RICHMOND DERMATOLOGY

9816 Mayland Drive, Richmond, VA 23233

Phone: 804-282-8510 **Fax:** 804-285-5750

General Patient Information: ❑ New Patient ❑ Name Change ❑ Address Change ❑ Ins Change

Last Name: _____ First Name: _____ M.I. _____

Gender: ❑ Male ❑ Female Date of Birth: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Please check preferred communication methods: ❑ Email Address: _____

❑ Home: _____ ❑ Work: _____ ❑ Cell: _____

❑ **Check if you agree to receive information by email for patient portal records access and special promotions.**

May we leave personal medical information and/or test results on your voicemail? **Y / N**

Primary care physician: _____ Phone #: _____

How were you referred to Richmond Dermatology Specialists? _____

Ethnicity: ❑ Hispanic or Latino ❑ Non-Hispanic or Latino

Race: ❑ Asian ❑ White ❑ Black or African America ❑ American Indian or Alaska Native

❑ Native Hawaiian or Other Pacific Islander ❑ Other

Insurance: PLEASE PRESENT YOUR INSURANCE CARD(S) WITH THIS COMPLETED FORM

Primary Insurance: _____ Subscriber's Name: _____
Date of Birth: _____ Gender: ❑ Male ❑ Female

Patient Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Financial Responsibility

Person Responsible for Patient Account: _____

Gender: ❑ Male ❑ Female Date of Birth: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Is this person a patient at this office? **Y / N**

Authorization and Acknowledgement Must Be Signed Prior to Treatment Being Rendered

I hereby authorize the release of any information relating to my insurance claims. I hereby authorize payment to the doctor of benefits otherwise payable to me but not to exceed the charges shown. I agree to pay for the services rendered and acknowledge that I am legally liable for the services. I understand that insurance is being filed as a courtesy to me and that I am responsible for the full bill 60 days from the date the insurance is filed. I agree to pay all collection agency fees/attorney fees, court cost or other expenses incurred if my account is referred to an outside collection agency or attorney for collections. I understand that there is a $35 fee for any check returned by the bank and a $50 fee if any appointment is cancelled without 24 hours' notice. I understand that my insurance will not cover any cosmetic services.

Signature of Patient (or Parent/Guardian if minor): _____ **Date:** _____

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History and Intake Form

Patient Name: _____ Date of Birth: _____

Reason for today's visit: _____

Do you have any cosmetic concerns? **Y / N** If so, please specify _____

Are you interested in learning about treatments offered at our Aesthetics Center? **Y / N**

Are you pregnant, nursing or planning to become pregnant? _____

Past medical history

	Anxiety		Hearing Loss
	Arthritis		Hepatitis
	Asthma		Hypertension
	Atrial Fibrillation		HIV/AIDS
	Bone Marrow Transplant		Hypercholesterolemia
	BPH (Benign Prostatic Hyperplasia)		Hyperthyroidism
	Breast Cancer		Hypothyroidism
	Colon Cancer		Leukemia
	COPD (Emphysema)		Lung Cancer
	Coronary Artery Disease		Lymphoma
	Depression		Prostate Cancer
	Diabetes		Radiation Treatment
	End Stage Renal Disease		Seizures
	GERD (Acid Reflux		Stroke
	NONE		Pacemaker
	OTHER:		

Past Surgical History

	Appendix Removed		Liver transplant
	Bladder Removed		Liver shunt
	Breast Biopsy: **R / L**		Ovaries Removed: endometriosis
	Lumpectomy: **R / L**		Ovaries Removed: Ovarian Cancer
	Mastectomy: **R / L**		Ovaries Removed: Cyst
	Colectomy: colon cancer resection		Ovaries: Tubal Ligation
	Colectomy: Diverticulitis		Prostate Biopsy
	Colectomy: IBD		Prostate Removed: Prostate Cancer
	Colostomy		TURP
	Gallbladder removed		Rectum: APR
	Biological valve replacement		Rectum: Low anterior resection
	Coronary Artery Bypass		Basal cell carcinoma surgery
	Heart Transplant		Melanoma surgery
	Mechanical valve replacement		Skin biopsy
	PTCA		Squamous cell carcinoma surgery
	Joint replacement hip: **R / L**		Spleen Removed
	Joint replacement knee: **R / L**		Testicles Removed: **R / L**
	Kidney Biopsy		Hysterectomy: Fibroids
	Kidney Stone Removal		Hysterectomy: Uterine Cancer
	Kidney Transplant		Hysterectomy: Cervical Cancer
	Nephrectomy		**NONE**
	Hepatectomy		OTHER:

