Please Print

Patient Information

Name _____ __ _____ "_____"
First MI Last Preferred Name

Address _____ _____ _____ _____ _____
Street Apt # City State Zip

Social Security # _____ Date of Birth _____ Age _____

Sex _____ Marital Status _____ Spouse's Name _____

Home Phone _____ Work Phone _____

Cell Phone _____ e-mail _____

Employer _____ Preferred method of contact: ☐ Home ☐ Cell ☐ Work

Emergency Contact _____ Relationship to Patient _____

Phone _____ Alternate Phone _____

My protected health information may be shared with the following individuals:

Name: _____ Phone _____

Name: _____ Phone _____

OPTIONAL – Used only for government mandated reporting

Race: _____

Ethnicity: _____

Language: _____

Insured party ☐ **Check box if same as patient.**

Name _____ __ _____
First MI Last

Address _____ _____ _____ _____ _____
Street Apt # City State Zip

Date of Birth _____ Social Security # _____

Phone _____ Relationship to Patient _____

CONTINUED ON BACK

Account Guarantor ☐ **Check box if same as patient.**

Name _____ __ _____
First MI Last

Address _____ _____ _____ _____ _____
Street Apt # City State Zip

Date of Birth _____ Employer _____

Phone _____ Alternate Phone _____

Relationship to Patient _____ Social Security # _____

I authorize payment of any insurance benefits directly to the physician. I also understand that I am responsible for any portion of my bill not covered by my insurance carrier.

I authorize the release of any medical records to my insurance carrier for the purpose of processing insurance claims. A photocopy shall be as good as the original.

I understand that it is my responsibility to verify that the Provider is participating with my insurance network. I will be responsible for any charges incurred in the event that the Provider is considered to be out of network by my insurance plan.

I agree to be contacted about my account at any telephone number (including wireless) associated with my account and/or to receive recorded/artificial voice messages and/or the use of an automatic dialing device if applicable.

Credits created by insurance claim processing will be refunded automatically. Refund checks will not be reissued. Credit balances of less than $5 will remain on account or refunded upon request.

There will be a $25.00 charge for returned checks. Interest may be charged on balances over 30 days old.

Failure to cancel an appointment ("No Show") may incur a $50.00 fee and/or discharge from our practice.

Patient's/Guarantor's Signature _____ Date _____
(Parent/Legal Guardian should sign here if the patient is a minor child.)

I, _____, give my permission for my minor child, _____, to be examined, diagnosed, and treated by Southwestern Dermatology. Diagnosis and treatment may include necessary testing and/or procedures. This consent also applies to follow-up visits but may be revoked in writing at any time.

Authorized signature: _____ Date _____

Relationship to Patient _____

SOUTHWESTERN DERMATOLOGY
8315 South Walker Avenue
Oklahoma City, OK 73139-9449
T ~ (405) 636 - 1506 F ~ (405) 636 - 1511

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 READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is referring you to a specialist or a primary care doctor.
- Payment means such activities as obtaining reimbursement for services, confirming insurance coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. One example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI to law enforcement or for other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it. (see page 2)

- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of 8-14-2017 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practices from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer, Christy Atkinson, (405) 636-1506 ext. 135, for more information, in person or in writing.

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I hereby acknowledge receipt of Southwestern Dermatology's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____ Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of Southwestern Dermatology 's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: Parent Legal Guardian

Signature: _____ Date: _____

Today's Date: _____

Name: _____ Date of Birth: _____

Pharmacy: _____ Phone #: _____

Pharmacy Address: _____

Skin History	No	Yes	Previous Treatments	Location
Melanoma	☐	☐		
Psoriasis	☐	☐		
Skin Cancer	☐	☐		
Sun Exposure	☐	☐		
Tanning bed use	☐	☐		
Infection of the Skin	☐	☐		
Skin Disease	☐	☐		

Medical History			Details
Asthma	☐	☐	
Bleeding Disorder	☐	☐	
Cancer (not skin)	☐	☐	
COPD	☐	☐	
Diabetes	☐	☐	
Heart Disease / Attack	☐	☐	
Hepatitis	☐	☐	
High Blood Pressure	☐	☐	
Kidney Disease	☐	☐	
Tuberculosis	☐	☐	
HIV	☐	☐	
Arthritis	☐	☐	
Pacemaker	☐	☐	
Liver Disease	☐	☐	
High Cholesterol	☐	☐	
Seizures	☐	☐	
Blood Thinners	☐	☐	
Require antibiotics prior to procedures	☐	☐	
Other	☐	☐	

Family History			Afflicted Family Member (parents, grandparents, children, siblings)
Alopecia	☐	☐	
Autoimmune Disorders	☐	☐	
Cancer (not skin)	☐	☐	
Diabetes	☐	☐	
Melanoma	☐	☐	
Skin Cancer Other	☐	☐	