PATIENT DATA

Please fill out this form so that we will have enough information to effectively bill your insurance. (Only1 form is needed for each patient)

Name _____ Date of Birth_____ Sex: F / M
Address _____ Phone #1 _____ home / cell / work
City/St/Zip_____ Phone #2 _____ home / cell / work
Email Address _____ Race_____
Preferred Language_____ Marital Status_____
Social Security #_____ Ethnicity_____

Employer/Occupation_____ Employer Phone_____
Emergency Contact_____ Relation_____ Phone_____
Referring/Family Physician _____ Phone_____
☐ Check here if you would like a letter sent to your referring doctor after each visit.

FINANCIAL RESPONSIBILITY

Who is financially responsible for this bill?

Name_____ Relation to Patient _____
Address_____ Phone #1 _____ home / cell / work
City/St/Zip_____ Phone #2 _____ home / cell / work
Social Security #_____ Date of Birth _____ Sex: F / M

I am financially responsible for non-covered services. **A service charge of 10% will incur if the bill is not paid within 30 days.**

*SIGNED_____ DATE_____

INSURANCE INFORMATION

PRIMARY Insurance Name_____ Phone _____
Address_____
ID #_____ Group # _____
Copay _____ Deductible: Y / N Amount _____ Effective Date _____
Primary Insured Name _____ _____ Relation to Patient_____
Date of Birth_____ Sex: F / M Social Security #_____
Employer Name _____ Employer Phone _____

SECONDARY Insurance Name_____ Phone _____
Address_____
ID #_____ Group # _____
Copay _____ Deductible: Y / N Amount _____ Effective Date _____
Primary Insured Name _____ _____ Relation to Patient_____
Date of Birth_____ Sex: F / M Social Security #_____
Employer Name _____ Employer Phone _____

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits to be paid directly to Accent Dermatology. I also authorize the physician to release any information required to process any claims.

*SIGNED_____ DATE_____

Patient Medical History

Patient_____ Date of Birth___/___/____ Today's Date___/___/___

Reason for today's visit: _____

Have you ever had dental anesthesia (Novocaine) ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Past Medical History	YES	NO		YES	NO
Anxiety	☐	☐	Hypertension	☐	☐
Arthritis	☐	☐	Hyper/hypothyroidism	☐	☐
Asthma	☐	☐	Leukemia	☐	☐
Breast Cancer	☐	☐	Lung Cancer	☐	☐
Colon Cancer	☐	☐	Lymphoma	☐	☐
Depression	☐	☐	Pacemaker	☐	☐
Diabetes	☐	☐	Prostate Cancer	☐	☐
Hearing Loss	☐	☐	Radiation Treatment	☐	☐
Hepatitis	☐	☐	Seizures	☐	☐
HIV/Aids	☐	☐	Stroke	☐	☐

Other _____

Please list any surgeries you have had in the past: _____

_____

Skin History	YES	NO		YES	NO
Acne	☐	☐	Flaking/Itchy Scalp	☐	☐
Actinic Keratoses	☐	☐	Melanoma	☐	☐
Basal Cell Skin Cancer	☐	☐	Precancerous Moles	☐	☐
Bleed Easily	☐	☐	Problems Healing	☐	☐
Blistering Sunburns	☐	☐	Psoriasis	☐	☐
Dry Skin	☐	☐	Squamous Cell Skin	☐	☐
Eczema	☐	☐	Cancer		

Other_____

Do you develop skin rashes in reaction to: ☐ Medication ☐ Food ☐ Environment ☐ Bandages ☐ Neosporin

Do you wear sunscreen? ☐ YES ☐ NO Family history of Melanoma? ☐ YES ☐ NO

If Yes, what SPF? _____ If Yes, which relative? _____

Medications/Allergies

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

_____

_____

_____

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

_____

Any other known allergies?_____

Social History	YES	NO	
Do you drink alcohol?	☐	☐	If yes, _____ drinks per day
Do you use IV drugs?	☐	☐	If yes, what?_____How often?_____
Do you smoke?	☐	☐	If yes, how much?_____
Have been exposed to HIV/Aids?	☐	☐	
(Women) Are you pregnant?	☐	☐	If yes, due date?_____

What is your occupation?_____ Hobbies?_____

_____	___/___/___	___/___/___	_____
Signature	Date	Updated	Initial

Accent Dermatology
HIPAA Notice of Privacy Practices

THIS NOTICE DESCIBRES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCES TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected heal information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your PHI may be used and disclosed by your physician, our office staff and others outside the office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure they have the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may use a sign in sheet at the registration desk where you will be asked to sign your name as indicated. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases, health oversight: abuse or neglect, Food and Drug Administration requirements, Legal Proceedings; Law Enforcement; coroner; funeral directors; and organ donation; research, criminal activity, military activity, national security, workers compensation; inmates. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object, unless required by law. Any other uses or disclosures not described in this notice will be made only with your authorization, including those for marketing or sales purposes. PHI will be used may be used for fundraising communications, however, patients have the right to opt out of receiving such communications.

You may revoke any authorization at any time, in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care for notification purposed 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 a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your protected health information will not be restricted. You then have the right to use another healthcare professional. The exception to this is any instance in which you paid for healthcare out of pocket, in which case the practice must agree to the patient's requested restriction with respect to communication to the patient's health plan.

You have the right to receive confidential communications 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, ie: electronically.

You have the right to have your physician amend your PHI. If we deny your request for amendment, you 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 we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. The practice will also inform any individual affected by a breach in PHI.

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

This notice was published and becomes effective on/or before September 1, 2013.

We are required by law to maintain the privacy of Protected Health Information. We are bound by, and required to provide individuals with, this notice of our legal duties and privacy practices with request to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

PATIENT NAME _____

HIPAA PATIENT ACKNOWLEDMENMT

(Must be filled out by a parent/guardian if the patient is under the age of 18)

We are required by law to maintain the privacy of protected health information and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please feel free to speak with our HIPAA Compliance Officer in person or by phone.

Your signature below is only acknowledgment that you understand that we maintain the privacy of your protected health information. If you would like a formal copy of our Notice of Privacy Practices, please ask for one at the front desk.

Print Name _____

Signature _____

Date _____

Permission to Discuss Medical Information

I _____ give permission for Dr. David High, Dr. Elyse Harrop, Dr. Rachel Klein, and the staff of Accent Dermatology to discuss my medical information including test results with the following friends or family members (If left blank, information will only be given directly to the patient.)

_____

_____

This authorization will stay in effect until the above patient terminates it.

_____	_____	_____
Patient Name (please print)	**Patient Signature**	**Date**