers upon their written request and I assign to Alaska Center for Dermatology all payments for medical services rendered.*

_____ _____

Patient Signature (RP, if Patient is a Minor) **Date**

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PEdiAtriC DeRmAtoLogY InTake FoRm

Patient Name_____**Date of Birth**_____

Parent's Name(s)_____ **Preferred Pharmacy & Location**_____

Who is your primary care provider? (MD, NP, PA-C, etc) _____

Were you referred for this appointment? ☐ Yes ☐ No **If so, by whom?** _____

Medication/Allergies

Does the child take any prescription or non-prescription medication? If yes, list with dosage. ☐ Yes ☐ No

_____

Please list all allergies to medication: ☐ No Known Drug Allergies

_____

Skin

	Yes	No	
Has anyone in the child's family had skin cancer?	☐	☐	If Yes, what type? _____
Does the child have a history of any specific skin diseases?	☐	☐	If Yes, list: _____
Does the child have problems with healing or develop keloids?	☐	☐	
Does the child have any Birthmarks?	☐	☐	
Does the child have a personal history of Eczema?	☐	☐	

Does the child develop skin rashes in reaction to ☐ Medications? ☐ Food? ☐ Environment?

If Yes, explain: _____

Does the child have food allergies? If yes, list:_____

Are there any pets in the Household? If yes, what kind?_____

Medical History

Select any of the following medical conditions the child has or has had in the past:

☐ Congenital heart problems/defects	☐ Allergies/hay fever	☐ Asthma	☐ HIV/AIDS
☐ Ulcerative colitis/Crohn's	☐ Arthritis	☐ Depression/Anxiety	☐ Seizures
☐ Thyroid problems	☐ Tuberculosis	☐ Hepatitis B/C	☐ Cancer
☐ Immunosuppression	☐ Autism spectrum	☐ Other (explain):_____	

Family History (if Yes, provide specifics)

Birthmarks (location on body):_____ Severe acne/isotretinoin use:_____

Skin Disease:_____ Autoimmune disease:_____

Skin Cancer:_____ Asthma/Allergies:_____

Development

Birth History (problems with pregnancy, on time vs. premature delivery, birth weight):

_____

Has the child's growth, gross motor, and language development been in the normal range? ☐ Yes ☐ No

List any surgeries the child has had in the past: _____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Prefer not to answer **Preferred Language**:_____

Race: ☐ Caucasian or European American ☐ African American ☐ Asian or Asian American
☐ Native Alaskan or Native American ☐ Native Hawaiian or Other Pacific Islander ☐ Prefer not to answer

Signature of Parent/Guardian:_____**Date**_____

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Payment for Services

Patient Name _____ **DOB**_____

Patient Responsibility

- Insurance coverage is not a guarantee of payment.
- We are contracted with Premera Blue Cross and with Aetna, and we will bill most other insurance companies as a patient courtesy if you present your insurance card(s) at the time of your appointment.
- We have an out-of-network agreement with MultiPlan which may apply to you if your current insurance card shows a MultiPlan, PHCS, or Beech Street logo.
- Copayments and coinsurance percentages are due at the time of service.
- If we do not receive a response from your insurance company within forty-five days from the date we bill them, the balance will become your responsibility.
- You will receive a statement after all applicable insurances have been applied. 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:
    - You do not have insurance coverage
    - You have not brought your insurance card(s) with you
    - You have not met your deductible
    - All cosmetic services
    - Any procedures or treatments we believe are not covered by insurance

Laboratory Services

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

By my signature below I acknowledge that I have read and understand the above statements and that I am willing to accept responsibility to pay for services rendered if my insurance does not cover them. I also understand that I am responsible for laboratory charges. This authorization is not limited in time.

_____ _____

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