

New Patient Information

Patient Title Dr. Mr. Mrs. Ms. Miss

Last Name _____ First Name _____ M.I. _____

Address _____ Apt/Ste # _____ City _____ State _____ Zip _____

Date of Birth ____/____/____ Age: _____ Male Female

Home Phone _____ Cell Phone: _____

Is it okay to leave a detailed message? Yes No

Social Security # _____ Email: _____

Preferred Language _____ Race: _____ Ethnic Group: _____

Marital Status S M D W

Primary Care Doctor: Name _____ Phone: _____ Fax _____

No Current Primary Care Doctor

Occupation/Employer _____

Emergency Contact Name/Relation _____ Phone Number: _____

Would you like to receive emails on the latest advances in skin care treatments? Yes No

How did you hear about us? _____

Insurance Coverage – Primary Carrier _____

Contract #: _____ Group #: _____

Policy Holder (insured) Name: _____ Date of Birth: _____

Insurance Coverage – Secondary _____

Contract #: _____ Group #: _____

Policy Holder (insured) Name: _____ Date of Birth: _____

Homewood
T: 205.871.7332
F: 205.871.7336
1920 Huntington Rd
Homewood, AL 35209

Chelsea
T: 205.678.7518
F: 205.677.2079
398 Chesser Dr, Suite 6
Chelsea AL 35043

Patient History and Intake Form

Past Medical History: *(Please check all that apply.)*

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Hyperthyroid |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypothyroid |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> GERD | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Bone Marrow Transplantation | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> COPD | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| | | <input type="checkbox"/> NONE |

Other _____

Past Surgical History: *(Please check all that apply.)*

- | | |
|---|---|
| <input type="checkbox"/> Appendix Removed | <input type="checkbox"/> Kidney Removed (Right, Left) |
| <input type="checkbox"/> Biological Valve Replacement | <input type="checkbox"/> Kidney Stone Removal |
| <input type="checkbox"/> Bladder Removed | <input type="checkbox"/> Kidney Transplant |
| <input type="checkbox"/> Breast Biopsy (Right, Left, Bilateral) | <input type="checkbox"/> Lumpectomy (Right, Left, Bilateral) |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Mechanical Valve Replacement |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Mastectomy (Right, Left, Bilateral) |
| <input type="checkbox"/> Colectomy: Colon Cancer Resection | <input type="checkbox"/> Ovaries Removed: Endometriosis |
| <input type="checkbox"/> Colectomy: Diverticulitis | <input type="checkbox"/> Ovaries Removed: Cyst |
| <input type="checkbox"/> Colectomy: IBD | <input type="checkbox"/> Ovaries Removed: Ovarian Cancer |
| <input type="checkbox"/> Coronary Artery Bypass | <input type="checkbox"/> Prostate Biopsy |
| <input type="checkbox"/> Gallbladder Removed | <input type="checkbox"/> Prostate Removed: Prostate Cancer |
| <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Spleen Removed |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> TURP (Prostate Removal) |
| <input type="checkbox"/> Hysterectomy: Fibroids | <input type="checkbox"/> Testicles Removed (Right, Left, Bilateral) |
| <input type="checkbox"/> Hysterectomy: Uterine Cancer | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Joint Replacement, Hip (Right, Left, Bilateral) | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Joint Replacement, Knee (Right, Left, Bilateral) | |
| <input type="checkbox"/> Joint Replacement within last 2 years | |
| <input type="checkbox"/> Kidney Biopsy (Nephrectomy) | |

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Patient History and Intake Form (continued)

Skin Disease History: *(Please check all that apply.)*

- | | | |
|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Poison Ivy |
| <input type="checkbox"/> Actinic Keratoses | <input type="checkbox"/> Eczema | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Melanoma | <input type="checkbox"/> 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 and dosage.)*

Allergies: *(Please list all allergies.)*

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Patient History and Intake Form (continued)

Social History: *(Please do not leave blank. Check all that apply.)*

Cigarette Smoking:

- Currently smokes
- Has smoked in the past
- Never smoked

Alcohol Use:

- Less than 1 drink per day
- 1-2 drinks per day
- 3 or more drinks per day
- None

If you are 65+, have you ever received the Pneumonia Vaccine: *(Please circle one.)* Yes or No

Family Medical History: *(Only first degree relatives.)*

Preferred Pharmacy

Name _____

Phone _____

City or Zip Code _____

Special Alerts *(Please check all that apply.)*

Are you pregnant or currently trying to get pregnant? Yes No

- | | |
|---|--|
| <input type="checkbox"/> Allergy to adhesive | <input type="checkbox"/> Breast feeding |
| <input type="checkbox"/> Allergy to lidocaine | <input type="checkbox"/> Defibrillator |
| <input type="checkbox"/> Allergy to topical antibiotics | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Artificial joint replacement | <input type="checkbox"/> Require antibiotics prior to surgical procedure |
| <input type="checkbox"/> Blood thinners | <input type="checkbox"/> Rapid heartbeat with epinephrine |

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Statement of Patient Financial Responsibility

*Please Initial

____ I understand that if I am uninsured or have an insurance that is not accepted at the practice, I will be responsible for payment in FULL at the time of service.

____ I understand all insurance copays must be paid in full at time of appointment and all deductibles must be current to be seen. Failure to make payments when requested could result in legal action. The undersigned agrees to pay all cost for collections, including a reasonable fee, and hereby waives his/her rights of exemption under the laws of the State.

____ I understand that I will be responsible for payment of any deductible and co-payment/ coinsurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

____ I authorize the release of medical information to my primary care or referring physician, to consultations if needed and as necessary to process insurance claims, insurance applications and prescriptions.

____ I am aware that the practice has a Notice of Privacy Policies that contains a section of Patient Rights. I have been given the opportunity to review this notice and the option to obtain a personal copy.

____ By initialing here, you give SWD consent to send automated text messages and/ or emails that will include information about promotions, events and other marketing information.

Patient Signature _____ Date _____

Self-Pay

In the event you do not have insurance coverage, we are pleased to offer a self-pay option for our patients. Effective January 1st, 2017 Skin Wellness Dermatology will charge \$150 for a new self-pay patient appointment and \$85 per follow-up self-pay appointment. The self-pay charge covers your visit with the provider, however, if additional services (i.e. biopsies, freezing, in office application of medication, etc.) are needed, they will hold individual charges. Please let us know when you make your appointment if you would like to utilize our self pay option.

I do not have health insurance and will be responsible for services rendered here at Skin Wellness Dermatology. I agree to pay the practice the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature _____ Date _____

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Appointment Policy

In an effort to keep appointments running smoothly and in a timely manner, the following policies have been implemented. Please completely read the policy before signing. If you have any questions, they may be directed to our office staff.

- For first office visits, please arrive 15-20 minutes early. New Patient forms must be completed prior to seeing the doctor. These forms are also available on our website at www.skinwellness.com under "Patient Resources" if you wish to complete prior to your office visit.
- Each time a patient misses an appointment without providing notification (no-shows), another patient is prevented from receiving care. A failure to be present at the time of your scheduled appointment will be recorded in the medical record, and an administrative fee of \$50 will be charged to you (not your insurance company). If an individual has three (3) no-shows within a three (3) year period, they may be discharged from the practice.
- Please be aware that Monday appointments must be canceled by noon on the previous Friday. If you are scheduled for surgery, a procedure for Accutane follow-up and you cancel or no show, we may not be able to reschedule another appointment in a timely manner.
- Any time that you will be late for an appointment, please call to inform us. If you are running more than 15 minutes late, you may be asked to reschedule if our schedule is tight. This may also result in a Late Cancellation Fee of \$50 charged to you (not your insurance company). We will always try to accommodate as we all run late sometimes.

Appointment times reflect the health issues provided to the receptionist at the time the appointment is scheduled (i.e. is the visit for acne, a mole check, a surgical procedure or a consultation regarding a specific skin and/or cosmetic concerns?). Lengthy delays result from patients asking for additional time to address issues other than those originally scheduled. Please be considerate of those waiting.

