

NEW PATIENT INFORMATION (PLEASE PRINT)

PATIENT'S SS# _____ DATE _____ CELL PHONE NO. _____
 PATIENT'S NAME _____ WORK PHONE NO. _____
 MAILING ADDRESS _____ HOME PHONE NO. _____
 CITY, & STATE _____ ZIP _____
 EMAIL _____
 MALE _____ FEMALE _____ DATE OF BIRTH _____ AGE _____ MARITAL STATUS: SINGLE or MARRIED

PATIENT'S EMPLOYER _____ WORK PHONE _____
 EMPLOYER'S ADDRESS _____ PHONE _____

SPOUSE'S NAME _____ SPOUSE'S BIRTHDATE _____

SPOUSE'S EMPLOYER _____ EMPLOYER'S ADDRESS _____

MINORS ONLY (UNDER 18 YEARS OF AGE)

FATHER'S NAME & ADDRESS _____
 FATHER'S BIRTHDATE _____ SS # _____ WORK PHONE _____
 FATHER'S EMPLOYER & ADDRESS _____
 MOTHER'S NAME & ADDRESS _____
 MOTHER'S BIRTHDATE _____ SS # _____ WORK PHONE _____
 MOTHER'S EMPLOYER & ADDRESS _____

INSURANCE INFORMATION

FIRST INSURANCE COMPANY NAME AND ADDRESS _____

 POLICY AND GROUP NUMBER _____ ID NUMBER _____
 SUBSCRIBER'S NAME _____ BIRTHDATE _____ SS # _____
 SECOND INSURANCE COMPANY NAME AND ADDRESS _____

 POLICY AND GROUP NUMBER _____ ID NUMBER _____
 SUBSCRIBER'S NAME _____ BIRTHDATE _____ SS # _____

REFERRING PHYSICIAN _____ DRUG ALLERGIES _____

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

SIGNED _____ DATE _____

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW

SIGNED (INSURED OR AUTHORIZED PERSON) _____

SIGNED (INSURED OR AUTHORIZED PERSON) _____

The undersigned herewith authorizes **Derm One PLLC** to receive and/or release medical data, medical history and/or other information to any hospital, physician, agency, or person if such a release of information is for the purpose of consultation, prescription or future treatment and in the interest of the proper management of your medical condition/disability.

By signing below, I hereby acknowledge Receipt of Derm One PLLC Notice of Privacy Practice and consent to the uses and disclosures described in the Notice of Privacy practices. I agree to all the above policies of Derm One PLLC.

Signature - Patient, Parent or Guardian _____

Date _____

Witness _____

Date _____

MEDICARE PATIENTS ONLY

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Patient Signature: _____

Date _____



Patient Information Release Form

Patient Name: _____

I authorize the person(s) listed below to have access to my medical information. These people may call and speak with the nurse/doctor about my case.

I have the right to terminate this agreement at any time by informing the staff in writing.

Authorized Person(s)

Relationship to Patient

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

BLUEFIELD, VA
276-326-DERM (3376)
725 S. College Ave.
Bluefield, VA
24605

RADFORD, VA
540-633-3015
1804b E. Main Street
Radford, VA
24141

WYTHEVILLE, VA
276-228-2022
150 Peppers Ferry Rd.
Wytheville, VA
24382

BECKLEY, WV
304-255-9434
250 George Street
Beckley, WV
25801

PRINCETON, WV
304-425-9448
206 New Hope Road Suite 1
Princeton, WV
24740

DERM ONE

Dermatology Care

Because there are so many different insurance plans, all benefits are not alike and you can no longer assume that all medical services will have a covered benefit. Because we are considered specialists, your plan may now require that you first seek treatment from or be referred to us by your primary care physician or family physician. In addition, recommended treatment plans and surgical procedures may require prior authorization. If your insurance provider determines that a service is not covered, you will be responsible for payment in full. There are numerous rules that could apply to your current coverage. These rules are dictated by your insurance provider.

Each person covered under a group plan should receive a member ID card. However, possession of an ID card does not guarantee coverage or payment for services rendered. Patients will now be required to present this card at each visit to assure coverage and benefits have not changed since last visit. This will aid our staff in verifying eligibility and benefits and filing claims on your behalf.

