Central Oregon Dermatology Health History and Review of Systems

Patient:_____Date of Birth:_____Today's Date_____
Nickname:_____Reason for today's visit:_____

List Allergies to Medications: _____

Do you have allergy to dental anesthesia? Yes/No Do you have a band aid allergy? Yes/No

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	Yes	No
Emphysema	☐	☐
Asthma/Hay fever	☐	☐
Cardiovascular:	Yes	No
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Shortness of breath	☐	☐
Stroke	☐	☐
Fever Blisters	☐	☐
Artificial joint	☐	☐
Blood Clots	☐	☐
Pacemaker	☐	☐
Artificial Heart Valve	☐	☐
Other Systemic:	Yes	No
Fever or Chills (currently)	☐	☐
Headache (currently)	☐	☐

Other Systemic cont:	Yes	No
Diabetes	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Lupus	☐	☐
Arthritis/muscle pain	☐	☐
Anemia	☐	☐
Liver Disease	☐	☐
Hepatitis	☐	☐
HIV/AIDS	☐	☐
Blood Transfusion	☐	☐
Cancer	☐	☐
Rheumatologic disease	☐	☐
Multiple Sclerosis/numbness	☐	☐
Recent Weight loss	☐	☐
Depression	☐	☐
Malaise (feel sick)	☐	☐

List any other diseases or conditions: _____

Recent Surgeries/Hospitalizations: _____

Skin:

Have you ever had any of the following? (Please circle)

Melanoma/Skin Cancer, If yes what type? (Basal Cell / Squamous Cell)
Unusual moles / Blistering Sunburns / Psoriasis / Eczema / Excessive Scarring / Keloids /
Other _____

Family History

Have any close relatives had any of the following? (Please circle): Melanoma / Skin Cancer / Unusual moles / Severe acne / Psoriasis/ Eczema

Women: ☐ Pregnant ☐ Breastfeeding ☐ Trying to get pregnant

List All Medications (prescription and non-prescriptions):

_____ _____ _____ _____
_____ _____ _____ _____

Do you take (circle) **Vitamin E, Aspirin, Motrin / Ibuprofen / Aleve / Coumadin / Other Blood Thinner**

What is your occupation? _____

Patient Social History:

Use of alcohol ☐ Never ☐ Social ☐ Moderate
Use of tobacco ☐ Never ☐ Previously, but quit Current packs / day _____
Use of illegal substances? ☐ No ☐ Yes **Use sunscreen**? ☐ No ☐ Yes **Wear hats**? ☐ No ☐ Yes

Patient Signature_____Date_____Staff Signature_____

Financial Information

Central Oregon Dermatology is contracted with several insurance groups and will be happy to bill your insurance. You may need to contact your insurance carrier to find out if we are contracted with your individual plan. If Central Oregon Dermatology has a contract with your insurance carrier, we are required by that contract to bill for any covered noncosmetic services. Please be aware your insurance coverage is a contract between you and your insurance carrier, so if you have any questions regarding your specific insurance coverage you will need to contact your carrier. The customer service telephone number can be found on the back of your insurance card. Your co pay and any deductible not met are expected at the time of service. ***Any prices quoted to you are estimates.*** *The completed billing may differ from your estimate as we review all documentation for completion before we submit a final bill to your insurance carrier. Any balance due will be billed to you at that time and payment is expected within 30 days unless other arrangements are made with the billing department.* ***_____initial***

Any treatment that you have done is considered a ***surgical procedure*** *and your insurance carrier may process your claim according to your major medical benefit. (If you have questions regarding your major medical benefits please contact your insurance carrier). This means that charges may be applied to your deductible, your carrier may pay only a percentage of the total charge or you may be billed for surgical co-insurance. We have no way of knowing your specific insurance coverage, so we* ***cannot*** *provide individual reimbursement information. You will need to contact your carrier for your specific coverage information.*

If we are not billing insurance, payment is due at the time of service. The cost of any date of service is not complete until the finished documentation of that visit is reviewed for accuracy and completion and you may be sent an additional statement.

Dr. Hall will determine if your procedures are medically necessary or considered cosmetic. Cosmetic procedures are payable in full at the time of service and ***will not*** *be billed to your insurance carrier.*

Some methods of Treatment

The treatment of skin conditions depends on the type and location of the growth, and the symptoms you are having. Dr. Hall will discuss the treatment options that are the best for you. Some forms of treatment are:

Cryosurgery *-destroys skin tissue by freezing it with liquid nitrogen. This is a treatment used for warts and precancerous lesions known as actinic keratosis.*

Curettage *- scraping of the skin with a sharp surgical instrument to remove skin tissue*

Laser surgery *the use of an intense beam of light to burn and destroy tissue.*

Shaving or tangential excision- *is the horizontal removal of a lesion*

Surgical excision *the site is injected with a local anesthetic followed by cutting into the skin with a surgical instrument, removing the growth and closing the wound.*

Some treatments like cryosurgery and laser surgery may require several visits to treat and each is billed separately. This is especially true for treatment of warts.

