

Patient Information Sheet

Date: _____

Patient Name: _____ **Gender:** F / M
Last First Middle Initial

Date of Birth: _____ **Email:** _____

Address: _____

Home Phone: _____ **Cell:** _____ **Work:** _____

- Best number to contact you regarding appointments: **Home / Cell / Work**
- Do you authorize the office to leave messages regarding appointments and lab results at this number? **Y/N**
- Do you authorize the office to contact you via email for promotions and appointment reminders? **Y/N**

Marital Status: S / M / D / W **Primary Language:** _____

Ethnicity: _____ **School/Employer:** _____

Primary Care Physician and location: _____

Referring Physician and location: _____

Preferred Pharmacy: _____ **Pharmacy Location:** _____

If the patient is under 18, please list the legal parent/guardian _____

If applicable, who has Power of Attorney? _____

Emergency Contact Name: _____ **Relationship:** _____ **Phone:** _____

How did you hear about Skin Oasis Dermatology? _____

Insurance Information

Primary Insurance: _____

Member ID: _____ **Group Number:** _____

Policy Holder's Name: _____ **Policy Holder's DOB:** _____

Relationship to Patient: _____ **Policy Holder's Employer:** _____

Specialist Copay: \$ _____ **Deductible Amount:** \$ _____

Secondary Insurance: _____

Member ID: _____ **Group Number:** _____

Policy Holder's Name: _____ **Policy Holder's DOB:** _____

Relationship to Patient: _____ **Policy Holder's Employer:** _____

Specialist Copay: \$ _____ **Deductible:** Amount: \$ _____

Patient Medical History

Current Medical Problems

Skin Cancer

No history of skin cancer _____
(List skin cancer type, location, treatment and date)

Surgeries

Medications (List prescribed medications, vitamins and herbal supplements)

Allergies

Patient Review of Systems (please circle)

Infectious

- Tuberculosis
- HIV/AIDS
- Hepatitis B/C
- Herpes
- Other: _____

Cardiovascular

- Heart Valve Disease
- Pacemaker
- High Blood Pressure
- Heart Disease
- Other: _____

Pulmonary

- Asthma
- Shortness of Breath
- Bronchitis
- Sarcoidosis
- Other: _____

Gastrointestinal

- IBS
- Stomach Ulcers
- Liver Disease
- Other: _____

Kidneys

- Kidney Insufficiency
- Dialysis
- Other: _____

Rheumatology

- Arthritis
- Lupus
- Rheumatoid Arthritis
- Joint surgery
- Other: _____

Gynecological/Genitourinary

- Irregular Periods
- Menopause
- Excessive bleeding
- Polycystic ovarian syndrome
- Urinary Incontinence
- Prostate Cancer
- Benign Prostate Hypertrophy
- Other: _____

Neurologic

- Seizures
- Stroke
- Other: _____

Psychiatric

- Depression
- Anxiety
- Eating Disorder
- Other: _____

Blood Disorders

- Sickle Cell
- Blood Clotting Disorder
- Lymphoma/Leukemia
- Anemia
- Low white cell count
- Low platelets
- Other: _____

Dermatologic

- Keloids
- Hives
- Eczema
- Hair loss
- Other: _____

Endocrine

- Diabetes/ Thyroid Disorder
- Other: _____

Social History

- Tobacco Use: **Never** ___ **Currently** ___ **Formerly** ___
- Alcohol Use: **Never** ___ **Currently** ___ **Formerly** ___
- How much alcohol per day? _____
- Recreational Drug Use: Yes No
- Tanning Bed Use: Yes No
- Are you pregnant? Yes No
- Are you planning a pregnancy? Yes No
- Are you breast feeding? Yes No

Patient Consent for Use and Disclosure of Protected Health Information

Your health information is personal and confidential. Our office will take all precautions to protect against unauthorized use and disclosure of your health information. You have the right to request in writing restricted use of your personal health information related to treatment, payment, or office operations but the practice does not have to agree to those restrictions. If the practice does agree to your restrictions provided in writing, then Skin Oasis Dermatology is bound by this agreement except in the case of an emergency.

You give Skin Oasis Dermatology permission to use and disclose your protected health information for the dedicated purpose of healthcare operations. You give permission for Skin Oasis Dermatology to contact you by phone, email, or by mail for the purpose of treatment, payment, and healthcare operations at the contact information that you have provided.

Examples of how we will use or disclose your Protected Health Information include but are not limited to:

- Medical treatment
- Payment processes
- Scheduling appointments and appointment reminders
- Response to disputes
- Laboratory and pathology results

You have certain rights regarding your personal health information, which include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to a paper copy of this notice
- The right to request confidential communications

Please refer to Skin Oasis Dermatology Notice of Privacy Practices for a more complete description of such uses and disclosures and rights. I have reviewed the Notice of Privacy Practices prior to signing this consent. Skin Oasis Dermatology reserves the right to revise its Notice of Privacy Practices at any time. You have the right to revoke this consent in writing, at any time and any future disclosure will then cease. If I do not sign this consent, then I understand that Skin Oasis Dermatology may decline to provide treatment to me.

