DERMATOLOGY HEALTH SPECIALISTS

1693 SW Chandler Ave, Suite 250 Bend, OR 97702
57067 Beaver Drive, Sunriver OR 97707
Phone: 541-382-8819
Fax: 541-797-7971

General Information

Please fill in all missing information, *verify and/or correct any printed information. Please print legibly.*

Patient's Name: ______________________________ **Age:** ______ **Birthdate:** __________
Last *First* *Middle*

Address: ______________________________ **E-mail:** __________
Street and Apt Number *City* *State* *Zip*

Home Phone: __________ **Cell Phone:** __________ **Work Phone:** __________ **Ext.** ______

Primary contact: *Home*☐ *Work*☐ *Cell*☐ ***Auth. to E-mail:*** Yes☐ No☐ ***Auth. to Leave Voicemail:*** Yes☐ No☐ ***Auth. to Text:*** Yes☐ No☐

Sex: ______ **Marital Status:** ______ **Race:** ______ **Ethnicity:** ______ **Language:** ______

Referring Physician: ______________________ **Phone number:** __________

Address: ______________________________
Street and Suite Number *City* *State* *Zip*

Primary Care Physician: ______________________ **Phone number:** __________

Address: ______________________________
Street and Suite Number *City* *State* *Zip*

Emergency Contact: ______________________ **Relationship to Patient:** __________

Home Phone: __________ **Work Phone:** __________ **Other Phone:** __________

Parent or Responsible Party: *(If different from patient)* **Name:** __________ **Phone:** __________

Address: ______________________________ **Relationship to patient:** __________
Street and Apt Number *City* *State* *Zip*

Primary Insurance Company: __________ **Policy #:** __________ **Group #:** __________

Name of Subscriber: __________ **Subscriber Date of Birth:** __________ **Relationship:** __________

Secondary Insurance Company: __________ **Policy #:** __________ **Group #:** __________

Name of Subscriber: __________ **Subscriber Date of Birth:** __________ **Relationship:** __________

How did you hear about us: ______________________________

Please Read Carefully. I hereby authorize and assign my insurance benefits to be paid directly to Dermatology Health Specialists, P.C. I authorize release of information to facilitate treatment, payment or heath care operations. I give Dermatology Health Specialists, P.C. permission to treat me and take photographs. Co-payments and/or outstanding balances are due at the time of your appointment. I agree that I will be financially responsible for any treatment I receive, in the event that my insurance company denies payment. I will be responsible for a $50 fee in the event that: (1) my check is returned for insufficient funds, or: (2) my account is turned over to a collection agency, or; (3) I fail to show up for my appointment and have not notified your office **at least two business days** in advance of the appointment. I understand that any illicit, sexually suggestive or otherwise inappropriate behavior by me may result in immediate termination of service and dismissal. My signature below signifies my understanding and agreement to comply with these policies.
I have read and understand the Notice of Privacy Rights and Practices and Dermatology Health Specialists Policies.

Signature of Patient (or responsible party) ______________________________ Date __________

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Notice of Privacy Practices

Please review this carefully. This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

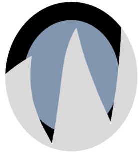
This Notice applies to Dermatology Health Specialists, P.C., including its providers, medical assistants and other personnel. As of April 14th, 2003, we are required under the Health Insurance Portability and Accountability Act (HIPAA) and currently under Oregon law to maintain the privacy of your health information, and to provide you with this Notice of Privacy Rights & Practices. This document explains in detail how we use your Protected Health Information (PHI) which is any information about you that could identify you, your past, present, or future physical or mental health condition(s). Your acknowledgement of receipt of this document will be required the first time you receive services after April 14th, 2003. Examples of how we can use and disclose your information without your authorization include:

• Treatment – we keep a record of each visit and/or admission. These records may include your test results, diagnoses, medications or other therapies. These records are used and disclosed to allow doctors, nurses, and other healthcare and clinical staff providers to offer high quality care to meet your needs.
• Payment – we maintain a record of and may use and disclose information related to services and supplies you receive at each visit and/or admission, so that we can be paid by you, an insurance company, or a third party. We may tell your health plan and other payors about an upcoming treatment or service, which requires their prior approval and authorization.
• Health Care Operations – we use and disclose your medical information to improve the services we provide, to train staff and students, for business management, and for customer service purposes. Your information may be shared amongst Dermatology Health Specialists, P.C., other health care providers, third party payors and or Business Associates to facilitate treatment, payment or health care operations.