Central Oregon Dermatology reserves the right to charge a $25.00 NSF fee on any check returned for nonpayment.

If Dr. Hall biopsies or removes a lesion there will be a separate charge for pathology. This charge will be in addition to your office visit charge. Occasionally a second opinion may be required; in this case, you will receive a bill from the Pathologist and our office.

_____initial

I certify that I have read, and fully understand the Central Oregon Dermatology, PC, financial policy and I have had my questions answered.

_____ _____

PATIENT NAME (PLEASE PRINT) *DATE*

*X*_____

PATIENT SIGNATURE

revised September 3, 2010

Central Oregon Dermatology
Mark Hall, MD

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

PATIENT NAME: _____ DATE OF BIRTH _____
OTHER NAMES: _____
ADDRESS: _____ TELEPHONE: _____
_____
_____

PLEASE RELEASE MY RECORDS TO: CENTRAL OREGON DERMATOLOGY, PC
388 SW Bluff Drive
Bend, OR 97702
TELEPHONE: 541-678-0020 **FAX:** 541-323-2174

FROM: _____
_____
_____
Mail_____ Fax _____

_____ALL HEALTH CARE RECORDS
_____ ONLY RELEASE RECORDS PERTAINING TO
_____
_____
_____

THIS AUTHORIZATION EXPIRES ON _____ (ONLY GOOD FOR 1 YEAR)

YES_____ NO_____ I authorize the release of my Sexually Transmitted Disease (STD) results, including HIV/AIDS testing, whether negative or positive to the persons listed above.

YES _____ NO_____ I authorize the release of any records regarding drug, alcohol or mental health treatments to the persons listed above

_____ _____
Patient Signature Date Signed

I fully understand that the entity that receives this information is not required to comply with federal privacy information the information my no longer be protected.
I may **REVOKE** this authorization at any time. To Revoke this Authorization I must notify Central Oregon Dermatology in writing. I understand that I do not have to sign this authorization and that my refusal to sign in no way affects my treatment from Central Oregon Dermatology, PC.

I have received a copy of Central Oregon Dermatology PC, Notice of Privacy Practices. This notice was provided to me in accordance with HIPAA and had an effective date of 07/15/2008.

_____ _____

Patient's Name, please print *Date*

*X*_____

Signature

If patient is a minor or otherwise unable to sign:

_____

Signature of patient's representative

_____

Relationship to patient

_____

Patient received a copy Central Oregon Dermatology Clinic's notice of Privacy Practices; However we were unable to obtain written acknowledgement.

_____ _____

Central Oregon Dermatology Staff *Date*

Reason unable to obtain signature:

_____

Revised July 23, 2008

Central Oregon Dermatology
Mark Hall, MD

PATIENT INFORMATION _____NEW PATIENT

INFORMATION CHANGE: __ NAME ___ADDRESS ___INS.

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: DATE: _____/_____/_____

NAME: _____

Last First Middle Initial

Date of Birth: _____/_____/_____ Social Security #_____ Male Female

MAILING ADDRESS: _____

CITY State Zip

Home Phone: ( ) _____ Cell: (_____) _____

Occupation: _____ Work Phone: (_____)_____

Email Address _____

Marital Status: ____Single _____Married _____Divorced _____Widowed_____ Separated

RESPONSIBLE PARTY IF DIFFERENT FROM PATIENT:

NAME: _____

Last First M.I

Address: _____

City State Zip

Home Phone: (____)_____ Work Phone: (_____)_____

Date of Birth: _____/_____/_____ Social Security #:_____ _____

Relationship to Patient

INSURANCE COVERAGE - PRIMARY:

INS. CO NAME: _____ PHONE : (_____) _____

ADDRESS: _____

INSURED: _____ DATE OF BIRTH _____/_____/_____

POLICY #: _____ GROUP #: _____

RELATIONSHIP TO INSURED: _____

INSURANCE COVERAGE - SECONDARY

INS. CO NAME: _____ PHONE : (_____) _____

ADDRESS: _____

INSURED: _____ DATE OF BIRTH _____/_____/_____

POLICY #: _____ GROUP #: _____

RELATIONSHIP TO INSURED: _____

HOW DID YOU HEAR ABOUT US? _____INTERNET _____PHONE BOOK _____ DOCTOR

_____ RADIO _____ NEWSPAPER _____FRIEND ____OTHER

DO WE HAVE PERMISSION TO:

