Alexandria ASSOCIATES IN DERMATOLOGY

PATIENT REGISTRATION FORM

PATIENT DEMOGRAPHICS:

*Name: _____ *Date of Birth (MM/DD/YY): _____

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

*Phone (C) : _____ (H): _____ (W): _____

*Email Address: _____

***Preferred Contact Method**: ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email

☐ I would like to **opt out** of receiving text messages regarding- my care, including appointment reminders. (if yes, please check) *

☐ Is it OK to leave a Voicemail Message if we cannot reach you? (If yes, check) *

Social Security Number: _____ Marital Status: _____ Gender: _____

Race: _____ Ethnicity: _____

PRIMARY CARE PHYSICIAN (PCP) INFORMATION:

PCP Name: _____ PCP Phone #: _____

PCP Address: _____

REFERRING PROVIDER INFORMATION:

Name: _____ Phone #: _____

Address: _____

BILLING INFORMATION: PLEASE PROVIDE YOUR INSURANCE CARD AND PHOTO ID TO RECEPTIONIST AT EACH VISIT.

*Primary Insurance Name: _____ Member ID: _____

Policy Holder Name: _____ Policy Holder DOB (MM/DD/YY): _____

Policy Holder SSN: _____ Relationship to Patient: _____

Policy Holder Address (if different than patient) _____

***Does your Health Insurance Policy require a referral?** ☐ **Yes** ☐ **No**

THIS IS A DOUBLE-SIDED FORM, PLEASE COMPLETE BOTH SIDES

BILLING INFORMATION CONTINUED:

***Do you have another Health Insurance Policy (i.e., Secondary Insurance)?** ☐ **Yes** ☐ **No**

If yes, please fill in the section below

Secondary Insurance Name: _____ Member ID: _____

Policy Holder Name: _____ Policy Holder DOB (MM/DD/YY): _____

Policy Holder SSN: _____ Relationship to Patient: _____

Policy Holder Address (if different than patient) _____

***EMERGENCY CONTACT INFORMATION:**

Name: _____ Relationship to Patient: _____

Address (Street, City, State, ZIP): _____

Phone (C):_____ (H): _____ (W): _____

Email Address: _____

Preferred Contact Method: ☐ Cell Phone ☐ Home Phone ☐ Work Phone

TO WHOM ARE YOU AUTHORIZING ACCESS OF INFORMATION & WHAT INFORMATION MAY BE RELEASED?

***May we discuss your medical condition with any member of your family?** ☐ **Yes** ☐ **No**

If **YES**, please provide the name and contact information for the person(s) with whom we may discuss your care:

Name: _____ Relationship to Patient: _____

Phone (C):_____ (H): _____ (W): _____

Email Address: _____

Preferred Contact Method: ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email

WHAT INFORMATION MAY BE SHARED? (CHECK ALL THAT APPLY):

☐ Financial Information ☐ Labs/Pathology Results

☐ Breach of Information ☐ Medical Office Visit Note

We will bill your insurance company if we participate with that company. You are responsible for any & all charges that your insurance company does not cover such as deductibles, co-pays, and non-covered services, which are payable at the time of service. Parents/Guardians are responsible for payments on minor/dependent accounts. All tissue removed will be sent for pathologic examination at the discretion of your provider. I authorize for insurance payments to go directly to physician and for release of necessary medical records to the insurance company and to the billing service to receive payment. HMO Participants: In order for your insurance company to pay for your visit, it is your responsibility to obtain referrals from your primary care physician for each visit.

