



TONI C. STOCKTON, MD, FAAD, PLLC

16611 S. 40th Street, Suite 100, Phoenix, Arizona 85048 480.610.6366 www.StocktonDermatology.com

PATIENT REGISTRATION

Date: _____ Please circle: **NEW** or **UPDATED** ****Please PRINT and COMPLETE using BLACK INK only****

LAST Name: _____ **FIRST** Name: _____ Middle Initial: ___ **DOB**: _____ **Age**: _____ **Sex**: _____

Race: _____ **SSN**: _____ - _____ - _____ **Marital Status**: Married / Divorced / Widowed / Single

Address: _____ **City**: _____ **State**: _____ **ZIP**: _____

Alternate Address: _____ **City**: _____ **State**: _____ **ZIP**: _____

Primary Phone for Contact: (_____) _____ - _____ **Cell/Other Phone**: (_____) _____ - _____

Emergency Contact Name: _____ **Emergency Contact Phone**: (_____) _____ - _____

Email Address: _____ **Occupation**: _____

Primary Care Physician: _____ **Primary Care Physician Phone**: (_____) _____ - _____

Referring Physician: _____ **Referring Physician Phone**: (_____) _____ - _____

Preferred Pharmacy: _____ **Pharmacy Phone Number** (_____) _____ - _____

Dermatology Brand-Name medications are often more effective than Generic medications.

Do you prefer? Brand-Name Usually Generic Meds if Equally Effective Generic Meds Even if Less Effective to Save Cost

Primary Insurance Company: _____ **Policy Holder Name**: _____

Relationship to Patient: _____ **Policy Holder SSN**: _____ - _____ - _____ **DOB**: ____/____/____

Insurance ID#: _____ **Employer**: _____

Secondary Insurance Company: _____ **Policy Holder Name**: _____

Relationship to Patient: _____ **Policy Holder SSN**: _____ - _____ - _____ **DOB**: ____/____/____

Insurance ID#: _____ **Employer**: _____

PLEASE NOTE: All required referrals must be coordinated by the PCP and faxed prior to or presented at the time of the appointment

Our office uses a HIPAA compliant automated system called CallPointe to remind you of upcoming appointments and the availability of laboratory results and/or reports.

Health Portability and Accountability Act of 1996 (HIPAA) also includes protected health information.

Signing below signifies that you have had the opportunity to view and/or receive explanation of the privacy notice. You may request a copy or read a copy located in the waiting room.

Printed Name _____ **Patient Signature** _____ **Date** _____

Witness _____ **Date** _____

You authorize sharing of your Personal Health Information (PHI) with someone else? No Yes *If Yes, who? _____

Aesthetic services and cosmetic procedures that our office provides:

- Restylane® •Juvederm® •Perlane® •Botox® •Dysport™ •Intense Pulsed Light •Spider Vein Therapy •Facials •Chemical Peels •Microdermabrasion

•Procedures for Wrinkles, Sun Damage, Skin Tightening, Dark Spots, Unwanted Hair or Acne

Would you like to schedule a consultation with an aesthetician at a later date? Yes No

Would you like to receive email notifications regarding monthly treatment and skin care specials? Yes No

How did you hear about Stockton Dermatology?

___ Friend ___ Facebook ___ Twitter ___ Our Website ___ Newspaper ___ Yellow Pages ___ Other _____

*****FOR OFFICE USE ONLY BELOW*****FOR OFFICE USE ONLY BELOW*****

MR #: _____ **Call Pointe ID #**: _____ **Provider**: _____



PATIENT MEDICAL HISTORY

Date: _____ Please circle: NEW or UPDATED **Please PRINT and COMPLETE using BLACK INK only**

LAST Name: _____ FIRST Name: _____ Middle Initial: ___ DOB: _____ Male Female

Are you allergic to any medications? No Yes Aspirin Codeine Erythromycin Penicillin Sulfa Other _____

