EAST COAST DERMATOLOGY PC

Today's Date_____

Last Name _____ **First Name** _____ **Middle initial**_____

Name of parent or guardian (if applicable) _____

Date of Birth _____ **Gender** □ Male □ Female

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

Address _____ **Apt #**_____

City _____ **State** _____ **Zip** _____

Email Address_____

Preferred Method for Appointment Confirmation: □ Email □ Cell Phone □ Home Phone □ Work Phone

Preferred Method for RESULTS: □ Email □ Cell Phone □ Home Phone □ Work Phone

If phone, is it ok to leave a message with RESULTS? □ Yes □ No

Who else we can share your results _____

Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino **Race:** _____
Marital Status: □ Single □ Married □ Legally Separated □ Divorced □ Widowed □ Domestic Partner

Emergency Contact _____ _____
Name Relationship Tel. No.

Weight _____ **□ lb □ kg**
Height_____ **□ cm □ in**

Primary Care Physician _____ **Tel. No.** _____

Referring Physician _____ **Tel. No.**_____

Pharmacy Name _____ **Tel. No.**_____
Address _____

Employer_____ **Occupation**_____

How did you hear about us? _____

PRIMARY INSURANCE
Insurance Company: _____
ID No.: _____ **Group Number:** _____
Name of Insured: _____ **Relationship to Patient:** _____
Insured's Birth Date: _____ **Insured's Employer:** _____
Address: _____ **Tel No.:** _____
SECONDARY INSURANCE
Insurance Company: _____
ID No.: _____ **Group Number:** _____
Name of Insured: _____ **Relationship to patient:** _____
Insured's Birth Date: _____ **Insured's Employer:** _____

EAST COAST DERMATOLOGY PC

As a courtesy service to our patients, the Practice participates with several insurance carriers and employs a billing service to manage claims to those companies. Please familiarize yourself with your insurance's practices, policies and our policy below.

1. If your insurance carrier requires you to pay a portion of your healthcare visit by way of co-pays, co-insurances, etc., we are legally required to collect them, no exceptions will be made. Co-pays are collected at the time of your visit.
2. If your carrier requires you to have a referral to be seen in our office, you must provide a referral before your appointment or you cannot be seen. Attaining referrals is the responsibility of the patient. If a claim is denied due to a missing referral, you are responsible for the cost of the visit.
3. If your insurance requires you to meet an annual deductible before your healthcare is covered, you will be billed for the services rendered, if you have not met your deductible.
4. Only medical office visits will be billed to your insurance. Consultations and/or questions regarding cosmetic procedures to improve or enhance your appearance are NOT covered by insurance and are considered to be cosmetic.

Assignment and Release

I, the undersigned, have insurance coverage and assign all medical benefits to EAST COAST DERMATOLOGY PC. I understand that I am financially responsible for all charges, in full or in part, not paid by my insurance. This includes copays, deductibles, coinsurance, claims unpaid due to the lack of a valid referral, and missed appointment/cancellation fees. If uninsured at time of visit, I understand that I am financially responsible for all charges. I hereby authorize the Practice to release all information necessary to secure the payment of benefits and to use this signature on all my insurance submissions.

Signature _____ **Date** _____

5. **Cancellation Policy:** We require a notice prior to cancelling or rescheduling an appointment. Monday appointments should be notified by noon on the previous Friday. Cancelling or rescheduling your appointment within 24-hours of the scheduled time may result in a $50 cancellation fee for non-cosmetic appointments or 50% of the fee for the scheduled cosmetic procedure(s). If you are unable to give sufficient notice or miss an appointment, a cancellation fee may automatically be billed to your account. The cancellation fee is non-refundable. By making an appointment with us, you are agreeing to this policy. **Initials** _____

HIPAA Privacy Practices Notification

I, the undersigned, have been issued the HIPAA Notice of Privacy Practices. I fully understand that the Practice is required by law to maintain the privacy of my medical and health information. I acknowledge that the Practice will use and disclose my health information for the purposes of treating me, obtaining payment for services rendered to me and conducting health care operations.

