River Region DERMATOLOGY & LASER | SKINCEUTICALS ADVANCED CLINICAL SPA

Patient Name: _____ Visit Date ___/___/___

Date of Birth: _____

Patient Medical History

Past Medical History: (Please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ GERD
- ☐ Hearing loss
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Renal Disease
- ☐ Thyroid Problems
- ☐ Seizures
- ☐ Stroke

Other_____

Past Surgical Procedures:

- ☐ Yes Please list: _____
- ☐ No

Skin Disease History: (Please check all that apply)

- ☐ Acne
- ☐ Actinic keratosis
- ☐ Basal Cell Carcinoma
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking/ itching scalp
- ☐ Melanoma
- ☐ Precancerous moles
- ☐ Psoriasis
- ☐ Squamous cell carcinoma
- ☐ None

Do you wear sunscreen? Yes No If yes, what SPF? _____
Do you use or have a history of using a tanning salon? Yes No
Do you have a family history of melanoma? Yes No If yes, who? _____

Medication *Please list all medications. Attach list, if necessary.*	**Allergies** *Please list all allergies.*	**Smoking Status** *Please check one*	**Alcohol Use** *Please check one*
1.	1.	☐ Unknown	☐ Less than 1 drink
2.	2.	☐ Currently smokes	☐ 1-2 drinks per day
3.	3.	☐ Past history of smoking	☐ 3 or more drinks per day
4.	4.	☐ Never smoked	☐ Never

Family History: (Please circle one)

Melanoma Yes No Relative:	**Psoriasis** Yes No Relative:	**Hair Loss** Yes No Relative:	**Unknown**
Skin Cancer Yes No Relative:	**Eczema** Yes No Relative:	**Lupus:** Yes No Relative:	**Other**

Alerts: (Please circle one)

Are you currently pregnant or trying to get pregnant? Yes No
If you are over 65, have you received a pneumonia vaccine? Yes No

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Visit Date _____/_____/_____

GENERAL INFORMATION

Name:	Age:	Date of Birth: / /
SS#:	Sex: M/F	Marital Status:
Email:		Occupation:
Preferred Language:	Race:	Ethnic Group:
Mailing Address:		
City:		State: Zip:
Phone: *Home* ( ) - *Work* ( ) - *Cell* ( ) -		

Is it okay to leave a detailed message regarding your health information? _____Yes _____No

In case of an Emergency, who should be notified?

Name _____Phone _____Relationship _____

Would you like to activate your patient portal using the above email address to receive benign path/lab results? _____Yes _____No

PLEASE PRESENT PHOTO ID & INSURANCE CARD AT TIME OF CHECK- IN

Insurance Subscriber Information (if different from patient):

Name _____ Date of Birth ___/___/___ Relationship_____

I authorize River Region Dermatology & Laser to communicate PROTECTED HEALTH INFORMATION regarding me or my condition to the following individual:

Name _____Phone _____Relationship _____

Preferred Pharmacy Name: _____
City: _____ Zip: _____ Phone: _____
Primary Care Physician: _____ Phone: _____
Referring Physician: _____ Phone: _____

How did you hear about River Region Dermatology and Laser?

☐ Family/ Friend ☐ Billboard ☐ Magazine ☐ Physician ☐ Previous Patient ☐ Radio

All above information is correct to the best of my knowledge and I agree to notify this office in a timely manner of any changes.

Patient or Guardian Signature: _____ Date ___/___/__

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STATEMENT OF PATIENT RESPONSIBILITIES

Patient Name: _____ Date of Birth: ____/____/____

Financial Responsibility
You are financially responsible for charges not covered by your insurance and for any charges that you do not want submitted to your insurance company. You are also responsible for payment of any deductible and co-payment determined by your contract with your insurance carrier. These payments are due at the time of service. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue past your approved period, you will be responsible for your balance in full.

You are also responsible for any outstanding balances and must accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

You agree for River Region Dermatology & Laser and/or our agents to contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

Self -Pay Policy
If you do not have health insurance, you will be responsible for services rendered by River Region Dermatology and Laser. The entire amount of the treatment given to the above-named patient will be due at each visit.

Routine Testing
I understand that routine testing may be needed to determine what treatment, counseling or referral may be required.

Appointment Policy
- Please arrive 10 minutes early for your initial visit to complete paperwork;
- Please call 24 hours in advance to cancel your appointment. Failure to do so will result in a $25 "No Show" fee. Monday appointments must be canceled by noon on the previous Friday.
- Please call to inform us any time that you will be late for an appointment. If you are running more than 15 minutes late, you may be asked to reschedule your appointment.

Healthcare Professionals
River Region Dermatology and Laser, PC supports training of healthcare professionals. I understand and agree to be interviewed, examined or counseled with a student present when receiving services.

Photography
I consent for medical photographs to be taken during my visit. By consenting to these medical photographs, I understand that I will not receive payment from any party. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. (Please initial indicating YES or NO below)

___YES ____NO For use in my medical record.

___YES ____NO On our website for prospective patients.

___YES ____NO For demonstration purpose including an office photo album.

___YES ____NO In print advertisements and/or professional journals.

By signing this form below, I confirm that above information has been explained to me in terms which I understand.

Patient or Guardian Signature _____ Date ____/____/____

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NOTICE OF PRIVACY PRACTICES & PATIENT DISCLOSURE ACKNOWLEDGMENT

In accordance with the American Medical Association Code of Ethics, our practice believes that the patient-physician relationship is based on trust and the confidentiality of communication. The free and uninhibited disclosures of personal information within this relationship are the cornerstone of good medical care. The privacy of your medical records is of the utmost importance to River Region Dermatology and Laser, PC. We have therefore taken measures to ensure that your medical records receive the highest level of confidentiality and security. This office adheres to the following procedures to ensure protection of your private medical records.

- Our office staff has received education and training regarding the use and handling of patients' protected health information (PHI)
- All patient paper records are secured in a locked facility during non-office hours
- Access to office keys are limited to the staff of this facility, building management and cleaning staff, who have all signed confidentiality agreements with our practice, and we have the ability to track access
- Access to electronic information is secured via passwords
- Your private medical information is only released as required or permitted by state and federal law

In order to continue to provide personalized service to our patients and function effectively:

- We utilize outside services, such as transcriptionists or consultants
- Your name, status and location may be revealed within the office setting
- Laboratory, test results, and clinical notes may be shared with other physician(s) participating in your medical care
- Confidentiality can be expanded to exclude information issued to insurance companies by choosing to not use any health insurance or third-party payment as payment for services. In this scenario any and all health care services rendered, we will submit your charges to your health insurance, other third party, or employ the services of a collection agency
- If you request copies of your records, we will charge you per our states recommended fees
- Unless, you opt-out of participation, we will provide marketing materials to you that we deem appropriate for your care

I have received a copy of the River Region Dermatology and Laser PC Notice of Privacy Practices. My signature below confirms that I understand my rights and responsibilities.

_____ _____

Print Patient Name | Date of Birth

_____ _____

Patient Signature | Date

_____ _____

Signature of Parent or Legal Guardian | Print Parent or Legal Guardian Name

November 2016