HEIDELBERG DERMATOLOGY, P.C.

PATIENT INFORMATION

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

Name

_____

Last *First* *M.I.*

Date of Birth: ____/____/____ Age: _____ Sex: ☐ Male ☐ Female

ADDRESS:

Mailing Address _____

City *State* *Zip*

Home Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____ e-mail: _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(if different from patient)*

Name: _____ Date of Birth: ____/____/____

Last *First* *M.I.*

Address:_____

City *State* *Zip*

Home Phone: ( )_____ Work Phone: ( )_____

INSURANCE CARRIER INFORMATION:

Primary Insurance Carrier: _____

Secondary Insurance Carrier: _____

PLEASE SIGN SO WE MAY HAVE YOUR INSURANCE AUTHORIZATION ON FILE

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment.

Date: ____/____/____ Signature: _____

Please provide your insurance card(s) and driver's license to the receptionist along with this form

Heidelberg Dermatology, P.C. – The Science of Skin

20400 Livernois Ave., Detroit, Michigan 48221 - (313) 864-3766

FINANCIAL POLICY ACKNOWLEDGEGMENT FORM

Thank you for choosing Heidelberg Dermatology, P. C. as your skin care physicians. As of April 14, 2003, please note the following financial policy, which we require be read and signed prior to treatment. Please refer any billing questions to the Office Manager or Billing Department; the physician is unable to address your concerns.

OUR FINANCIAL POLICIES ARE AS FOLLOWS: Heidelberg Dermatology, P.C. participates with most major insurance companies. As such, we are required to verify health insurance coverage and check identification prior to each visit. We appreciate your patience and understanding during this process. Having current and accurate information also allows us to process your claim promptly and correctly.

PATIENT RESPONSIBILITIES: Patients are responsible for paying co-pays, deductibles and non-covered services as specified by their insurance plan coverage in effect **on the date of service.** We accept Cash, Checks Care Credit and All Major Credit Cards. In addition the following also apply:

- Any co-insurance, deductible and balances left by insurance should be paid upon receipt of the first statement.
- In the case of estranged or divorced parents, the parent accompanying the minor to the visit is responsible to pay for services rendered – regardless of coverage arrangements. We will gladly furnish you with necessary statements for reimbursement.
- If you are experiencing financial difficulties please discuss with the Office Manager or Billing Department. We will gladly work with you to make payment arrangements. Accounts over 90 days past due may be referred to an outside collection agency.
- A charge of $25.00 will be assessed for each returned check to cover corresponding bank charges and related costs.
- Multiple skin concerns or "new concerns" at the time of an appointment will be billed as an office visit and a copay may apply.
- Advise the staff at check in of any address or insurance changes prior to receiving services. Failure to do so will result in your responsibility for all charges incurred. Understand that the office will not retroactively bill your new insurance plan.

HMO patients are required to obtain a written authorization from their primary care physician prior to any procedures, surgeries and evaluation/management visits. It is the patient's responsibility to make sure you bring the referral or that it is at our office prior to your appointment. We will not contact your primary care physician for any reason to obtain your referral. HMO contracts do not allow our physicians to see patients without the appropriate referral on file. Without a referral you will sign a waiver and will be responsible for all charges incurred on the date of service.

YOUR INSURANCE WILL BE BILLED FOR THE SERVICES YOU RECEIVE. PLEASE BE AWARE THAT SOME AND PERHAPS ALL OF THE SERVICES PROVIDED MAY NOT BE COVERED OR CONSIDERED NOT RESONABLE OR NECESSARY UNDER SOME INSURANCE PLANS. THEREFORE, YOU MAY ULTIMATELY BE RESPONSIBLE FOR YOUR CHARGES. YOUR ACTUAL PAYMENT TO HEIDELBERG DERMATOLOGY, P.C. MAY BE GREATER THAN THE STANDARD COPAY REQUIRED.

I have read and acknowledge the above policies and standards for Heidelberg Dermatology, P.C.

Date:_____ Patient (Please Print):_____

Signature: _____

Acknowledgement of Receipt of Notice of Privacy Practices (to be filed in the patient's medical record)

The Notice of Privacy Practices has been made available to me, detailing how my health information may be used and disclosed as permitted under federal and state law; outlining my rights regarding my health information. A copy will be provided upon my request.

Fundraising: Unless you request us not to, we will use your name, address or email to support our fund raising efforts. If you do not want to participate in fund raising efforts, please check the box: ☐ Please do not use my information for fund raising purposes

Marketing: Unless you request us not to, there are some marketing activities for which we may use your name, address or email to provide you with information regarding services available at our practice. If you'd rather not receive marketing communication from our practice, please check the box: ☐ Please do not use my information for marketing purposes Signed: _____ Date: _____
Relationship (if not signed by patient):_____

I wish to place the following restrictions on disclosure of my health information: _____

Internal Use Only: If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign: _____

HEIDELBERG DERMATOLOGY, P.C. 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.

Uses and Disclosures

Treatment:. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of Heidelberg Dermatology, P. C. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement:. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

You can request that any information related to medical services paid in full and out of pocket may not be disclosed to an insurance company. This request must be made in writing and has to identify what information is restricted and the name of the insurance company.

Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes when financial remuneration is involved. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

Additional Uses of Information

Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find interesting. We may also send you information describing other health-related products and services that we believe may interest you.

Marketing: Unless you request us not to, there are some marketing activities for which we may user your name, address or email to provide you with information about services available at our practice.

Fundraising: Unless you request us not to, we will use your name, address and email to support our fundraising efforts.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Heidelberg Dermatology, P.C. Duties:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices outlined in this notice. In the event of a breach of unsecured protected health information, if your information has been compromised it is our duty to notify you.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Office Manager. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints and Violations of Privacy:

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Attn: Office Manager
Heidelberg Dermatology, P.C.
20400 Livernois Ave.
Detroit, MI 48221

Contact Person

The name and address of the person you may contact for further information concerning our privacy practices is the same as listed above.

This notice is effective on or after September 15, 2013

Heidelberg Dermatology: Patient History Form

Name: _____ Date of Birth: _____

Briefly explain what brings you in today:

_____

_____

_____

Past Medical History (Check all that apply):

- ☐ NONE
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Bone Marrow Transplantation
- ☐ BPH (Prostate Enlargement)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End State Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension (High Blood Pressure)
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia (Cholesterol)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other: _____

Past Surgical History (Check all that apply):

On the line provided specify what surgery

- ☐ NONE
- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: (Type)_____
  Left Right Both
- ☐ Colon: Colon Cancer Resection
- ☐ Colon: Diverticulitis
- ☐ Colon: Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: (Type)_____
- ☐ Joint Replacement: Hip Left Right
- ☐ Joint Replacement: Knee Left Right
- ☐ Kidney: (Type)_____
- ☐ Liver: (Type)_____
- ☐ Tubal Ligation
- ☐ Pancreas(Pancreatectomy)
- ☐ Prostate: (Type)_____
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Spelectomy
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy)

1. Have you had a colonoscopy? Y N
   If yes, what year? _____

Females Only:

2. Have you had a mammogram? Y N
   If yes, when? (MM/YY)_____

Heidelberg Dermatology: Patient History Form

Name: _____ Date of Birth: _____

Skin Disease History (Check all that apply):

- ☐ NONE
- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous cell skin cancer
- ☐ Connective tissue disease
- ☐ Other: _____

1. Do you wear sunscreen? Y N
   SPF: _____
2. Do you tan in a tanning salon? Y N
3. Family history of melanoma? Y N
   If yes, who? _____

List Current Medications & Dose:

- ☐ NONE

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

List All Allergies:

- ☐ NONE

_____
_____
_____
_____

Social History (Check all that apply):

- ☐ Current every day smoker
- ☐ Occasional smoking
- ☐ Former smoker
- ☐ Never smoker

- ☐ No alcohol consumption
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3+ drinks per day

Heidelberg Dermatology: Patient History Form

Name: _____ Date of Birth: _____

Symptoms Today (Check all that apply):

- ☐ NONE

- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring (hypertrophic/keloid)
- ☐ Changing mole
- ☐ Depression
- ☐ Fever or Chills
- ☐ Hay fever/Allergies
- ☐ Joint Aches
- ☐ Muscle weakness
- ☐ Night sweats
- ☐ Seizures
- ☐ Thyroid problems
- ☐ Unintentional weight loss
- ☐ Cough or wheezing
- ☐ Blurry vision
- ☐ Anemia
- ☐ Rash
- ☐ Itching
- ☐ Nail changes
- ☐ Nausea/Vomiting/Abdominal pain

Family History (Check & Circle all that apply):

- ☐ NONE

- ☐ Asthma:
  Mother Father Sister Brother Son Daughter

- ☐ Eczema:
  Mother Father Sister Brother Son Daughter

- ☐ High Blood Pressure:
  Mother Father Sister Brother Son Daughter

- ☐ Diabetes:
  Mother Father Sister Brother Son Daughter

Alerts for Doctor:

1. Currently taking blood thinners? Y N
2. Currently/planning a pregnancy? Y N
3. Yeast infections with antibiotics? Y N
4. Allergy to topical antibiotic ointments? Y N

Heidelberg Dermatology: Patient History Form

Name: _____ Date of Birth: _____

Meaningful Use Information:

RACE:

- ☐ African-American
- ☐ Caucasian
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other: _____
- ☐ Declined

LANGUAGE:

- ☐ English
- ☐ Arabic
- ☐ Spanish
- ☐ Chinese
- ☐ French
- ☐ Other:_____
- ☐ Declined

ETHNICITY:

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Declined

Immunizations:

Have you had a flu vaccine? (Oct.-Mar.)

- ☐ Yes, this year
- ☐ Yes, in previous years
- ☐ No, never

Have you had a pneumonia vaccine?

- ☐ Yes
- ☐ No

Pharmacy:

Name:

Phone:

Fax:

Crossroads:

City:

State:

Zip Code:

Type (Circle One): Retail Mail

Primary Care Physician:

Name(First Last):

Phone:

Fax:

Last Visit (MM/YY): _____

Advance Care Plan:

Do you have a living will?

- ☐ Yes
- ☐ No

Height? _____

Weight? _____