Eagle Creek Dermatology

PATIENT INFORMATION

NAME _____ _____ DOB _____ GENDER ☐M ☐F
LAST NAME FIRST NAME MI PREFERRED NAME

ADDRESS _____ CITY/STATE/ZIP _____

HOME # _____ CELL # _____ MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

EMPLOYER _____ PHONE # _____

IF MARRIED: SPOUSE'S NAME _____ CELL # _____ WORK # _____

PARENT INFORMATION *COMPLETE ONLY IF PATIENT IS A MINOR*

MOTHER'S NAME _____ DOB _____ PHONE # _____

MOTHER'S EMPLOYER _____

FATHER'S NAME _____ DOB _____ PHONE # _____

FATHER'S EMPLOYER _____

PATIENT RESIDES WITH _____ RELATIONSHIP TO PATIENT IF OTHER THAN PARENT _____

It is the policy of this office that the person accompanying the child for treatment be held responsible for payment. We will not bill the other parent.

PRIMARY POLICY HOLDER INFORMATION

NAME OF PRIMARY INSURANCE _____

NAME _____ BIRTHDATE _____

ADDRESS _____ PHONE # _____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER _____ GENDER ☐ M ☐ F

SECONDARY POLICY HOLDER INFORMATION

NAME OF SECONDARY INSURANCE _____

NAME _____ BIRTHDATE _____

ADDRESS _____ PHONE # _____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER _____ GENDER ☐ M ☐ F

NAME OF PRIMARY CARE PHYSICIAN _____ **PHONE #** _____

PREFERRED PHARMACY _____ **PHONE #** _____

WHO CAN WE THANK FOR YOUR REFERRAL? _____

Acknowledgement of Office Policies

Consent to Treatment: I consent to the performance of diagnostic exams and procedures provided by the medical provider and/or their staff as deemed necessary. I also understand that photographs may be taken during treatment. If photographs are selected for commercial use I will be contacted for consent.

The staff of this office pledges to give the finest care our capacities allow. Complications are seldom seen in the many procedures performed, however, even small procedures can scar, occasionally bleed, and rarely become infected or incite allergic response.

I authorize the transfer of medical information to my other healthcare providers, pharmacies, and consultants, if needed and as necessary to process insurance claims, applications, and prescriptions.

I understand if I have a surgical procedure or biopsy performed there will be at least two charges. The first is for the provider collecting the biopsy and the second is for the examination of the specimen. It is possible that a specimen could be sent out for a second opinion if needed. If my biopsy is sent to an outside laboratory, such as Indiana University Health, a separate bill may be sent to me from this outside laboratory for their pathology charges. Eagle Creek Dermatology will provide the outside laboratory with billing/insurance information for the outside laboratory to process these charges.

Acknowledgement of Financial Policies

Consent for Filing Insurance Claims: I understand that, in order to file claims and release medical information to any insurance company(s) I have listed in my financial record, Eagle Creek Dermatology is required to keep my signature on file. I hereby authorize Eagle Creek Dermatology to receive benefits directly from my insurance company/Centers for Medicare and Medicaid Services and its agents when an assigned claim is filed. I also authorize Eagle Creek Dermatology to appeal any denial to my insurance company on my behalf and authorize the release of any medical information to my insurance company(s) that is necessary for the processing of claims. I also authorize payment of any Medigap benefits on my behalf to Eagle Creek Dermatology for services furnished to me.

As a courtesy Eagle Creek Dermatology will file claims to all insurance carriers for medical services. I understand that it is my responsibility to determine if Eagle Creek Dermatology is a network provider for my insurance carrier. I understand it is my responsibility to contact the insurance carrier to determine insurance benefits, as we cannot guarantee your insurance coverage for our services. I acknowledge that it is my responsibility to notify Eagle Creek Dermatology of any insurance changes. I also understand that it is my responsibility to obtain all necessary referrals if my plan requires one. All necessary copays are due and collected at the time of service.

I understand that if my account has not been paid in full within 90 days from the time my insurance responds, the account may be referred to our collection agency. I understand I will be responsible for all collection cost, which maybe up to 40% of original balance due, attorney fees, and court fees.

I understand that returned checks will incur a $25 insufficient funds fee. Balances must be handled by cash or credit card.

Patient Name: _____ **Date of Birth:** _____

X _____ _____ **Date:** _____
Signature of Patient, Parent/Guardian, or Personal Representative

INSTRUCTIONS FOR COMMUNICATION

□ I authorize my doctor or staff to leave messages including certain medical information on my answering machine/voicemail:
This information may include lab results, instructions regarding treatments, medications prescription refills and/or appointments.

□ home □ work □cell/mobile phone □ **all phone numbers listed**

□ I authorize my doctor or staff to leave messages with the following individuals:

_____ _____ _____

□ NO. I prefer that my doctor or staff speak with me personally regarding any medical information. Do not leave messages concerning my medical information.

