



Richmond Dermatology
 9816 Mayland Drive, Richmond, VA 23233
 Ph: 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 voicemail? Yes No

Primary Care Physician: _____ Phone # _____

How were you referred to Richmond Dermatology Specialists? _____

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: _____

Subscribers Name: _____ Date of Birth: _____

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

Secondary Insurance: _____

Subscribers Name: _____ Date of Birth: _____

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

Financially Responsible 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 (if minor): _____ Date: _____



Treatment Policy & Release of Information

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 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 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.

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 (if minor): _____ **Date:** _____



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)

Medication Name	Route	Dose	Form	Strength	Units	Frequency

Allergies: (Please enter all allergies)

Social History:

- | | | | |
|--|--|---|--|
| <u>Cigarette Smoking:</u>
<input type="checkbox"/> Never smoked
<input type="checkbox"/> Quit: former smoker
<input type="checkbox"/> Smokes less than daily
<input type="checkbox"/> Smokes daily | <u>Alcohol Consumption</u>
<input type="checkbox"/> None
<input type="checkbox"/> Special Occasions
Drinks per Day: _____
Drinks per Week: _____ | <u>Advanced Care Plan</u>
<input type="checkbox"/> No
<input type="checkbox"/> Yes
Name of Designee: _____ | <u>Language</u>
<input type="checkbox"/> English
<input type="checkbox"/> Spanish
<input type="checkbox"/> 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: _____

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: _____



HIPAA WRITTEN ACKNOWLEDGEMENT FORM

Patient Name: _____ **Date/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.

Signature of Patient, Parent, or Legal Guardian

Date

Print Name of Patient, Parent, or Legal Guardian

Relationship to patient



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.

Effective Date: April 2017



How we may Use or Disclose Protected Health Information

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.