Waterside Dermatology and Laser Center
7476 Waterside Loop Road, Suite 600
Denver, NC 28037
Phone (704)601-4381

COMMUNICATION CONSENT

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996, a federal law. The Administrative Simplification section of this Act is of concern to our practice and requires us to comply with specific rules regarding:

Unique Identifiers for health plans, providers, individuals and employers
Healthcare Transactions & Code Sets for transmitting electronic data
Privacy Regulations over disclosure and use of health information
Security Regulations over protections of electronic health information

All of these rules have been developed by the Department of Health & Human Services and will become final in a staged manner.

It will be the policy of *Waterside Dermatology and Laser Center* to ***not*** release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, e-mail, cellular phone, pager and/or fax. Whenever returning telephone calls and an answering machine picks up, we will not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will not be left with an unauthorized person who may answer your telephone.

If you would like to have your medical information released to someone other than yourself, please complete the following:

I authorize *Waterside Dermatology and Laser Center* to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Waterside Dermatology and Laser Center can contact me anywhere reasonably necessary for medical care.

Home Telephone __________ Yes No
Answering Machine Yes No
Work Telephone __________ Yes No
Voice Mail Yes No
Cellular Phone ___________ Yes No
Pager ____________________ Yes No

Please list authorizations:
Spouse/Fiancé ___________ Yes No
Parent ___________________ Yes No
Brother/Sister ___________ Yes No
Son/Daughter ____________ Yes No
Friend/Roommate _________ Yes No

Patient/Guardian Signature_________________________________ Date___________________

CONSENT TO THE USE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, *Waterside Dermatology and Laser Center* originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, 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 communications among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and procedural information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that *Waterside Dermatology and Laser Center* reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided, upon written request to do so. I understand that I have the right to see and obtain copies of my medical record upon written request and during normal business hours and a designated time set by *Waterside Dermatology and Laser Center*. I understand that I have the right to request amendments be made to my medical record. All amendments need to be written on a separate sheet of paper and duly indicated "Amendment To The Record". I understand that a six-year history of all disclosures will be accessible to me including the purpose of the disclosure and the address of the recipient. I may receive a copy of this history within 60 days of my written request and I understand that I may have to pay a reasonable charge for any copies. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is required to agree to the restrictions requested. If *Waterside Dermatology and Laser Center* does agree to any restrictions, the agreement is binding on use. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information.
____
____
____

I hereby consent to the use and disclosure of my individually identifiable health information for treatment, payment and healthcare operation purposes.

Patient's Name (please print) ________________________________

Signature of Patient or Legal Representative ______________________Date __________________

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

Effective November 01, 2009

Waterside Dermatology and Laser Center may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, referrals to other providers for treatment. Payment examples include, but are not limited to**,** insurance companies for claims including coordination of benefits with other insurers and collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records.

Waterside Dermatology and Laser Center is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. An example would be for public health requirements, court order or to report child abuse.

Waterside Dermatology and Laser Center will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be in writing.

Waterside Dermatology and Laser Center may at times contact the patient (or parent, if minor) to provide appointment reminders or information regarding treatment alternatives or other health-related benefits and services that may be of interest to the individual patient.

Waterside Dermatology and Laser Center may use protected health information to converse or by written means with pharmacies or pharmaceutical companies that may be of interest to the individual patient.

Waterside Dermatology and Laser Center will abide by the terms of this notice or the notice currently in effect at the time of the disclosure.

Waterside Dermatology and Laser Center reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains.

Waterside Dermatology and Laser Center will provide each patient with a copy of any revisions of its *Notice of Privacy Practices* at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our office.

Any person/Patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Office at the following phone number (phone #). All complaints will be addressed and the results will be reported to the Corporate Compliance Officer and Managing Partners.

It is **Waterside Dermatology and Laser Center's** policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

The name, title and telephone number of the person in the office to contact for further information **Kate Edwards**, Privacy Officer at **(704)601-4381**.

NOTICE OF PRIVACY PRACTICES

Acknowledgment of Receipt

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of **Waterside Dermatology and Laser Center.** Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by: contacting our organization at (704)601-4381.

If you have any questions about our *Notice of Privacy Practices,* please contact a staff member.

I acknowledge receipt of the *Notice of Privacy Practices of* **Waterside Dermatology and Laser Center**.

Signature:____Date:___________________

(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained: _______________________________

Signature of Provider Representative: ____________________________ Date:___________________

Waterside Dermatology and Laser Center

PATIENT REGISTRATION

Name(First,Middle,Last) ____Nickname__________________

Date of Birth_____________________Age______ Sex___M____F SS#_________________________________

Address____City________________ State______ Zip___________

Telephone – Home_____________________Work________________________Cell__________________________

Email Address____

Employer________________________PhoneNumber_______________________Occupation___________________

Employment Status: Full Time Part Time Not Working/Laid Off Retired Full Time Student (Circle one)

Marital Status: Single Married Divorced Widowed Separated (Circle one)

Spouse's Name__________________________________DOB__________Spouse's Employer______________________

Parent/Guardian's Name(If Minor) ________________________________Phone Number________________________

Emergency Contact______________________________Relationship_______________PhoneNumber________________

Primary Care Physician_________________________________Phone Number_______________________________

How did you hear about us? Advertising Existing Patient Word of Mouth Insurance Co. Internet (Circle one)

Primary Care Physician Specialist Hospital

Referred By _______________________________

INSURANCE INFORMATION

Primary Insurance Carrier

Insurance Name _________________________ID# /Policy #_________________________Group#________________

