Patient Information (DERM)

Last Name: _____ Primary Contact: (___) _____ ☐ Hm ☐ Cell ☐ Wk

First Name: _____ M.I. _____ Secondary Contact: (___) _____ ☐ Hm ☐ Cell ☐ Wk

Street Address: _____ E-mail: _____

City: _____ State: _____ Date of Birth: _____

Zip Code: _____ Sex ☐ M ☐ F Social Security #: _____

Driver License #: _____ Marital Status: _____

Employer: _____ Who may we thank for referring you to this office?:

Occupation: _____ _____

Emergency Contact: _____ Preferred Pharmacy: _____

Phone: _____ Relationship: _____ Pharmacy Phone #: _____

Preferred Appointment Reminder: Mail Order Pharmacy: _____

☐ Text ☐ Auto. Voice message ☐ Email

Guarantor/ Parent/ Insured Information (Send Bill To):

Last Name: _____ Social Security #: _____

Employer: _____ Phone: _____

Street Address: _____ Relationship to Patient: _____

Primary Insurance Carried By Patient

Insurance Co. Name: _____

Billing Address: _____

_____

Group or Policy#: _____

Member ID: _____

Local Union #: _____

Name of Insured: _____

Insured's D.O.B: _____

Secondary Insurance Information

Insurance Co. Name: _____

Billing Address: _____

_____

Group or Policy#: _____

Member ID: _____

Local Union #: _____

Name of Insured: _____

Insured's D.O.B: _____

Thank you for choosing our small boutique concierge practice. We strive to maintain a consistent and reliable medical practice. I am a board certified internist and have expanded my expertise into cosmetic, medical dermatology and offer superficial radiation therapy which is a treatment alternative to a moh's surgical procedure. My medical practice includes Kate Stults, Dermatology Nurse Practitioner specializing medical and cosmetic dermatology, Diana Rios, Nurse Practitioner, specializing in the newest weight management medications and women's health including hormone therapy. And lastly, Jack Kennis, MD a previously retired ER physician with an amazing background in internal medicine and emergency medicine. He will be available to see patients when I am unavailable.

_____

Patient Signature *Printed Name* *Date*

_____

Parent or Guardian Signature of a Minor

Notice Of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Susan Sleep MD and Associates, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to you insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associate, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointment. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files.
- You have the right to see and receive a copy of your health information, with few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but we will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but we will add the new information.
- You have the right to receive a copy of this notice.

If we change any of the details in this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at (562) 936-0292.

This notice goes into effect as of April 14, 2003.

Acknowledgement
I have received a copy of the Susan Sleep MD And Associates of Privacy Practices.

Signed *Print Name*

If signing as a parent or guardian, please note the name of the patient

Patient Name *Date*

Consent for Use of Photographs

I consent for medical photographs to be taken of me or my child (or for person whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching at Susan Sleep MD & Associates, or for publication in medical textbooks or journals as I have designated below. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact the staff at Susan Sleep, MD & Associates at 562-936-0292.

☐ I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information on such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes at Susan Sleep MD & Associates and to be used in my medical record.

Patient Signature *Date*

☐ I agree to the use of my images for teaching purposes AND to be used for my medical record but NOT FOR medical publication.

Patient Signature *Date*

☐ I agree to the use of my image for medical records ONLY.

Patient Signature *Date*

Financial Policy

Payment is expected as services are rendered, In addition to applicable annual concierge fee. We accept cash, Visa, MasterCard, Discover, American Express, and personal checks. Please read and initial whichever policy that applies to you below:

- Cash and out-of-network PPO patients: If you are a cash patient or your physician is not a contracted provider for your insurance company, we will collect payment in full at the end of your visit. Initial visits are charged a standard consultation fee plus additional fees for any procedures performed at the time of your visit. Feel free to discuss these charges with your doctor prior to the procedure. We will submit a electronic claim to your insurance company as a courtesy for direct reimbursement. Internal Medicine patients are responsible for the annual concierge fee, this fee is not covered by insurance. *Initials* _____

- Medicare patients: We will bill Medicare for you and Medicare will forward the claim to your supplemental insurance for processing. If there is any balance on your account, you will receive an invoice from us. Internal Medicine patients are responsible for the annual concierge, this fee is not covered by Medicare. *Initials* _____

All patient refunds will be kept as a credit on the patient's account toward their next visit unless a refund request is initiated by the patient. Refunds are up to the discretion of the office manager, and the following criteria must be met prior to issuing a patient refund: there are no outstanding insurance claims on the patient's account, and there are no outstanding balances on the patient's account.

All returned checks will be subject to a $25.00 fee per occurrence.

I understand that I will be expected to pay for all applicable fees for the day of service. I understand that I am responsible for any balances not covered by insurance. I will assume responsibility of notifying this office of any changes in insurance coverage. I authorize the office of Susan Sleep MD & Associates to release to any company providing me with medical insurance any information, including the diagnosis and the records of all treatments and/or examinations provided to me by my physician for the purpose of billing (if applicable).

I have read, understand, and agree to the above policies.