ADDITIONAL USES AND DISCLOSURES:

There are additional times when we are permitted or required to use/disclosure medical information without your permission. These circumstances are listed below:

- In emergency treatment situations
- If required by law
- To assist incommunicative patients
- For reporting child, elder, or disabled persons neglect
- To avert serious threat to public health or safety
- For law enforcement
- For public health activities (tracking diseases or medical devices)
- For health oversight activities such as fraud investigations
- For certain judicial or administrative proceedings
- For government functions such as national security & intelligence
- For research following an appropriate review or waiver of authorization by an institutional review board to ensure protection of information



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NOTICES OF PRIVACY RIGHTS & PRACTICES.

We may also use information without your permission to:

- Recommend treatment alternatives
- Tell you about health benefits and/or services
- Send or call you with appointment reminders
- To communicate with those involved in your care

Except as otherwise permitted by law, all other uses and disclosures not described above will require your signed authorization. You may revoke any authorization you provide at any time by delivering a written statement directly to the Dermatology Health Specialists, except to the extent that we have already taken action in reliance on your authorization.

Please know that federal and state laws require special privacy protections for certain highly confidential information about you. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

YOUR RIGHTS:

Under HIPAA, you have the right to request in writing:

- Restrictions on how we use and/or disclose your medical information.
- Confidential communications to an alternate phone or address other than you home.
- Access to your medical information to review and obtain a copy, subject to federal and state laws (fees may apply).
- An amendment to your medical information if you feel you or your health care provider needs to make additions or corrections.
- An accounting of disclosures of your medical information for purposes other than treatment, payment, health care operations or made pursuant to an authorization.
- A paper copy of this notice even if you have received it electronically.
- A revocation of any specific authorization obtained in connection with your privacy, such as for marketing and research.

While we will consider all requests for privacy restrictions carefully, we are not required to agree to any requested restrictions.

OUR RESPONSIBILITIES: We are required by law to maintain the privacy of your medical information, to provide you with written Notice of Privacy Rights and Practices, and to abide by the terms of the Notice currently in effect. We reserve the right to change this Notice and our privacy practices and make the new provisions effective for all information we maintain. Revised Notices will be posted in our facilities and offices, and will be available from your direct treatment provider.

FOR MORE INFORMATION: If you would like further information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact our Privacy Officer at the address and phone number below. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Officer will provide you the correct address for the Director. We will not retaliate against you if you file a complaint with us or with the Director.

I have read and understand the privacy policies.

______________________________ ______________________________

Patient Signature Date

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Authorization to share patient medical and financial information with others (optional):

I authorize the following person(s) to have access to my medical and financial information. This authorization may be revoked in writing at any time.

Family Members

Name:______________________________ Phone number: ____________________

Name:______________________________ Phone number: ____________________

Name:______________________________ Phone number: ____________________

Name:______________________________ Phone number: ____________________

Others

Name:______________________________ Phone number: ____________________

Name:______________________________ Phone number: ____________________

Name:______________________________ Phone number: ____________________

Name:______________________________ Phone number: ____________________

Signature of Patient (or responsible party) ________________________ Date __________

Patient's Printed Name ______________________________Date of Birth __________

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RELEASE OF MEDICAL INFORMATION AUTHORIZATION

Date: ______________________

I give my consent to Dermatology Health Specialists, P.C. to (send / receive) my records (to/ from) :

Provider Name:____

Provider Address:____

____

Provider Phone:____

Patient name: ____

Patient Date of Birth: ____

Patient Address:

____

____

City State Zip

Phone: ________________________ E-mail:__________________________________

Type of record requested:
_____ Path/Lab report(s)
_____ Office note(s)
_____ Photo(s)
_____ Entire Medical Record(s)
_____ Other: ____________________________________

____ _______________

Signature of Patient or Guardian Date

Please check one:

☐ Fax to provider listed
☐ Mail to provider listed
☐ Call patient for pick-up

Expiration Date: One year after signed