DERMATOLOGY ASSOCIATES, INC Date:_____/_____/_____

PATIENT:

LAST NAME _____FIRST NAME_____ MIDDLE INIT_____

DATE OF BIRTH _____/_____/_____ SEX: __ MALE __ FEMALE MARITAL STATUS: __ SINGLE __ MARRIED __ OTHER

MOBILE PHONE _____ - _____ - _____ HOME _____ - _____ - _____ WORK _____ - _____ - _____

*PREFERRED CONTACT METHOD: ___MOBILE ___HOME ___WORK

EMAIL ADDRESS _____

***EMAIL REQUESTED TO ESTABLISH ACCESS TO YOUR WEB PATIENT PORTAL. YOU CAN USE THE PORTAL TO ACCESS YOUR HEALTH INFORMATION, COMMUNICATE ANY NON URGENT MESSAGES DIRECTLY WITH OUR PROVIDER, AND MAKE ACCOUNT PAYMENTS**

PREFERRED LANGUAGE:_____ RACE:_____ ETHNIC GROUP:_____

ADDRESS_____

CITY_____ STATE _____ ZIP _____

EMERGENCY CONTACT_____ PHONE _____ - _____ - _____

PRIMARY CARE PROVIDER _____

REFERRING PROVIDER _____

PREFERRED PHARMACY_____STREET/CITY_____

GUARANTOR (RESPONSIBLE PARTY IF PATIENT IS UNDER 18 OR LEGAL GUARDIAN/POA):

LAST NAME_____ FIRST NAME_____ MIDDLE INIT_____

DATE OF BIRTH _____/_____/_____ RELATIONSHIP TO PATIENT _____

PHONE _____ - _____ - _____ ADDRESS_____

CITY_____ STATE_____ ZIP_____

INSURANCE:

*PRIMARY INSURANCE_____

POLICY HOLDER NAME_____ BIRTHDATE _____/_____/_____

EMPLOYER _____ REALTIONSHIP TO POLICY HOLDER_____

*SECONDARY INSURANCE_____

POLICY HOLDER NAME_____ BIRTHDATE _____/_____/_____

EMPLOYER_____ RELATIONSHIP TO POLICY HOLDER_____

Dermatology Associates, Inc.

As a medical practice we are required to keep several signatures on file. Please review the following, initial and sign where appropriate.

_____ Initial — I am presenting myself for diagnosis and treatment by the physicians, physician assistants and/or nurse practitioners of Dermatology Associates, Inc. I voluntarily consent to the providing of such care which may include diagnostic procedures and medical treatments if needed by providers, in their judgment and with my consent, be necessary or advisable to treat my condition.

_____ Initial — I have been offered a copy of Dermatology Associates Inc. Notice of Privacy Practices as set forth by HIPAA regulations.

_____ Initial — I understand that it is my responsibility to update my HIPAA release of information. I also understand that this can be done at any time by contacting the office directly.

_____ Initial — I authorize payment of medical benefits to the rendering physician.

_____ Initial — I have been offered a copy of Dermatology Associates Financial Policy. *Please be advised that we are not in network with any forms of Medicaid plans.

Medicare Patients Only

_____ Initial — I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

MEDIGAP (Medicare Crossover) Patients Only

_____ Initial — I request authorized MEDIGAP benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____/_____/_____

Patient/Guardian Signature Date

_____

Patient/Guardian name **printed**

If not signed by patient, please indicate relationship to patient: _____

DERMATOLOGY ASSOCIATES, INC.
12780 ROACHTON RD, PERRYSBURG, OH 43551 / 3141 CENTRAL PARK WEST, TOLEDO, OH 43617
PHONE 419.872.0777 FAX 419.872.2369

Authorization for Disclosure of Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____/_____/_____

Please list your preferred phone number: (_____) _____-_____ (____Cell/____Landline/____Work)
****IF PT UNDER 18, PLEASE LIST GUARDIAN PHONE**

EMAIL ADDRESS _____

PRIMARY CARE PROVIDER _____ **PHARMACY** _____

Purpose of request (who will be authorized to receive information other than those covered under HIPAA): I authorize Dermatology Associates to disclose or provide protected health information about me to the individual(s) listed below:

Please list who will be authorized to receive your protected health information:

No one but myself: _____

Name: _____ Relationship: _____ Phone: (_____) _____-_____

Name: _____ Relationship: _____ Phone: (_____) _____-_____

Name: _____ Relationship: _____ Phone: (_____) _____-_____

Description of information to be disclosed: I authorize the practice to disclose the following protected health information about me to the entity/person(s) identified above:

_____ Entire patient record; **OR** check **only** those items of the record to be disclosed:

_____ Office notes _____ Nursing home, home health, hospice, and other physician records

_____ Financial history (previous 3 years) _____ Lab results, pathology reports and/or x-rays

_____ Only disclose the following_____

- This authorization will expire one year from the date of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than one year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____ / _____ / _____

Patient / Guardian Signature Date

_____Patient / Guardian name **PRINTED**

Medical History and Intake Form

Name: _____ Date of birth: _____

Past Medical History: (please circle all that apply)

Anxiety Disorder
Arthritis
Asthma
Atrial Fibrillation
Benign Prostatic hyperplasia (BPH)
Cerebrovascular accident (Stroke)
COPD
Coronary Artery Disease
Depression
Diabetes
Hypertension
End-stage Kidney Disease
Epilepsy
Acid Reflux (GERD)
Hearing Loss
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Inflammatory Disease of Liver (Hepatitis)
Leukemia
Lymphoma
Breast Cancer
Colon or Rectal Cancer
Lung Cancer
Prostate Cancer
Bone Marrow Transplant

Other _____

Past Surgical History: (please circle all that apply)

Breast Biopsy
Prostate Biopsy
Coronary Artery Bypass Graft (CABG)
Kidney Transplant- Right Left
Basal Cell Carcinoma Excision
Melanoma Excision
Squamous Cell Carcinoma Excision
Colostomy
Tubal Ligation
Appendix Removal (Appendectomy)
Mastectomy- Right Left
Gall Bladder Removal (Cholecystectomy)
Colon Removal (Colectomy)
Heart Valve Replacement- Tissue graft or Mechanical
Bladder Removal (cystectomy)
Hysterectomy
Kidney Biopsy
Rectal Resection
Lumpectomy, Breast- Right Left
Ovaries Removal (Oophorectomy)
Pancreas Removal (Pancreatectomy)
Prostate Removal (Prostatectomy)
Spleen Removal (Splenectomy)
Skin Biopsy
Kidney Removal (nephrectomy)- Right Left
Testicle Removal (orchidectomy)- Right Left
Hip Replacement- Right Left
Knee Replacement- Right Left
Heart Transplant
Liver Transplant

Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses(pre-cancer)
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

Other _____

Name: _____ Date of birth: _____

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, please indicate: Parent? _____ Sibling? _____ Child? _____

Do you have a family history of other cancers? Yes No Type of cancer: _____
If yes, please indicate: Parent? _____ Sibling? _____ Child? _____

Medications: Please enter all current medications, type of medication (cream, tablet, injection, etc.), strength, how often you take it and start date (if known).

Name of medication including type	Strength	How often taken	Approximate start date

Allergies: (Please enter all allergies)

_____ _____ _____

_____ _____ _____

Social History: (Please circle all that apply)

Currently Smokes Has smoked in the past Never smoked

Occupation_____

Who were you referred by? _____

Approximate Height_____ **Approximate Weight**_____

Immunizations: (Please enter approximate month/year)

Influenza vaccine _____ **Pneumonia vaccine**_____ **COVID-19 vaccine** _____

DERMATOLOGY ASSOCIATES, INC.
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts 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 physical or mental health condition and related healthcare services.
Our practice is legally required to maintain the confidentiality of your PHI, and to follow specific rules when using or disclosing this information. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules when using or disclosing your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permit- ted 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 by law to follow the terms of this Notice. We reserve the right to change the terms of the Notice, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a copy of our current Notice if you call our office and request that a revised copy be sent to you in the mail, or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.
You have the right to authorize other use and disclosure - This means we will only use or disclose your PHI as described in this Notice, unless you authorize other use or disclosure in writing. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or 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, fax, telephone), and/or 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 obtain a copy your PHI* - This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you will also have the right to request a copy in electronic for- mat. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. We are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the expected date when the request will be fulfilled.
You have the right to request a restriction of your PHI* - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. 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 will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.
You have the right to request an amendment to your protected health information* - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.
You have the right to request a disclosure accountability* - You may submit a written request for a listing of dis- closures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.
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 a risk assessment that notification is required.