Policyholder Name_____________________________________DOB________________SS#_____________________

Employer Name__________________________________ Insurance Phone# ________________________________

Claims Address_____________________________________City________________State_______Zip____________

Patient's Relationship to Policyholder: Self Spouse Child Dependent Other:_________________ (Circle one)

Secondary Insurance Carrier

Insurance Name _________________________ID# /Policy #_________________________Group#________________

Policyholder Name_____________________________________DOB________________SS#_____________________

Employer Name__________________________________ Insurance Phone# ________________________________

Claims Address______________________________________City_________________State______Zip____________

Patient's Relationship to Policyholder: Self Spouse Child Dependent Other:_________________ (Circle one)

PARENT OR RESPONSIBLE PARTY *(if different than patient)*

Name(First,Middle,Last)____DOB______________

Address____City________________State_______Zip___________

Home Phone_____________________Work Phone_____________________Cell Phone__________________________

Revised 10.09

Financial Responsibility Agreement

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment in full is required for services at the time they are rendered unless you are on an insurance and/or prepaid plan in which we participate. For those patients, applicable copayments, coinsurance and deductibles will be collected. Some insurance companies have a fixed copay amount that is due at time of service. Some insurance companies have a percentage of the charge in which you are responsible for. We will estimate you copay for services rendered.

If you have a managed care insurance that requires an authorization for your visits, it will be your responsibility as a patient to make sure we have a current authorization on file for your upcoming visit. If you do not have a current authorization on file, you will need to contact your Primary Care Physician to get the referral you need. If you show up for your visit and you do not have an authorization on file, it will be your responsibility to pay in full for your visit or you will need to reschedule your appointment.

I authorize the release of any information necessary to process insurance claims and to obtain reimbursement. I request that payment of authorized benefits be made on my behalf to Waterside Dermatology and Laser Center. This assignment will remain in effect until revoked by me in writing. It is your responsibility to pay any deductible, copay, or balance not paid by your insurance. We accept payment in the form of cash, check, debit card, or credit card.

Your signature below signifies your understanding and willingness to comply with these policies. I understand that I am financially responsible for all charges not paid by insurance.

Patient / Responsible Party Signature____Date______/______/_______

Print Patient/Responsible Name ____

Revised 10.09

Patient Name____ DOB___________________________

Reason for today's visit: (chief complaint)____

____

Current or past problems with: (Review of systems)

	No	Yes	(if yes, explain)
General Health	◻	◻	______________________________
Eyes	◻	◻	______________________________
Ears/Nose/Throat/Mouth	◻	◻	______________________________
Heart	◻	◻	______________________________
Lungs	◻	◻	______________________________
Stomach/Bowel	◻	◻	______________________________
Kidneys	◻	◻	______________________________
Arthritis/Muscles/Joints	◻	◻	______________________________
Skin	◻	◻	______________________________
Headaches/Seizures	◻	◻	______________________________
Psychological Disorder	◻	◻	______________________________
Thyroid/Diabetes	◻	◻	______________________________
Blood/Bleeding Disorder	◻	◻	______________________________
Allergic/Immunologic	◻	◻	______________________________

Allergies:

Current Medications: (including vitamins and herbal supplements)

Females: Are you pregnant? N / Y Are you *able* to become pregnant? Y / N (If N, please explain)________________________
Currently using birth control? N /Y (if Y, please specify)_________________________________

Family History:

Mother: living / deceased, age____ *Father*: living / deceased, age____ No. of children_____ age(s)_____________________

Check the following medical conditions that have occurred in your family:

Disease	Mother	Father	Blood Relative	Disease	Mother	Father	Blood Relative
Allergies	◻	◻	◻	High Blood Pressure	◻	◻	◻
Arthritis	◻	◻	◻	Lung Disease	◻	◻	◻
Asthma	◻	◻	◻	Malignant Melanoma	◻	◻	◻
Cancer	◻	◻	◻	Psoriasis	◻	◻	◻
Diabetes	◻	◻	◻	Skin Cancer	◻	◻	◻
Eczema	◻	◻	◻	Tuberculosis	◻	◻	◻
Heart disease	◻	◻	◻	Other_____________	◻	◻	◻

Social History:

Do you live alone? N / Y
Do you drink alcohol? N / Y
Occupation: __________________________________

Do you smoke? N / Y – Frequency ___________________
Do you use recreational drugs? N / Y – Freq.____________
Hobbies/Leisure activities ___________________________

The information above is complete and accurate to the best of my knowledge, I understand that omitting or providing false information may significantly impact the course of my medical treatment, and/or significantly impact my personal health and well being. I understand that Waterside Dermatology and Laser Center will not be held responsible for any medical/health consequences resulting from such errors or omissions.

Patient/Guardian signature____Date______________________

MD Reviewed_____________________________**Date**__________ **revised 10.09**

Waterside Dermatology and Laser Center

Name:________________________ Date: ____________________

Do you want a full body skin exam? Y / N

Do you want a sun-exposed skin exam? Y / N

What type of laundry detergent do you use? (Brand, liquid or powder)

Do you use fabric softener? Y / N Liquid or Dryer Sheets

What type of soap do you use on your face and/or body?

What type of moisturizers, creams, lotions or make-up do you use?

Do you bathe in cold, warm or hot water?

Do you use sunscreen? (never, on occasion, daily) What SPF?

____

Are you interested in any other services? (Please check all that apply)

__ Laser Hair Removal

__ Laser Facial / Photo-rejuvenation

__ Chemical Peels

__ Botox / Restylane

__ Microdermabrasion

Chart # _____________ Reviewed: ____________