Current Oral / Topical / Injectable Medications / None

Do you use any natural, herbal or alternative medicine products? No Yes please list _____

What is the MAIN REASON for your visit today? _____

Where is the location of the problem? _____ When did this current episode begin? _____

How long have you had this problem? Days Weeks Months Years Unknown Off and On for Years

Have you had previous treatment for this condition in the past? No Yes

Over-the-Counter _____ Rx Oral Meds _____ Rx Long-Term Meds _____

Rx Topical Meds _____ Surgery _____ Light Therapy _____ Laser _____ Biopsies _____ Blood Work _____

Did the treatment help? No Yes

If it is a skin lesion, is the lesion changing in Color Size Shape? _____ Slowly or Rapidly?

Skin History Do you now or have you in the past had any skin related problems? None

Abnormal Scars/ Keloids Cold Sores Herpes I or II Bleeding Disorders Slow Wound Healing Accutane Use

Acne Rosacea Folliculitis Boils Hives Dermatitis/Skin Rashes/Eczema Psoriasis Contact Dermatitis

Pre-cancerous Lesions Abnormal Moles (Dysplastic Nevi)

Skin Cancer Type and Location Please Circle Below and Write Location How Long Ago? _____

Basal Cell Carcinoma _____ Squamous Cell Carcinoma _____ Melanoma _____

Social History

Do you smoke? No Yes Do you use any recreational or IV drugs? No Yes If Yes, what? _____

For women, are you pregnant? No Yes If Yes, due date? _____ Are you breastfeeding? No Yes

What is your occupation? _____

Have you ever used a tanning booth? No Yes Are you exposed to the sun excessively? No Yes

Do you have any other MAJOR medical problems? No Yes What? _____

Do you require antibiotics prior to surgical procedures? No Yes Why? Artificial Joint or Valve or Murmur

PAST MEDICAL HISTORY do you now or in the past have a history of any of the following?

Table with 3 columns: Category, None, and Specific Medical History items (e.g., Allergy/Immunology, Blood/Lymph, Bowel/Stomach, etc.)

*****FOR OFFICE USE ONLY BELOW*****FOR OFFICE USE ONLY BELOW*****

Medical History Form Completed by Patient other and reviewed for completion by B/O Dated

HIPAA Notice of Privacy Practices

This notice is effective as of Sept. 23, 2013 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 Practice and to make the new notice provision effective for all PHI that we maintain.

This notice describes how medical information about you may be used and disclosed per the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It also describes how you can get access to this information. Please review it carefully.

Protected Health Information Protected Health Information (PHI) is about you, is obtained from you, as a record of your contacts and or visits for healthcare services with Stockton Dermatology. Specifically, PHI is information that may identify you including demographic information (i.e. name, address, phone, etc.) and relates to your past, present or future physical or mental health condition and related healthcare services.

Stockton Dermatology is required by the HIPAA Act of 1996 to follow specific rules on maintaining the confidentiality of your PHI, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This notice describes your protected health information to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under the HIPAA Act of 1996

You have the right to receive and we are required to provide you with a copy of this Notice of Privacy Practices. We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new version of this notice will be effective for all PHI that we maintain at that time. Upon our request we will provide you with a revised Notice of Privacy Practice if you call our office and request a copy of the revision be sent to you via US Postal Services at your next visit.

You have the right to authorize other use and disclosure. This means you have the right to authorize or deny any other use or disclosure of PHI not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to designate a personal representative. This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of your PHI.

You have the right to inspect and copy your PHI. This means you may inspect and obtain a copy of your PHI that is contained in your patient record.

You have the right to request a restriction of your PHI. This means you may ask us, in writing, not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI be disclosed to family members or friends who may be involved in your care or for notification purposes as

described in this Notice of Privacy Practices. **In certain cases, however, we may deny your request for a restriction and/or we may refuse to treat your condition.**

You may have the right to amend your PHI. You may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

You have the right to request disclosure accountability. You may request a listing of your PHI disclosures we have made to entities outside our office.

