VIRGINIA DERMATOLOGY
AND SKIN SURGERY CENTER

Thank you, _____, for choosing Virginia Dermatology & Skin Surgery Center for your medical needs! We sincerely appreciate your visit with us, and we look forward to providing you quality services, as well as a rewarding and positive experience.

Please review the following information we currently have in your patient record and make any necessary changes. Please return this form with a copy of your photo identification, insurance card(s), and co-payment and/or account balance owed.

PATIENT NAME: **Co-pay for today: $** **Email address:**

Birth Date:	*Sex:*	*SSN#:*		
Race: ☐ American Indian/Alaska Native	☐ Asian Native Hawaiian/Other Pacific Islander	☐ African American	☐ Caucasian	☐ Decline
Ethnicity: ☐ Hispanic /Latino	☐ Not Hispanic/Latino	☐ Decline	*Preferred Language:* ☐ English	☐ Other (*Please specify*):
Street:	*Apt #:*	*City:*	*State:*	*Zip:*
Home Phone:	*Cell Phone*	*Work Phone:*		
Referring Provider Name:		*Primary Care Provider Name:*		
Emergency Contact Name:	*Phone:*	*Relation:*		
Employment: ☐ Full time	☐ Part time	☐ Retired	*Company*:	*Profession:*
How did you hear about us? ☐ Physician Referral	☐ Friend/Family	☐ Newspaper	☐ Insurance	☐ Other:

RESPONSIBLE PARTY:

Birth Date:	*Sex:*	*SSN#:*		
Street:	*Apt #:*	*City*	*State:*	*Zip:*

PRIMARY INSURANCE:

Policy/ID #:	*Group #:*
Subscriber Name:	*Relation to Patient:*
Subscriber Birth Date:	*Subscriber SSN:*

SECONDARY INSURANCE:

Policy/ID #:	*Group #:*
Subscriber Name:	*Relation to Patient:*
Subscriber Birth Date:	*Subscriber SSN:*

RELEASE: I authorize the release of medical information necessary to process insurance claims to insurance companies and/or their agencies (including Medicare). I authorize payment of medical benefits be assigned to Virginia Dermatology and Skin Surgery Center. I attest that the information I have provided is true and accurate to the fullest extent of my knowledge. I further understand any changes I fail to report may result in my claims being denied. I will accept full responsibility of payments owed, including interest, court costs, and reasonable attorney's fees for failure to remit payment. I permit a copy of this release to be used in place of the original.

Patient/Responsible Party Signature*:**_____ ***Date signed:

Appointments If you are a new patient, please arrive 30 minutes prior to your scheduled appointment. Photo identification is required,

and if you are covered by insurance, you must bring your insurance card(s). This information must be presented at check-in to ensure your claims are filed promptly and accurately. If you are an established patient, you will be asked to revalidate your existing patient information at each visit. Please note: it is your responsibility to inform our office of any changes to your registration record, including, but not limited to, any address and insurance plan changes. All patients are expected to bring all medications, or a medication list, to each appointment so we can update your medication record.

If your insurance policy requires a referral from your primary care physician, it is your responsibility to ensure a valid referral has been obtained and approved by your insurance company. Please be sure to bring a copy or ensure your primary care physician office has sent us the required information. If we do not have a valid referral, you may be asked to reschedule your appointment or pay in full for services rendered.

Cancellation and Missed Appointments A medical treatment relationship is built on mutual trust and respect. As such, every effort will be made to be on time for your scheduled appointment, and we ask that you give the same courtesy of a call when you are unable to keep your appointment. We make every effort to remain on schedule; however, as a courtesy to other appointments, if you arrive more than 15 minutes after your scheduled appointment time, you may be asked to reschedule your visit.

