Jacks DERMATOLOGY

NEW PATIENT FORMS

JACKS DERMATOLOGY | 1718 West 42nd Avenue | Pine Bluff, AR 71603 | (870) 534-7546

PATIENT REGISTRATION FORM

PLEASE PRESENT INSURANCE AND PHOTO ID CARD TO RECEPTIONIST TO BE COPIED

First Name: _____ M.I:_____ Last Name: _____

Address: _____

City:_____ State: _____ Zip: _____

Social Security #: _____ Date of Birth: _____ Age: _____

Home #: _____ Work #: _____ Cell #: _____

E-mail: _____

Employer: _____ Phone: _____

Primary Physician: _____ Referring Physician: _____

Race: _____ Gender: _____ Circle One: Minor S M D W

Responsible Party Information

First Name: _____ M.I:_____ Last Name: _____

Address: _____

City:_____ State: _____ Zip: _____

Social Security #: _____ Date of Birth: _____ Age: _____

Home #: _____ Work #: _____ Cell #: _____

Insurance Information

Primary Insurance: _____ Policy Holder: _____

Policy Holder's DOB: _____ Relationship to Policy Holder: _____

ID #:_____ Group #:_____

Secondary Insurance: _____ Policy Holder: _____

Policy Holder's DOB: _____ Relationship to Policy Holder: _____

ID #:_____ Group #: _____

Emergency Contact

Name: _____ Phone #: _____

I authorize the release of medical information necessary to process claims and also authorize payment of medical benefits to the physician.

Patient/Guardian Signature: _____ Date: _____

DERMATOLOGY MEDICAL HISTORY

Name:	Age:	DOB:	Sex: **M F**	Race:
Reason for today's visit:				
Family Physician:		Referring Physician:		
Are you allergic to any medications? **Yes No**	*If yes, please list:*			

Please List all current medications (including prescriptions, over-the-counter, vitamins, and herbals): *Use back if necessary*

Medication	Dosage	Medication	Dosage	Medication	Dosage
1.		4.		7.	
2.		5.		8.	
3.		6.		9.	

Please check if you have or ever had the following diseases/ conditions:

Medical History	Yes	No	Explain
Allergies			
Arthritis			
Asthma			
Autoimmune Disorder			
Bleeding Disorder			
Breast Cancer			
Cancer			
Depression			
Diabetes			
Dysplastic Nevus			
Easy Bleeding			
Eczema			
Gastrointestinal			
Heart Disease			
Heart Murmur			
Hepatitis			
High Blood Pressure			
Hives			
Hyperlipidemia			
Kidney Stones			
Neurological Disorder			
Other			
Psychiatric Disorder			
Seizures			
Stroke			
Thyroid Disorder			
Tuberculosis			
Ulcers			
X-Ray Therapy			
Are You Pregnant?			**Due Date:**

Skin History	Yes	No	Explain
Acne			
Actinic Keratosis			
Basal Cell Carcinoma			
Dysplastic Nevus			
Eczema			
Fever Blister			
Keloid Scars			
Malignant Melanoma			
Onychomycosis			
Other			
Suspicious Lesions			
Psoriasis			
Rash			
Rosacea			
Seborrheic Dermatitis			
Skin Cancer			
Squamous Cell Carcinoma			
Urticaria			
Vitiligo			
Warts			

Social History	Yes	No	Explain
Do you smoke?			Packs per day/week:
Do you drink alcohol?			Drinks per day/week:
Have you ever been exposed to HIV/AIDS?			

Has a family member had a skin cancer?	*If yes, whom?*
Do you tan? *Indoor or Outdoor*	*If yes, how often?*

Completed By: *Please Check One*

	Patient		Parent
	Guardian		Medical Assistant

Surgical History

Surgery:	Date:	Surgery:	Date:

Family Medical History

Disease/Condition	Relation	Disease/Condition	Relation

Patient/Parent/Guardian Signature:		**Date:**
Reviewed by Provider:		**Date:**

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose you protected health information (PHI) to carry out treatment, payment or health care operation (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosure of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose you protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroner, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine or compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will be made Only With Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of you protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of you protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications form us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have you physician amend you protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe you privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of you complaint. **We will not retaliate against you for filling a complaint.**

This notice was published and becomes effective on/or before **April 14, 2013.**

Do we have your permission to?

- Leave a message on you home/cell answering machine? Yes No N/A
- Leave a message at your place of employment? Yes No N/A
- Discuss you medical condition with any member of your household? Yes No N/A

(If yes, whom: _____Relationship_____

_____Relationship_____)

We are required by law to maintain the privacy of, any provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, please ask to speak with our HIPAA compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

Jacks DERMATOLOGY

OFFICE POLICIES AND PROCEDURES:

The following office policies and procedures are in place to help ensure the highest quality of service and care to our patients. Please contact our office staff prior to your visit if you have any questions regarding these procedures.