LEAVE A PRE-RECORDED MESSAGE ON YOUR CELL PHONE? _____YES _____NO

LEAVE A MESSAGE ON YOUR ANSWERING MACHINE AT HOME? _____YES _____NO

LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMEN T? _____YES _____NO

DISCUSS YOUR MEDICAL CONDITION WITH A HOUSEHOLD MEMBER? _____YES _____NO

IF YES, WITH WHOM: _____ RELATIONSHIP_____

SEE PAGE 2 PLEASE

PAGE 2

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME: _____

ADDRESS: _____

CITY STATE ZIP

PHONE #: (_____) _____ RELATIONSHIP: _____

ASSIGNMENT OF BENEFITS/RELEASE

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY PRIMARY CARE OR REFERRING PHYSICIAN. I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS INCLUDING MEDICARE (IF APPLICABLE) BE MADE ON MY BEHALF TO **CENTRAL OREGON DERMATOLOGY,PC** FOR THE SERVICES FURNISHED TO ME. I FURTHUR UNDERSTAND THAT MY SIGNATURE AUTHORIZES THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF OTHER HEALTH INSURANCE IS INDICATED ON THIS REGISTRATION FORM, OR ELSEWHERE ON OTHER APPROVED CLAIM FORMS OR ELECTRONICALLY SUBMITTED CLAIMS, MY SIGNATURE AUTHORIZES THE RELEASE OF MEDICAL INFORMATION TO THE INSURER OR AGENCY SHOWN. IN MEDICARE ASSIGNED CLAIMS, **CENTRAL OREGON DERMATOLOGY,PC** AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE, AND I UNDERSTAND THAT I WILL BE BILLED ONLY FOR THE DEDUCTIBLE, COINSURANCE AND NONCOVERED SERVICES BASED ON THE DETERMINATION OF THE MEDICARE CARRIER.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS IN FORMATION.
PLEASE REVIEWIT CAREFULLY.

Central Oregon Dermatology, PC provides this notice to comply with Privacy Regulations issued by the Department of Health and Human Services in accordance with Health Insurance Portability and Accountability Act of 1996. (HIPAA). This notice describes information about privacy practices followed by all of our employees; providers, medical support staff, administrative and clerical staff and our business associates.

OUR COMMITMENT TO PROTECTING YOUR HEALTH INFORMATION:
In the course of your treatment we generate medical records related to your health and the healthcare services provided. This information is called *protected health information* (PHI). We are required by law to:
• Maintain the privacy of your health information
• Provide you with Notice of our Privacy Practices and your legal rights with respect to your health information; and
• Comply with the conditions of the Notice that is currently in effect.
We reserve the right to make changes to this Notice and to make such changes effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office with its effective date in the lower left hand corner. **You** ***are entitled to a copy of the notice currently in effect***
HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:
The following categories describe the different ways we may use and disclose health information for treatment, payment, or heath care operations. The category examples are not inclusive; explanation is provided for your general information only.
Treatment. We may use and disclose health information about you to provide, coordinate or manage your health care and related services. We may consult with other health care providers regarding your treatment and coordinate and manage your health care with others. For example, we may use and disclose health information when you need a prescription, lab work, or other diagnostic testing. In addition, we may use and disclose health information about you when referring you to another health care provider. We may also disclose medical information about

you to family members and other healthcare providers outside this practice who are involved in your medical care.

Payment. We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and collected from you, an insurance company or a third party. For example, we may give your health plan information about a service you received or a treatment you are going to receive in order to obtain reimbursement, prior approval, or benefit coverage determination.

Health Care Operations. We may use and disclose health information about you in order to run our office more efficiently and make sure that all our patients receive quality care. The following are examples of the use and disclosure of health information for health care operations:

• to evaluate the performance of our staff in caring for you.

• In deciding what additional services we should offer, how to improve efficiencies, or whether certain new treatments are effective.

• Providing training programs to doctors, nurses, technicians, medical students and other personnel for review and learning purposes.

• Cooperating with outside organizations that evaluate, certify, or license health care providers or staff.

• Cooperating with business associates who assist us in complying with legal requirements; business planning and development; billing processes; technological improvements.

Communications. We may contact you to remind you of appointments and to provide you with information about treatment alternatives or health related benefits and services that may be of interest to you. This contact may be by phone, in writing, or e-mail and may involve the leaving of a message which could potentially be retrieved by others.

Individuals Involved in Your Care. We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so, or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure to your health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is being discussed.

In situations where you are not capable of giving consent (because you are not present or are incapacitated) we may, using our professional judgment and experience, determine that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, x-rays, or other things that may contain health information.

Required By Law. We will disclose health information about you when required to do so by federal, state or local law.

