clearchoice DERMATOLOGY

-PATIENT INFORMATION-

Legal Name: _____

Date of Birth:		Age:		Cell Phone Number:	
SSN:		Sex:		Home Phone Number:	

Race:

☐Prefer not to answer ☐Black/African American ☐White/Caucasian☐Not Sure

☐Asian or Pacific Islander☐Native American ☐Hispanic/ Latino ☐Other: _____

Physical Adress: _____

Email Adress: _____

Marital Status:

☐Single ☐Married ☐Widowed ☐Divorced ☐Other: _____

Emergency contact: _____

☐Parent/Legal Guardian of Patient

Relationship to Patient: _____ Phone Number: _____

Primary Care Provider: _____

☐I don't have a PCP
☐I don't want to share my PCP's information

PARENT/ LEGAL GUARDIAN INFORMATION (IF PATIENT IS A MINOR)

Responsible Party's Name: _____

Date of Birth: _____ SSN: _____-_____-_____

Address: _____

INSURANCE INFORMATION:

Primary Insurance Name:	Secondary Insurance Name:
_____	_____
Member ID: _____	Member ID: _____ Group
Group Number: _____	Number: _____
Policy Holder's Name :_____	Policy Holder's Name :_____
Date of Birth: _____	Date of Birth:_____
Relationship to Patient :_____	Relationship to Patient :_____

REASON FOR VISIT: ***If you are only here for a routine skin exam please skip to MEDICAL CHECKLIST***

**** PLEASE PROVIDE MEDICAL STAFF WITH MEDICATION AND ALLERGY LIST****

Type of problem: _____ Duration of condition: _____

Treatment used for condition: _____

Questions:	Yes	No
Do you have a bleeding disorder?	☐	☐
Do you have a pacemaker/defibrillator?	☐	☐
Are you currently suffering from seasonal allergies?	☐	☐
Are you taking any blood thinners?	☐	☐
Frequent sun exposure?	☐	☐

Symptoms:

☐ Painful ☐Itchy ☐Burning ☐Stinging ☐Bleeding ☐Unsightly

☐Spreading☐Tingling ☐Other: _____

Area(s) of body affected:

☐Right Upper Extremity ☐Left Lower Extremity ☐Scalp ☐Face ☐Ear ☐Nails ☐Right Lower Extremity ☐Left Upper Extremity ☐ Neck ☐Chest ☐Back ☐Abdomen ☐All over ☐Other: _____

Past Medical Conditions:

☐None
☐Arthritis
☐Atrial fibrillation
☐Cerebrovascular accident
☐Chronic Obstructive Lung disease
☐Depressive disorder
☐Diabetes mellitus
☐End-stage renal disease
☐Gastroesophageal reflux disease
☐History of: Hypertension
☐Human immunodeficiency virus infection
☐Hypercholesterolemia
☐Hyperthyroidism
☐Hypothyroidism
☐Leukemia
☐Malignant lymphoma
☐Malignant tumor of breast
☐Malignant tumor of colon
☐Malignant tumor of lung
☐Malignant tumor of prostate
☐Radiation therapy treatment management
☐Transplantation of bone marrow
☐Other: _____

Past surgeries:

☐None
☐Bilateral replacement of knee joints
☐Coronary artery bypass graft
☐Entire transplant kidney
☐Excision of basal cell carcinoma
☐Excision of melanoma
☐Excision of squamous cell carcinoma
☐History of: Colostomy
☐History of tubal ligation
☐History of colectomy
☐History of tissue graft
☐Heart valve replacement
☐Hysterectomy
☐Mechanical heart valve replacement
☐Splenectomy
☐Total replacement of left hip joint
☐Total replacement of left knee joint
☐Total replacement of right hip joint
☐Total replacement of right knee joint
☐Transplantation of heart
☐Transplantation of liver
☐Other: _____

Skin conditions:

☐None
☐Acne
☐Actinic Keratosis
☐Basal Cell Carcinoma
☐Dysplastic nevus of skin
☐Eczema
☐History of Asthma
☐History of Hay Fever
☐Malignant Melanoma
☐Pruritus of Scalp
☐Psoriasis
☐Squamous Cell Carcinoma
☐Sunburn of Second degree
☐Other: _____

Patient Consent Form

PATIENT INFORMATION			
LAST NAME		FIRST NAME	M.I.
SSN	DATE OF BIRTH	SEX	MRN
STREET ADDRESS			
STREET ADDRESS CONTD.			
CITY		STATE	ZIP CODE
HOME PHONE	CELL PHONE		EMPLOYER NAME

HIPAA

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Clear Choice Dermatology LLC values you as a patient, and protection of your privacy is very important to us. In conducting our business, we will create and maintain records that contain protected health information (PHI) about you and the healthcare services provided to you.
PHI is information about you—including individually identifiable information about where you live—that can reasonably be used to identify you and which relates to your past, present, or future physical or mental health or condition; the provisioning of healthcare to you; or the payment for that care.

This Notice of Privacy Practices takes effect on date signed and will remain in effect until we replace or modify it.
1.This Notice of Privacy Practices describes our privacy practices, which include how we may use, disclose, collect, handle, and protect your PHI. We are required by certain federal and state laws to maintain the privacy of your PHI. We are also required by the federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to give you this Notice about our privacy practices, our legal duties, and your rights concerning your PHI.
2.We protect your privacy by taking the following precautions:

a.Limiting who may see your PHI.
b.Limiting how we may use or disclose your PHI.
c.Informing you of our legal duties with respect to your PHI.
d.Explaining our privacy policies.
e.Adhering to the policies currently in effect.

Copies of this Notice

1.You may request a copy of our Notice of Privacy Practices at any time. It is your right and our duty to deliver a copy of the Notice to you on the very first opportunity we provide healthcare services to you.
2.Based on your preference, the Notice may be delivered electronically through email, a physical copy, or both. The Notice shall also be made available on our website.
3.We shall retain and document details of the delivery of the Notice to you, and we may seek your signatures as acknowledgement of receipt.
4.If you want more information about our privacy practices, or have questions or concerns, please contact us using the contact information at the end of this Notice.

Changes to this Notice

1.The terms of our Notice of Privacy Practices apply to all records created or retained by us that contain your PHI. We reserve the right to revise or amend the terms of this Notice. A revised or amended Notice will be effective for the entire PHI that we already have about you as well as for any PHI we may create or receive in the future. We are required by law to comply with whatever privacy notice is currently in effect. You will be notified of any material change to our privacy notice before the change becomes effective.

How We May Use and Disclose Your Protected Health Information (PHI)

1.We are permitted to use and disclose your PHI to provide treatment to you, to be paid or request payment for our services, and to conduct healthcare operations. This section of our Notice of Privacy Practices discusses each of these types of uses and disclosures of PHI:

a.For Treatment—we may use PHI about you to provide you with healthcare treatment or services. For example, we may use your PHI when performing medical procedures. We may disclose PHI about you to our organization's workforce as well as to doctors, nurses, hospitals, clinics, or other healthcare providers who are involved in your care.

b.For Payment—we may use and disclose PHI about you so the services and items you receive may be billed to and payment may be collected from you, an insurance company, or a third-party payer. We may need to give your health plan information about the services or items you received so that your health plan will pay us or reimburse you for the services or items.

c.For Health Care Operations—we may use and disclose PHI about you for healthcare operations. These uses and disclosures are necessary to make sure you receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in providing services to you. We may also disclose information to doctors, nurses, hospitals, clinics, and other healthcare providers for review and learning purposes. We may remove information that identifies you from this set of PHI so others may use it to study healthcare and healthcare delivery without learning the names of the specific individuals.

