

**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.

\_\_\_\_\_ I am presenting myself for diagnosis and treatment by the physicians, physician  
Initial 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.

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

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

\_\_\_\_\_ 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  
Initial that we are not in network with any forms of Medicaid plans.

**Medicare Patients Only**

\_\_\_\_\_ I authorize any holder of medical or other information about me to release to the Social  
Initial 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**

\_\_\_\_\_ I request authorized MEDIGAP benefits to be made on my behalf for any services furnished  
Initial 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: \_\_\_\_\_

**Authorization for Disclosure of Protected Health Information (PHI)**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please list your preferred phone numbers: 1. (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_ Cell/\_\_\_\_ Landline/\_\_\_\_ Work)  
**\*\*IF PT UNDER 18, PLEASE LIST GUARDIAN PHONE**  
2. (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_ Cell/\_\_\_\_ Landline/\_\_\_\_ Work)

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**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: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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

Other \_\_\_\_\_

**Past Surgical History:** (please circle all that apply)

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

Other \_\_\_\_\_

**Skin Disease History:** (please circle all that apply)

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

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

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

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

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

\_\_\_\_\_  
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 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 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 format. 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 disclosures 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 healthcare 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 information 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

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# Dermatology Associates, Inc.

12780 Roachtown Rd., Perrysburg, Ohio 43551  
7640 Sylvania Ave., Ste. E Sylvania, OH 43560  
Phone (419) 872-0777

## Financial Policy

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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 an 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.