Complaint Procedures You may contact our office with any complaints you may have regarding this privacy policy. Or, if you believe we have violated our privacy rights, you may contact the Secretary of Health and Human Services. You may file a complaint with us by notifying our Compliance Officer of your complaint.

How We May Use or Disclose Your PHI Following are examples of the use and disclosures of your PHI that are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For Treatment. We may use and disclose your PHI to provide, coordinate or manage your healthcare and related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment (i.e. a pharmacy, laboratory and/or other physicians who maybe involved in your care and treatment. We may also call you by name in the waiting room when your provider is ready to see you. We may also use or disclose your PHI as necessary to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or test and to recommend treatment alternatives regarding your care. And we may contact you to provide information about health related benefits and services offered by our office.

For Payment. Your PHI will be used, as needed to obtain payment for services rendered by our practice. This may include certain activities that your insurance carrier may undertake prior to approving or paying for healthcare services we recommended for you such as; determining eligibility or coverage of insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations. We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally, it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

HIPAA Notice of Privacy Practices

To Others Involved in Your Healthcare. We will only disclose your PHI to a member of your family, or any other person you designate below. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death.

As Required by Law. We may use or disclose your PHI to the extent that law requires the use or disclosure.

For Legal Proceedings. We may disclose PHI in the course of any judicial or administrative proceedings, in response to an order of the court or administrative tribunal (to the extent disclosure is expressly authorized) in certain conditions in response to a subpoena, discovery request or other lawful process.

For Public Health. We may disclose your PHI to any Federal State public health authority that is permitted by law to collect or receive the information, including but not limited to the following entities:

- Center for Communicable Diseases
- Health Oversight
- Cases of Abuse or Neglect
- Department of Food and Drug Administration
- Various Law Enforcement Agencies
- Coroners, Funeral Directors and Organ Donation Organizations
- Military Activity and National Security
- Worker's Compensation
- When an Inmate

Other Required Uses and Disclosures Under the law, the HIPAA Act of 1996, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the law.

HIPAA Patient Information Form

The Department of Health and Human Services has established a 'Privacy Rule' as part of The HIPAA Act of 1996 to help insure that personal health care information is protected for privacy. The HIPAA Act was also created in order to provide a standard for health care providers to obtain their patients' consent for use and disclosure of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. WE strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for treatment, payment or healthcare operations. These entities are most often not required to obtain patients consent.

If you have paid for services "out of pocket", in full, 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.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose not to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that you have already been taken which relied on this or a previously signed consent.

If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review the above privacy notice. Signing below signifies that you have had the opportunity to view the privacy notice.

Compliance Assurance Notification for Our Patients

The misuse of Protected Health Information (PHI) has been identified as a national problem causing patients inconvenience and money. We want you to know that our entire staff continually undergoes training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) of 1996, with particular emphasis on the 'Privacy Rule.' We strive to achieve the highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determining the appropriate use of PHI in accordance with governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing dilemma of improper disclosure of PHI. As part of the plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know we are not perfect. Because of this fact, our policy is to listen to our employees and patients without any thought of penalization. If you feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may resolve the situation promptly.

Thank you for your continued confidence in Dr. Toni C. Stockton, MD, FAAD, and the rest of the staff of Stockton Dermatology.



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FINANCIAL POLICY

Thank you for choosing Stockton Dermatology for your care. We want you to understand and be aware of our office policies. If you have any questions or would like to discuss these policies, we can arrange for discussion with our office manager prior to your visit.

INSURANCE ASSIGNMENT OF BENEFITS AND PAYMENT POLICY

Medicare We are Medicare participating providers. We accept assignment of all claims. We cannot bill Medicare for any cosmetic or not medically necessary procedures (as defined by Medicare). You are responsible for meeting the Medicare annual deductible and co-pays at the time of service.