Skin Disease History

	Acne		Dry Skin		Poison Ivy
	Actinic Keratosis		Eczema		Precancerous Mole
	Asthma		Flaking or Itchy Scalp		Psoriasis
	Blistering Sunburns		Hay Fever/ Allergies		
	Melanoma (Location and year):				
	Basal cell skin cancer (Location and year):				
	Squamous cell skin cancer (Location and year):				
	OTHER:				
	NONE				

Do you wear sunscreen? **Y / N** If yes, what SPF? _____

Do you have a family history of melanoma? **Y / N**

If yes, which relative(s)? _____

Any other family history? _____

Medications: Please enter all current medications

Medication Name	Route	Dose	Form	Strength	Units	Frequency

Allergies: Please list all allergies

_____

Social History

Cigarette Smoking		Advanced Care Plan		Language		18 & under
	Never Smoked		No		English	Height:
	Quit: Former Smoker		Yes		Spanish	Weight:
	Smokes less than daily				Other	
	Smokes daily	Name of Designee:				

Have you ever received a pneumonia vaccine? **Y / N**

Did you receive a flu vaccine during the most recent flu season? **Y / N**

Pharmacy:_____ Phone Number:_____

Street Address: _____ City: _____ State: _____ Zip:_____

**I certify that the information contained in this health history form is true and accurate to the best of my knowledge.*

Signature of Patient (or Parent/Guardian if minor): _____ **Date:** _____

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Treatment Policy

TREATMENT POLICY — I understand and consent to the following:

- The physicians and/or physician extenders of Richmond Dermatology and its clinical and technical employees may administer any treatment or perform any procedures deemed advisable during your care or treatment. You have the right to consent or refuse any proposed procedure or therapeutic course of treatment.
- If you are planning to send your child to a subsequent appointment alone or with a non-guardian adult, you must sign a separate **Consent to Treat a Minor**, allowing Richmond Dermatology to treat your child and share protected health information (PHI) with that person. We ask that you confirm your child's referral and insurance information in advance of each visit.
- Richmond Dermatology will provide the best care possible, consistent with the prevailing standards of medical practice, but the practice of medicine is not an exact science, and that diagnosis and treatment may involve risk of injury, or even death.
- No assurances or guarantees have been made as to the results of examination or treatment.
- The Code of Virginia (32. 1-45.1) authorizes health care providers to test patients for HIV (Human Immune Deficiency Virus), Hepatitis B virus and Hepatitis C virus when a healthcare provider is directly exposed to blood or body fluids of a patient in a manner which may transmit these viruses. In the event of such exposure, the patient will be deemed to have consented to such testing and to have consented to the release of the test results to the health care provider who has been exposed.

Signature of Patient (or Parent/Guardian if minor) **Date**

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Payment Policies

Please review and sign the following statement of our Payment Policies prior to receiving treatment. For purposes of this document, the terms "you" and "your" shall mean the Patient or the Patient's Guardian. The Patient's Guardian is a parent or individual who accepts financial responsibility for services rendered to the Patient and is legally authorized to consent and take action on the Patient's behalf.

PAYMENT POLICIES- You understand and agree to the following:

- By signing this document, you agree to assign Richmond Dermatology any and all health care benefits to which you are entitled under any policy of insurance, and authorize to the extent permitted by law, payment of those benefits directly to Richmond Dermatology.
- Richmond Dermatology may release, by facsimile or otherwise, any medical or incidental information to any requesting insurance company, third party vendors associated with obtaining prior authorizations or assisting in the billing process, federal agency, and other physicians as necessary.
- I hereby authorize the release of any information relating to my insurance claims. I hereby authorize payment to the doctor of benefits otherwise payable to me but not to exceed the charges shown. I agree to pay for services rendered and acknowledge I am legally liable for those services.
- I understand that insurance is being filed as a courtesy to me and that I am responsible for the full bill 60 days from the date the insurance is filed.
- I understand that appointment cancellations are required in advance of scheduled appointments. I will be charged a $50 cancellation fee if I do not contact our office 24 hours prior to my scheduled appointment to make changes or cancel my appointment.
- I understand there is a $35 returned check fee for any check returned by the bank.
- I understand that my insurance will not cover any cosmetic charges.
- I agree to pay all Collection Agency Fees and/or Attorney Fees, Court Costs, or other expenses incurred if my account is referred to an outside collection agency or attorney for collections. Specifically, I agree to pay, in addition to the balance of the account, all collection fees in the amount of thirty-five percent (35%) of the total unpaid balance due. I agree to pay the costs of collection whether or not suit is filed, and I agree that one and a half percent (1.5%) per month, eighteen percent (18%) per annum, beginning on the date of judgement. I agree that the County of Henrico, Virginia shall be the proper venue for any action brought pursuant to this agreement. A photocopy of this agreement shall be considered as valid as the original. I authorize the practice and its agents to contact me regarding collection efforts at any phone number and/or email address associated with my account.
- I understand that I am required to obtain a referral or authorization from my Primary Care Physician (PCP) prior to going to a specialist for services. My insurance carrier determines when a referral is necessary. If I do not have a referral on the date of service, I understand and agree that I will be financially responsible for all charges, physicians and labs that are not covered by my insurance company for this visit. I understand in some instances, my PCP may approve a retro referral before initial billing activity takes place, and this referral follow-up is my responsibility.
- I understand that I am required to present a valid insurance card at the time of service so that my physician may follow the plan requirements. I understand and agree that if I do not have my card available, I will be financially responsible for all charges, physicians and labs that are not covered by the insurance company for this visit.