I have been provided with the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. My requested restrictions of use of this information are notated above. I certify that I understand the above and that the information I have given is correct to the best of my knowledge:

_____ _____

**Signature (parent/guardian if minor)* * *Date (MM/DD/YY)*

Alexandria ASSOCIATES IN DERMATOLOGY

HISTORY AND INTAKE FORM
(PLEASE PRINT)

Name: _____ DOB: _____

Occupation: _____

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: _____

MAJOR SURGERIES:

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

SKIN DISEASE HISTORY:

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 Skin Cancer

Other: _____

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MEDICATIONS:
(Please list all current medications and doses)

_____
_____
_____
_____
_____
_____

ALLERGIES:
(Please list all allergies and associated reactions)

_____
_____
_____
_____
_____
_____

SOCIAL HISTORY: *(Please circle all that apply)*

Tobacco	Alcohol	Drugs
Current Smoker	Social Only	None
- Daily	< 1 drink daily	Other: _____
- Not Daily	1-2 drinks daily	_____
Has smoked in the past	≥ 3 drinks daily	_____
Has never smoked	None	

FAMILY HISTORY: *(Please circle all that apply)*

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

Family History of Basal Cell Skin Cancer? ☐ Yes ☐ No If yes, who: _____

Family History of Squamous Cell Skin Cancer? ☐ Yes ☐ No If yes, who: _____

Family History of Melanoma Skin Cancer? ☐ Yes ☐ No If yes, who: _____

Did you get a Flu shot during the current flu season? □ Yes □ No

(initial here _____) ***I authorize AAID to test my blood for hepatitis and HIV if, in their opinion, an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.***

I certify that I understand the above and that the information I have given is correct to the best of my knowledge.

_____ _____

Signature (parent/guardian if minor) **Date (MM/DD/YY)**

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed by Alexandria Associates in Dermatology and how you can get access to this information. Please read it carefully.

YOUR RIGHTS, UPON WRITTEN REQUEST:

- Ask to see or get an electronic or paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost based fee. We will provide this information as soon as possible, but no later than 30 working days from the date of request.
- Ask us to correct your health information you think is incorrect or incomplete. We reserve the right to say "no" but will tell you why in writing within 60 days.
- You may ask us to communicate with you in a certain way (for example home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree with your request and may say "no" if it would affect your care.
- If you pay for a service or health care item out of pocket in full, ad you ask us not to share that information for payment or our operations with your health insurer, we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the last six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost based fee.
- Revoke an authorization to use or disclose Protected Health Information (PHI) at any time, except where action has already been taken.

YOU MAY ALSO:

- Chose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can excise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide the copy promptly.
- File a complaint if you feel your rights have been violated. You may contact our privacy officer, AAID Privacy Officer, 1900 N Beauregard Street, Suite 110, Alexandria, VA 22311, 703-212-7546
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington D.C., 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. ***We will not retaliate for filing a complaint.***

OUR RESPONSIBILITIES - The law requires us to:

- Maintain the privacy and security of your Protected Health Information (PHI).
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Not use or share your information other than what is described in this notice unless you tell us we can in writing. If you tell us we can and then change your mind, submit your revocation to us in writing stating that you have changed your mind.

YOUR CHOICES - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us.

In these cases, you have both the right and the choice to tell us to:

- share information with your family, close friends, and others involved in your care and share information in a disaster relief situation.
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest.
- We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information in less you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- In the case of fundraising, we may contact you for fundraising efforts, but you may tell us not to contact you again.

OUR USES AND DISCLOSURE; we typically use or share your information in the following ways:

- Treatment: We can use your health information and share it with other professionals who are treating you.
- Payment: We can use your share your health information to bill and get payment from health plans or other entities.
- Health Care Operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Other ways we can use or share your health information – we are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes.

- Help with public health and safety issues: we can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.
- Comply with the law: we will share information about you if state or federal law requires it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.
- Respond to organ and tissue donation requests: We will share health information about you with organ procurement organizations.
- Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when you die.
- Address workers' compensation, law enforcement, and other government requests:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services
  - Respond to lawsuits and legal actions: We can share your health information to respond to a court or administrative order, or in response to a subpoena.
  - Research: we can use or share your information for health research.

This notice is subject to change at any time, and changes will apply to all information we have about you. The new notice will be available upon request, in or office and on our website.