Public Health Risks. We may use or disclose health information to public health authorities or other authorized persons to carry out certain activities related to public health, including the following activities:

• To prevent or control disease, injury, or disability;

• To report disease, injury, birth, or death;

• To report child abuse or neglect;

• To report reactions to medications or problems with products or devices;

• To notify people of recalls of products they may be using;

• To notify a person who may have been exposed to a communicable disease in order to control

who may be at risk of contacting or spreading the disease; or
• To report to your employer, under limited circumstances, information related primarily to workplace injuries or illness, or workplace medical surveillance.

Abuse, Neglect, or Domestic Violence: We may disclose health information in certain cases to proper government authorities if we reasonably believe that **a** patient has been **a** victim of domestic violence, abuse, or neglect.

Research. We may use and disclose health information about you for research purposes under certain limited circumstances. We must obtain written authorization to use and disclose health information about you for research purposes except in situations where a research project meets specific, detailed criteria established by the HIPAA Privacy Rule to ensure the privacy of health information

Organ and Tissue Donation. If you are an organ donor, we may release health information to organizations that help procure, locate, and transplant organs in order to facilitate the donation and transplantation of organs or tissue.

To Avert A **Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be made to someone who has the ability to help prevent the threat.

Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with certain laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information in response to a subpoena, discovery request, or other lawful process. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information requested if you so desire. We may also use such information to defend ourselves or any member of our practice against any actual or threatened action.

Law Enforcement. We may release health information to law enforcement officials for the following purposes where the disclosure is:
• In response to a court order, subpoena, warrant summons or similar process;
• To report a death that we suspect was the result of criminal conduct;
• To identify or locate a suspect, fugitive, material witness, or missing person;
• About a suspected crime victim if, under certain limited circumstances, we are unable to obtain a person's agreement;
• About a crime or suspected crime committed at our office; or
• In response to emergency circumstances to report a crime, including the nature of the crime, the location, the victim, and the identity of the person(s) who committed the crime.

Coroners, Medical Examiner, Funeral Directors. We may disclose health information to a coroner or medical examiner for the purpose of identification and determination **as to the cause of** death. In addition, we may disclose health information to funeral directors, as authorized by law, so that they may carry out their job duties.

Information Not Personally Identifiable. We may use and disclose health information about you in a way that does not personally identify you or reveal who you are.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *authorization.* If you give us authorization to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take

back any uses or disclosures already made with your permission.
In some instances, we may need specific, written authorization from you in order to disclose certain types of protected information such as HIV status or substance abuse information.

YOU'RE RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our HIPAA Compliance Official in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the cost of copying, mailing or other associated supplies.

We may deny your request to inspect and/or copy health information in certain limited circumstances. If you are denied access to medical information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Request Restrictions. You have the right to request a restriction or limitation on health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it. For example, you could ask that we not use or disclose information about a cosmetic procedure you had.

We are not required to **agree to** ***your request.*** If we do agree, we will comply with your request unless your health information is needed to provide you with emergency treatment, or we are required by law to use or disclose the information.

Requests for restrictions **must** be submitted in writing to our Privacy Official. We can supply you
with a REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION
FORM (available at our reception desk) or you can submit your own request by indicating:

• What information you want to restrict;
• whether you want to restrict use, disclosure or both;
• to whom you want the restrictions to apply.

Right **to Amend.** You have the right to request that we amend your health information if you feel it is incorrect or incomplete, as long as such information is kept by our practice. To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/
CORRECTION FORM to our Privacy Official. Forms are available at our reception desk. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information including, but not limited to:

• Information we did not create, unless the provider or entity that created the information is no longer available to make the amendment.
• Information that is not part of the health records that we keep.
• Information which you would not be permitted to inspect and copy.
• Information that is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures"; a listing of disclosures we made of medical information about you, to others for

must be submitted in writing to our Privacy Official. It must state a time period, but no longer than six years, or prior to July 24, 2008. Your request should indicate in what form you want the list (for example on paper, electronically). We shall supply one list within a 12-month period for free, but we may charge you for the costs of providing additional lists. We will notify you of the costs prior to incurring the expense in case you want to withdraw or modify your request.

Right to Request Confidential Communications. You have the right to request how we communicate with you about medical matters. For example, that we contact you only by mail, or email; that we not leave voice messages on your answering machine.

To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION to our Privacy Official.

Forms are available at our reception desk. We will accommodate all reasonable requests so long as

you specify how or where you wish us to contact you.

Right to a Paper Copy of This Notice. You have a right to receive a paper copy of this Notice. You are entitled to a paper copy of this Notice even if you have previously agreed to receive this Notice electronically.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with our Privacy Official or the Secretary of the United States Department of Health and Human Services.

You will not be penalized for filing a complaint.

Questions. If you have any questions about this Notice, please contact:

Central Oregon Dermatology, PC
Privacy Official
388 SW Bluff Drive Bend OR 97702
(541) 323-2181

Effective Date 07/15/2008 Privacy Practices

Updated 04-18-2011