*** If you have questions regarding your privacy rights, or would like to submit any type of written request described above, please feel free to contact our Privacy Manager. Contact information is provided at right under Privacy Complaints.**

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 uses and 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.
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 health- care services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.
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.
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, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.
We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.
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 purposes 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 or disclosure of PHI (e.g., in a disaster relief situation), 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 and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose in- formation to the health plan sponsor for plan administration; 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 Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.
You may ask questions about your privacy rights, file a complaint, or submit a written request (for access, restriction, or amendment of your PHI or to obtain disclosure accountability) by notifying our Privacy Manager at: 419-872-0777
Effective Date: 3/02/2021 Publication Date: 3/02/2021

Dermatology Associates, Inc.

12780 Roachton Rd., Perrysburg, Ohio 43551
3141 Central Park West, Toledo, Ohio 43617
Phone (419) 872-0777

Financial Policy

We appreciate your confidence in choosing Dermatology Associates, Inc. Please take a moment to review the important financial information below.

We accept the following forms of payment: Cash, Check, Mastercard, Visa or Discover. We are contracted providers for Medicare, Tricare, Paramount, Frontpath, Anthem BC/BS, Aetna, Medical Mutual of Ohio, Cigna, Great West, Ohio Health Choice, United Healthcare, Cofinity, and McClaren. WE ARE NOT CONTRACTED WITH ANY FORM OF MEDICAID PLAN.

If we are *not* directly contracted with your insurance company this means that we do not discount the cost of your medical services. Your insurance would consider our practice to be out-of-network providers. The penalties for seeing and out-of-network provider may include 1) a larger deductible than usual, 2) a larger out of pocket expense for the patient or 3) no benefits at all. As a courtesy, we will bill your insurance company for you. Any amount that is excluded, denied or not covered by your insurance company will be your responsibility to pay.

With certain insurance policies you are required to have a referral in order for your medical services to be covered. It is your responsibility to know if a referral is required and to obtain authorization for services you wish to have rendered.

In the event that there is a balance due from you after your insurance has paid its portion, we will bill you. We only send three statements. If no payment is received 30 days after the last statement the account will be turned over to our collection agency. To avoid this, please pay your balance promptly after you receive your first statement. If you do not understand the reason you owe a balance, please do not hesitate to call our office.

Our staff is dedicated to working with you and your insurance carrier to obtain the proper reimbursement for your medical services. Patients, however, have a responsibility regarding their coverage as well. We appreciate your assistance in working with our staff.

Our practice requires 24 hour notice for cancellations. A $20.00 fee will be charged to your account if less than 24 hour notice is provided.

If you are an enrollee of an insurance plan with a known copay, you are required to pay this copay each time you are seen. If not paid at the time of service, an $8.00 fee will be applied to your account.

Refund Policy: We recognize the importance of resolving any and all account payments. We employ a team of highly trained personnel dedicated to resolving account over payments as quickly as possible. We routinely research all patient accounts with credit balances. In the event we are notified by a carrier or patient of an overpayment before we have reviewed the account, the account can be submitted for an expedited refund.

Routine patient overpayments less than $50.00, will remain on the patient account as a credit balance for the period of up to three years. This overpayment may be applied to future services incurred during that time period. After the three year period, if the funds have not been used, a refund check will be issued to the patient or guarantor on file. Routine patient overpayments of $50.00 or more will be refunded as they occur. They will not be held as a credit balance.

Please keep this information and our Notice of Privacy Practices for your records. If at any time you have questions about the care you are receiving, please speak up immediately. We can only provide you the best care if we have good communication.