If you are unable to keep a scheduled appointment, you must contact the office via telephone at least 48 hours in advance. This allows us the opportunity to offer the appointment to another patient. If you fail to notify the office of your cancellation within 48 hours and miss your scheduled appointment, a fee for the appointment you have missed or cancelled will be charged. At the time of cancellation, another appointment will be offered to you that may work better for your schedule. Three (3) missed or cancelled appointments within the time stated above--they need not be consecutive--can result in an administrative discharge from the practice.

Our missed appointments fees are as follows:	**General dermatology appointment:**	**$50 fee**
	Any surgical appointment:	**$250 fee**

Insurance Our practice is contracted with most major insurance plans. Co-payments will be collected at the time of service. Any co-payment, deductible, and/or coinsurance amount is your responsibility. If we are not in-network with your insurance, fees for services rendered are due in full at the time of service. We will provide you with an itemized statement so you can submit to your insurance If you do not have insurance, you are expected to pay at the time of service.

Financial Policy Our office accepts major credit cards. If you fail to remit payment or to contact our office at (540)373-6647 to discuss payment arrangements, your account may be sent to an attorney for collection. In consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay 18% interest per annum on all balances which are unpaid; plus attorney fees which are here by stipulated to be 33 1/3% of such outstanding balance whether suit is filed or not; plus court costs. The undersigned understands that personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with federal "HIPPA" regulations.

Billing Questions If you have a question regarding a bill, it is best to contact your insurance company first. We process claims according to what your insurance company has advised us. If you still have questions, please contact our office at (540)373-6647.

Prescriptions If you need a refill on a prescription, please call the pharmacy at least 48 hours in advance. Your pharmacy will send us a refill request that will be reviewed by your provider. Should an appointment be required before your refill can be made, our office will be in contact with you to schedule an appointment.

Lab Results Please be advised that lab results may take up to 10 days to be received and reviewed. Urgent results will be addressed on an individual basis. If you do not hear from our office, please keep your follow-up appointment at which time the results will be discussed in detail.

Parent/Legal Guardians All minor patients must be accompanied by a parent or legal guardian. If a parent or legal guardian is not present, written consent from a legal guardian is required to provide services. Any minor without a parent or legal guardian present will be required to reschedule their visit.

For questions regarding our policies, please call our office (540) 373-MOHS (6647)

I acknowledge read, received, and accept all the terms and conditions of the policies.

Patient/Responsible Party Signature*:**_____ ***Date signed:

HISTORY AND INTAKE FORM

PAST MEDICAL HISTORY: (*Please check all that apply)*

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ None
- ☐ Coronary Artery Disease
- ☐ Hyperthyroidism

☐ Other_____

If you answered yes to diabetes, when was the last time you had a Hemoglobin A1C and what was the result?_____

Have you ever been tested for Hepatitis C? _____

PAST SURGICAL HISTORY: (*Please check all that apply)*

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (right/left)
- ☐ Lumpectomy (right/left)
- ☐ Breast Biopsy (right/left)
- ☐ Colon: Colostomy
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement-Knee (right/left)
- ☐ Joint Replacement-Hip (right/left)
- ☐ Joint Replacement within last 2 years
- ☐ Kidney Biopsy
- ☐ Kidney Removed (right/left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Cancer Surgery
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (right/left)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Cervical Cancer
- ☐ Liver Removed
- ☐ Liver Transplant
- ☐ Liver Shunt
- ☐ Pancreas Removed
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Tubal Ligation
- ☐ None

☐ Other_____

SKIN DISEASE HISTORY: (*Please check all that apply)*

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ 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
- ☐ None

☐ Other_____

FAMILY HISTORY OF CANCER: (*Only first degree relatives*)

_____

_____

HISTORY AND INTAKE FORM *(Continued)*

SKIN DISEASE HISTORY:

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)? ☐ Mother ☐ Father ☐ Sister ☐ Brother

MEDICATIONS: *(Please list all current medications)* ☐ *Not Currently Taking Any Medications*

