PATIENT INFORMATION: Date:_____/_____/_____ **CAMPEN DERMATOLOGY**

Name: _____, _____, _____ ☐Male ☐Female
Last First Middle

DOB:_____/_____/_____ SSN:_____-_____-_____ | ☐Single ☐Married ☐Divorced ☐Widowed

Place of Birth: _____, _____ ☐USA ☐Other:_____
City State

Physical Address:_____City:_____State:_____Zip:_____

Mailing Address: _____City:_____State:_____Zip:_____

Seasonal Address: _____City:_____State:_____Zip:_____

Ethnic Group: _____ Race: _____

Home Phone ( ) _____ - _____

Work Phone ( ) _____ - _____

Cell Phone ( ) _____ - _____

Primary Phone: ☐Home ☐Work ☐Cell

Is it OK for us to leave a detailed message? ☐Yes ☐No

Email Address:_____

Emergency Contact:_____

Contact Relation to Patient:_____

Contact Number: ( ) _____ - _____

Spouse's Name:_____

Caretaker:_____

Primary Care Physician:_____

Physician Number: ( ) _____ - _____

INSURANCE INFORMATION:

Primary Insurance:_____

Policy Holder:_____

Policy Holder's DOB:_____/_____/_____

Policy Holder's SSN: _____-_____-_____

Holder's Relationship to Patient: _____

INSURANCE INFORMATION:

Secondary Insurance:_____

Policy Holder:_____

Policy Holder's DOB:_____/_____/_____

Policy Holder's SSN: _____-_____-_____

Holder's Relationship to Patient: _____

I authorize the following people for release of records, pathology results, billing information, etc.

Name: _____, _____, _____ Relationship: _____
Last First Middle

Name: _____, _____, _____ Relationship: _____
Last First Middle

Notice to Patient: By signing this form you grant us consent to treat you and to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our Notice of Privacy Practices provides details on out treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it. It provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in out Notice of Privacy Practices, we reserve the right to change our privacy practices. If we do so, we will issue a revised Notice. Since revision may apply to your health care information, you have a right to receive a copy by contacting our privacy office.

You have the right to revoke your consent by giving written notice to our privacy officer. The revocation will not affect actions that were already taken in reliance upon consent. You should also understand that if you revoke this consent we might decline to treat you.

You are entitled to a copy of this Consent Form after you have signed it.

Patient's Signature:_____ Date:_____/_____/_____
Or Signature of Representative

Printed name of Patient's Representative: _____

To help us provide you with the best possible care please fill out this form completely.

Did a physician refer you to Dermatology Services? ☐No ☐Yes If yes, Physician's Name: _____

Present Problem(s):_____

Past Medical History: (Please check all that apply)

◯ **None**

- ◯ Anxiety Disorder
- ◯ Arthritis
- ◯ Asthma
- ◯ Atrial Fibrillation
- ◯ Benign Prostatic Hyperplasia
- ◯ Cerebrovascular Accident
- ◯ Chronic Obstructive Lung Disease
- ◯ Coronary Arteriosclerosis
- ◯ Depressive Disorder
- ◯ Diabetes Mellitus
- ◯ Disease caused by 2019-nCoV
- ◯ Elevated Blood Pressure
- ◯ End-Stage Renal Disease
- ◯ Epilepsy
- ◯ Gastroesophageal Reflex Disease
- ◯ H/O: Hypertension
- ◯ Hearing Loss
- ◯ Human Immunodeficiency Virus Infection
- ◯ Hypercholesterolemia
- ◯ Hypothyroidism
- ◯ Inflammatory Disease of Liver
- ◯ Leukemia
- ◯ Malignant Lymphoma
- ◯ Malignant Tumor of Lung
- ◯ Malignant Tumor of Breast
- ◯ Malignant Tumor of Colon
- ◯ Malignant Tumor of Prostate
- ◯ Radiation Therapy Treatment Management
- ◯ Transplantation of Bone Marrow

Other: _____

Past Surgical History: (Please check all that apply)