Skin Wellness Dermatology is committed to timely appointments, so we appreciate your cooperation and understanding on these matters.

Patient's Name _____ Date _____
(please print)

Signature of Patient or Legal Guardian _____

No Recording Policy

Skin Wellness Dermatology prohibits the use of any recording devices in the waiting area or the exam rooms. Any unauthorized recording or photography may result in dismissal from the practice.

Patient Signature: _____

Date: _____

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Corey L. Hartman, MD, FAAD
Rayna M. Dyck, MD, FAAD
Deborah H. Youhn, MD, FAAD
Brittany Rigsby, CRNP

Cancellation/ No Show/ Late Arrival Appointment Policy

Skin Wellness Dermatology is committed to providing you with excellent care and timely appointments. No shows, late arrivals (15-minutes or more), and/or appointments cancelled with less than 24-hour advance notification inhibit us from treating you and others; and are subject to a \$50 administrative fee. This fee is not reimbursable by insurance and is the sole responsibility of the patient. A valid credit card must be provided/maintained for appointment scheduling. If you are running more than 15-minutes late, please contact us. We will always do our best to accommodate and get you in whenever we can.

When scheduling, please communicate to reception the primary reason(s) for your visit so that we may allot the appropriate amount of time to address; your concerns during your visit. We truly appreciate your cooperation and thank you in advance for helping us to serve you better.

Please indicate your preferred method of payment below: Card Type:

Mastercard Visa American Express Discover

Credit Card #: _____ Expiration Date: ____/____

Billing Zip Code: _____ CVV _____

My signature confirms that I understand and accept Skin Wellness Dermatology's appointment policy.

_____	_____	_____
Patient or Legal Guardian Full Name	Patient or Legal Guardian Signature	Date

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info@skinwellness.com
skinwellness.com

HIPAA Patient Consent Form

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The practice (HIPAA). provides this form to comply with the Health Insurance Portability and Accountability Act of 1996. (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

I understand that as a part of my healthcare, this practice originates and maintains health records describing my history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I wish to NOT disclose my medical information to anyone.

I wish to GIVE permission to disclose my medical information.

You may disclose my information to the following family members and physicians:

Patient Signature: _____ Date _____

Witness Signature: _____ Date _____

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Office Procedures

The following information will help you understand our office procedures. These procedures are in place so that our staff can give the best care to all our patients. Thank you for allowing us to take care of you!

MEDICATION REFILLS

Please allow up to 48 hours on all prescription requests. We try to do them the **SAME DAY** you call if possible, but **DO NOT** wait until last minute. We ask that you submit your request via the patient portal, as this can result in a quicker response time. You can also leave a voicemail on the office **NURSE** line to request a refill. Please leave your **full name, DOB, name of medication requested, pharmacy name and pharmacy phone number**. Please contact the office that you are seen in, either Homewood or Chelsea.

LAB AND TEST RESULTS

Some test and lab results can take up to 10-14 days. Your abnormal results will be called to you. Your normal results will be available on the patient portal. You may request a copy of your records.

REFERRALS

You are responsible for insurance authorizations. You will need to know if a referral is needed from your insurance company for your visit. If your doctor wants to refer you for a test, or to another specialist, please allow 5 days for the medical staff to process your referral.

MEDICAL RECORDS

Medical records require a 72-hour notice and are \$1 per page for the first 25 pages, and 50¢ for each additional page. A **medical records release** form must be on file for records to be released. Records can be faxed to another provider free of charge.

PHONE CALLS AND APPOINTMENTS

- The appointment line voicemail is checked every hour. If you have a more urgent matter that needs to be handled, you may send an email to info@skinwellness.com.
- Please do not leave multiple messages on the nurse line. You can also submit request or questions through the patient portal or info@skinwellness.com.
- Three "No Show" appointments or recurrent cancellations will result in **DISMISSAL FROM THE CLINIC**. Please call as soon as you know you will not be able to make your appointment. Please see **APPOINTMENT POLICY** for further detail on fees that can be associated with same day cancellations and no-show appointments.