APPOINTMENTS:

If you are a new patient, plan to arrive 15 minutes before your scheduled appointment to check-in. If you have received your paperwork in the mail, please bring your completed copy with you. When visiting our office please bring:

- Up-to-date Insurance Cards
- Photo Identification Card
- Copay or full payment if self-pay
- Parent or legal guardian if under the age of 18
- Authorization or Referral from insurance carrier if required—these forms may be received from your primary care physician when the appointment is scheduled

Please note that if not provided, we reserve the right to reschedule or cancel your appointment.

LATE PATIENTS/CANCELLATIONS/NO SHOWS

If a patient arrives more than 15 minutes late, the appointment may be rescheduled or cancelled. Our office attempts to contact all patients prior to scheduled appointments. If you are unable to keep an appointment, we kindly ask that you provide at least a 24 hour notice. **A $25.00 no show/cancellation fee will be applied to all patient accounts when an appointment is not cancelled at least 24 hours prior to the scheduled appointment.** This courtesy makes it possible to give appointments to other patients. If a patient cancels without proper notice or no shows three consecutive times, we reserve the right to deny any future appointments.

PRESCRIPTION REFILLS:

Please contact your pharmacy and ask that they fax a refill authorization request to fax number: 870-534-2343. The physician will review your request. For most prescriptions, refills may be granted if patient has had an appointment within the year. In certain cases, the patient may be required to return to the office, and our staff will call to schedule an appointment.

Patient Signature: _____ **Date:** _____

Jacks DERMATOLOGY

We are committed to providing you with the best possible care.

If you have medical insurance we will try to help you receive your maximum allowable benefits. In order to achieve these goals, we need your understanding of our financial policy. Payment for services is due at the time of service. We accept cash, checks, MasterCard, Visa, and Discover. We currently only accept Care Credit for cosmetic procedures.

Returned check fees are $20.00 per incident

Balances over 90 days will be sent to an outside collection agency after efforts have been made to collect the outstanding balance. Patients whose accounts are not in good standing could be dismissed from our practice.

Please Know That

1. Your insurance is a contract between you, your employers, and the insurance company. We are not a party of that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Our fees fall within the usual, customary, and reasonable fees for this region.
4. Payment for cosmetic procedures and due IN FULL at the time of service.

Insurance

I authorize the release of any information concerning my (or my child's) healthcare and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I understand that this office will file my insurance for me as a patient courtesy, and that my insurance benefits can only be estimated. If my insurance company does not respond to the submitted claim within 60 days, I understand that I become responsible for the balance in full.

Signature of patient, or parent/guardian_____ Date_____

Fees and Payment

I agree to be responsible for payment of this account. All balances are due in full. All accounts 61 days old are subject to a finance charge in accordance with Arkansas law. Should this account be referred to an outside collection agency, the responsible party agrees to a collection fee and any unpaid balance.

Signature of patient, or parent/guardian_____ Date_____

Jacks DERMATOLOGY

You agree, in order for us to service your account or to collect any amounts you may owe us, we may call you at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also communicate with you by sending text messages or e-mails to your wireless number or e-mail address. Methods of contact may include using a pre-recorded/ artificial voice and/or the use of an automated dialing device. These authorizations shall remain in effect until individually withdrawn by you in writing to our facility and/or any others to which authorization has been extended.

I have read this disclosure and agree that 'your office or agent' may contact me as described above.

SIGNATURE _____ DATE _____

PRINTED NAME _____

Jacks DERMATOLOGY

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Jacks Dermatology as your healthcare provider. We are honored by your choice and committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies, which are as follows:

- The patient is ultimately responsible for the payment of his/her treatment and care.
- The patient is responsible for charges associated with insurance co-pays or non-covered charges
- The patient is responsible for any costs associated with collection of patient balances.
- Patient statements are mailed monthly. The patient is responsible for making a payment, or for arranging a payment plan, within 30 days of the date that appears on his/her patient statement.
- The patient is aware that failure to pay for his/her treatment and care will result in collection actions being taken to collect the debt (i.e. begin sent to a collection agency).
- By my signature below, I hereby authorize assignment of financial benefits to Jacks Dermatology and associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- IF MY INSURANCE COMPANY DENIES PAYMENT FOR LACK OF MEDICAL NECESSITY, I AGREE THAT I WILL NOT LOOK TO MY INSURANCE COMPANY TO COVER THESE SERVICES AND THAT I SHALL BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT FOR ALL SUCH SERVICES INCLUDING ANY FOLLOW-UP SERVICES THAT MAY BE REQUIRED TO COMPLETE THE TREATMENT OR TO REPAIR ANY DAMAGE OR ADDRESS ANY COMPLICATION OF THE TREATMENT.

I have read, understand, and agree to the provisions of the Patient Financial Responsibility Form:

Signature of patient, or parent/guardian _____ Date_____

Name of Patient _____ Date_____