DERMATOLOGY HEALTH SPECIALISTS

1693 SW Chandler Ave, Suite 250, Bend, OR 97702
1245 NW 4th St, Redmond, Suite 201, OR 97756
16440 3rd St, La Pine, OR 97739
480 NE A St, Madras, OR 97741
Phone: 541-382-8819
Fax: 541-797-7971
www.derm-health.com

Patient Demographics

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

Patient's legal name: _____ **Age:** _____ **Birthdate:** _____
Last *First* *Middle*

Preferred first name: _____ **Sex assigned at birth:** _____ **Preferred pronouns:** _____

Marital status: _____ **Race:** _____ **Ethnicity:** _____ **Language:** _____

Address: _____
Street and apt number *City* *State* *Zip*

☐ **Home phone:** _____ ☐ **Cell Phone:** _____ **Email:** _____
Please check box of primary contact number **Authorized to:** ☐ **Email** ☐ **Text** ☐ **Leave voicemail**

Referring provider: _____ **Phone number:** _____

Address: _____
Street and suite number *City* *State* *Zip*

Primary care provider: _____ **Phone number:** _____

Address: _____
Street and suite number *City* *State* *Zip*

Emergency contact: _____ **Relationship to patient:** _____

Primary phone number: _____ **Secondary phone number:** _____

Parent or responsible party *(If different from patient)*: _____ **Relationship to patient:** _____

Primary phone number: _____ **Address:** _____
Street and apt number *City* *State* *Zip*

How did you hear about us? _____

Primary Insurance Name: _____ **Policy Holder Name:** _____

Subscriber ID #: _____ **Policy Holder DOB:** _____

Secondary Insurance Name: _____ **Policy Holder Name:** _____

Subscriber ID #: _____ **Policy Holder DOB:** _____

Please Initial:

_____ When biopsies or removal of a lesion is performed by a provider, your specimen will be sent out to an external pathology lab for processing and diagnosis. You will receive a separate bill from that outside pathology office for reading and processing the specimen. **This charge will be in addition to our charges.**

Please Read Carefully. I hereby authorize and assign my insurance benefits to be paid directly to Dermatology Health Specialists, P.C. I give Dermatology Health Specialists, P.C. permission to treat me and take photographs. I understand that co-payments and/or outstanding balances are due at the time of my 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 my check is returned for insufficient funds, or my account is turned over to a collection agency. I understand that as a patient I have rights and responsibilities and that if I violate any of my responsibilities as a patient I may be terminated as a patient. My signature below signifies my understanding and agreement to comply with all Derm Health patient 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 payers 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/disclose medical information without your permission. These circumstances are listed below:

• In emergency treatment situations

• If required by law

• To assist uncommunicative 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.

Signature of Patient (or responsible party) _____ Date _____

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Authorization to share patient medical and financial information with others:

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:_____

Patient's Printed Name _____ Date of Birth _____

Signature of Patient (or responsible party) _____ Date _____

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Late Arrival /Cancellation and "No-Show" Policy

Late Cancellations & No-shows

Our goal is to help clients, patients, and the community receive quality dermatological care. Cancellations less than 48 hours or 2 business days in advance and "no-shows" inconvenience those individuals who need access to treatment and services. In order to be respectful of the needs of other clients and patients, we request that you call Dermatology Health Specialists promptly if you are unable to attend an appointment. Appointments are in high demand and your early cancellation will give another person the possibility to have access to exceptional care and services in a timely manner.

If it is necessary to cancel your scheduled general dermatology appointment, we require that you call at least 2 business days in advance.

If it is necessary to cancel your scheduled dermatologic surgery or procedure appointment, we require at least 2 business days in advance.

If this policy is not followed, a **$50.00** cancellation or "no-show" fee will be incurred for all general dermatology visits and **$200** for all surgical or procedure visits. Please note that the fee will be waived for cases of illness, emergencies, or when we are able to reschedule the appointment for the same business day as the cancellation.

A late cancellation is an appointment that is canceled within the 2 business days prior to the scheduled appointment (as outlined above). A "no-show" is an appointment a patient does not attend due to failure to notify our office of the cancellation or need to reschedule.