We May Use and Disclose Your PHI without Your Authorization in the Following Cases:

1.Uses and Disclosures Required by Law

As described below, we may use or disclose your PHI under the requirements of law without an authorization from you:

a.To the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

b.To a public health authority that is authorized by law to collect or receive such information for the purposes authorized by law including cases of child abuse or neglect.

c.To a person subject to the jurisdiction of the Food and Drug Administration (FDA) with respect to an FDA-regulated product or activity.

d.Of a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition for intervention or investigation.

e.To an employer of an individual who is provided healthcare on the request of the employer; and to help conduct an evaluation of medical surveillance of a work environment or related to a work-related illness. The disclosure is limited to the purpose mentioned and shall include a written notification to the individual on such disclosure.

f.To a school about an individual who is a student or prospective student of the school limited to information on immunization—where such requirement is legal. Such disclosure shall be supported by an agreement with the parent/guardian of the individual in case of a minor or with the individual in case of an adult or emancipated minor.

2.Disclosures about Victims of Abuse, Neglect or Domestic Violence

We may disclose PHI about an individual who is reasonably believed to be a victim of abuse, neglect or domestic violence to a government authority, including a social service or protective services agency authorized by law to receive such reports. The disclosure will be bound by the following restrictions:

a.Extent of disclosure as required and in compliance with the law.

b.With or without the agreement of the individual to such disclosure, as long as the disclosure is authorized by law and/or in exercise of professional

judgment by The Skin Docs.

c.The individual or their personal representative shall be informed of such disclosure unless a professional judgment indicates risk or harm to the individual with such information disclosure to the individual.

3.Disclosures for Health Oversight Activities

We may disclose PHI to a health oversight agency for oversight activities authorized by law—including audits; civil, administrative and criminal investigations; inspections, licensure and disciplinary actions; civil, administrative and criminal proceedings; and actions or other activities necessary for appropriate oversight of the following:

a.The healthcare system.

b.Government benefit programs for which health information is relevant to beneficiary eligibility.

c.Government regulatory programs for which health information is necessary for determining compliance with program standards.

d.Civil rights laws for which health information is necessary for determining compliance.

e.A health oversight activity does not include an investigation or other activity in which the individual is the subject of the investigation or activity.

4.Disclosures for Judicial and Administrative Proceedings

a.We may disclose PHI for the purposes of judicial and administrative proceedings in response to an order of a court or an administrative tribunal.

b.In response to a subpoena or discovery request without a court order under one of the following circumstances:

i.Satisfactory assurances in writing with evidence that reasonable efforts have been made by such party to ensure that the individual who is the subject of the PHI that has been requested has been given notice of the request.

ii.Satisfactory assurance from the party seeking the information that reasonable efforts have been made to secure a qualified protective order.

5.Disclosures for Law Enforcement Purposes

a.We may disclose PHI for a law enforcement purpose to a law enforcement official under the following conditions:

i.As required by law including laws that require the reporting of certain types of wounds or other physical injuries.

ii.In compliance with and as limited by the relevant requirements of a court order. The disclosure shall be made as relevant to the purpose of enquiry and when de-identified information could not be used.

b.We may disclose to a law enforcement official PHI if it is believed in good faith that the information constitutes evidence of criminal conduct that occurred on the premises of The Skin Docs.

c.The Skin Docs in the course of a medical emergency, shall disclose PHI to a law enforcement officer if the individual is suspected to be a victim of crime or violence.

6.Uses and Disclosures for Research Purposes

a.We may disclose PHI for research—regardless of the source of funding of the research—under the following conditions:

i.With documentation related to approval of a waiver of authorization by an institutional review board or a properly constituted privacy board.

ii.Acceptance of necessity for the purpose of research and description of the information sought.

7.Uses and Disclosures to Avert a Threat to Health or Safety

a.We may—consistent with law and in good faith—disclose PHI to avert a serious threat to health or safety under the following conditions:

i.To prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

ii.When necessary for law enforcement authorities to identify or apprehend an individual.

iii.When it appears from all the circumstances that the individual has escaped from a correctional institution or from lawful custody.

iv.The extent of the disclosure shall be limited to the purpose.

