SUMMIT VIEW DERMATOLOGY

DERMATOLOGY AND SKIN CANCER CENTER

General Information:

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ▫ Cell ▫ Home ▫ **OK to leave detailed message?**

Email Address: _____

Gender: ▫ Male ▫ Female **Marital Status:** ▫ Single ▫ Married ▫ Widowed ▫ Divorced

Race: ▫ American Indian/Alaskan Native ▫ Asian/Asian American ▫ Black/African American
▫ Native Hawaiian/Other Pacific Islander ▫ Caucasian ▫ Other

Ethnicity: ▫ Hispanic/Latino ▫ Non Hispanic or Latino

Emergency Contact:

Name: _____ Phone Number: _____

Relation to Patient: _____ ▫ **OK to discuss medical information**

Medication History:
Please list all prescription AND over the counter medications

Preferred Pharmacy: _____ Phone Number: _____

Cross streets: _____

Allergies to medications? (please list): _____

_____

_____

General Medical History:

▫ None	▫ Coronary Artery Disease	▫ High Cholesterol	▫ Lymphoma
▫ Anxiety	▫ Depression	▫ Hypertension	▫ Prostate Cancer
▫ Asthma	▫ Diabetes: T1___ T2___	▫ HIV/AIDS	▫ Radiation
▫ A-Fib	▫ End Stage Renal Failure	▫ Hyperthyroidism	▫ Seizures
▫ Breast Cancer	▫ GERD	▫ Hypothyroidism	▫ Stroke
▫ Colon Cancer	▫ Hearing Loss	▫ Leukemia	▫ Tuberculosis
▫ COPD	▫ Hepatitis	▫ Lung Cancer	▫ Other: _____

_____

Skin Related Medical History:

▫ None ▫ Acne ▫ Actinic Keratoses ▫ Basal Cell Carcinoma ▫ Blistering Sunburns
▫ Dry Skin ▫ Eczema ▫ Flaking/Itching Scalp ▫ Hay Fever/Allergies ▫ Melanoma ▫ Psoriasis
▫ Precancerous Moles ▫ Squamous Cell Carcinoma ▫ Other: _____

Is there a **PERSONAL** history of skin cancer? ▫ YES ▫ NO
If yes, where/when?_____
Malignant Melanoma? ▫ Yes ▫ No

Is there a **FAMILY** history of skin cancer? ▫ YES ▫ NO If yes, who? _____
Malignant Melanoma? ▫ Yes ▫ No

Past Surgeries:_____
Pacemaker: ▫ Yes ▫ No **Artificial Joints:** ▫ Yes ▫ No
If yes, which joint/when: _____

Do you use sunscreen? ▫ Yes ▫ No If yes, what SPF? _____ Daily? ▫ Yes ▫ No
Have you ever used a tanning bed in the past? ▫ Yes ▫ No

_____

Social History:

Pregnant/Breastfeeding: ▫ Yes ▫ No
Smoking Status: ▫ Never ▫ Current ▫ Former Chewing Tobacco: ▫ Yes ▫ No
Alcohol Use: ▫ Never ▫ Current Drinker: Wine/Beer (circle one) ▫ Former Drinker
Recreational Drug Use: ▫ Never ▫ Marijuana ▫ IV Drug Use ▫ Illicit Drug Use
Sexual Orientation: ▫ Bisexual ▫ Heterosexual ▫ Homosexual ▫ Not Sexually Active
Have you had your influenza vaccine? ▫ Yes ▫ No
Have you had your pneumonia vaccine? ▫ Yes ▫ No
Do you have a living will (advanced healthcare directive)? ▫ Yes ▫ No

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HIPAA PRIVACY RULE OF PATIENT AUTHORIZATION AGREEMENT

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the health professionals who may contribute to my healthcare;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

HIPAA PRIVACY RULE OF PATIENT CONSENT AGREEMENT

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent
- This facility reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange the minimum necessary Protected Health Information for each transaction.

_____ _____

Patient Name **Today's Date**

_____

Patient Signature

SUMMIT VIEW DERMATOLOGY

DERMATOLOGY AND SKIN CANCER CENTER

OFFICE FINANCIAL POLICY

By signing this document, I am agreeing to the terms of this Financial Policy.

PAYMENT AT TIME OF SERVICE: Payment is due in full at the time of service unless you are covered by Medicare or an insurance company with which we participate. You will be charged a $25 service fee for any returned checks, no exceptions.