_____

_____

_____

ALLERGIES: *(Please list all allergies)* ☐ *No Known Allergies*

_____

_____

SOCIAL HISTORY: *(Please check all that apply)*

☐ Currently Smokes-Daily
☐ Currently Smokes-Not Daily
☐ Has smoked in the past
☐ Never Smoked
☐ Drug Use
☐ None

Alcohol Use:

☐ None
☐ 1 drink per day
☐ 1-2 drinks per day
☐ 3 or more drinks per day

WHEN WAS YOUR LAST FLU SHOT? _____
WHEN WAS YOUR LAST PNEUMONIA SHOT? _____
Have you had any falls in the last year that have caused injury AND sent you to the hospital? _____

AGES 13+
WHEN WAS YOUR LAST Tdap? _____ LAST HPV SHOT? _____ MENINGOCOCCAL VACCINE? _____

MEDICAL DIRECTIVES:

Do you have a "living will"? _____
Should you become unable to make your own medical decisions, who do you elect to do so for you?
Name: _____
Relation: _____
Phone Number: _____

HISTORY AND INTAKE FORM *(Continued)*

PREFERRED PHARMACY: _____
PHARMACY PHONE: _____
City or Zip Code: _____

EMPLOYER: _____
PROFESSION: _____

ALERTS: *(please circle all that apply*)

Allergy to Adhesive	Allergy to lidocaine	Allergy to topical antibiotics
Artificial heart valve	Artificial joint replacement	Blood thinners
Defibrillator	MRSA	Pacemaker
Require antibiotics prior to a surgical procedure		Rapid heart beat with epinephrine

Are you pregnant or currently trying to get pregnant?

Please sign below. By doing so, you certify that the responses provided in this questionnaire are complete and accurate to the best of your belief.

Patient Signature:_____ ***Date signed:***
(Or responsible party, if minor)

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Today's Date:

I _____**,** hereby authorize Virginia Dermatology & Skin Surgery Center, and/or their representatives to release any and all information pertaining to my health care, results, procedures, billing, and/or accounting information to the following person(s) or agencies:

☐ Myself only

☐ Spouse, full name:_____☐ Parent, full name(s) :_____

☐ Other(s) – Specify name and relationship:_____

I further authorize Virginia Dermatology & Skin Surgery Center and/or their representatives to release results of my medical exams in one or more of the following ways:

May call me (patient): ☐ at home between_____☐ am/ ☐ pm to_____☐ am/ ☐ pm

☐ at work between_____☐ am/ ☐ pm to_____☐ am/ ☐ pm

May leave a message: ☐ at home ☐at work ☐on answering machine at home and/or at work

I understand that this office will release any information to those persons who I have determined may receive this information without separate consent. I also understand that this relates to all medical and billing/account information. **THIS WILL BE ACTIVELY ENFORCED.** If you wish to change the status of this form, you must do so in writing.

_____ ***Date signed:***

Patient Signature
(Or responsible party, if minor)

_____ ***Date signed:***

Virginia Dermatology & Skin Surgery Center

HIPAA NOTICE OF PRIVACY PRACTICES

Effective February 6, 2012

THIS NOTICE IS REQUIRED BY FEDERAL LAW AND DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Once you sign our Patient Information consent form, we may use and disclose your medical information in order to treat you, obtain payment, and to operate the practice.

This Notice of Privacy Practices ("Notice") describes the ways in which we may use and disclose your Protected Health Information (PHI) and how you can get access to this information. "Protected Health Information" is information about you that is contained in your medical and billing records maintained by this organization. It includes demographic information and information that relates to your present, past or future physical or mental health and related healthcare services.

If you have any questions about this Notice, please contact our Privacy Officer.

Uses and Disclosures of Protected Health Information: We may use and disclose your Protected Health Information for purposes of healthcare treatment, payment and healthcare operations as described below.