I authorize that the designated person(s) listed below may have access to my medical information (spouse, parent, sibling or child).

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices for Skin Oasis Dermatology.

Signature of Patient/Legal Guardian **Date**

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason: _____
- Other: _____

Signature: _____ **Date:** _____

Skin Oasis Dermatology

Acknowledgement of Payment and Consent

PLEASE REVIEW CAREFULLY, INITIAL EACH POLICY AND SIGN FORM
(Initialing indicates that you have read and understand each policy)

_____ **I understand if I have insurance** a claim for reimbursement for service rendered will be submitted **once** to my insurance company based on the information I provide to Skin Oasis Dermatology (the "Practice"). I assign insurance payments for such services directly to the Practice. **I understand that I must pay co-pays, deductibles, co-insurance and for non-covered services at the time of my visit.** The Practice will rely on information I provide today to submit my insurance claim and order additional services (laboratory and testing that are essential). If my insurance company does not pay the Practice **within 30 days**, I will pay the balance due in full.

_____ **I understand if I participate in an HMO/IPA/PPO** that I am responsible for paying all charges I incur without proper authorization from my HMO/IPA/PPO. If I agree to recommended services which my insurance company later deems not medically necessary, I will pay in full at the time of billing.

_____ **I understand if I am Self Pay** because at the time of my visit I do not have valid/verified health insurance; or am uncertain as to which insurance I have; or do not want my insurance company to be billed; or do not comply with the terms of my insurance policy such as not supplying adequate information or obtaining proper referrals; and for services I receive that my insurance company later deems as not medically necessary, no claim will be submitted by the Practice at any time and I will pay for all charges in full at the time of the visit.

_____ **I understand if I participate in Medicare** that I authorize the release of my private health information and any information needed for this and related Medicare claims to the Social Security Administration and Health Care Finance Administration or its intermediaries or carriers. I request payment of medical insurance benefits either to myself or to the Practice, and assign insurance payments directly to Practice for services rendered. I understand that I am responsible for any health insurance deductibles, co-insurance and non-covered services.

_____ **Outstanding Balances/Miscellaneous: I understand** for balances, including but not limited to copays, deductibles, co-insurance, no show and late cancellation fees, referred to collections, I agree to pay all costs of collections, including but not limited to court costs and attorney fees, the reasonableness of which will not be contested. I understand that additional service fees will be charged based on non-payment of co-pays at time of service, late cancellation of appointments, no shows (**medical \$40 fee and cosmetic service 25% deposit**) and other policies of the Practice which may change from time to time without notice. A monthly billing surcharge will be added to subsequent statements for all balances **not paid with 30 days** of the date of the first statement. I further understand that a fee (**\$35**) will be added to subsequent statements for returned checks. A fee for medication management telephone calls will be charged. I agree that the Practice may query the Surescripts prescription database when making decisions regarding my medical care.

_____ **Statement are mailed to our patient monthly.** The statement shows an itemized statement on any outstanding balance on your account. The balance should be paid in full upon receipt unless financial arrangements have been made with the billing office. **Statements paid after 30 days of the statement date will incur a \$10 late payment fee.** Past due accounts will be reviewed for possible collection action.

NOTE: ALL cosmetic procedures/products are FINAL SALE – NO REFUNDS

This agreement is valid for all episodes of care rendered by the Practice. A copy may be used in place of the original. By signing below, I, as the patient or other responsible party (for minors, the person who consents to services on behalf of the minors), consent to the foregoing, certify that all insurance information provided is correct and complete as of today and agree to make all required payments. Any modifications to this agreement are ineffective and void. The Practice reserves the right to deny care in the event the term and conditions of this agreement are not accepted. The Practice may contact me using any information I provide. I acknowledge that I have reviewed the Practice's Notice of Privacy Practices and authorize the release of any medical or other information related to my visit to the Practice, the Health Care Financing Administration, my insurance company or other similar entity, as appropriate.

Please print: _____ **Sign:** _____

Date: _____

Skin Oasis Dermatology

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 review it carefully.

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

2401 Brandermill Blvd., Suite 240
Gambrills, MD 21054
410-451-0500 phone
410-451-0575 fax
info@skinoasisderm.com

Effective Date: December 1, 2014

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: Skinoasisderm.com.

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI 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.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclose your PHI in other situations without your permission:

- **If 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. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- **Public health activities:** The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- **Health oversight agencies:** 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.
- **Legal proceedings:** To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- **Police or other law enforcement purposes:** The release of PHI will meet all applicable legal requirements for release.
- **Coroners, funeral directors:** 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
- **Medical 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.
- **Special government purposes:** Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- **Correctional institutions:** Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- **Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your

Revised February 7, 2017

information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- 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.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing to Privacy Officer, Skin Oasis Dermatology, 2401 Brandermill Blvd., Suite 240, Gambrills, MD 21054.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after December 1, 2014. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Privacy Officer
Skin Oasis Dermatology
2401 Brandermill Blvd., Suite 240
Gambrills, MD 21054
410-451-0500

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on December 1, 2014.