I understand that I may notify my doctor's office at any time to change this request. I understand this would require a new form to be completed.

_____
Patient's Name

_____ _____ _____
Patient Signature (parent/guardian if patient is a minor) Printed Name Date

Notice of Privacy Practices

Eagle Creek Dermatology

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Medical records are written and/or electronic records of your contacts or visits for healthcare services with our practice. Specifically, medical records are information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is legally required to maintain the confidentiality of your medical records, and to follow specific rules when using or disclosing this information. This Notice describes your rights to access and control your medical records. It also describes how we follow applicable rules when using or disclosing your medical records to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under the Privacy Rule Following is a statement of your rights, under the Privacy Rule, in reference to your Medical Records.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required by law to follow the terms of this notice. We reserve the right to change the terms of the notice, and to make the new notice provisions effective for all medical records that we maintain. We will provide you with a copy of our current notice if you call our office and request that a copy be sent to you in the mail or ask for one at the time of your next appointment.

You have the right to authorize other use and disclosure - This means we will only use or disclose your medical records as described in this notice unless you authorize other use or disclosure in writing. For example, we would need your written authorization to use or disclose your medical records for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your medical records. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your medical records* - This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your medical records to a third party. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. We are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the expected date when the request will be fulfilled.

You have the right to request a restriction of your medical records* - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your medical records* - This means you may submit a written request to amend your medical records for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability* - You may submit a written request for a listing of disclosures we have made of your medical records to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment, or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured medical records and determines through a risk assessment that notification is required.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your medical records to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your medical records, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose medical records to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your medical records will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services, we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your medical records to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your medical records, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your medical records that directly relates to that person's involvement in your healthcare. 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 medical records to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of medical records (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the medical records that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your medical records without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc.); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

You may ask questions about your privacy rights, file a complaint, or submit a written request (for access, restriction, or amendment of your medical records or to obtain a disclosure accountability) by notifying our Privacy Manager at: Phone: 317-329-7050 or Fax: Attn: Privacy Officer at 317-328-6809 or Mail: Attn: Privacy Officer, 6820 Parkdale Place, Suite 211, Indianapolis, IN 46254

X_____ _____

Signature of Patient, Parent/Guardian, or Personal Representative **Date**

Patient: _____ **Date:** _____ / _____ / _____

Reason for today's visit: _____

Current Medications: list all medications you are currently taking, including prescription, over-the-counter meds, vitamins, and herbals:

_____**Attach list if needed*

Are you allergic to any medications? ☐ NO ☐ YES (please list) _____

Have you ever had a reaction to dental anesthesia (novocaine)? ☐ NO ☐ YES (please explain) _____

Do ***you have now or have you ever had disease or conditions of: (please check YES or NO)***:

Lungs	**YES**	**NO**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐

Cardiovascular	**YES**	**NO**
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Murmur	☐	☐
Heart Attack	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

Other Systemic	**YES**	**NO**
Diabetes	☐	☐
Excessive thirst/hunger	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Bladder	☐	☐
Fainting	☐	☐
Arthritis/Joint Deformity	☐	☐
Arthralgia	☐	☐
Limited motion	☐	☐
Artificial joint	☐	☐
Frequency/Burning with urination	☐	☐
Convulsions/Epilepsy/Seizures	☐	☐

Gastrointestinal	**YES**	**NO**
Stomach absorptive disorder	☐	☐

When taking antibiotics do you develop the following:

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Yeast Infections

Skin	**YES**	**NO**
Actinic Keratosis	☐	☐
Psoriasis	☐	☐
Blistering Sunburns	☐	☐
Eczema	☐	☐
Atypical Moles	☐	☐
Basal Cell Skin Cancer	☐	☐
Squamous Cell Skin Cancer	☐	☐
Melanoma	☐	☐

	YES	**NO**
Has anyone in your family had skin cancer?	☐	☐
Do you have problems with healing?	☐	☐
Do you develop keloids (scars) after surgery?	☐	☐
Do you bleed easily?	☐	☐
Do you wear sunscreen?	☐	☐
Do you tan in a tanning salon?	☐	☐

Do you develop skin rashes in reaction to:

☐ Medication ☐ Food ☐ Environment

(please explain) _____

List any other disease/conditions: _____

List all surgical procedures you have had in the last 6 months: _____

Social History:

Do you drink alcohol? ☐ NO ☐ YES number of drinks per day _____

Do you use IV drugs? ☐ NO ☐ YES what drugs? _____ how often? _____

Do you smoke? ☐ NO ☐ YES number of packs per day _____

WOMEN: Are you pregnant? ☐ NO ☐ YES due date: _____

Have you tested positive for HIV / AIDS? ☐ NO ☐ YES

Have you been exposed to HIV / AIDS? ☐ NO ☐ YES

What is your occupation? _____ Hobbies? _____

Patient/Guardian Signature: _____ Date: _____Completed by: ☐ Patient ☐ Parent ☐ Medical Assistant Reviewed by: _____