INSURANCE: Patients will be asked to present their insurance card to the receptionist for copying upon check-in at the office each time they are seen for medical services. Please make it a point to bring your insurance card with you each time that you visit our office. Claims not paid within 45 days by your insurance company will become your responsibility. You will receive a statement for these services and you will need to contact your insurance company for reimbursement.

For those patients covered by insurance plans with which we ARE participating providers, all co-payments, deductibles and noncovered services are due at the time of service. We will file your insurance claim to the insurance company. In the event that your insurance coverage changes to a plan with which we ARE NOT participating providers, we will require payment in full at the time of service and we will file your claim to the insurance company as a courtesy. Any charges that are not paid by your insurance company are your responsibility. Your insurance policy is a contract between YOU and your insurance company. Any pre-certifications of procedures or testing are your responsibility. Please let us know in advance if your insurance company requires this.

COLLECTIONS: Please note, if payment is not received from either you or your insurance company within 60 days from the date of service(s), your account will be considered delinquent and subject to referral to an outside collection agency.

_____ _____

Patient Name Today's Date

_____

Patient Signature

SUMMIT VIEW DERMATOLOGY

DERMATOLOGY AND SKIN CANCER CENTER

CONSENT FOR TEXT/EMAIL/PHONE COMMUNICATION

I authorize Summit View Dermatology to send me text message appointment reminders and email appointment reminders to me on my provided cell phone and email address. I understand that these will only be used to confirm my appointments. This information will remain confidential. I understand that this communication will only include my appointment information and will not include medical information. I also authorize the office to leave a message on my phone if they need me to call the office to go over any information. At no time will medical information be left on a voicemail recording. By signing below, I give my consent for this communication.

CONSENT TO BE PHOTOGRAPHED

I consent for medical photographs to be taken of me by the staff or representatives of PRACTICE NAME. I understand that the images will be placed in my medical record and may be used for evaluation by employees of PRACTICE NAME. 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.

I also give permission for transfer of these photographs via a non-encrypted email exclusively for the purposes of third-party diagnostics, treatment and continuing medical care (e.g. communication with my primary care physician).

Refusal to consent to photographs will in no way affect the medical care I will receive.

If I wish to withdraw my consent in the future, I may do so with a written request.

_____ _____

Patient Name Today's Date

_____

Patient Signature

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BIOPSY CONSENT

PATIENT CONSENT FOR TREATMENT

I hereby authorize the performance of biopsy(ies) or scraping of skin to obtain tissue for diagnostic purposes. I also authorize the administration of local anesthetics by my Medical Provider, as deemed necessary, and as explained to me by the physician, and/or their employees, or anyone else they may direct. Sutures (stitches) may be required.

I understand that these procedures have possible risks and complications that include, but are not limited to, infection, bleeding, hematoma (bruising), prolonged or poor wound healing, scar or keloid formation, pigment changes (dark or white marks), allergic or other reaction to the anesthetic or injection, and incomplete tumor removal and/or the recurrence of skin cancer(s) or other growth(s) necessitating further treatment(s) in the future. As the specimen will be sent to the laboratory for evaluation, I will receive a separate bill for those services.

The effect, nature, and location of the above-noted procedures, the risks involved, as well as alternate treatments have been fully explained to me. Although unlikely, these complications may lead to disablement or death, which therefore must be listed as possible consequences of the procedure(s). I am also aware that the type and extent of the above-noted risks and complications cannot be determined before administration of the anesthetic and performance of the procedure(s). I have informed my physician of any allergies to medications, underlying medical conditions, medications including vitamins and health food supplements I take prior reactions to procedures, the need to premedicate (take antibiotics before procedures), and whether I have a pacemaker. I consent to the submission of tissue to a laboratory for testing. I am aware that there will be a separate charge from the laboratory for the pathology and other tests performed.

CRYOSURGERY CONSENT

PATIENT CONSENT FOR TREATMENT

I hereby authorize the destruction of actinic keratoses (pre-cancers), seborrheic keratoses, warts, skin tags, oil glands or other growths by cryosurgery (freezing). I also authorize the administration of local anesthetics by my Medical Provider, as deemed necessary, and as explained to me by the physician, and/or their employees, or anyone else they may direct.

I understand that these procedures have possible risks and complications that include, but are not limited to, infection, bleeding, hematoma (bruising), prolonged or poor wound healing, scar or keloid formation, pigment changes (dark or white marks).