◯ **None**

- ◯ Abdominoperineal Resection
- ◯ Bilateral Replacement of Knee Joints
- ◯ Biopsy of Breast
- ◯ Biopsy of Prostate
- ◯ Coronary Artery Bypass Graft
- ◯ Entire Transplanted Kidney
- ◯ Excision of Basal Cell Carcinoma
- ◯ Excision of Melanoma
- ◯ Excision of Squamous Cell Carcinoma
- ◯ H/O: Colostomy
- ◯ H/O: Tubal Ligation
- ◯ History of Appendectomy
- ◯ History of Bilateral Mastectomy
- ◯ History of Cholecystectomy
- ◯ History of Colectomy
- ◯ History of Liver Excision
- ◯ History of Percutaneous Transluminal Coronary Angioplasty
- ◯ History of Tissue Graft Heart Valve Replacement
- ◯ History of Total Cystectomy
- ◯ Hysterectomy
- ◯ Kidney Biopsy
- ◯ Low Anterior Resection of Rectum
- ◯ Lumpectomy of Breast (Left / Right)
- ◯ Mastectomy of Breast (Left / Right)
- ◯ Mechanical Heart Valve Replacement
- ◯ Oophorectomy
- ◯ Pancreatectomy
- ◯ Percutaneous Extraction of Kidney Stone with Fragmentation Procedure
- ◯ Portosystemic Shunt Operation
- ◯ Prostatectomy
- ◯ Prosthetic Arthroplasty of Bilateral Hips
- ◯ Splenectomy
- ◯ Surgical Biopsy of Skin
- ◯ Total Nephrectomy
- ◯ Total Orchidectomy
- ◯ Total Replacement of Hip Joint (Left / Right)
- ◯ Total Replacement of Knee Joint (Left / Right)
- ◯ Transplantation of Heart
- ◯ Transplantation of Liver

Other:_____

Skin Conditions: (Please check all that apply)

◯ **None**

◯ Acne
◯ Actinic Keratosis
◯ Asteatosis Cutis
◯ Basal Cell Carcinoma of Skin
◯ Contact Dermatitis due to Poison Ivy
◯ Dysplastic Nevus of Skin
◯ Eczema
◯ H/O: Asthma
◯ H/O: Hay Fever
◯ Malignant Melanoma
◯ Pruritus of Scalp
◯ Psoriasis
◯ Squamous Cell Carcinoma
◯ Sunburn of Second Degree

Other: _____

Do you wear sunscreen? ☐No ☐Yes: SPF:_____

Do you tan in a tanning salon? ☐No ☐Yes

Family History: Do you have a family history of:

Melanoma? ☐No ☐Yes:
Relative(s):_____

Psoriasis? ☐No ☐Yes:
Relative(s):_____

Skin Cancer? ☐No ☐Yes:
Relative(s):_____

Eczema? ☐No ☐Yes:
Relative(s):_____

Other Diseases? ☐No ☐Yes: Disease(s):_____
Relative(s):_____

Medications: (Please enter all current medications)

◯ **None**

1)_____ Dosage: _____
2)_____ Dosage: _____
3)_____ Dosage: _____
4)_____ Dosage: _____
5)_____ Dosage: _____
6)_____ Dosage: _____
7)_____ Dosage: _____
8)_____ Dosage: _____
9)_____ Dosage: _____
10)_____ Dosage: _____
11)_____ Dosage: _____
12)_____ Dosage: _____

Preferred Local Pharmacy Name: _____

Street: _____ City: _____

Preferred Mail Order Pharmacy Name: _____

Have you had your Flu Shot? ☐No ☐Yes

If you are over 65, have you had your Shingles Shot? ☐No ☐Yes

If you are over 65, have you had your Pneumonia Shot? ☐No ☐Yes

Do you have a health care proxy in the event you are unable to make your own medical decisions? ☐No ☐Yes

If Yes: Name: _____, _____ Phone Number: ( ) _____ - _____
Last First

Which statement(s) best reflects your wishes on advanced care recommendations?

☐ **Do Not Intubate**: I do not wish to have a breathing tube, even if it is necessary to save my life.

☐ **Do Not Resuscitate**: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

☐ **Full Cardiopulmonary Resuscitation**: I want full cardiopulmonary resuscitation efforts to be made.

Allergies to Medications: (Please enter all allergies)

◯ **None**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Alerts: (Please check all that apply)

◯ **None**

◯ Allergy to Adhesive
◯ Allergy to Lidocaine
◯ Allergy to Topical Antibiotics
◯ Artificial Heart Valve
◯ Artificial Joint Replacement
◯ Blood Thinners
◯ Defibrillator
◯ History of MRSA
◯ Pacemaker
◯ Require Antibiotics Prior to a Surgical Procedure or Before Going to the Dentist
◯ Rapid Heartbeat with Epinephrine

Are You Pregnant Or Currently Trying to Get Pregnant? ☐No ☐Yes

Social History: (Please check all that apply)

Cigarette Smoking:

◯ Never Smoked
◯ Former Smoker
  Estimated Quit Year: _____
  Total Years Smoking: _____
  Number of Packs Per Day: _____
◯ Current Smoker
  Total Years Smoking: _____
  Number of Packs Per Day: _____

Alcohol Use:

◯ None
◯ Less than 1 Drink Per Day
◯ 1-2 Drinks Per Day
◯ 3 or More Drinks Per Day

If you are older than 65, how many times in the past year have you had:

Male: 5 or More Drinks in One Day _____
Female: 4 or More Drinks in One Day _____

What is your current occupation and workplace? _____

What is your current place of residence? _____

Patient or Patient Representative Signature Date

LABORATORY SERVICES AUTHORIZATION

Most insurance companies are now specifying which commercial laboratories you may use for studies. It is **YOUR** responsibility to obtain this information. If your lab work is sent to a non-preferred lab, **YOU WILL BE RESPONSIBLE FOR PAYMENT**. Laboratory services are billed by the laboratory directly to you or your insurance carrier. The insurance carrier will determine payment based on the network/contract status.

