# Richmond Dermatology and Laser Specialists

9816 Mayland Drive • Richmond, VA 23233 • 804.282.8510 • FAX 804.285.5750

## General Patient Information: ☐ *New Patient* ☐ *Name Change* ☐ *Address Change* ☐ *Insurance 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:_____

☐ I agree to receive information by email for patient portal record access and special promotions.

☐ Home_____ ☐ Work_____ ☐ Cell_____

May we leave personal medical information and/or test results on your answering machine or voicemail? Yes or No

Phone #:_____

Primary Care Physician: _____ Phone # _____

Ethnicity: ☐ *Hispanic or Latino* ☐ *Non-Hispanic or Latino*

Race: ☐ *Asian* ☐ *Native Hawaiian or Other Pacific Islander* ☐ *American Indian or Alaska Native*
☐ *White* ☐ *Black or African American* ☐ *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* _____

**Secondary Insurance**: _____

Subscriber's Name: _____ Date of Birth: _____

Gender: ☐ *Male* ☐ *Female* Patient Relationship to Subscriber: ☐ *Self* ☐ *Spouse* ☐ *Child* ☐ *Other* _____

## Responsible (Or Insured) Party Information

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? ☐ *Yes* ☐ *No*

## 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 COSTS OR OTHER EXPENSES INCURRED IF MY ACCOUNT IS REFERRED TO AN OUTSIDE COLLECTION AGENCY OR ATTORNEY FOR COLLECTIONS. I UNDERSTAND THERE IS A $35 FEE FOR ANY CHECK RETURNED BY THE BANK AND A $35 FEE IF AN APPOINTMENT IS CANCELLED WITHOUT 24 HOURS NOTICE. I UNDERSTAND THAT MY INSURANCE WILL NOT COVER ANY COSMETIC SERVICES.

Signature of Patient (or Guardian): _____ Date: _____

# RICHMOND DERMATOLOGY

9816 Mayland Dr, Richmond, VA 23233
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## Treatment Policy & Release of Information

**TREATMENT POLICY** – I understand and consent to the following:

- The physicians and/or physician extenders of Richmond Dermatology and Laser Specialists and it's clinical and technical employees may administer any treatment or perform any procedures deemed advisable during my care or treatment; I have the right to consent, or to refuse consent, to any proposed procedure or therapeutic course of treatment;
- If planning to send my child to a subsequent appointment alone or with a non-guardian adult, I must sign a separate **Consent to Treat a Minor**, allowing Richmond Dermatology and Laser Specialists to treat my 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 and Laser Specialists will provide the best care possible, consistent with the prevailing standards of medical practice, but that 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; and;
- The Code of Virginia (32. 1-45.1) authorizes health care providers to test patients for HIV (Human Immune Deficiency Virus), Hepatitis B virus, Hepatitis's 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, I 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.

**Do you authorize our office personnel to discuss your medical information with anyone else? □ *No* □ *Yes***

| Name | Relationship | Phone # |
|---|---|---|
| | | |
| **Name** | **Relationship** | **Phone #** |
| | | |

**In case of an emergency, contact:** _____

**Relationship:** _____ **Phone:** _____

**Print Patient Name:** _____

**Signature of Patient (or Guardian):** _____ **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 and Laser Specialists 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 and Laser Specialists;
- Richmond Dermatology and Laser Specialists may release, by facsmilie 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 schedule appointments and I will be charged a $35 cancellation fee if I do not contact the office 24 hours prior to my scheduled 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 half percent (1 ½%) 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 my 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 since I do not have my card available, I will be financially responsible for all charges, physicians and labs that are not covered by insurance company for this visit.

The information given to Richmond Dermatology and Laser Specialists is complete and correct to the best of your knowledge. I, the undersigned, have read, understand and agree to the policies described above, and the understand that Richmond Dermatology and Laser Specialists 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 and the original and that any attempted modification of the above terms shall be void and without effect. This policy is in place until further notice.

Print Patient Name: _____ Date: _____

Patient (or Guardian) Signature _____

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# History and Intake Form

Date: _____

**Patient Name:** _____ **Date of Birth:** _____

Reason for today's visit: _____

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

## Past Medical History:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH (Benign Prostatic Hyperplasia)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (Emphysema)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Acid reflux)
- ☐ **None**
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Pacemaker
- ☐ Other _____

## Past Surgical History:

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Lumpectomy (Right, Left, Bilateral)
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colostomy
- ☐ Gallbladder Removed
- ☐ Biological Valve Replacement
- ☐ Coronary Artery Bypass
- ☐ Heart Transplant
- ☐ Mechanical Valve Replacement
- ☐ PTCA
- ☐ Joint Replacement, Hip (Right, Left, Bi)
- ☐ Joint Replacement, Knee (Right, Left, Bi)
- ☐ Kidney Biopsy

- ☐ **None**
- ☐ Other_____
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Nephrectomy
- ☐ Hepatectomy
- ☐ Liver Transplant
- ☐ Liver Shunt
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Prostate Biopsy
- ☐ Prostate Removed: Prostate Cancer
- ☐ TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Basal Cell Cancer Surgery
- ☐ Melanoma Surgery
- ☐ Skin Biopsy
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer

*CONTINUE TO NEXT PAGE*

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## Skin Disease History

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
  Location & Year: _____
- ☐ Blistering Sunburns
- ☐ Other _____
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
  Location & Year: _____
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
  Location & Year: _____
- ☐ **None**

Do you wear sunscreen? ☐ Yes-SPF_____ ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No

If yes, which relative(s)? _____

Any other family history: _____

**Medications**: (Please enter all current medications) or circle **NONE**

| Medication Name | Route | Dose | Form | Strength | Units | Frequency |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
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| | | | | | | |
| | | | | | | |
| | | | | | | |

**Allergies**: (Please enter all allergies) or circle **NO KNOWN DRUG ALLERGIES**

_____

## Social History:

Cigarette Smoking:
- ☐ Never smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily

Alcohol Consumption
- ☐ None
- ☐ Special Occasions

Drinks per Day: _____
Drinks per Week: _____

Advanced Care Plan
- ☐ No
- ☐ Yes

Name of Designee: _____
_____

Language
- ☐ English
- ☐ Spanish
- ☐ Other: _____

Have you ever received a pneumonia vaccine? ☐ Yes ☐ No

Did you receive a flu vaccine during the most recent flu season? ☐ Yes ☐ No

## Pharmacy:

_____Phone:_____

Street Address: _____

City_____ State: _____ Zip Code: _____

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 Guardian (if minor):_____Date: _____

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## HIPAA WRITTEN ACKNOWLEDGEMENT FORM

**Patient Name: _____Date of Birth_____**

**Our Notice of Health Information Practices provides information about how we may use and disclose PHI (PROTECTED HEALTH INFORMATION) about you. As provided in our notice, the terms of our notice may change. You may request a copy of this Notice at any time.**

**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.**

_____ _____
Signature of Patient, Parent, or Legal Guardian Date

_____ _____
Print Name of Patient, Parent, or Legal Guardian Relationship to patient

# RICHMOND DERMATOLOGY

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***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 your 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 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.

**How we may Use or Disclose Protected Health Information**

Effective Date: April 2017

# RICHMOND DERMATOLOGY

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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 health care 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, of your 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