Patient Registration Form

Please complete all the information below in print, please do not leave any questions blank. Thank You!

PATIENT INFORMATION:

Last Name: __________________ First Name: __________________ Middle: ____________ Date of Birth: _________

Address: ____ City: _________________ State: ____ Zip: _______

Home Ph: ______________________ Work Ph: ______________________ Mobile Ph: ______________________

Gender: _____________ Marital Status: _____________ SSN: _________________ Language: ______________

Race: _____________ Ethnicity: _____________ Email Address: ____

EMERGENCY CONTACT:

Name: ____ Relationship: ______________________

Home Ph: _____________________ Mobile Ph: ______________________

PRIMARY INSURANCE INFORMATION:

Name: ____________________ Policy No: ____________ Group No: ___________ Phone: ______________________

Address: ____ City: _________________ State: ____ Zip: _______

PolicyHolder:__________________________Relationship: ____________________________DOB: _______________

SECONDARY INSURANCE INFORMATION:

Name: ____________________ Policy No: ____________ Group No: ___________ Phone: ______________________

Address: ____ City: _________________ State: ____ Zip: _______

PolicyHolder:_________________________Relationship: _____________________________DOB: _______________

PRIMARY CARE PROVIDER:

Name: ____________________________ Address: __________________________________Phone:_______________________

REFERRING PROVIDER:

Name: ____________________________ Address: __________________________________Phone:_______________________

PREFERRED PHARMACY:

Name: __________________________ Phone: _________________ Fax: __________________

Address: _______________________ City: ___________________ State: ____ Zip: ________

Sign (Patient or Guardian) ____ Date: _______________________

Medical History Form

Please complete all the information below in print and check all that applies, please do not leave any questions blank. Thank You!

MEDICAL HISTORY: *Check any of the following that you currently have*

- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal
- ☐ Disease
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizure
- ☐ None
- ☐ Other

Have you had a *Flu Vaccine* this flu season (October – March 31st)? **YES / NO** Height:______ Weight: ______

PAST SURGICAL HISTORY: *Have you had any of the following surgeries?* None

- ☐ Organ Transplant: Organ:___________ Year_____
- ☐ Joint Replacement: Joint ___________ Year_____
- ☐ Other_____________________________________
- ☐ None

SKIN DISEASE HISTORY: *Have you had any of the following?*

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Carcinoma
  - Yr: ______ Location: _______
  - Yr: ______ Location: _______
  - Yr: ______ Location: _______
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Melanoma
  - Yr: _____ Location: ________
  - Yr: _____ Location: ________
- ☐ Atypical/Dysplastic Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
  - Yr: _____ Location: ________
  - Yr: _____ Location: ________
  - Yr: _____ Location: ________

Do you wear sunscreen? YES / NO ***If yes***, what SPF? _____________ Have you tanned in a salon? YES / NO

Do you have a **FAMILY** history of Melanoma? YES / NO ***If yes***, which relative?_______________________________

MEDICATIONS: ***please list all (or attach)***	**ALLERGIES TO MEDICATIONS:** ***please list all***
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

SOCIAL HISTORY:

Smoking Status (*Please choose one*):

- ☐ Current, every day smoker
- ☐ Current, occasional smoker
- ☐ Former smoker
- ☐ Never smoked

Alcohol Intake (*please choose one*):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Sign (Patient or Guardian) ____ Date: ______________________

Financial Policy

Thank you for choosing Vivida Dermatology as your healthcare provider! Our mission is to provide exceptional care and state of the art treatment to every patient, every appointment, every day. **Please read this document in full, initial at each line, and sign in the space below.** A copy can be provided to you upon request.

