Alexandria Associates in Dermatology
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1900 N. Beauregard Street, Suite 110
Alexandria, VA 22311

Thank you for scheduling an appointment with our office.

We have attached our new patient packet for your review and completion. In order to make your waiting room experience as short as possible, we ask that you take a few moments and complete the attached paperwork prior to your arrival to our office.

Effective December 1, 2016, all new patients will be asked for a credit card when scheduling their first appointment with us. The credit card will be kept on file. We are taking the information in the event that a new patient does not come for their appointment or call to cancel their appointment. At the time of the "no show", we will charge the credit card on file a $75.00 non-refundable fee.

Upon arrival, please give your new patient packet to our staff at the front desk. They will complete your check-in process as quickly as possible. You will be asked to take a photo for identification purposes. The photo taken at the front desk remains with your account for security purposes. Any phots taken in the exam room will become part of your medical chart and are separate from the photo taken at the front desk. You will also be asked to pay any required insurance co-payments as part of your check-in process.

Thank you for choosing Alexandria Associates in Dermatology for your dermatological needs. We look forward to seeing you and welcome you to the practice!

Alexandria Associates in Dermatology

Office Phone: (703) 212-7546
Office Fax: (703) 212-7282
www.alexandriaderm.com

PATIENT INFORMATION FORM

PLEASE PROVIDE THE REQUESTED INFORMATION BELOW IN ORDER TO MANAGE YOUR CARE, INSURANCE, CONSENTS, AND METHODS FOR CONTACT

PATIENT NAME & ADDRESS & PHONE:

NAME (FIRST, MIDDLE, LAST):_____

DATE OF BIRTH (MONTH, DATE, YEAR): _____

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

(STATE, CITY, ZIP)_____

PHONE (H): _____(C): _____ (W): _____

EMAIL: _____

PREFERRED CONTACT METHOD (CHECK ONE): ❑ HOME ❑ CELL ❑ WORK ❑ TEXT ❑ EMAIL

❑ OK TO LEAVE A VOICEMAIL MESSAGE IF WE CANNOT REACH YOU? (IF YES, CHECK)

PRIMARY CARE PHYSICIAN (PCP) INFO:

PCP NAME:_____

DEMOGRAPHICS (WE HATE HAVING TO ASK THIS, TOO, BUT WE'RE REQUIRED TO BY LAW):

GENDER: _____ RACE/ETHNICITY: _____

MARITAL STATUS:_____

RESPONSIBLE PARTY INFO (WHO'S ULTIMATELY RESPONSIBLE FOR YOUR BILL?):

❑ CHECK HERE IF SAME AS PATIENT INFO ABOVE

NAME: _____ RELATIONSHIP: _____

ADDRESS (STREET, CITY, STATE): _____

PHONE (H):_____ (C):_____ (W): _____

PREFERRED CONTACT METHOD (CHECK ONE): ❑ HOME ❑ CELL ❑ WORK ❑ TEXT ❑ EMAIL

EMERGENCY CONTACT INFO (WHO CAN WE CONTACT IN CASE OF AN EMERGENCY?):

NAME: _____ RELATIONSHIP: _____

ADDRESS (STREET, CITY, STATE): _____

PHONE (H):_____ (C):_____ (W): _____

INSURANCE INFO (WE REALLY NEED THIS, OTHERWISE YOU'LL BE RESPONSIBLE FOR ALL VISIT COSTS):

PRIMARY INSURANCE NAME:_____

POLICY HOLDER NAME: _____DOB:_____

ADDRESS FOR THE HOLDER OF THE **PRIMARY INSURANCE** (STREET, CITY, STATE):

_____

❑ CHECK HERE IF ADDRESS IS THE SAME AS LISTED IN PATIENT INFO SECTION ABOVE

❑ CHECK HERE IF ADDRESS IS THE SAME AS LISTED IN RESPONSIBLE PARTY INFO SECTION ABOVE

DO YOU HAVE **ANOTHER HEALTH INSURANCE POLICY?** (i.e. *SECONDARY INSURANCE*)
SECONDARY INSURANCE NAME:_____
POLICY HOLDER NAME: _____DOB:_____
ADDRESS FOR THE HOLDER OF THE SECONDARY INSURANCE (STREET, CITY, STATE):
_____

