INSURANCE INFORMATION PAGE 1

First Name: _____ MI: _____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Sex: □ M □ F Social Security #: _____-____-_____ Marital Status_____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____Work Phone: (_____) _____-_____

Employer: _____Job Title: _____

Student: □ Full-Time □ Part-Time (Please check one for insurance purposes.)

In case of EMERGENCY, who should we notify? _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Relationship: _____

Primary Care Physician: _____Phone: (_____) _____-_____

Referring Physician: _____ Phone: (_____) _____-_____

PRIMARY INSURED INFORMATION

Type of Insurance: _____ COPAY: _____

Name: _____ Relationship: _____

Address: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Date of Birth: ____/____/____ Sex: □ M □ F Social Security #: _____-____-_____

Employer: _____ Address: _____

SECONDARY INSURED INFORMATION

Type of Insurance: _____ COPAY: _____

Name: _____ Relationship: _____

Address: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Date of Birth: ____/____/____ Sex: □ M □ F Social Security #: _____-____-_____

Employer: _____ Address: _____

PARENT/GUARDIAN IF PATIENT IS A MINOR (If different from primary insured)

Name: _____ Relationship: _____

Address: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Patients Signature: _____ Date: _____

INSURANCE INFORMATION PAGE 2

- In the event of hospitalization or major procedures, we request insurance information for your records, Please furnish the front office with your insurance cards.
- I authorize the release of medical information necessary to process this claim and also authorize the payments of medical benefits to the physician.

Patient Signature: _____Date: _____

PAYMENT POLICIES

- In order to establish optimal relations with our patients and avoid misunderstandings. For all self-pay patients, PAYMENT IS REQUIRED FOR ALL SERVICES AT THE TIME THEY ARE RENDERED. We accept payment in the form of cash, check, or credit card.
- For all insured patients, our office will file the appropriate insurance. However, before such claims are filed, COVERAGE MAY BE PRE-VERIFIED AND YOU MAY BE ASKED TO PAY ANY UNMET DEDUCTIBLES, NON-COVERED SERVICES, AND CO-PAYMENTS.

MEDICARE/MEDICAID AUTHORIZATION

- PLEASE SIGN SO WE MAY HAVE YOUR MEDICARE AUTHORIZATION ON FILE. I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, its intermediaries or carrier any information needed for this or any related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment or benefits apply.

SUPPLEMENTAL AUTHORIZATION

- PLEASE SIGN SO WE HAVE YOUR SUPPLEMENTAL AUTHORIZATION ON FILE. I request authorized supplemental benefits to be made on my behalf for any service furnished to me. I authorize any information needed to determine these benefits payable for related services.

YOUR SIGNATURE BELOW SIGNIFIES YOUR UNDERSTANDING AND WILLINGNESS TO COMPLY WITH THIS POLICY.

Patient Signature: _____Date: _____

NEW PATIENTS

Reason for Visit:

_____

_____

How long has this condition been present? _____

What are your symptoms, if any? (itching, burning, bleeding, etc)

PLEASE LIST: _____

Please list the names of prescription and over the counter medications that have been used to treat this condition (topically- creams/ointments and/or orally- pills) and their results? (You may need to call your pharmacy to get the names and correct spellings of previous medications tried.) :

_____

_____

_____

MEDICATION LIST (Taken on a DAILY BASIS)

1_____/7_____

2_____/8_____

3_____/9_____

4_____/10_____

5_____/11_____

6_____/12_____

DRUG ALLERGIES: _____

_____

Pharmacy: _____ Location: _____

Patient Name: _____

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 THIS INFORMATION CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer that you may use to
pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **Acacia Dermatology.** For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement agencies to support government mandated reporting.

Public health reporting. Your health information may disclose to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosures of your health information or its uses for any purpose other than those listed above require your specific written authorization. If you change your mind after authorizing a use or disclosure of your decision to revoke the authorization will
not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to occasionally send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you find interesting on the treatment and management of your medical condition. We may also send your information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.
- The right to amend or submit corrections to your protected health information.

Acacia Dermatology Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices outlined in this notice.

Right to Revise Privacy Practice

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting **Receptionist** or **Office Manager.** Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

This notice is effective on or after **October 1, 2008.**

Your signature signifies that you have read and understand this policy.

A copy of this form is available upon request.

Patients Signature: _____ Date: _____

MEDICAL HISTORY

PLEASE USE BLACK INK

PLEASE FILL OUT CLEARLY AS THIS WILL BE PART OF YOUR PERMANENT MEDICAL RECORDS.

	YES	NO
Have you ever had skin cancer / melanoma?	❑	❑
Any family members with a history of melanoma?	❑	❑
Have you ever had any skin lesions biopsied / removed?	❑	❑

If yes, please list the location and results of the biopsy and when it was done: _____

_____

_____

LUNGS	YES	NO
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑

HEART		
High blood pressure	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Pacemaker	❑	❑
Artificial Valve	❑	❑

MUSCULOSKELETAL		
Joint stiffness, pain, swelling	❑	❑
Artificial Joint	❑	❑

NEUROLOGICAL		
Depression	❑	❑
Anxiety	❑	❑
Convulsions/Seizures	❑	❑
Stroke	❑	❑
Glaucoma	❑	❑

ONCOLOGY		
Cancer other than skin	❑	❑

If yes, please list the cancer(s)_____

_____

URINARY	YES	NO
Bladder infections	❑	❑
Kidney infections	❑	❑
Kidney Disease	❑	❑
Prostate cancer	❑	❑

HEMATOLOGICAL		
Bleed easily	❑	❑
Problems with skin healing	❑	❑
Anemia	❑	❑
Cancer of the blood (leukemia)	❑	❑
HIV/AIDS	❑	❑

GASTROINTESTINAL		
Viral Hepatitis (liver)	❑	❑
Liver Disease	❑	❑
Ulcerative Colitis	❑	❑
Crohn's Disease	❑	❑
Peptic Ulcers (stomach/duodenum)	❑	❑

ENDOCRINE		
Low Thyroid (Hypothyroid)	❑	❑
High Thyroid (Hyperthyroid)	❑	❑
Diabetes	❑	❑

WOMEN		
Are you pregnant?	❑	❑
Do you currently breast feed?	❑	❑

Are there any major medical problems not listed above? If yes, please list: _____

_____

_____

What is your occupation? _____ Weight in pounds _____

PATIENT NAME (please print clearly) _____