_____**Insurance**. We participate in most insurance plans, including Medicare. If you are not insured by a plan we are contracted with, **payment in full is expected at each visit.** If you do not have your card and/or we are unable to verify your eligibility and benefits, **payment in full is expected at each visit**. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

_____**Co-payments, Deductibles, and Coinsurances.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of our contract with your insurance company and is mandatory. Failure to pay for the estimated fees at the time of service, then your appointment may be rescheduled. Every effort is made to collect accurate payment at the time services are rendered. This is, however, only an **ESTIMATE** of benefits. Actual benefits are determined and based by the terms and conditions of your insurance plan or policy. If your insurance adjudicates your claims differently, our office will adhere to the policies set forth by your insurance. Occasionally, this could result in the need for additional payment.

_____**Proof of Insurance/Coverage changes.** All patients must complete our patient information form before seeing the provider. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. We will verify eligibility and benefits copay, coinsurance, and deductible amounts prior to your appointment as a courtesy, so it is imperative that you provide any updated insurance or personal information.

_____**Cash Pay Patients.** Every effort is made to collect accurate payment at the time services are rendered. However, the totals provided upon check-out are only an **ESTIMATE** of the cost of services rendered in our office, and self-pay patients may be subject to receiving an itemized bill after the date of service. All estimated payments for services rendered **must be paid at the time of service**. Failure to not pay for the estimated fees at the time of service will result to rescheduling your appointment.

_____**Claims submission.** We will submit your claims as a courtesy. If your claim is denied, we will assist you in any way we reasonably can to help get responsible payment to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Please be aware that some—and perhaps all—of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay in full for these services at the time of visit.

_____**Nonpayment.** If your account is over 45 days past due, you will receive a call or email stating that you have 14 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. If your account is assigned to a collection agency, you agree to pay all expenses we may incur in collecting the delinquent balance.

_____**Missed Appointments.** If you fail to show for a scheduled appointment and do not cancel or reschedule at least 24 hours in advance, you may be charged a $25.00 "No Show Fee".

_____**Medical Records/FMLA.** For all FMLA paperwork, there is a $50.00 fee. However, this does not guarantee the FMLA paperwork will ensure your time off will be approved, as the majority of our services do not require an extended amount of time away from work. For all general medical records requests, there is a $.60/page fee to be charged at 5 or more pages.

I have read and understand the payment policy and agree to abide by its guidelines:

Patient Name ____ DOB: ____________________________

Sign (Patient or Guardian) ____ Date: ____________________________

Terms of Services

Please initial:

______ I authorize Vivida Dermatology to send any specimen obtained through the course of my treatment to an outside lab. These labs analyses are separate services from those received in this office and will be billed separately by the lab. Vivida Dermatology will make every effort to send specimens to labs within the insurance network, however, it is my responsibility to inform Vivida Dermatology of the lab that is contracted with my insurance. I understand that I will be billed separately from both Vivida Dermatology (for the service of obtaining any specimen) and the lab (for the analysis of said specimen).

______ I authorize Vivida Dermatology to receive, mail, fax, and/or e-mail my records to another physician or medical facility in the course of my diagnosis and treatment.

______ I will present my most current insurance card(s) and photo ID when I check in for each appointment.

______ I understand that it is my responsibility to notify Vivida Dermatology of any changes to my information including, but not limited to: mailing address, phone number(s), insurance policies, or any other information that Vivida Dermatology needs to be able to contact me, collect payment, and/or otherwise carry out my treatment.

______ I authorize Vivida Dermatology to access my pharmaceutical records and history.

______ I acknowledge that it is my responsibility to understand my insurance policy and benefits. I am responsible for ensuring that the provider I am receiving services from is contracted (in-network) with my insurance. It is my responsibility to obtain a referral and/or prior-authorization/precertification if required by my insurance. Failure to understand my policy, benefits, network, and/or insurance requirements will not relieve me of my financial responsibility to Vivida Dermatology. Vivida Dermatology will make every effort to understand and explain my benefits, confirm the provider is contracted with my insurance, obtain any necessary referrals and/or prior authorization/precertification, and satisfy all insurance requirements for service. However, I acknowledge that is my responsibility to ensure that everything is satisfied correctly and I will not hold Vivida Dermatology liable for any failure on my part.