GENERAL CONSENT (THIS PROVIDES US WITH YOUR CONSENT TO RECEIVE CARE & TESTING):

___ **(INITIAL HERE)** General Consent: I consent to medical care at Alexandria Associates in Dermatology. This includes needed lab work and HIV testing. By law, I understand that if there is an at-risk exposure to my blood or body fluids, I may be tested for HIV, Hepatitis B or C virus. Those test results will be shared with the healthcare worker who was exposed.

I am aware that healthcare is not an exact science. No guarantees have been made.

FINANCIAL RESPONSIBILITY (THIS PROVIDES US WITH YOUR CONSENT TO BILL YOUR INSURANCE & ASKS YOU TO ACKNOWLEDGE YOUR FINANCIAL RESPONSIBILITY FOR SERVICES NOT COVERED BY YOUR INSURANCE):

___ **(INITIAL HERE)** Financial Responsibility: I agree to pay for ALL medical services provided. I understand that I may need to call my insurance company to see if they will approve and pay for the medical care. I understand I may receive a separate bill for laboratory services. **Please bill my health insurance plan as a service to me. I am aware that this does not mean that they will agree to pay for any services. I agree to pay whatever amount is not covered.** I assign all of my rights and claims for payment under any health insurance plan to Alexandria Associates in Dermatology and their laboratory vendors. **I appoint Alexandria Associates in Dermatology as my "authorized representative" to act for me in getting payment for services provided. If I pay more than what I owe, I agree that overpaid funds can be used to pay for ANY outstanding bills I have at Alexandria Associates in Dermatology.** I give permission to be contacted for treatment or payment purposes with a pre-recorded message, artificial voice, email message, or text message. Contact may also be made by businesses helping my providers collect money that I owe.

___ **(INITIAL HERE)** All cosmetic services and/or product purchases are payable at the time of service.

___ **(INITIAL HERE)** Cancellation/"No show" Policy: We require 24 hours notice. I understand that my credit card will be charged **$75 for a new patient "no show"** appointment and **$35 for an established patient "no show"** appointment.

___ **(INITIAL HERE)** Returned Checks: I understand I will be charged **$40 for all returned checks.**

SIGN BELOW TO ACKNOWLEDGE AGREEMENT WITH THE ABOVE GENERAL & FINANCIAL CONSENTS:

PATIENT SIGNATURE: _____ **DATE:** _____

(THIS CONSENT IS VALID FOR 2 YEARS)

Alexandria ASSOCIATES IN DERMATOLOGY

HISTORY & INTAKE FORM

(PLEASE PRINT)

Patient: _____ Date of Birth: ____/____/____

Primary Care Physician: _____ Occupation: _____

Pharmacy & Pharmacy Address: _____

Past Medical History/Alerts: (Please circle all that apply)

ALERTS:
- Artificial Joint
- Artificial Heart Valve
- Blood Thinners
- Defibrillator
- GI Upset w/ Antibiotics
- HIV/Hepatitis
- Immunosuppressant
- Pacemaker
- Pre-meds Prior to Procedure
- Pregnant/Nursing
- Yeast Infection w/ Antibiotics

MEDICAL HISTORY

- Anxiety
- Arthritis
- Rheumatoid Psoriatic Arthritis
- Asthma
- Atrial Fibrillation
- Bone Marrow Transplant
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Hearing Loss
- Hepatitis
- HIV/AIDS
- Hyper or Hypotension
- Hypercholesterolemia
- Hyper or Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Polycystic Ovarian Disease
- Ovaries Removed
- Prostate Cancer
- Prostate Issues
- Radiation Treatment
- Seizures
- Stroke
- None

Other: _____

Social History: (Please circle all that apply)

Current Smoker
- Daily
- Not Daily

Has smoked in the past

Has never smoked

Alcohol
- Social Only
- < 1 drink daily
- 1-2 drinks daily
- ≥ 3 drinks daily
- None

