Processor Initials _____

STOCKTON DERMATOLOGY

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: <u>All required referrals must be coordinated by the PCP and faxed prior to or presented at the time of the appointment</u>

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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_____

Rev. TCS 1/2010

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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

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

Allergy/Immunology	☐ None	☐ Allergy Shots ☐ Fibromyalgia ☐ HIV Positive ☐ Lupus ☐ Other _____
Blood / Lymph	☐ None	☐ Anemia ☐ Easy Bruising ☐ Transfusion ☐ Leukemia/Lymphoma (type)_____ ☐ Bleeding Disorder ☐ Low Platelets ☐ Blood Clot Issue ☐ Hemophilia ☐ Other _____
Bowel / Stomach	☐ None	☐ Colon Cancer ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Liver Problems ☐ Ulcers
Ear, Nose, Throat	☐ None	☐ Fever Blisters ☐ Permanent Lip Makeup ☐ Sinus Problems ☐ Other _____
Eyes	☐ None	☐ Conjunctivitis ☐ Dry Eyes ☐ Glaucoma ☐ Permanent Eye Makeup ☐ Other _____
General	☐ None	☐ Dizziness/Vertigo ☐ Fatigue ☐ Psychiatric Concerns ☐ Weight Change ☐ Other _____
Genital / Urinary	☐ None	☐ Bladder Problems ☐ Herpes ☐ Kidney Problems ☐ Genital Rash ☐ Irregular Menses ☐ Polycystic Ovarian Disease ☐ Fibroids ☐ Recently Stop/Start Hormone Therapy ☐ Other _____
Heart / Circulation	☐ None	☐ Artificial Valve ☐ Chest Pain ☐ High Blood Pressure ☐ Irregular Heart Beat ☐ Murmur ☐ Leg Ulcers ☐ Pacemaker ☐ Varicose Veins ☐ Other _____
Hormones	☐ None	☐ Diabetes ☐ Pituitary Problems ☐ Thyroid Problems ☐ Other _____
Lung	☐ None	☐ Asthma ☐ Sarcoidosis ☐ Tuberculosis ☐ Valley Fever ☐ Other _____
Muscle / Bone	☐ None	☐ Arthritis ☐ Artificial Joint ☐ Joint Swelling ☐ Weakness ☐ Other _____
Nerve / Neurological	☐ None	☐ Lou Gehrig's(ALS) ☐ Migraine ☐ Multiple Sclerosis ☐ Seizure ☐ Stroke ☐ Other _____
Skin	☐ None	☐ Yes _____
Surgeries	☐ None	☐ Skin Cancer(s) _____ ☐ Transplant (type) _____ ☐ Other _____
Family History	☐ None	☐ Acne ☐ Atypical Moles (Dysplastic Nevi) ☐ Arthritis ☐ Diabetes ☐ Eczema ☐ Heart ☐ Lupus ☐ Psoriasis ☐ Sarcoid ☐ Thyroid ☐ Other _____ Skin Cancer ☐ Basal Cell Carcinoma ☐ Lymphoma ☐ Melanoma ☐ Squamous Cell Carcinoma

**********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 _____
REV.TCS 1-2010 Provider_____ Ok to Scan

STOCKTON
DERMATOLOGY

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 your 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.

STOCKTON
DERMATOLOGY

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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Processor Initials _____

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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. _____**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 24 hours notice if you are not able to make a scheduled appointment**. A fee of $40 will be charged to you for missed or broken appointments without 24 hour notice on appointments scheduled Monday - Friday. A fee of $50.00 will be charged to you for Saturday missed or broken appointments without 24 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: _____