8.Disclosures for Workers' Compensation

a.We may disclose PHI as authorized by, and to the extent necessary to comply with, laws relating to worker's compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault.

We May Use and Disclose Your PHI Only with Your Authorization in the Following Cases:

1.Disclosure of PHI for Marketing Purposes

We shall obtain an authorization for any use or disclosure of PHI for marketing, except if the communication occurs in the form of one of the following:

a.A face-to-face communication made by a Covered Entity to an individual.

b.A promotional gift of nominal value provided by the Covered Entity.

c.If the marketing involves disclosure of PHI with intent of sale and financial remuneration to The Skin Docs from a third party, the authorization shall state that such remuneration is involved.

d.We shall obtain an authorization for any use or disclosure of PHI for the purpose of the sale of PHI as authorized by the regulations. Such authorization shall state that the disclosure shall result in remuneration to The Skin Docs.

2.Valid Authorizations

An authorization to disclose PHI shall be communicated in plain language and contain the following elements:

a.A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.

b.The name or other specific identification of the person(s) or class of persons authorized to make the requested use or disclosure.

c.The name or other specific identification of the person(s) or class of persons to whom The Skin Docs may make the requested use or disclosure.

d.A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not or elects not to provide a statement of the purpose.

e.An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statements "end of the research study," "none," and similar language are sufficient if the authorization is for a use or disclosure of PHI for research—including for the creation and maintenance of a research database or research repository.

f.Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual must also be provided.

3.A copy of the authorization duly signed by you shall be retained by us for our records, and we will provide a copy to you.

Rights You Can Exercise with Regard to Your PHI

You have the following rights regarding the PHI we maintain about you. Requests to exercise your rights must be in writing.

1.Right to Access Your PHI

You have the right to inspect or receive copies of your PHI contained in a designated record set. Generally, a “designated record set” contains medical, enrollment, claims and billing records we may have about you as well as other records we may use to make decisions about your healthcare.

2.Right to Copy

You may request that we provide copies of your PHI in a format other than photocopies. We will use the format you request unless we cannot practicably do so. We may charge a reasonable fee for copies of PHI (based on our costs), for postage, and for a custom summary or explanation of PHI. You will receive notification of any fee(s) to be charged before we release your PHI, and you will have the opportunity to modify your request in order to avoid and/or reduce the fee. In certain situations, we may deny your request for access to your PHI. If we do, we will tell you our reasons in writing.

3.Right to Request an Amendment to PHI

You have the right to request that we amend your PHI if you believe there is a mistake in your PHI or that important information is missing. To request an amendment to your PHI, your request must be made in writing. In addition, you must provide a reason that supports your request. We will generally make a decision regarding your request for amendment no later than 60 days after receipt of your request. However, if we are unable to act on the request within this time, we may extend the time for 30 more days.. If we deny your requested amendment, we will provide you with a written denial. Approved amendments made to your PHI will also be sent to those who need to know. We may also deny your request if, for instance, we did not create the information you want amended. If we deny your request to amend your PHI, we will tell you our reasons in writing and explain your right to file a written statement of disagreement.

4.Right to an Accounting of Certain Disclosures

You may request, in writing, that we tell you when we or our Business Associates have disclosed your PHI (referred to as an “Accounting”). Any accounting of disclosures will not include those we made under these conditions:

a.for payment or healthcare operations

b.To you or individuals involved in your care

c.With your authorization

d.For national security purposes

e.To correctional institution personnel

5.To request an accounting of such disclosures, your request must be submitted in writing. Your request must also state a time period, which may not be longer than six (6) years. Your request should also specify the format in which you prefer to receive the accounting, i.e. paper or electronic. We may charge you for the costs of providing the accounting. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

6.Right to Request Restrictions

You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to your request. However, if we do agree, we will be bound by our agreement—except when required by law, in emergencies, or when information is necessary to treat you. An approved restriction continues until you revoke it in writing or until we tell you we are terminating our agreement to a restriction.