If you do not know which laboratories are networked with your insurance, **you will need to call your insurance Customer Service Department and find out. The number to call will be listed on the back of your insurance card.**

Indicate below your insurance carrier's preferred laboratory or laboratories. Inaccurate or erroneous information will result in you being held responsible for all lab charges.

- ◯ Labcorp
- ◯ Pathgroup
- ◯ Biopsy Diagnostics (BxDx) (Aurora)
- ◯ Memorial
- ◯ Quest
- ◯ St. Joseph Candler

◯ Other _____

(Patient's Name) _____, I understand that if the laboratory services are needed and I have not provided this information my insurance carrier may deny payment or pay at a lower reimbursement rate based upon the network/contract status and I will be financially responsible for those services

_____ _____/_____/_____
Patient's Signature Date

Note: If laboratory preference is not stated, a copy of this form will be included with the lab services request at the time of service.

COSMETIC PROCEDURES ARE CONSIDERED NON PAYABLE BY MOST INSURANCE COMPANIES. YOU MAY BE RESPONSIBLE FOR THESE CHARGES. PLEASE CHECK WITH YOUR INSURANCE COMPANY.

_____ _____/_____/_____
Patient's Signature Date

Campen Dermatology, LLC

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish. _____ (please initial)

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize my insurance benefits to be paid directly to Campen Dermatology and acknowledge that I am responsible for any balance not covered by those benefits. I authorize Campen Dermatology to release information requested concerning my care to insurers paying such benefits _____ (please initial)

OFFICE FINANCIAL POLICY

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

1. We are a Medicare participating provider. We will bill Medicare. **You will be responsible at the time of service for the annual deductibles, co-payments, and charges for non-covered or cosmetic services.**
2. If you have Medicare as well as secondary coverage with a commercial plan, we will bill the carrier. If no payment is received from your secondary/supplemental carrier within 60 days after we file a claim, you will be sent a bill and will be responsible for the balance.
3. If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all covered, medically necessary services rendered. We will bill both your primary and secondary insurance plans. **You will be responsible at the time of service for the annual deductibles, co-payments, and charges for non-covered or cosmetic services.**
   In the event that you, as the patient, or we, as the physician, are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.
4. Copayments must be paid on the date service is received. A **$10.00** billing fee will be charged to your account if the co-pay in not paid on the applicable date of service.
5. **IT IS YOUR RESPONSIBILITY TO VERIFY NETWORK PARTICIPATION OF THIS PHYSICIAN WITH YOUR INSURANCE CARRIER.** As a courtesy we bill your insurance carrier. However, if we are not a participating/contracted provider with your carrier, you will be billed for services rendered.
6. I understand that time is reserved for me when I make an appointment. If I need to cancel an appointment, 8 business hours is required. A **$25.00** fee will be charged to your account if you "NO-SHOW" for an appointment or if you fail to notify us 8 hours in advance when canceling an appointment. _____ (please initial)
7. In the event your account is turned over to a collection agency, a charge equal to **25%** of the outstanding account balance will be added to your account to cover the additional collection costs and fees. _____(please initial)

Prescription Refill Policy

Please read carefully of our office policy regarding prescription refills.

1. Topical medications can be refilled up to six months from your last visit.
2. Oral medications can be refilled up to three months from your last visit.
3. After this time, we will not refill your prescription without seeing you for a follow up appointment. If you need a refill, it is your responsibility to make sure that you have been seen within this time frame. _____ (please initial)

Red Flag Compliance

It is the policy of Campen Dermatology to follow all federal and state laws and reporting requirements regarding identity theft. As of September 1, 2009, The Federal Trade Commission intends to apply its new "Red Flags Rule" regulations to physician practices. According to FTC Rule, physician practices that accept insurance must have adequate written policies and procedures in place to protect against identity theft. As a patient, you will be asked to provide a Driver's License, Military ID card (if applicable), insurance card; and a photograph will be taken for our records. _____ (please initial)

Your signature below signifies that you understand our office policies as stated above.

_____ _____

Patient's/Guarantor's signature Date

Campen Dermatology, LLC

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on (insert date) and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and he new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Samantha Herceg. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary need to know" standards that limit various staff members' access to your health information according to their primary job junctions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under he custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $.50 for each page and the staff time charged will be $15.00 per hour including the time required to locate and copy your health information. If you want the copies mailed to you postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergencies). Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights or if you disagree with a decision we made regarding your access to your health information you can complain to us – in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: Campen Dermatology, LLC

Privacy Officer: Samantha Herceg

Telephone: 912-356-3604