Absolute Dermatology & MEDI-SPA

Today's Date: _____ MR #:_____

PATIENT INFORMATION

Last Name_____ First Name_____ MI ____ Sex: M F

Age_____ Birth Date _____ Social Security #_____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone_____

(Appointment confirmations are only made via text message and email. There may be a charge for appointments missed without 24 hour notice)

Cell Phone _____ Email _____

Are you married? Y N Name of spouse/partner _____ Phone _____

If minor, name of parent child lives with. _____ Phone _____

Pharmacy you normally use _____ Phone _____

Location (cross streets) _____

Who do you authorize us to speak to regarding your medical care? Please list name, relationship and phone number.

_____

PRIMARY INSURANCE INFORMATION

Insurance Company Name _____ Customer Service #_____

Claims Address _____

Policy Holder's Name _____ Date of Birth _____

Relationship to Patient _____ Social Security # _____

ID # _____ Group # _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name _____ Customer Service #_____

Claims Address _____

Policy Holder's Name _____ Date of Birth _____

Relationship to Patient _____ Social Security # _____

ID # _____ Group # _____

Referring Physician _____Primary Care Physician _____

Patient Signature _____ Date _____

Absolute Dermatology & MEDI-SPA

Patient Name: _____ DOB _____ MR # _____ Date _____

What are you being seen for today? Please try to be as specific as possible. _____

_____

What medications are you currently taking? Please include all over the counter medications.

_____ _____

_____ _____

_____ _____

What medication allergies do you have? Please include the type of reaction you experienced.

_____

Please list any Dermatological surgeries you have had.

_____

Please list any skin issues you have received treatment for in the past.

_____

Female patients: Are you pregnant? Y N Are you breastfeeding? Y N

Have you had any adverse reactions to local anesthesia? (if yes, explain) Y N _____

_____

Have you ever had skin cancer? Y N Site? _____

Type? _____ Year? _____

Does a family member have a history of skin cancer? Y N Relation? _____

Type? _____ Site? _____ Year? _____

Please list any additional information you feel the physician should know about your health: _____

_____

Please list ALL medical conditions: _____

_____

_____

What is your occupation? _____ Hobbies? _____

Patient Signature Date

Absolute Dermatology & MEDI-SPA

FINANCIAL POLICY

Co-payments, co-insurance and deductible will be due at your visit. For your convenience, we accept cash, check, debit or credit card (MasterCard, Visa, Discover and American Express)

We are providers for several PPO and HMO insurance plans. If we are providers for your plan, we will file your claim for you if you provide us with your insurance card. **YOU ARE RESPONSIBLE FOR OBTAINING NECESSARY REFERRALS PRIOR TO YOUR VISITS. IF YOU DO NOT HAVE NECESSARY REFERRAL, YOU MAY BE ASKED TO RESCHEDULE YOUR APPOINTMENT.** All health plans are not the same and do not cover the same services. In the event your health plan determines that a service is "not covered", you will be responsible for the complete charge. Payment will be due on receipt of a statement from our office.

We will expect payment from the adult accompanying a minor for all services rendered to minor patients.

Medicare: We will accept assignment for our Medicare patients. If you do not have a Medicare supplement, we expect you to pay your deductible if not met at the time, as well as your 20 percent.

Please sign that you have read and agree with the financial policy as defined above.

_____ _____

Patient or Parent/Guardian Signature Date

RELEASE OF INFORMATION

I hereby authorize Absolute Dermatology & Medi-Spa to furnish medical information concerning my present injury or illness, including hepatitis and HIV information, to my family physician and referring physician (listed on the first page of this form) and insurance companies. I further authorize my family physician and referring physician to furnish all medical information concerning my present injury or illness to Absolute Dermatology.

_____ _____

Patient or Parent/Guardian Signature Date

ASSIGNMENT OF BENEFITS

I request payment of the surgical and/ or medical benefits, otherwise payable to me, directly to Absolute Dermatology & Medi-Spa for services provided by them. I understand that I am financially responsible for charges not covered by this Assignment of Benefits.

_____ _____

Patient or Parent/Guardian Signature Date

CONSENT FOR TREATMENT

I hereby authorize evaluation and treatment by Dr. Lori Honeycutt.

_____ _____

Patient or Parent/Guardian Signature Date

PRIVACY PRACTICES (HIPAA)

I hereby acknowledge that I have read Absolute Dermatology & Medi-Spa's Notice of Privacy Practices.

_____ _____

Patient or Parent/Guardian Signature Date

Absolute Dermatology & Medi-Spa
Notice of Health Information Practices
Effective Date April 14, 2003

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

Understanding Your Health Record / Information

Each time you visit our Office, or another physician or health care provider contacts us concerning your medical needs or history a record is made by our Office. This record contains medical information generated during your visits to our Office, received by our Office from other health care providers, or provided by you. In this "Notice of Health Information Practices," we shall refer to the information contained in your record as your "**health information**." This term shall have the same meaning as "**protected health information**" (**PHI**) defined in the Health Insurance Portability and Accountability Act of1996, as amended ("HIPAA").

Within the limits provided by federal and state law, you have the right to:

- Request restrictions on certain uses and disclosures of your health information;
- Received confidential communications of your health information. You may request that we communicate with you about your health information by alternative means or at an alternative location;
- Inspect and obtain a copy of your health information, except with regard to psychotherapy notes or information compiled in reasonable anticipation of certain civil, criminal or administrative proceedings;
- Request an amendment to your health information that we have created, except with regard to those portions of your health information that you are precluded from inspecting and copying as set forth above.
- Obtain an accounting of certain disclosures of your health information; and
- Receive a paper copy of this Notice in addition to any electronic copy you may receive.

This Office is required by law to:

Maintain the privacy of your health information;

- Provide you with this Notice of our legal duties and privacy practices with respect to health information we collect and maintain about you;
- Abide by the terms of this Notice, currently in effect, and as amended from time to time.
- Notify you if we are unable to honor your request to restrict a use or disclosure of, or to amend, your health information; and
- Accommodate reasonable requests you may have to communicate your health information by alternative means or at alternative locations

We reserve the right to change our privacy practices and to make the new provisions effective for all of your health information we already have, as well as any health information we receive or create in the future. Should our privacy practices change, we will post a copy of the revised Notice in our waiting area, which indicates the effective date of the amended Notice. You may request and obtain a copy of our Notice of Privacy Practices anytime you visit our office.

If a use or disclosure of your health information is not permitted under law without a written authorization, we will not use or disclose your health information without that written authorization. You may at any time revoke a written authorization in writing, except to the extent that we have already taken action in reliance of your authorization.

The following are examples of uses and disclosures of your health information which are permitted by law:

We will use your health information for treatment. We will use your health information to provide medical services to you. Any of our staff involved in your care will have access to your health information. We may also provide your health information to other health care providers involved in your care to assist them in providing services to you. H**owever, we will not disclose psychotherapy notes to health care providers who are not the originators of those notes unless we have your written authorization to do so.**

We will use your health information for payment. Your health plan or health insurer will require certain information about your condition and the services you receive from us, before payment will be made, or for pre-authorization purposes. Accordingly, for billing purposes, we may disclose your health information to your health plan or health insurer. We also may disclose health information to your health plan or health insurer when they require preauthorization of a recommended procedure.

We will use your health information for regular health care operations. Members of our staff may review and use health information from your record to assess the care and outcomes in your case and others like it. This information will then be used by us in an effort to continually improve the quality and effectiveness of our services.