Skin Oasis Dermatology **Cosmetic Interest Questionnaire**

Patient Name: _____ **Date:** _____

Please check any issues and/or procedures of interest to you and the front desk will give this form to the doctor or medical assistant during your visit.

- | | |
|--|---|
| <input type="checkbox"/> Skin-care advice and products | <input type="checkbox"/> Hair Restoration |
| <input type="checkbox"/> Sunscreen advice/Sun damage | <input type="checkbox"/> Redness/Rosacea |
| <input type="checkbox"/> Botox | <input type="checkbox"/> Brown spots/Melasma |
| <input type="checkbox"/> Dermal fillers | <input type="checkbox"/> Sagging skin |
| <input type="checkbox"/> Lip enhancement | <input type="checkbox"/> Acne & other scars |
| <input type="checkbox"/> Forehead wrinkles/Frown Lines | <input type="checkbox"/> Restoring volume to the face |
| <input type="checkbox"/> Double Chin | <input type="checkbox"/> Laser hair removal |
| <input type="checkbox"/> Toe nail fungus | |

Sign me up for the Skin Oasis-email, featuring the latest advances, specials in cosmetic dermatology, products and services.

Your email: _____

We encourage you to get information from Dr. Miles and her team, so you are able to stay in the know and take advantage of our monthly procedure, treatment and product specials.

Thank you!

Skin Oasis Dermatology

Cosmetic Financial Policy

PLEASE REVIEW CAREFULLY, INITIAL EACH POLICY AND SIGN FORM
****Initialing indicates that you have read and understand each policy****

(Insurance does not cover cosmetic procedures)

_____ I understand that there is a **25% deposit** for all COSMETIC PROCEDURES, payable when scheduling an appointment/checking-in. Please provide a **48 hour (2 business days) notice** if you need to cancel the appointment. **Your deposit is non-refundable if our office does not receive a 48 hour cancellation notice.**

_____ **Outstanding Balances/Miscellaneous:** I understand that for balances referred to collections, I agree to pay all costs of collections, including but not limited to court costs and attorney fees, the reasonableness of which will not be contested. **A fee for COSMETIC management telephone calls may be charged.**

All costs are payable via credit cards or cash only

NOTE: ALL cosmetic procedures/products are FINAL SALE – NO REFUNDS

This agreement is valid for all episodes of care rendered by the Practice. A copy will be used in place of the original. By signing below, I, as the patient or other responsible party (for minors, the person who consents to services on behalf of the minors), consent to the foregoing. Any modifications to this agreement are ineffective and void. The Practice reserves the right to deny care in the event the term and conditions of this agreement are not accepted. The Practice may contact me using any information I provide.

I acknowledge that I have reviewed The Practice's Notice of Privacy Practices and authorize the release of any medical or other information related to my visit to the Practice, the Health Care Financing Administration, my insurance company or other similar entity, as appropriate.

Please print Name: _____

Sign: _____

Date: _____

Skin Oasis Dermatology Credit Card Policy

Initialing indicates that you have read and understand each policy

_____ I understand it is company policy that additional service fees will be charged based on non-payment of co-pays at time of service, late cancellation of appointments, no shows (**medical \$40 fee and cosmetic service 25% deposit**) and other policies of the Practice which may change from time to time without notice.

A monthly billing surcharge will be added to subsequent statements for all balances **not paid within 30 days** of the date of the first statement. I further understand that a fee (**\$35**) will be added to subsequent statements for returned checks. A fee for medication management telephone calls will be charged.

Medical appointments = 24 hours (1 full business day) notice
Cosmetic appointments = 48 hours (2 full business days) notice

Medical Appointment

_____ I understand it is company policy that we will charge your credit card the late cancellation fee and/or no show fee of **\$40** if you fail to cancel your appointment 24 hours prior (**1 full business day**) to your appointment time or if your appointment has been missed. Please list your valid credit card information below, as well as your signature authorizing the charge. We keep all files confidential and assure your personal information will not be shared.

Cosmetic Appointment

_____ I understand that there is a **25% deposit** for all COSMETIC PROCEDURES, payable when scheduling an appointment/checking-in. Please provide a **48 hour (2 full business days) notice** if you need to cancel the appointment. **Your deposit is non-refundable if our office does not receive a 48 hour cancellation notice.**

Credit Card Type: MC, Visa, AMEX, Discover, Care Credit (circle one)

Card Number _____ **Expiration Date** _____

CVC Code _____ - **Zip Code** _____

I, _____ hereby authorize **Skin Oasis Dermatology** to charge my card the fee of **\$40 in the event I "no show"** for a scheduled appointment or I fail to cancel an appointment **24 and/or 48 hours prior**, or to pay any fees owed for services.

After insurance claims have been processed, **remaining balances such as copays, deductibles and co-insurances will be charged to the credit card on file.**

Signature _____ **Date** _____