It is to your benefit to know and understand your insurance coverage. Failure to do so could result in your financial loss through reduced benefits or denied payments of your claims. We will bill your insurance company. This office cannot accept responsibility for collections and your insurance claim or negotiating a settlement on a disputed claim.

ALL PATIENTS ARE ASKED TO PAY THE CO-PAY AMOUNT THAT IS LISTED OR REQUIRED ON THEIR INSURANCE CARD. IF YOUR INSURANCE CARD DOES NOT STATE A CERTAIN CO-PAY AMOUNT, YOU ARE ASKED TO PAY 20% OF THE CHARGE AT THE TIME OF SERVICE, OR THE FULL AMOUNT OF THE CHARGE IF YOU HAVE NOT MET YOUR REQUIRED DEDUCTIBLE.

AUTHORIZATION TO BILL AND RECEIVE A PAYMENT AND RELEASE MEDICAL INFORMATION TO YOUR INSURANCE COMPANY

I request that payment of authorized Medicare or insurance benefits be made directly to the provider for any service provided to me. I authorize the release of any necessary medical and related information to any insurance provider to determine payment and/or process claims.

Signature of Patient or Responsible Party

Date

SELF PAY PATIENT

I understand that if I have no medical insurance, I will be held responsible for any charges services rendered by Derm One, PLLC.

Signature of Patient or Responsible Party

Date

Notice of Privacy Practices

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about the privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect.

We reserve the right to change our policy practices and terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to change our policy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For information about our privacy practices, or for additional copies of the notice, please contact us using the information listed at the end of the notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations.

For example:

Treatment – We may use or disclose your health information to a physician or other healthcare providing treatment to you.

Payment – We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare operations – We may use or disclose your health information in connection with our healthcare operations.

Healthcare includes quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization – In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends – We must disclose your health information to you, as described in the Patient Rights section of the notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care – We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services – We will not use your health information for marketing communications without your written authorization.

Required by Law – We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect – We may disclose your health information to appropriate authorities if we have reason to believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert serious threat to your health or safety or the health or safety of others.

National Security – We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders – We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient / Agent / Guardian Signature

Date

Witness Signature

Date

Derm One

Phone: 1-866-878-0031

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff times. You may also request access by sending us a letter to the address below. If your request copies, we will charge you \$1.00 per page. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee schedule.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before February 13, 2005.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or locations, and provide satisfactory explanation how payments will be handled under the alternative means or locations you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notices: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive the notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made or restrict the use or disclosure of your health information or to have us communicate with by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact Officer: Dale Tolliver
Telephone: 276-326-5058
Fax: 276-326-3046
E-mail: daletolliver@derm-one.com
Address: 725 South College Ave. Bluefield, VA 24605

Patient / Agent / Guardian Signature

Date

Witness Signature

Date

General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, cosmetic or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that 1.) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment has been recommended and 2.) you consent to treatment at this office or any other Derm One office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Patient / Agent / Guardian Signature

Date

Witness Signature

Date

Medical History

Patient Name: _____ Date: _____

Date of birth: _____ Primary Care Physician: _____

Pharmacy Name and Location: _____

Reason for today's visit: _____

Do you have a health care proxy in the event you are unable to make your own medical decisions (65 years and older)? ☐ Yes ☐ No Designee's name (optional): _____

Medical History (Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Benign prostatic hyperplasia (BPH) | <input type="checkbox"/> Hyperthyroidism (high) |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> Hypothyroidism (low) |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Prostates Cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> GERD | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Hearing Loss | |
| <input type="checkbox"/> Other: _____ | |

