PATIENT INFORMATION

Patient First & Last Name:____ Sex: (circle) M / F

Address: ________________________________ City: _________________________ State: ______ ZIP: ___________

Social Security Number: _______- ______- ________ Date of Birth: ____ / ____ / ________ Marital status: (circle) S M D W

Phone Number: (circle preferred) Home: ______________________ Cell: ______________________

Work: ______________________ ext: ___________ E-Mail: ____

Who to notify in case of **emergency**? ______________________________________ Relationship: ________________

Daytime Phone Number: ______________________ Alternate Phone Number: ______________________

Race: (circle) American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White / Other Race / Prohibited by State Law / Declined to State

Ethnic Group: (circle) Hispanic or Latino / *Not* Hispanic or Latino / Prohibited by State Law / Declined to State / Other: ________________

Preferred Language: _______________________

EMPLOYMENT INFORMATION

Employer: ____ Occupation: ________________________________

INSURANCE INFORMATION

Primary: ______________________________________ / Secondary: ____

Primary Responsible Party's Name: ___________________________________ Date of Birth: ____ / ____ / ____

If applicable: Social Security Number ____-____-_____

Secondary Responsible Party's Name: ___________________________________ Date of Birth: ____ / ____ / ____

Patient's Relationship to Insured: (circle) Spouse / Child / Other: ____

REFERRAL INFORMATION

How were you referred to our practice? (circle): Friend / Physician / Insurance / Facebook / Instagram / Website / Search Engine

If applicable:

Primary Care Physician: _______________________________ Referring Physician: _______________________________

I hereby authorize the above information is correct.

Patient/Responsible Party Signature: ___________________________________ Date: _______________ Revised 4/25/17

LUX DERMATOLOGY

An Affiliate of Artius Dermatology Associates, PC

Review of Systems

Patient Name ______________________ **Date of Birth:** ______________________

Gastrointestinal

	Yes	No		Yes	No
Nausea			Vomiting		
Heartburn			Food sticking in Throat		
Painful Swallowing			Vomiting blood		
Black Stool			Red blood in stool		
Abdominal Pain			Constipation		
Diarrhea			Loss of appetite		
Early satiety (feeling full fast)			Bloating		

HEENT

	Yes	No		Yes	No
Sore throat			Hoarseness		

Neurological

	Yes	No		Yes	No
Seizures			Headaches		

Cardiovascular

	Yes	No		Yes	No
Abnormal heart rhythm			Chest pain		
Palpitations					

Musculoskeletal

	Yes	No		Yes	No
Joint pain			Arthritis		

Respiratory

	Yes	No		Yes	No
Cough			Shortness of breath with activity		
Shortness of breath at rest			Wheezing		

Psychiatric

	Yes	No		Yes	No
Dementia			Depression		
Anxiety					

Dermatology

	Yes	No
Rash		

Constitutional

	Yes	No		Yes	No
Recent weight gain			Recent weight loss		
Fever			Fatigue		

Genitourinary

	Yes	No		Yes	No
Frequent urination			Kidney failure / dialysis		
Painful urination			Date of last menstrual period: ______________		

New Patient Questionnaire

Patient Name: ____________________________________ MRN#: ____________________________

Ethnicity: _____________________________ Date of Birth: ______________________

Race: ________________________________ Language: _________________________

Medical History

Ascites (extra fluid in abdomen)	No	Yes	High Blood Pressure	No	Yes
Asthma	No	Yes	Kidney Failure	No	Yes
Bleeding Disorder	No	Yes	Kidney Stones	No	Yes
Cancer What type	No	Yes	Liver Disease	No	Yes
Congestive Heart Failure (CHF)	No	Yes	Migraine Headaches	No	Yes
Coronary Artery Disease (CAD)	No	Yes	Pancreatitis	No	Yes
Depression	No	Yes	Peripheral Vascular Disease	No	Yes
Diabetes	No	Yes	Rheumatic Fever	No	Yes
Emphysema or COPD	No	Yes	Seizures	No	Yes
Endometriosis	No	Yes	Sleep Apnea	No	Yes
Gallstones	No	Yes	Stomach Ulcer	No	Yes
Heart Arrythmia (A Fib/ SVT/ A.Flutter)	No	Yes	Stroke/TIA	No	Yes
Heart Attack	No	Yes	Thyroid Disease	No	Yes
Hepatitis	No	Yes	Valvular Heart disease orEndocarditis	No	Yes

Skin Disease History

Basal Cell Skin Cancer	No	Yes
Melanoma	No	Yes
Squamous Cell Skin Cancer	No	Yes

If yes, please explain: ________________________________

____

Family History

Do you have family history of melanoma? No Yes

If yes, please explain: ________________________________

____

Social History

Are you a Tobacco Smoker? Never Yes Quit

Alchol Consumption? How many per week: ______________

Drug Allergies/Intollerance

Allergy to adhesive	No	Yes
Allergy to lidocaine	No	Yes
Artificial heart valve	No	Yes
Artificial joint w/in past two years	No	Yes
Defibrillator	No	Yes
Pacemaker	No	Yes
Allergy to topical antibiotic ointments	No	Yes
Allergic anaphylactic reaction	No	Yes
Use any type of Retin-A	No	Yes
MRSA (history or current)	No	Yes
History of cold sores	No	Yes
Rapid heartbeat	No	Yes
Faint with procdures	No	Yes
Pregnancy or planning a pregnancy	No	Yes