Drug Use
- None
- Other:

_____

_____

Skin Disease History: (Please circle all that apply)

- Acne
- Actinic Keratosis
- Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking or Itchy Scalp
- Hay Fever/Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Rosacea
- Squamous Cell Cancer

Other: _____

PLEASE SEE BACK SIDE

Review of Systems: Are you currently experiencing any of the following? (Please circle all that apply)

Pregnancy or Planning	Problems with bleeding	Yeast Infections with Antibiotics
Breastfeeding or Lactation	Problems with healing	GI Upset with Antibiotics
Allergy to numbing agents	Problems with scarring	Immunosupression

Major Surgeries:

Hysterectomy	Kidney Surgeries	Other:
Joint Replacement	Mastectomy	_____
Mitral Valve Replacement	Breast Surgeries	_____

Family History:

High Blood Pressure	Lupus	Cancers:
High Cholesterol	Psoriasis	Type:_____
Diabetes	Melanoma	Family Member: _____

Medications:
(Please enter all current medications)

_____
_____
_____

Allergies
(Please enter all allergies and associates reactions)

_____
_____
_____

_____ Patient Initials
_____/_____/_____ Date

AUTHORIZATION FOR INFORMATION ACCESS

(THIS FORM DESIGNATES WHO CAN WE SHARE YOUR INFORMATION WITH)

*THIS FORM AUTHORIZES THE RELEASE OF PROTECTED HEALTH INFORMATION BY **ALEXANDRIA ASSOCIATES IN DERMATOLOGY** TO THE NAMED PERSON(S) BELOW REGARDING THE PATIENT LISTED BELOW*

NAME OF PATIENT & DATE OF BIRTH:

NAME OF PATIENT: _____

DATE OF BIRTH:_____

WHO ARE YOU AUTHORIZING ACCESS OF INFORMATION TO & WHAT INFO CAN BE RELEASED?

NAME OF PERSON & RELATIONSHIP:

_____

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY):

- ❑ MEDICAL OFFICE VISIT NOTES (LIST TYPE OR DATE, IF KNOWN) _____
- ❑ FINANCIAL INFORMATION
- ❑ LABS/PATHOLOGY RESULTS
- ❑ BREACH OF INFORMATION
- ❑ OTHER(LIST):_____ _____

BY WHAT MEANS CAN WE CONTACT YOUR DESIGNEE? (CHECK ALL THAT APPLY)

❑ EMAIL* ❑ TEXT* ❑ PHONE/VOICEMAIL

*IF EMAIL/TEXT IS SELECTED, I UNDERSTAND THAT INFORMATION SENT IS NOT ENCRYPTED, THEREFORE IT COULD BE ACCESSED INAPPROPRIATELY.

*EMAIL:_____

*PHONE (H):_____ (C):_____

YOUR PATIENT RIGHTS:

- THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME; I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME
- I MAY INSPECT OR COPY THE PROTECTED HEALTH INFORMATION TO BE DISCLOSED VIA THIS DOCUMENT
- REVOCATION IS NOT EFFECTIVE IN CASES WHERE THE INFORMATION HAS BEEN DISCLOSED BUT WILL BE EFFECTIVE GOING FORWARD
- INFORMATION USED OR DISCLOSED AS A RESULT OF THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT & MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW
- I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION & MY TREATMENT WILL NOT BE CONDITIONED ON SIGNING

SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE & DATE

Signature: _____ Today's date: _____

Alexandria Associates in Dermatology, PC

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

  _____
- ☐ Other: _____

  _____

Prepared By _____

Signature _____

Date _____

Alexandria Associates in Dermatology, PC
Notice of Privacy Practices

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.

If you have any questions about this Notice please contact the Privacy Officer.
Practice Administrator

Effective Date: April 14, 2003 **Revised: July 7, 2016**

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: alexandriaderm.com

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.

- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. [Describe how the patient may obtain the written request document and to whom the request should be directed, i.e. practice manager, privacy officer.]

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14,

2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

[Insert name of responsible person responsible and contact information]

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 13, 2003 **or date practice adopted the Notice**