I authorize the staff of Skin Wellness Dermatology to leave message(s) concerning my care on the voicemail of the following phone number(s):

E-mail: _____

Patient Signature: _____ Date: _____

Homewood
T: 205.871.7332
F: 205.871.7336
1920 Huntington Rd
Homewood, AL 35209

Chelsea
T: 205.678.7518
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Notice of Privacy Practices

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

The policy of Skin Wellness Dermatology is to protect the confidentiality, integrity and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use or disclosure of such information. We are required by law to maintain the privacy of your health information and provide you with this notice of our duties and obligations. This policy applies to patients who are current or former patients of Skin Wellness Dermatology.

Individually identifiable health and personal information are any information obtained by Skin Wellness Dermatology in connection with providing healthcare treatment, obtaining payment and related health care operations. This relates to past, present or future information that Skin Wellness Dermatology receives from you as our patient.

Skin Wellness Dermatology collects personal information in order to learn about your medical history and medical conditions to render treatment and collect payment for our services. We gather this information from your patient forms, health questionnaires and other forms you will be asked to complete from time-to-time. In addition, we will assemble information based on our discussions and conversations with you, your personal representative and your family members. Your healthcare plan or insurance carrier may provide information to our office.

We will use this information to provide caring and quality medical care to you. Examples include diagnosis, treatment and communications such as follow up and appointment reminders, as well as treatment alternatives or other health-related benefits. As part of our standard treatment and healthcare operations, we may share information with a facility such as a hospital, laboratory, diagnostic service or healthcare provider to efficiently coordinate your treatment plan. For contracted insurers, your information will be used for claims management and to obtain payment from your insurance carrier. As required by your insurance contractor, we will exchange paper and electronic data with your insurance carrier for activities such as eligibility, benefit and coverage determinations, precertification, utilization review and related activities. For worker's compensation, information about work-related condition can be exchanged with the employer.

Your information is maintained in our office in our practice management computer system. We also maintain information about you in your medical chart. Skin Wellness Dermatology limits the access to your protected health information to those employees and business associates who need to know that information. With some limitations, you have the right to inspect, amend, copy and receive an accounting of disclosures of your medical and billing records.

Notice of Privacy Practices (continued)

We do not disclose personal information to third parties unless one of the following exceptions applies:

- We receive explicit authorization from you to release individually identifiable information. This authorization must be in writing and give exact details regarding to whom the disclosure applies, the nature of the data to be released, the applicable dates and signed by the patient (or guardian). You may revoke this authorization by providing a written statement to the Skin Wellness Dermatology Privacy Officer.
- Federal, state or other applicable law requires us to share protected information or records.

We are obligated to abide by the terms of this notice. If, at any time in the future, it is necessary to disclose any of your personal information in a way that is materially different from this policy, Skin Wellness Dermatology will give you notice of the change through a mailed announcement or on your visit following the change.

With some exceptions, you have the right to review and obtain a copy of your health information. This request must be in writing and there may be a reasonable charge to provide you with a copy of your information. You also have the rights to request your records be amended, to request special accommodations and restrictions of your health information and to receive an accounting of the disclosures of your information. You have the right to request to receive confidential communications of your information. Skin Wellness Dermatology is not obligated to agree to a requested restriction. We must receive a written request from you to administer these rights. Please speak to the receptionist for further information or to begin the process to exercise any of these rights.

If you have a complaint about the management of your health information or believe your privacy rights have been violated, contact **Vickie Miles at (205) 871-7332**. You have the right to file a complaint with the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. There will be no retaliation for filing a complaint.

Other uses of PHI:

- Your medical information may be reviewed by our medical staff for possible inclusion and referral in research studies. You will be contacted prior to the use of your information in a research study.
- We may leave a message on your answering machine, voice mail, or email to contact you about appointments or to have you call our office.
- We may send emails about new services or promotional events for new cosmetic services.