Patient Information

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date ____/____/____

Patient Name ____
Last First M.I.

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

Mailing Address ____
City State Zip

Home Phone: ( )______________________ Work Phone: ( )______________________
Cell Phone: ( )______________________ e-mail: ______________________

PARENT, SPOUSE, OR RESPONSIBLE PARTY (if different from patient)
Name: ____ Date of Birth: ____/____/____
Last First M.I.

Address: ____
City State Zip

Home Phone: ( )______________________ Work Phone: ( )______________________
Cell Phone: ( )______________________ e-mail: ______________________

INSURANCE COVERAGE - PRIMARY:

Insurance Co. Name: ______________________________
Address of Claim Center: ____
____
City State Zip

Name of Policy Holder (Insured): ______________________________
Policy Holder (Insured) Date of Birth: ____/____/____
Policy #: ______________________ Group Name or #: ______________________
Policy Type: ☐ HMO ☐ PPO
If patient is child, check relationship to insured: ☐ Mother ☐ Father ☐ Other______________________

INSURANCE COVERAGE - SECONDARY:

Insurance Co. Name: ______________________________
Address of Claim Center: ____
____
City State Zip

Name of Policy Holder (Insured): ______________________________
Policy Holder (Insured) Date of Birth: ____/____/____
Policy #: ______________________ Group Name or #: ______________________
Policy Type: ☐ HMO ☐ PPO
If patient is child, check relationship to insured: ☐ Mother ☐ Father ☐ Other______________________

Please present your insurance card(s) and a photo ID to the receptionist
along with this completed form.
Thank you.

Dermatology & Dermatologic Surgery Group of Northern Virginia, PLLC

REFERRAL INFORMATION:

Patient Name:____
Today's Date ____/____/____
Other family members that are patients of our practice______________________________________
Referred by: ____

Primary Care Physician ____
Phone (   )_______________

EMERGENCY CONTACT INFORMATION:

In case of Emergency, who should be notified?____
Phone (   )_______________
Relationship to patient: ______________________________________

Do you give our office permission to discuss your medical information with family members?
☐ YES ☐ NO If yes, please provide their names and phone numbers below.

Name: ____
Relationship: __________________________
Phone # (day): (______)__________________ Phone # (evening): (_____)_________________

May we leave personal medical information on your answering machine or cell phone? ☐YES ☐NO
May we e-mail personal medical information to you? ☐YES ☐NO
E-mail address: ____

PAYMENT POLICY:

HMO, PPO or other managed care patients: You will be responsible for paying your annual deductible,copayment and charges for any non-covered, cosmetic services at the time of service.
Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 50% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient or Responsible Party Signature ____
Date ____/____/___

Dermatology & Dermatologic Surgery Group of Northern Virginia,
BOARD CERTIFIED IN DERMATOLOGY

243 Church Street, NW, Suite 200-C
Vienna, VA 22180
Tel. 703-938-5700 Fax 703-938-4467

Date___________ **Name**____ **Date of Birth**____________________
LAST, FIRST, MI — mo / day / year
REVIEWED BY STAFF__________________

Past/family/social/history Circle and give details

Personal History: Eczema Asthma Hay fever/allergic rhinitis Psoriasis Multiple Sclerosis

Family History : Eczema Asthma Hay fever/allergic rhinitis Psoriasis Multiple Sclerosis

Occcupation____ Hobbies____

Use of sun screen______________________ SPF___________ **Smoker** - Yes_____No____

History of Skin Cancer Melanoma Basal cell Squamous cell

History of Other Cancer____metastasis___________

Family History of Skin Cancer Melanoma Non-Melanoma skin cancer

History of Hepatitis? **History of Blood Transfusion** **HIV/exposure**

Reaction/contact Dermatitis: Tape/Bandage Topical Antibiotic Other

Surgeries:

ROS PLEASE ANSWER YES OR NO to the Following - If YES - Circle and give details

YES	NO	
____	____	**Trouble Healing** Thick Scar/Keloid
____	____	**Immunosuppression** Cause Organ Transplant
____	____	**Vision Problem** Cataracts Glaucoma Glasses Other vision problems
____	____	**Hearing, Smelling, Swallowing, Dental/Mouth problems** Hearing loss
____	____	**Difficulty Breathing** Asthma Emphysema Other
____	____	**Urinary difficulty** (Men) Prostate Incontinence
____	____	**Abdominal pain/Ulcer** Blood in stool Diarrhea Other
____	____	**Joint Pain** Artificial Joints Knee ☐ Hip ☐ Muscle Weakness Other
____	____	**Enlarged Lymph Nodes** Excessive Bleeding Abnormal white blood cells
____	____	**Irregular heart beat** Chest Pain Pacemaker /Defibrillator Enlarged heart
		High Blood Pressure Murmur Mitral Valve Prolapse Blood Clots
____	____	**Numbness/Loss of Sensation** Loss of movement control Headache
____	____	**Abnormal Moods** **Depression** Anxiety Learning Disability Other
____	____	**High Blood Sugar** Enlarged Thyroid /Goiter Excessive hair growth Weight gain
____	____	**Women** Abnormal Cycle/Irreg. Menses Infertillity Heavy Bleeding Post Menopausal
		Pregnant? Trying to conceive? Breast Feeding? Using contraception? Breast Lumps Breast Cancer
		Current Medication(s) Oral Iv mg_____, Frequency__________
		Names of meds____
____	____	**Latex (Rubber) Allergies**
____	____	**Allergy to Anesthetic**
____	____	**History of reaction to local anesthesia**
____	____	**Medication Allergy/Reaction**
____	____	**Vaccination for pneumonia**
____	____	**Vaccination for flu**

Are you taking- **Aspirin** **Coumadin** **Ibuprofen** **Naproxen**

Do you - **faint easily** **Take antibiotic before dental procedures**

EXHIBIT P3: (2 pages)

Notice of Privacy Practices

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

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information (“PHI”) is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to “opt out” with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, how ever, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.

- The right to inspect and copy your PHI.

- The right to amend your PHI.

- The right to receive an accounting of disclosures of your PHI.

- The right to obtain a paper copy of this notice from us upon request.

- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services “out of pocket”, in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of 09/01/2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer (Dr. Linda P. Nims-703-938-5700) for more information.

EXHIBIT P4:

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I am a patient of D&DSG. I hereby acknowledge receipt of D&DSG ‘s Notice of Privacy Practices.

Name [please print]: ____

Signature: ____

Date: ____

OR

I am a parent or legal guardian of ____
[patient name].

I hereby acknowledge receipt of D&DSG ‘s Notice of Privacy Practices with respect to the patient.

Name [please print]: ____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: ____

Date: ____