Surgical History (Please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Appendix (Appendectomy) | <input type="checkbox"/> Kidney: Nephrectomy |
| <input type="checkbox"/> Bladder (Cystectomy) | <input type="checkbox"/> Liver: Hepatectomy |
| <input type="checkbox"/> Breast: Breast biopsy | <input type="checkbox"/> Liver: Liver Transplant |
| <input type="checkbox"/> Breast: Lumpectomy (Circle) Left Right Both | <input type="checkbox"/> Liver: Shunt |
| <input type="checkbox"/> Breast: Mastectomy (Circle) Left Right Both | <input type="checkbox"/> Ovaries: (Oophorectomy): Endometriosis |
| <input type="checkbox"/> Colon (Colectomy): Colon Cancer Resection | <input type="checkbox"/> Ovaries: (Oophorectomy): Ovarian Cancer |
| <input type="checkbox"/> Colon (Colectomy): Diverticulitis | <input type="checkbox"/> Ovaries: (Oophorectomy): Ovarian Cyst |
| <input type="checkbox"/> Colon (Colectomy): Inflammatory Bowel Disease | <input type="checkbox"/> Prostate (Prostatectomy): Prostate Biopsy |
| <input type="checkbox"/> Colon: Colostomy | <input type="checkbox"/> Prostate (Prostatectomy): Prostate Cancer |
| <input type="checkbox"/> Gallbladder (Cholecystectomy) | <input type="checkbox"/> Prostate (Prostatectomy): TURP |
| <input type="checkbox"/> Heart: Biological Valve Replacement | <input type="checkbox"/> Rectum: APR |
| <input type="checkbox"/> Heart: Coronary Artery Bypass | <input type="checkbox"/> Rectum: Low Anterior Resection |
| <input type="checkbox"/> Heart: Heart Transplant | <input type="checkbox"/> Skin: Basal Cell Carcinoma |
| <input type="checkbox"/> Heart: Mechanical Valve Replacement | <input type="checkbox"/> Skin: Melanoma |
| <input type="checkbox"/> Heart: PTCA | <input type="checkbox"/> Skin: Squamous Cell Carcinoma |
| <input type="checkbox"/> Joint Replacement: Hip (Circle) Left Right Both | <input type="checkbox"/> Spleen (Splenectomy) |
| <input type="checkbox"/> Joint Replacement: Knee (Circle) Left Right Both | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Kidney: Kidney Stone Removal | <input type="checkbox"/> Testicles (Orchiectomy) |
| <input type="checkbox"/> Kidney: Kidney Transplant | <input type="checkbox"/> Uterus (Hysterectomy): Fibroids |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Uterus (Hysterectomy): Uterine Cancer |
| | <input type="checkbox"/> Uterus (Hysterectomy): Cervical Cancer |
| | <input type="checkbox"/> NONE |

(Continued)

Skin Disease History

- ☐ **NONE**
- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Skin Cancer

- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Melanoma

- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Other: _____

☐ Sunscreen use
If so, what SPF? _____

☐ Tanning Salon Use
If so, currently or past? _____

☐ Family history of Melanoma
If so, who? _____

Medications

☐ **CHECK BOX IF NONE**

(Please list all **current** medications and supplements)

Allergies

☐ **CHECK BOX IF NONE**

Social History

- ☐ Current Smoker
- ☐ Past smoker / history of tobacco use
- ☐ Alcohol use

- ☐ Pneumonia vaccine (65 years and older)
- ☐ Shingles vaccine (65 years and older)
- ☐ Flu vaccine during flu season

Review of Systems

(Please check all that you **ARE CURRENTLY EXPERIENCING**)

- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring
(hypertrophic or keloid)
- ☐ Rash
- ☐ Immunosuppression
- ☐ Hay Fever
- ☐ Chest Pain
- ☐ Fever or Chills

- ☐ Night sweats
- ☐ Unintentional weight loss
- ☐ Thyroid problems
- ☐ Sore throat
- ☐ Blurry vision
- ☐ Abdominal pain
- ☐ Bloody stool
- ☐ Bloody urine
- ☐ Joint Aches

- ☐ Muscle Weakness
- ☐ Neck Stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Anxiety
- ☐ Depression

Alerts

- ☐ Allergy to adhesive
- ☐ Allergy to Lidocaine
- ☐ Allergy to topical antibiotic ointments
- ☐ Artificial heart valve
- ☐ Artificial joints within the past *TWO years*
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Premedication prior to procedures

- ☐ Rapid heartbeat with epinephrine
- ☐ Pregnant: _____ weeks
- ☐ Planning pregnancy
- ☐ Hepatitis
- ☐ Diabetic
- ☐ Transplant patient
- ☐ Allergies to medications
- ☐ Breast feeding
- ☐ West Africa: Travel or Contact
- ☐ HIV/AIDS positive