7.Right to Request Confidential Communications

You have the right to request, in writing, that we use alternate means or an alternative location to communicate with you in confidence about your PHI. For instance, you may ask that we contact you by mail rather than by telephone, or at work rather than at home. Your written request must clearly state that the disclosure of all or part of your PHI at your current address or that the method of contact we have on record could be an endangerment to you. We will require that you provide a reasonable alternate address or other method of contact for the confidential communications.

8.Right to a Paper Copy of This Notice

You have the right to receive a paper copy of our Notice of Privacy Practices. You can request a copy at any time, even if you have agreed to receive this Notice electronically.

9.Right to File a Privacy Complaint

If you believe your privacy rights have been violated, or if you are dissatisfied with our privacy practices or procedures, you may file a complaint with The Skin Docs's Privacy Office and/or with the U.S. Secretary of the Department of Health and Human Services. The Skin Docs assures you that filing a complaint will not in any way impact the services we provide to you, nor will there be any retaliatory acts against you.

10.If you feel the need to interact with us on any issues related to this Notice or to file a privacy complaint with us, you may contact the Privacy Office as follows:

Privacy Officer
Clear Choice Dermatology LLC

My signature below affirms that I have read and understand this consent, and that all of my questions have been answered.

Witness Signature Date

Patient / Agent / Guardian Signature Date

clearchoice DERMATOLOGY

MIPS DOCUMENTATION EVERY 3 MONTHS

MIPS ARE A GOVERNMENT REQUIRED PROGRAM DESIGNED TO PROVIDE OUR PATIENTS WITH THE BEST CARE POSSIBLE.
WE APPRECIATE YOU UPDATING MIPS EVERY 3 MONTHS.

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____

- **Can we send your Biopsy Results to your Primary Care Physician?** ☐ **No**, WHY ☐I don't have a PCP ☐Refuse
  ☐ **Yes**, **PCP Name:** _____

- **Have you been diagnosed with Melanoma?** ☐ **No** ☐ **Yes:** Diagnosed ☐< 5 years ago ☐> 5 years ago Date/s:_____
  If Yes, seen by same surgeon this year for recurrence? ☐ **No** ☐ **Yes**, Provider Name:_____

- **Do you smoke Tobacco?** ☐ **No** ☐ **Yes** ☐ **Former**
  If Yes, did you receive tobacco cessation counseling within the past year? ☐ **No** ☐ **Yes**

- **Did you provide or review your current medication list?** ☐ **No** ☐ **Yes**

- **Immunizations for Adolescents (11-18 years old)?** ☐ **N/A**
  - Have you received Tdap vaccine between ages 10-13? ☐ **No,** WHY ☐Refuse ☐Allergies ☐ **Yes**
  - Have you received 1 dose meningococcal vaccine between ages 11-13 ☐ **No,** WHY ☐Refuse ☐Allergies ☐ **Yes**
  - Have you received 3 HPV vaccine between ages 9-13 ☐ **No,** WHY ☐Refuse ☐Allergies ☐ **Yes**

- **For patients 60-years-or older:** Do you have an Advance Care Plan? ☐ **N/A** ☐ **No** ☐ **Yes -** If yes, answer below
  - Do you want CPR (resuscitation) if your heart stops? ☐ **No ("Do not Resuscitate)** ☐ **Yes**
  - Do you wish to have a breathing tube if needed to save your life? ☐ **No ("Do Not Intubate)** ☐ **Yes**
  - Do you have a Living Will? ☐ **No** ☐ **Yes**
  - Do you have a Healthcare Proxy (a person who makes medical decisions if you cannot)? ☐ **No** ☐ **Yes**
  - If yes, Name and Phone number: _____

- **For patients with psoriasis or dermatitis. Are you itchy?** ☐ **N/A**
  ☐ **No** ☐ **Yes,** how severe on scale 1-10 _____