The effect, nature, and location of the above-noted procedures, the risks involved, as well as alternative treatments have been fully explained to me. Although unlikely, these complications may lead to disablement or death, which therefore must be listed as possible consequences of the procedures. I am also aware that the type and extent of the above-noted risks and complications cannot be determined before administration of the anesthetic and performance of the procedures.

I have informed my physician of any allergies to medications, underlying medical conditions, medications including vitamins and health food supplements I take prior reactions to procedures, the need to premedicate (take antibiotics before procedures), and whether I have a pacemaker.

_____ _____

Patient Name Today's Date

_____

Patient Signature

SUMMIT VIEW DERMATOLOGY

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INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for Insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my Insurance and/or Medicare benefits, and I authorize payment of these benefits to Dr. DOCTOR NAME on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer of the agency shown, and authorizes my doctor to act as my agent, as above.

PRACTICE NO SHOW POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, patients who do not show up for their appointment without a call to cancel at least 24 hours before the appointment time will be considered as NO-SHOW.

Summit View Dermatology has the right to charge a fee of $50.00 for all missed appointments ("no shows").

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid in full prior to your next appointment.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Patient Name Today's Date

_____

Patient Signature

SUMMIT VIEW DERMATOLOGY

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I do hereby authorize the use of and the administration of such drugs, anesthetics, and other treatments, including the performance of a skin biopsy, the use of cryosurgery with liquid nitrogen, and the injection of intralesional kenalog (cortisone), should any of these be deemed advisable, desirable, or necessary for diagnostic, therapeutic, or investigational purposes by Dr. Lehrer or by any physician, physician assistant or appropriately trained and/or licensed health care personnel on the staff of Summit View Dermatology, for or upon me or my minor. I further consent to the examination for diagnostic, investigational purposes, and disposal by authorities of the above named medical facility or its designees herein, of any tissue or parts which may be removed.

BIOPSY (if necessary):

- A biopsy is a surgical procedure used to obtain a sample of tissue for microscopic examination to aid the physician in diagnosis. The entire lesion may not be removed in this procedure. Further medical or surgical treatment may be needed when the diagnosis is made.

- I understand that a biopsy requires obtaining a sample of tissue and is a surgical procedure. As in any surgical procedure, there are certain inherent risks including bleeding, post-operative pain, infection, reactions to sutures, anesthetics or topical antibiotics, and scarring. Although all reasonable efforts will be made to minimize the possibility of these potential complications, no guarantees can be made since many factors beyond the control of the physician (such as the degree of sun damage or patient compliance with postoperative instructions) affect ultimate healing.

- The tissue obtained in this biopsy procedure will be examined by a pathologist. I understand that I may receive a separate bill from the pathologist or laboratory for this microscopic examination.

LIQUID NITROGEN (if necessary):

- I understand that the destruction with liquid nitrogen of precancerous lesions, which are also known as actinic keratoses or solar keratoses, may be deemed necessary by Dr. Lehrer or a member of the medical staff of Summit View Dermatology, to decrease the risk that these lesions evolve into Squamous Cell Carcinomas.

- I understand that the destruction by liquid nitrogen of warts or mollusca may be advised, but these types of lesions are not cancerous and do not necessarily have to be treated. I recognize that because they may be contagious, they should be treated. Should Dr. Lehrer, or a member of the medical staff of Summit View Dermatology, recommend destruction of these lesions by

liquid nitrogen, I consent based on that advice. I am aware that these lesions may require more than a single treatment.

- I understand that this procedure has possible risks and complications that include, but are not limited to pain, blister, infection, bleeding, hematoma (bruising), prolonged or poor wound healing, scar and keloid formation, and pigmentary changes (dark or white marks).

KENALOG INJECTION (if necessary):
- I understand that the injection of triamcinolone (cortisone) for the treatment of scars, cysts, acne, and inflammatory conditions like psoriasis, atopic dermatitis, and alopecia areata, may be deemed necessary, advisable or desirable by Dr. Lehrer or a member of the medical staff of Summit View Dermatology.

I understand that any of the above procedures may have some unwanted effects, which include, but are not limited to permanent scarring, permanent discoloration of the skin at the site of treatment, atrophy (thinning or depression of the skin), infection, bleeding, nerve damage resulting in temporary or permanent numbness or temporary or permanent loss of function of certain muscles (paralysis).

I recognize the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT.

Signature_____

Date_____