Are you taking any blood thinners (Coumadin, Warfarin, Plavix, Pletal, Pradaxa, etc?) No Yes

Current Medications -

Please list all prescription and over the couter medicines including doses

Surgical History

Pharmacy:____ Address: ____

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to the physician/practice individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that LUX Dermatology is unable to collect from my insurance carrier for whatever reason.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the patient information Privacy Policy. I hereby Authorize to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and medical treatment. In addition, I give permission to have a biopsy(s), minor surgical procedures and any subsequent treatment as deemed necessary as long as the risk and complication are discussed with me prior to the procedure. I understand that no guarantee has been made as to the results that may be obtained.

ACKNOWLEDGEMENT:

My signature below acknowledges that I have read and understand the disclosures & consents.

Patient Signature: ___________________________________ **Date:** _______________________________

PRINT NAME: ___________________________ RELATIONSHIP TO PATIENT____________________

GUARANTOR SIGNATURE: ____ DATE: _________

(If different from patient)

E-PRESCRIBING CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. E-Prescribing greatly reduces medication errors, and enhances convenience for the patient while maximizing patient safety. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program.

These include:

- Formulary and benefit transactions – Gives the prescriber information about which drugs are covered by the patient's drug benefit plan.
- Medication history transactions – Provides the physician with information about medications the patient is already taking to minimize adverse drug events.
- Fill status notification – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription needs to be refilled, has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that LUX Dermatology, can electronically transmit your prescriptions directly to your pharmacy.

E-Prescribing is an optional service and you may choose to decline. Please note that consenting to E-Prescribing also permits the use of your prescription medication history from other healthcare providers and/or third-party benefit payors (i.e., your insurance company) for treatment purposes only. Understanding all of the above, I hereby provide informed consent to LUX Dermatology to enroll me in the E-Prescribe Program.

______________________________	______________________________
Signature of Patient (or Guardian)	Date of Birth
______________________________	______________________________
Print Patient Name	Relationship to Patient

If you choose to participate in E-Prescribing, please list your preferred pharmacy information below.

______________	______________________	____________________
Pharmacy Name	**Location (City and Street Name)**	**Pharmacy Telephone Number**

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Full payment is due at the time of service unless your health insurance carrier has made prior arrangements. For your convenience, we accept cash, checks or credit cards.

Your Insurance

We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment and co-insurance at the time of service. This office's policy is to collect this copayment and co-insurance when you arrive for your appointment.

If your insurance requires a referral it is your responsibility to provide the referral to our office prior to seeing the physician. If unable to provide the referral prior to the visit payment in full will be required at the time of the visit.

If you have Medicare, PART B only you are responsible for your Medicare deductible and your 20% of the charges at the time of service.

If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.

In the event that your health plan determines a service to be **"not covered,"** you will be responsible for the complete charge. Payment is due at the time of service.

We will bill your health plan for all services provided. Any balance due is your responsibility and is due at the time of service or upon the receipt of a statement from our office.

If you have lab work performed, you will receive a separate bill from the lab offices that prep and provide lab results.

LUX Dermatology charges a fee for failure to cancel your appointment within 24 hours of your scheduled appointment $25.00 for office visits $50.00 for scheduled surgeries.

Patient Signature: ___________________________________ **Date:** _______________________________

Acknowledgement of Receipt of the Notice of Privacy Practices

Patient Name: ___________________________________
Birthdate: _________________

Address: _____________________________________ Telephone No. __________________
____
____

I hereby acknowledge that I have received from LUX Dermatology a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how LUX Dermatology may use and/or disclose my personal health information both with and without my authorization. I further understand that I may contact the Medical Director if I have any questions regarding the contents of this Notice of Privacy Practices or to file a complaint about the privacy practices of LUX Dermatology.

____ Date_____________________
Signature of Patient or Patient's Representative

Email Marketing Permission

Please let us know if you are interested in receiving information on special offers, events and promotions on our products and services at Lux dermatology.

☐ **Opt-In** -Yes, I am interested in receiving emails about special offers, events and promotions from Lux Dermatology.

☐ **Opt-Out** -No, I am not interested in receiving emails about special offers, events or promotions from Lux Dermatology.

Email: ____

____

Print Patient's Name

____ _______________________

Patient's Signature Date

* Lux Dermatology will not share your information with any outside agencies. Your information will be solely used for the purpose of providing you with information on current offers, events and promotions happening at our clinics. We, at Lux Dermatology, are committed to protecting your privacy.

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health 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. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to

permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

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 laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access

may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction in writing and given to our HIPAA Compliance Privacy Officer

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Privacy Officer in person or by phone at our main phone number.