To cancel your appointment, please call our office at **541-382-8819**. If you are unable to reach a front office staff member, we ask that you please leave a detailed message with your name, date of birth, date of scheduled appointment, and phone number on our secure voicemail. If you would like to reschedule, we will return your call within twenty-four business hours and provide you with upcoming available appointment times.

Late Arrivals

If you arrive after half of your visit is over, you may be asked to reschedule to another time when your provider is available and will be considered a missed appointment that may occur a fee of **$50.00**.

Thank you for your cooperation in helping us to provide the best possible care for you and for the community.

Patient (or responsible party) Printed Name: _____

Patient (or responsible party) Signature: _____Date _____

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Patient Rights and Responsibilities

The "patient" refers to the patient, patient's guardian, patients' power or attorney, if applicable.

As a patient of Dermatology Health Specialists, you have the Right to:

- Receive all communications, whether verbal or written, in a language and manner that you understand. Interpreters will be provided when necessary.
- Considerate, respectful and compassionate care in a safe and secure environment that is free of all forms of discrimination, abuse or harassment.
- The ability to exercise your rights without being subjected to discrimination or reprisal.
- The right to personal privacy and confidentiality concerning your medical care. Information can only be released with your consent, except as provided by law. You have the right to be advised as to the reason for the presence of any individual. HIPPA regulations will be observed.
- Receive information about your diagnosis, treatment, and expected result from your provider or designated staff in terms that you can understand. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
- Receive the necessary information and participate in decisions regarding a procedure or proposed treatment in order to give informed consent or to refuse this course of treatment.
- Reasonable continuity of care and to know, in advance, the time and location of appointment(s), as well as who the provider is providing the care.
- Request a second opinion from another provider or change providers if another qualified provider is available.
- Agree to or refuse to participate in research projects.
- Know the name and the professional status of the provider who has primary responsibility for coordination of your care and the names, professional relationships and credentials of other providers and health care workers you may see.
- Within the confines of the law, review your medical records. All communications and records pertaining to your care will be treated as confidential.
- Provide appropriate feedback, including suggestions and complaints.
- Examine and receive an explanation of your bill and our payment policies, regardless of the source of payment.
- Voice grievances, verbally or written, regarding treatment or care that is, or fails to be, furnished. For assistance in expressing grievances or complaints verbally or in writing to Dermatology Health Specialists:
    - Call the office at 541-382-8819
    - Ask for patient grievances form at the front desk or to be mailed to you.
    - Medicare Patients may visit www.cms.hhs.gov/center/ombudsman.asp or 1-800-medicare, www.healthoregon.org/hcrqi. Oregon Health Authority, Health Facility Licensing and Certification, PO Box 14260, Portland, OR 97293, 971-673-0540.

As a patient of Dermatology Health Specialists, you have the Responsibility to:

- Provide complete and accurate information about your health including present condition, past illnesses, hospitalizations, medications, including over-the-counter products and supplements, allergies and sensitivities, and any other information that pertains to your health.
- Be an active participant in your care.
- Make it known whether you clearly understand a treatment plan and what is expected of you, including if you anticipate not following the prescribed treatment or are considering alternative therapies. Ask questions when you do not understand.
- Follow the treatment plan recommended by your provider, which may include the instructions of medical assistants as they carry out the coordinated plan of care and implement the responsible provider's orders, and as they enforce the applicable rules and regulations.
- Report unexpected changes in your condition to the responsible provider.
- Accept the responsibility for your actions if you refuse treatment or do not follow the provider's instructions.
- Provide complete and accurate billing and insurance information for claim processing and to pay bills in a timely manner.
- Keep appointments, be on time for your appointments and notify the practice 48 hours or two business days prior if you cannot keep your appointments.
- Use communication channels appropriately and not excessively including but not limited to patient portal messages or phone calls.
- Be respectful of all Dermatology Health Specialists employees during every interaction.
- Be respectful of others and their property while in Dermatology Health Specialists facilities. This includes reducing excessive noise, refraining from smoking on premises and limiting the number of visitors to 1 for adults and 2 for children.

Failure to comply with any of the above may lead to termination from the practice.

Printed Name (or responsible party): _____ Date: _____

Signature of Patient (or responsible party): _____ Date: _____