Dermatology & Dermatologic Surgery Group of Northern Virginia, PLLC

PATIENT INFORMATION

❑ New Patient ❑ Name Change ❑ Address Change ❑ Insurance Change

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

Name ____
Last *First* *M.I.*

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

ADDRESS:

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: ( )______________________

INSURANCE COVERAGE - PRIMARY:

Insurance Co. Name:______________________________

Address of Claim Center:____

____
City *State* *Zip Code*

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 Code*

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.

REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name:____ Today's Date ____/____/____

Other family members that are patients ____

Primary Care Physician _________________________________ Phone (   )________________

EMERGENCY CONTACT INFORMATION:

In case of emergency, who should be notified?_________________________ Phone (   )________________

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 at home?

❑ YES ❑ NO

May we e-mail personal medical information to you?

❑ YES ❑ NO E-mail address: ____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

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

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.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 35% 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, PLLC
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
REVIEWED BY

Past/family/social/history

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

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)**

____|____ **Latex (Rubber) Allergies?**

____|____ **Allergy to Anesthetic?**

____|____ **History of reaction to local anesthesia?**

____|____ **Medication Allergy/Reaction**

Are you taking Aspirin___**Coumadin**___**Ibuprofen**___**or Naproxen**______

Do you faint easily?_____**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;
- Other uses and disclosures not described in this notice.

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, however, 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 if 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-703-938-5148) for more information, in person or in writing.

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: ____