The information given to Richmond Dermatology is complete and correct to the best of my knowledge. I, the undersigned, have read, understand, and agree to the policies described above, and understand that Richmond Dermatology will render medical services in consideration of and reliance on my authority to agree and my agreement to the above terms. I further understand and agree that a photocopy or facsimile of this agreement shall be as valid as the original and that any attempted modification of the above terms shall be void and without effect.

_____ _____

Patient Name (print) **Date of Service**

_____

Signature of Patient (or Parent/Guardian if minor)

RICHMOND DERMATOLOGY
9816 Mayland Drive Richmond, VA 23233

Privacy Policy

Notice of Health Information Practices

This Notice describes how your medical information may be used and disclosed and how you may get access to this information. Please read it carefully.

Protected Health Information (PHI), about you, is maintained as a written and/or electronic record of your contacts and/or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present, or future medical condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules, use, and disclose your PHI to provide treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under the Privacy Rule -Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices — we are required to follow the terms of this Notice. We reserve the right to change the terms of our Notice at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices. This Notice is available in our office and posted on our website.

You have the right to authorize other use and disclosure — this means you have the right to authorize any use or disclosure of PHI that is not specified in this Notice. For example, we would need your written authorization to use or disclose your PHI if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice, has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication — this means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/ phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI — this means you may inspect and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines. You have the right to ask us to correct health information that you think is incorrect or incomplete. We may say "no" to the request, but we will explain why, in writing within 60 days of the request.

You have the right to request a restriction of your PHI, in writing. If we agree to the requested restriction we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction.

You may have the right to request a disclosure of accountability — this means you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office within six years, upon request, we will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

You have the right to receive a privacy breach notice — you have the right to receive written notification if the practice discovers a breach of your unsecured PHI and determines through risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager.

Effective Date: April 2017

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How we may Use or Disclose Protected Health Information

The following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of disclosures.

Treatment —We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices —We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment — Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services, we recommend for you, such as making a determination of eligibility or coverage for insurance benefits. If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share the information for the purpose of payment or our operations with your health insurer. We will say "yes" unless required by law to share the information.

Healthcare Operations— We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization —The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purpose of treatment, payment, or healthcare operations.

To Others Involved in your Healthcare — Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present, or able to agree, or object to the use of disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses & Disclosures — We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food & Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints — You have the right to complain to us, or directly to the U.S. Department 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 the Privacy Manager at 804-282-8510. There will be no retaliation for filing a complaint. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue. S.W., Washington, D.C. 20201, calling 1-877-696-6775 or visiting www.hhs.gov/ocr/privacy/hippa/complaints.

Effective Date: April 2017

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9816 Mayland Drive Richmond, VA 23233

HIPPA Written Acknowledgement Form

Patient Name **Date of Birth**

Our Notice of Health Information Practices provides information about how we may use and disclose your PHI (PROTECTED HEALTH INFORMATION). As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I have received a copy of the Notice of Health Information Practices (Privacy Policies).

I have had an opportunity to read the Notice of Health Information Practices.

I understand that I may ask questions to the Medical Practice if I do not understand any information contained in the Notice of Health Information Practices.

Print name of Patient (or Parent/Guardian if minor) **Relationship to Patient** (if minor)

Signature of Patient (or Parent/Guardian if minor) **Date**

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Release of Information

May we leave personal medical information and/or test results on your voicemail? **Y / N**

Phone number: _____

Do you authorize our office personnel to discuss your medical information with anyone else?

❑ No, I do not authorize.

❑ Yes, I authorize the following individuals:

Name	Relationship	Phone Number
Name	Relationship	Phone Number

In case of emergency, contact: _____

Relationship: _____ Phone Number: _____

_____

Print Patient Name

_____

Signature of Patient (or Parent/Guardian if minor) **Date**