______ I authorize Vivida Dermatology, and their agents, to contact me by any method that I provide contact information for including: telephone calls (landline and wireless), voicemails/voice messages, text messages, emails, and mail. I understand that if I do not want Vivida Dermatology, or their agents to contact me in a certain way, then I will not provide the applicable telephone/wireless cellphone number, email address, or mailing address. If I provide any contact information, then I expressly consent my authorization for Vivida Dermatology, and their agents, to contact me by these means.

I have read and understand the terms of services and agree to abide by its guidelines:

Patient Name ____ DOB: _________________________

Sign (Patient or Guardian) ____ Date: _________________________

<u>If this does not pertain to you, please skip.</u>

Treatment to Minors (Under 18yrs old)

Patient Name: ____ Date of birth: _____/_____/______

Dear Parents/Guardians, this form has been prepared for your convenience should you at some time be unable to accompany your minor child to their medical appointment.

I hereby grant ____ to accompany my minor child when they arrive at the office for their medical appointment.

____ ________/_____/_______

Signature of Parent Date

Quality Measures (65yrs old and over)

Date: ______________________________

Patient Name: ____Date of Birth: ___/______/______

Vaccination Status

Have you received a Pneumonia vaccination? Yes / No

Advance Care Planning

Do you have a healthcare proxy in the event you are unable to make your medical decisions? Yes / No

Designee's Name ____

Designee's Phone Number ____

Do you have a living will? Yes / No

Please <u>initial</u> next to <u>one</u> of the statements that best reflects your wishes on advanced care:

______ Do not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
______ Do not resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

______ Full Cardiopulmonary Resuscitation (CPR): I want full cardiopulmonary resuscitation efforts to be made.

HIPAA NOTICE of PRIVACY PRACTICES

At Vivida Dermatology, we are committed to treating and using protected health information about you responsibly. This notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Vivida Dermatology, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for the future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Vivida Dermatology, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy your health record.
- Amend your health record.
- Obtain an accounting of disclosures of your health information.
- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Vivida Dermatology is required to:

- Maintain the privacy of your health information,
- Provide you with the notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice. We will discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer, ***Michael Borenstein*** at 702-255-6647. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is: *Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, D.C. 20201.*

Acknowledgement of Receipt of Privacy Notice

I hereby acknowledge that a copy of the "Notice of Privacy Practices" is available for my review, and I may receive a copy upon request.

Sign ____ Date __________________ Print Name ____

Please allow access to my Protected Health Information (PHI) which includes billing and medical records to my (*circle as many as apply*):

Spouse Child Parent Guardian Other

Name ____ Date___________________________ Relationship_________________________________

Patient Signature ________________________________ Date___________________________ Print Name__________________________________

6460 Medical Center St., Suite 200 & 350
Las Vegas, NV 89148
Ph: (702) 255-6647   Fax: (702) 933-1444

Authorization to Release Protected Health Information

Date of Request: ____________________________________

Patient Name: _______________________________________   Date of Birth: ______________________

Phone Number: _______________________   Treatment dates (if applicable): ___________ to ___________

I understand that this information shall be in effect following the date of the signature. However, Iunderstand that this authorization may be revoked at any time by giving oral or written notice to Vivida Dermatology

I understand that once my medical records have been released, Vivida Dermatology cannot retrieve them and has no controlover the use of the previously released copies.

Patient Signature: ____

☐ I hereby authorize Vivida Dermatology to **RECEIVE** copies of my medical records from:

☐ Personal ☐ Primary Care Physician ☐ Legal Representation ☐ Other

Facility Name: ____

Address: ____

Fax Number: _______________________ Phone Number: _______________________

☐ I hereby authorize Vivida Dermatology to **RELEASE** copies of my medical records to:

☐ Pathology Reports ☐ Progress Notes ☐ Operative Reports ☐ Photos ☐ Entire Medical Record

☐ Other ______________

Facility Name: ____

Address: ____

Fax Number: _______________________ Phone Number: _______________________