- **For patients on biologic medications:** ☐ **N/A**
  - Are you taking Skyrizi, Humira, Dupixent, Taltz, Cosentyx, or Stelara?
    ☐ No ☐ Declined ☐ Contraindications
    ☐ Yes: Started: ☐< 6 MTh ago ☐> 6 MTh ago ☐ Therapy Change Request
  - TB Test Results – Last Performed Date: _____
    ☐ Negative ☐Positive w/no evidence
    ☐No Results of TB Screen ☐ Unknow

CREDIT CARD ON FILE AUTHORIZATION

Clear Choice Dermatology offers a Credit Card on File program as a convenient method of paying for the portion of your services that are patient responsibility such as copay, deductible, and co-insurance. Your credit card information will be kept confidential and secure. After 30 days, the debit/credit card on file will be automatically charged for an outstanding balance. In the case the card has reached its limit, the patient will have an additional 60 days to arrange payment before the bill is forwarded to a collection agency.

I (we), the undersigned authorize and request that Clear Choice Dermatology charge my credit card for the balance due that my health plan has identified as my financial responsibility. This authorization relates to all charges not covered by my insurance company for services provided to me by Clear Choice Dermatology. My card will remain securely stored for future use my ModMed Pay, a secure credit card processor that partners with Clear Choice Dermatology to collect payments. This authorization will remain in effect until revoked by me in writing.

Patient's name: _____ DOB: _____

☐ **Please keep my credit card on file and charge my account to pay for charges not paid by my insurance plan**

☐ **I decline to have my card saved on file.**

*If you want your credit card on file, please fill out questions below:

Credit card information:

Card type: ☐Visa ☐MasterCard ☐Discover

Is this card a Flexible Spending/Health Savings card? ☐Yes ☐No

Card number ending in (las 4 digits):_____ (Full card number will be entered in the system or saved upon payment)

Expires: _____ Cardholder name: _____

Card's bill to address: _____

Transactions type: AUTHORIZATION

☐Email receipt to: _____

☐Mail receipt

_____***: Patient/Guardian signature***

Date: _____

Office Use:
Authorization received by: _____ Office location: _____

CONSENT TO DISCLOSE HEALTH INFORMATION:

ANY INFORMATION WILL NOT BE RELEASED TO PERSONS NOT LISTED BELOW

Can we speak to:	Yes	No	Name:	Address:	Phone number:
Primary Care Physician	☐	☐			
Referring Physician	☐	☐			
Pharmacy	☐	☐			

I give Clear Choice Dermatology, their clinicians (physicians, NPs, PAs) and staff, authorization to disclose my protected health information to the following family, friends, persons with power of attorney and/or facility or caregivers:

Name:	Phone Number:	Relationship to Patient:

**In the event Clear Choice Dermatology may need to communicate your test results or medical information via telephone, please check all communication options below that may be used:

- ✓ **ANY THAT APPLY**
- ☐ Only speak to YOU directly
- ☐ Leave a detailed voice message on your:
  ☐Cell Phone Number ☐Home Phone Number ☐Other: _____

****THE AUTHORIZATION IN THIS FORM EXPIRES:** ☐Never ☐One Year from Today

Please check only ONE of the following:

- ☐ I allow Clear Choice Dermatology to share my sensitive health information as noted above per the communication options checked on this form.
- ☐ I DO NOT allow Clear Choice Dermatology to share my sensitive health information with anyone but myself.

My contact information below is up to date: (If patient is minor, enter Guardian information)

Patient Name:		DOB:	
Mailing Address:		Phone Number:	

_____***Patient/Guardian Name***

_____*Date*

Guardian Name: _____ Phone number: _____ Relationship:_____

By signing above, I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment or healthcare operations as cited in the Notice of Privacy Practices.

I understand that authorizing the disclosure of this health information is voluntary. Clear Choice Dermatology and it entitles will not condition treatment, payment, enrollment, or eligibility for benefits on providing, or refusing to provide this authorization. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy Practices. *PLEASE ASK US IF YOU WOULD LIKE A COPY OF OUR PRIVACY PRACTICE POLICY