

HIPAA REQUIREMENTS

Lockman Dermatology cares about patient privacy. Health Insurance Portability and Accountability Act (HIPAA) updated their guidelines in September 2013.

___ I would like to read these guidelines ___ I would not like to read these guidelines. ___ I would like a copy of these guidelines. _____ (please initial).

Please provide names of persons that we may release your medical information to:

Table with 4 columns: Name, Phone, Relationship, Add as Emergency Contact. Two rows of blank lines for input.

May non-medical information be left on your answering machine? Yes ___ No ___ Don't have one ___
May we call you at work? Yes ___ No ___ Don't work ___

Patient or Parent Signature Date: _____

AUTHORIZATION TO TREAT, OBTAIN AND RELEASE MEDICAL INFORMATION

I, the undersigned, authorize Dr. Lockman and his staff to perform any procedures and take any photographs as necessary to diagnose and treat my conditions.
I hereby authorize Dr. David S. Lockman to obtain medical records and pharmacy records from other sources as may be needed for treatment.
I hereby authorize Dr. David S. Lockman to release information concerning this patient's treatment to other physicians involved in their care and treatment.

AUTHORIZATION FOR RELEASE OF INSURANCE INFORMATION

I, the undersigned, authorize the release of any medical or insurance information to the Social Security Administration and Health Care Financing Administration or the stated insurance company necessary to process insurance claims for services rendered by this facility. I hereby authorize (Ins. Co.) _____ to distribute the payment of my (or my dependents) medical coverage directly to the provider rendering services. I understand that I am fully responsible for all charges regardless of my insurance benefits. I authorize the use of this signature on all insurance submissions.

PAYMENT POLICY:

**Please make sure we have complete, correct insurance and address information when you check in for each visit. It is your responsibility to make sure we have the information to file your claims correctly the first time. **

MEDICARE: We are participating providers of the Medicare Program. We will accept assignment on all claims. Patients are responsible for meeting their deductible and paying the 20% coinsurance. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

HMO, PPO, OR OTHER MANAGED CARE PATIENTS: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered cosmetic services. Please note: most office procedures go against your deductible, if applicable.

SELF PAY: You will be expected to pay in full for your office exam and any procedures preformed unless arrangements have been made with the office manager.

PATIENT BALANCES: You will be expected to make payment within a timely manner. If the account becomes delinquent with no consecutive payments being made it will be placed with a third party collection agency and an additional 28% fee will be accrued.

NO SHOW POLICY: You will be expected to pay a \$25 fee for all appointments cancelled/rescheduled without a 24 hour notice, as well as all no show.

Patient or Parent Signature: _____ Date: _____

Dermatology Medical History

Patient: _____ Date: _____

Reason for today's visit: _____

Preferred Lab (For Bloodwork) ARMC LabCorp Quest (Pathology) ARMC Atlanta Derm

Are you allergic to any medications? Yes No If yes, list below:

1. _____ 2. _____

Any nausea, vomiting or diarrhea with antibiotic use? Yes No

Have you ever had dental anesthesia (Novocain)? Yes No Any bad reaction? Yes No

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals.

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check Yes or No)

Lungs:	YES	NO	Other Systemic:	YES	NO
Bronchitis - Chronic	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Low ___ High ___	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	If yes, explain _____		
Cardiovascular:	YES	NO	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what type _____		
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Cancers: (non-skin)	YES	NO
			If so, please list: _____		

List any other diseases or conditions: _____

Have you had or been exposed to HIV (AIDS) Yes No

List surgical procedures you have had in the last 6 months: _____

Skin:

Have you ever had skin cancer? Yes No Melanoma? Yes No
Has anyone in your family had skin cancer? Yes No BCC ___ SCC ___ Melanoma ___
Do you have a history of any specific skin disease? Yes No If yes, _____
Have you ever had a severe sun burn? Yes No
Do you or have you ever used a tanning bed? Yes No
Do you bleed easily? Yes No
Do you develop skin rashes in reaction to Medications Food Environment? _____

Social History:

Do you drink alcohol? Never Occasionally Daily If Daily _____ drinks per day
Do you smoke? Yes No If Yes, how much: _____

Please answer the following questions:

(Women) Are you pregnant? Yes No Due Date: ___/___/___
What is your occupation? _____ Hobbies? _____

Preferred Pharmacy Name and Location _____

Completed by Patient _____ Date: _____

Medical Assistant _____ Signed by Patient

Initials

Reviewed by _____ Date _____