Signature_____ **Date**_____

EAST COAST DERMATOLOGY PC

MEDICAL HISTORY

Name: _____ Date of birth: _____

Reason for Today's Visit _____

Past Medical History: (please check all that apply)

☐ Anxiety	☐ Coronary artery disease	☐ Hypertension	☐ None
☐ Arthritis	☐ Depression	☐ Hypothyroidism	
☐ Asthma	☐ Diabetes	☐ Leukemia	
☐ Atrial Fibrillation (Irregular Heartbeat)		☐ End Stage Renal Disease	
☐ Lung Cancer	☐ Prostate Cancer	☐ Benign prostatic hyperplasia	
☐ GERD	☐ Stroke	☐ Lymphoma	
☐ Bone Marrow Transplantation		☐ Hearing Loss	
☐ Breast Cancer	☐ Hepatitis	☐ Radiation Treatment	
☐ Colon Cancer	☐ HIV/AIDS	☐ Seizures	
☐ COPD			

☐ Other _____

Past Surgical History: (please check all that apply and circle side when applicable) ☐ None

_____
_____
_____

Skin Disease History: (please check all that apply)

☐ Acne	☐ Eczema	☐ Precancerous Moles	☐ None
☐ Actinic Keratosis	☐ Flaking or Itchy Scalp	☐ Psoriasis	
☐ Basal Cell Skin Cancer	☐ Hay Fever/Allergies	☐ Squamous Cell Skin Cancer	
☐ Blistering Sunburns	☐ Melanoma	☐ Blistering disorder	
☐ Dry Skin	☐ Poison Ivy	☐ Vitiligo	
☐ Connective tissue disease (specify bellow)		☐ Autoimmune skin/systemic disease (specify bellow)	

☐ Other _____
_____

Family History:
Do you have a family history of melanoma? ☐ Yes ☐ No If yes, which relative(s)? _____

Medications: (Please list all current medications) (name, strength, dose, frequency, date started:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies: (Please list all allergies and associated reactions):

_____

EAST COAST DERMATOLOGY PC

Social History:

☐ Alcohol- <1 drink daily
☐ Alcohol- 1-2 drinks daily
☐ Alcohol- ≥3 drinks daily
☐ Alcohol - None
☐ Drug Use

☐ Currently Smokes - daily
☐ Currently smokes- not daily
☐ Has smoked in the past
☐ Has never smoked

☐ Other _____

Are you currently experiencing any of the following? (Please check yes or no for the following)

Symptom	Yes	No
Personal History of Melanoma		
Pacemaker		
Defibrillator		
Artificial Joints within past two years		
Artificial heart valve		
Premedication prior to procedures		
Allergy to adhesive		
Allergy to topical antibiotic ointments		
Blood thinners		
Pregnancy or planning a pregnancy		
Breastfeeding or lactation		
Allergy to lidocaine		
Rapid heartbeat with epinephrine		
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Yeast infections with antibiotics		
GI upset with antibiotics		
Fainting		
Immunosuppression		
Changing mole		
Rash		
Hay fever		
Wheezing		

Other: _____

ADVANCED CARE:

Do you have a health care proxy in the event you are unable to make your own medical decision? ☐ Yes ☐ No

Name_____ Phone Number _____

EAST COAST DERMATOLOGY PC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to East Coast Dermatology PC (the "Practice") using and disclosing my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). I hereby acknowledge that I have had the right to review the Practice's Privacy Policy prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my PHI. I am aware that the Practice reserves the right to revise its Privacy Policy at any time. I am also aware that a revised Privacy Policy may be obtained by my forwarding a written request for same to the Practice.

Consent to Calls/Mail/Email

I hereby consent to the Practice calling my home, cell phone or other designated location and leaving a message on my voicemail or in-person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment.

I hereby consent to the Practice mailing to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I hereby consent to the Practice emailing me any items or communications that assist the Practice in carrying out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I understand that by signing this form, I have reviewed the Practice's non-disparagement policy and that I agree that I will not, directly or indirectly, in public or private, whether in oral, written, electronic or other format, disparage, deprecate, impugn or otherwise make any statements or remarks that would tend to or be construed to defame or slander the personal or professional reputations, professional qualifications, services and/or the Practice and/or its owner(s), independent contractors, employees and/or agents and/or successors, nor shall I in any manner assist or encourage any third party in doing so.

By signing this form, I am consenting to the Practice's use and disclosure of any PHI as specified in the Privacy Policy and this Patient Consent for Use and Disclosure of Protected Health Information.

I understand that I may revoke my consent in writing, except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, I understand that the Practice may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name **Date**

EAST COAST DERMATOLOGY PC

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Today's date _____

Full Name_____ Date of birth_____

Clinician Name_____

Introduction

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her dermatologist's office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

Initials _____

EAST COAST DERMATOLOGY PC

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My dermatologist has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my dermatologist of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent to The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize East Coast Dermatology PC to use telemedicine in the course of my diagnosis and treatment.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name **Date**