HMO, PPO or Other Managed Care Companies You are responsible for paying your annual deductibles, co-payments and charges for any non-covered or cosmetic services. These payments are due at the time of service. We do not bill for co-payments, non-covered or cosmetic services. Stockton Dermatology is not responsible for verifying insurance or obtaining receipt of any referrals that may be required by your insurance plan. You must obtain any referrals from your Primary Care Provider (PCP) and have the referral available to our office prior to or at the time of your appointment. There are numerous insurance companies, individual health plans and variable benefits. We can not guarantee your individual insurance coverage. You should contact your insurance representative for details specific to your plan. If you do not have a valid referral at the time of your appointment, you will be asked to reschedule or you can choose to be seen, but will assume financial responsibility for the visit as a self pay patient. Payment for the visit is due at the time of service. _____ **Please Initial**

Non-Contracted Plans We do not bill non-contracted plans. We will provide you with a statement of your visit charges. We do not coordinate referrals or authorizations for procedures or medications for non-contracted plans. We **do not** provide documentation for Workman’s compensation cases, office visits for litigation, or AHCCCS (Medicaid). Payment is due at the time of service.

Lab Tests, Pathology Charges and Procedures Please note that all procedures have additional costs which may not be included in regular office visit fees. These procedures include, but are not limited to, cryotherapy (liquid nitrogen treatment) to ‘burn-off’ lesions, mole mapping, acne procedures, slushes, peels, biopsies, surgeries, injections, cyst drainage, and mole or wart removal. If your visit includes biopsies, lab tests, or cultures, these specimens are sent out for processing. You will receive separate billings from the laboratory performing the service. You are responsible to notify us if your insurance company requires particular labs for coverage of the processing. _____ **Please Initial**

Unpaid Accounts Any payments, which are due, including those starting 30 days after insurance coverage has been completed, will be charged a \$15.00 monthly service charge; (or) at a rate of 1.5% interest per month based on the unpaid balance, whichever is larger. You understand that you are financially liable in the event of non-payment; you agree to pay any collection agency cost(s), and / or court cost(s) and reasonable attorney fees. Accounts not cleared within **90 days** may cause an adverse incident on your credit report. You understand and agree that if a check is returned for insufficient funds, Stockton Dermatology will only accept cash or credit card payment(s) thereafter, and you will be obligated to pay a returned check fee of \$30. All balances must be settled. If your account is sent to collections for an unpaid balance, you will be immediately discharged from the practice and not eligible to return. _____ **Please Initial**

Cosmetic Services and Non-Covered Services Procedures such as chemical peels, laser treatments, hair removal, Intense Pulsed Light (IPL), Restylane®, sclerotherapy, Botox® injections, Blu-U, microdermabrasion, and normal skin growth removal are considered cosmetic and are not covered by insurance. Some procedures performed that may be used for a medical condition can be deemed non-covered or not medically necessary. This is determined by your individual insurance company. We can not bill your insurance company for these procedures. Payment is due at the time of service for cosmetic, non-covered or not medically necessary procedures.

CANCELLATION POLICY

You understand and agree that you will give 48 hour’s notice if you are not able to make a scheduled appointment. **A fee of \$50 will be charged to you for missed or broken appointments without 48 hour notice on appointments scheduled Monday - Friday. A fee of \$60.00 will be charged to you for Saturday missed or broken appointments without 48 hour notice.** Stockton Dermatology uses an automated phone system for reminders of appointments. You understand this is a courtesy and Stockton Dermatology is not responsible for reminder calls not received. You are responsible for all appointments made. _____ **Please Initial**

By signing below you acknowledge you have read, understand and agree to the Stockton Dermatology Financial Policy.

Printed PATIENT Name: _____

Signature of Patient/Insured/Guardian: _____ **Date:** _____

Printed Name of Patient/Insured/Guardian: _____ **Relationship:** _____

Signature of Office Representative: _____ **Date:** _____