Patient Signature *Printed Name* *Date*

Medicare Recipients only: I request the payment to be made directly to Susan Sleep & Associates, AMC

Medicare Patient Signature or legally authorized

Patient Privacy Policy Consent

This consent will apply to all healthcare providers employed by and acting for the benefit of this office who conduct, plan, and direct treatment and follow-up, and may be involved in treatment, directly or indirectly. While providing services to you, this office will create, receive, and store health information that identifies you.

It is often necessary to use and disclose this health information to treat you, to obtain payment for services, and to conduct day-to-day health care operations. The Notice of Privacy Practices describes the uses and disclosures in detail. The use and disclosures of your health information may include care and services,

follow-up care from another health professional, disclosure of your information for billing purposes or processing claims for obtaining payment, or submission of claims to a third-party or insurer. You have the right to restrict the use of disclosure made for purposes of treatment or health care operations, but this office is not obligated to agree to these restrictions. If this office does agree, however, the restrictions are binding. You may revoke this consent in writing at any time, except to the extent that this office has acted relying on this consent.

I have read this document and understand it. I consent to the use and disclosure of my personal health information for purposes of treatment, payment and health care operations. I have received a copy of the Notice of Privacy Practices from this office.

_____

Patient signature or legally authorized individual ***Print name if signed on behalf of the patient*** ***Relationship - parent, legal guardian name***

Please initial and provide any additional information as required to enable us to appropriately use and disclose your protected health information for the following:

I agree to be contacted for appointments, biopsy/lab results, or follow-up information regarding my care by:

1. Phone: ☐ Yes ☐ No ☐ N/A Preferred Number: _____
   Okay to leave message/voice mail: ☐ Yes ☐ No
2. Text: ☐ Yes ☐ No ☐ N/A Mobile Number: _____
3. Email: ☐ Yes ☐ No ☐ N/A Email Number: _____
4. Mail: ☐ Yes ☐ No ☐ N/A Mailing Number: _____

Discuss personal health information with the following:

I agree to allow the practice to use and disclose information regarding my care to my family as needed.

Name:	*Relationship*	*Phone*
Name:	*Relationship*	*Phone*
Name:	*Relationship*	*Phone*

These consents will remain in effect until revoked by me in writing.

Patient Signature	*Printed Name*	*Date*

Medical History

Name | *Date of Birth* | *Today's Date*

Reason for today's visit | *Height* | *Weight*

Skin
☐ Melanoma ☐ Psoriasis
☐ Eczema ☐ Acne
☐ Basal Cell Skin Cancer
☐ Squamous Skin Cancer
☐ Scaring Keloids
☐ Other _____

Cardiovascular
☐ Heart Attack ☐ Heart Murmur
☐ Stent/Artificial Valve ☐ Pacemaker
☐ Irregular Heart Beat
☐ Chest Pain/Lightness
☐ Shortness of Breath
☐ High/Low Blood Pressure

Hematologic/Metabolic
☐ HIV/Aids ☐ Hepatitis C
☐ Anemia ☐ Diabetes
☐ Bleeding Disorders
☐ Autoimmune Disease
☐ Thyroid Disease
☐ Kidney Disease

Eye/Ear/Nose
☐ Blurry Vision ☐ Dry Eyes
☐ Ear Disease ☐ Glaucoma
☐ Nasal Allergies
☐ Nasal Obstruction
☐ Nasal Bleeding
☐ Sinus Disease

Gastrointestinal
☐ Gastritis ☐ Ulcers
☐ Colitis
☐ Diverticulitis

Musculosketal
☐ Arthritis ☐ Fybromyalgia
☐ Artificial Joints

Pulmonary
☐ Asthma ☐ Pneumonia
☐ COPD ☐ Tuberculosis

Neurologic/Psychiatric
☐ Seizures ☐ Headaches
☐ Depression
☐ Schizophrenia/Bipolar

Do you use:

Alcohol	☐ Yes ☐ No	Frequency	_____
Tobacco	☐ Yes ☐ No	Frequency	_____
Aspirin	☐ Yes ☐ No	Frequency	_____
Illicit Drugs	☐ Yes ☐ No	Frequency	_____

Are you: ☐ Pregnant ☐ Trying to conceive ☐ Breastfeeding

Family History:
Indicate any conditions of immediate family members – mother, father, siblings, children.

☐ Heart Disease
☐ Cancer (type) _____
☐ Melanoma
☐ Hypertension
☐ Autoimmune Disease
☐ Non-melanoma Skin Cancer
☐ Stroke
☐ Excema
☐ Asthma
☐ Diabetes
☐ Psoriasis
☐ Seasonal Allergies/Hay Fever

Surgical Procedure History (list all surgeries including cosmetic and laser)

Date	*Type*	*Physician*	*Complications*

Have you or anyone in your family had problems associated with surgery.
☐ Bleeding ☐ General Anesthesia ☐ Lidocaine Allergy ☐ Poor Scarring ☐ Other _____

Hospitalizations (other than surgery)

Date	*Reason/Illness*	*Physician*	*Complications*

Medications
(include vitamins, diet pills, birth control, herbal supplement, etc.)

Name	*Strength/Dose*

Allergies

Medication	*Reaction*

Are you allergic to: Latex: ☐ Yes ☐ No Adhesives: ☐ Yes ☐ No