CLEVELAND DERMATOLOGY

New/Updated Patient Information (updated Feb 2017)

A. PATIENT INFORMATION - PLEASE FILL OUT ALL AREAS

NAME:_____ MAIDEN NAME:_____
Last First Middle

ADDRESS:_____ City_____ State_____ Zip_____

DATE OF BIRTH:_____ AGE:_____ SOCIAL SECURITY #:_____ MALE or FEMALE

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE:_____

EMPLOYER:_____ CIRCLE MARITAL STATUS: *Single Married Separated Divorced Widowed*

PRIMARY CARE PROVIDER:_____

B. INSURANCE INFORMATION

Please provide the receptionist with you insurance card(s) to be copied.
IF card(s) are copied, ONLY ** HIGHLIGHTED AREAS NEED TO BE COMPLETED. Thank you.

DO YOU HAVE MEDICAL INSURANCE? Yes or No (*If no, please go to section C*)

1. **WHOSE NAME IS ON *PRIMARY* INSURANCE CARD? _____

**ADDRESS:_____ City_____ State_____ Zip_____ PHONE:_____

**DATE OF BIRTH:_____ SOCIAL SECURITY #_____ RELATIONSHIP TO PATIENT:_____

INSURANCE CO. NAME:_____ EMPLOYER:_____

CLAIMS ADDRESS:_____

ID #:_____ GROUP #_____ INSURANCE PHONE:_____

2. **WHOSE NAME IS ON *SECOND* INSURANCE CARD?_____

**ADDRESS:_____ City_____ State_____ ZIP_____ Phone:_____

** DATE OF BIRTH:_____ SOCIAL SECURITY #:_____ RELATIONSHIP TO PATIENT:_____

INSURANCE CO. NAME:_____ EMPLOYER:_____

CLAIMS ADDRESS:_____

ID #:_____ GROUP #:_____ INSURANCE PHONE:_____

C. PERSON RESPONSIBLE FOR THIS ACCOUNT

NAME:_____ RELATIONSHIP TO PATIENT:_____
Last First Middle

ADDRESS:_____ City_____ State_____ Zip_____

DATE OF BIRTH:_____ SOCIAL SECURITY #:_____ EMPLOYER:_____

HOME PHONE:_____ WORK PHONE:_____ CELL PHONE:_____

D. MISCELLANEOUS INFORMATION

In case of emergency notify:_____

Relationship to patient:_____ Phone Number:_____

Results of any lab work, pathology reports, or any other diagnostic test can be shared with the following:

_____Patient _____Spouse _____Parent _____Other _____

POWER OF ATTORNEY (If applicable): _____ Contact information:_____

I authorize the release of any medical or other information necessary to process claims. I also authorize payment of medical benefits to the physician or practice. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I understand that payment is expected at time of service if I do not have insurance.

SIGNATURE of PATIENT or LEGAL GUARDIAN_____ DATE:_____

Cleveland Dermatology Medical History

Name: _____

Past Medical History (Please circle all that apply)

Anxiety	Depression	Hyperthyroidism
Arthritis	Diabetes	Hypothyroidism
Asthma	End Stage Renal Disease	Leukemia
Atrial Fibrillation	GERD	Lung Cancer
Bone Marrow Transplant	Glaucoma	Lymphoma
BPH	Hearing Loss	Prostate Cancer
Breast Cancer	Hepatitis	Radiation Treatment
Colon Cancer	Hypertension	Seizures
COPD	HIV/AIDS	Stroke
Coronary Artery Disease	High Cholesterol	NONE

Other/Details: _____

_____

Past Surgical History (Please circle all that apply)

Appendix	Kidney Stone Removal
Bladder	Kidney Transplant
Breast Biopsy (Right/Left/Both)	Kidney Removal (Right/Left)
Lumpectomy (Right/Left/Both)	Liver Transplant
Mastectomy (Right/Left/Both)	Ovaries: Endometriosis
Breast Reduction	Ovaries: Ovarian Cancer
Breast Implants	Ovaries: Ovarian Cyst
Colon Cancer Resection	Ovaries: Tubal Ligation
Diverticulitis (Colon)	Pancreas Removal
Inflammatory Bowel Disease (Colon)	Prostate Biopsy
Colostomy	Prostate Cancer
Gallbladder	TURP (Prostate Removal)
Biological Valve Replacement	Basal Cell Carcinoma
Coronary Artery Bypass	Melanoma
Heart Transplant	Skin Biopsy
Mechanical Valve Replacement	Squamous Cell Carcinoma
Coronary Stenting	Spleen Removal
Hip Replacement (Right/Left/Both)	Testicles (Right/Left/Both)
Knee Replacement (Right/Left/Both)	Hysterectomy (Fibroids)
Kidney Biopsy	Hysterectomy (Uterine Cancer)
NONE	

Other/Details: _____

_____

Skin Disease History (Please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking/Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	NONE

Other: _____

Do you wear sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)?_____

Medications (Please list all current medications or provide us with a list to copy)

_____
_____
_____
_____

Allergies (Please list all allergies):

_____
_____
_____
_____

Smoking Status:
Current Every Day Smoker
Current Some Day Smoker
Never Smoked
Former Smoker

Alcohol Consumption:
None
Less Than 1 Drink Per Day
1-2 Drinks Per Day
3 or More Drinks Per Day

Occupation and Workplace: _____

Review of Systems (Please circle appropriate answer to all questions):
Pacemaker (Yes/No) Defibrillator (Yes/No) Preoperative Antibiotics (Yes/No)
Blood Thinners (Yes/No) Rapid Heartbeat with Epinephrine (Yes/No)
Lidocaine Allergy (Yes/No) Adhesive Allergy (Yes/No)

Pharmacy Name: _____ Pharmacy City or Zip Code: _____

Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES

Cleveland Dermatology

Practice Name

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do

agree to the restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of September 12, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer Heather Buhmeyer, R.N. for more information, in person or in writing.

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Cleveland Dermatology

_____

Practice Name

I am a patient of Cleveland Dermatology. I hereby acknowledge receipt of Cleveland Dermatology's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of Cleveland Dermatology 's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____