For Treatment: We may use and disclose your Protected Health Information to provide, coordinate or manage your healthcare and any related services. Examples of how we will disclose information for treatment may include sharing information about you with: referring physicians, your primary care physician, a specialist, hospitals, ambulatory care centers, pharmacies or home health agencies.

For Payment: Your Protected Health Information will be used and disclosed as required, so that we can bill and receive payment for the treatment and services you receive from us. Examples of how we will disclose information for payment include: contacting your health plan to confirm your coverage or obtain precertification of a service, or we ay provide information to any other healthcare provider who requests information necessary for them to collect payment.

For Healthcare Operations: We may use and disclose your Protected Health Information in performing business activities that we call "healthcare operations". This includes internal operations, such as for general administrative activities and to monitor the quality of care you receive at our facility. Examples include: quality of care assessments, training of medical staff, assessing certain services that we may want to offer in the future, evaluating the performance of our employees, licensing, or conducting or arranging other business activities. Other examples include: leaving messages on your answering machine; leaving messages at your place of employment or sending out recall notices. We may use or disclose your Protected Health Information when making calls to remind you of your appointment. We will use a sign-in sheet at the receptionist's desk where you will be asked to sign your name and the name of the provider you are seeing. We will also call you by name when you are in our waiting room.

Other Uses and Disclosures We May Make Without Your Written Authorization: Under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, we may use and disclose your Protected Health Information in which you do not have to give authorization. These situations include: those Required by Law, Public Health Risk Issues as required by Law, Communicable Diseases, Health Oversight Activities, reporting Victims of Abuse, Neglect or Domestic Violence, Legal Proceedings, Law Enforcement, Coroners, Medical Examiners, Funeral Directors, Organ/Tissue Donation Organizations, Research; Criminal Activity; Military Activity and National Security, Inmates/Law Enforcement Custody, and Worker's Compensation.

Any Other Use or Disclosure of Your Protected Health Information Requires Your Written Authorization: Will be made only with your consent, authorization or opportunity to object, unless required by law.

Your Rights Regarding Your Protected Health Information: You have the right to access your personal Protected Health Information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and Protected Health Information that is subject to law that prohibits access to Protected Health Information.

You Have the Right to Request Restrictions: You have the right to request a restriction on the way we use or disclose your Protected Health Information for treatment, payment or healthcare operations. You may make this request in writing, at any

time. If we do agree to the restriction, we will honor that restriction except in the event of an emergency and will only disclose the restricted information to the extent necessary for your emergency treatment.

You Have the Right to Request Confidential Communications: You have the right to request that we communicate with you concerning your health matter sin a certain manner or at a certain location. For example, you can request that we contact you only at a certain phone number or a specific address. We will accommodate your reasonable requests, but may deny the request if you are unable to provide us with appropriate methods of contacting you.

You Have the Right to Request that We Amend your Protected Health Information: If we deny your request, we will give you a written notice, including the reasons for the denial. You can submit a written statement disagreeing with this denial. Your letter of disagreement will be attached to your medical record.

You Have the Right to Request an Accounting of Certain Disclosures of Your Protected Health Information.

You Have the Right to Obtain a Paper Copy of This Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time by contacting our office in writing or by phone.

You May Issue a Complaint to our Privacy Officer (listed on the first page) or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. We will not retaliate against you for filing a complaint.

We Reserve the Right to Change the Terms of This Notice of Privacy Practices and to make the new provisions effective for all Protected Health Information we already have about you as well as any Protected Health Information we create or receive in the future. If we make any changes, we will:

a. Post the revised Notice in our office(s), which will contain the new effective date; and

b. Make copies of the revised Notice available to you upon request (either at our offices or through the contact person listed on the Notice.)

This notice was published and effective February 6, 2012.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I, _____, have received or have been offered a copy of the Notice of Privacy Practices for the practices listed above.

_____ ***Date signed:***

Patient Signature
(Or responsible party, if minor)

_____ ***Date signed:***

Virginia Dermatology & Skin Surgery Center