VANGUARD
DERMATOLOGY

Patient Information

Name _____ Date of Birth: _____

Address _____

City, State and Zip _____

Social Security No _____ Male ❑ Female ❑

Home # _____ Mobile #_____

Emergency Contact _____ Relationship _____

Home # _____ Mobile # _____ Work # _____

Payment Agreement

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED FOR "YOUR PART" (DEDUCTIBLES, CO-PAYMENT AND PAYMENT) OF THE CHARGES INCURRED. Your signature below indicates that you understand and accept this policy. We accept cash, checks, and Visa/Mastercard/AmEx.

Private Insurance:

I herein authorize payment of medical benefits to Vanguard Dermatology when an assigned claim is submitted. I understand and accept that if my primary insurance only covers a portion of my services, I will be responsible for the remaining balance. If I do not have a secondary insurance plan, I will be responsible for the balance.

Medicare:

I request that payment of authorized Medicare benefits be made on my behalf for any services furnished by Vanguard Dermatology Providers. I authorize Vanguard Dermatology to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

Signature of Patient / Legal Guardian **X**_____

Date _____ Patient Relationship to Policy Owner: ❑Self ❑Child ❑Spouse

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of Vanguard Dermatology's Notice of Private Practices (effective July 1, 2005) detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction (if any) concerning the use of my personal information:

Signature _____ Date _____

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Medical Information

Name _____ Date _____

Reason for visit _____

Referred by _____

Primary Care Physician / Tel # / Address _____

Pharmacy name and Tel # _____

Medications

(List all current medications including prescriptions, over-the counter meds, vitamins, and herbal supplements):

1 _____ 2 _____ 3 _____

4 _____ 5 _____ 6 _____

Medical History

Basal Cell Carcinoma	❑Yes	❑No	Asthma	❑Yes	❑No
Squamous Cell Carcinoma	❑Yes	❑No	Atopic dermatitis (eczema)	❑Yes	❑No
Melanoma	❑Yes	❑No	Seasonal allergies	❑Yes	❑No

Other _____

No drug allergies ❑ Allergies (List all medication allergies): _____

Surgical History _____

Hospitalization _____

Family History

Basal Cell Carcinoma	❑Yes	❑No	Asthma	❑Yes	❑No
Squamous Cell Carcinoma	❑Yes	❑No	Atopic dermatitis (eczema)	❑Yes	❑No
Melanoma	❑Yes	❑No	Seasonal allergies	❑Yes	❑No

Other _____

Social History

Occupation _____

Tobacco: ❑Yes ❑No ❑Occasionally Alcohol: ❑Yes ❑No ❑Occasionally

Difficulty swallowing	❑Yes	❑No	Wheezing / difficulty breathing	❑Yes	❑No
Musculoskeletal/joint pain	❑Yes	❑No	Fever	❑Yes	❑No
Lower leg edema/swelling	❑Yes	❑No	Chest pain/angina	❑Yes	❑No
Weight loss	❑Yes	❑No	Special diet	❑Yes	❑No
Stomach pain or heartburn	❑Yes	❑No	Currently pregnant	❑Yes	❑No

Signature _____ Date: _____

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Consent for Treatment /
Authorization for Release of Medication Information

I authorize Vanguard Dermatology to treat me and/or provide medical services for me, or for the minor in my care.

I authorize Vanguard Dermatology to release information requested by my insurance company or any of its agents. I also authorize Vanguard Dermatology to furnish my primary care physician, referring physician or other treating medical professional any and all information that may be requested regarding my physical or mental condition, treatment rendered by my Vanguard Dermatology Provider, or any records or results. This authorization shall remain in force until revoked in writing by the undersigned.

Signed (Patient or Responsible Party)

_____ Date_____

Staff Witness Name and Signature

_____ Date_____

Consent for Communication of Information

In addition to release of information as authorized above (Authorization for Release of Medical Information), and in the interest of confidentiality and compliance with HIPAA (Health Insurance Portability and Accountability Act), I authorize the release of information as it pertains to my care to the following individuals:

Name
_____Relationship _____Tel#_____

Name
_____Relationship _____Tel#_____

For the purpose of communicating test results, prescription refill requests, and other information, please provide us with acceptable ways of reaching you:
Vanguard Dermatology may leave messages only: (please check all that apply)

- ❑ On my home answering machine #_____
- ❑ On my cell phone voicemail #_____

I have the right to revoke and change my consent options as listed above. When circumstances change regarding my response or communication options, I will submit written changes, revocations, limitations, and restrictions to Vanguard Dermatology, attn: Nicole Dial, 2148 Ocean Avenue 5th Floor, Brooklyn NY 11229. Without written communication that makes changes to the acceptable methods of communicating information, Vanguard Dermatology will not be held liable for leaving messages or test results on the methods of communication listed above.

Signed (Patient or Responsible Party)

_____ Date_____

Internal use only:
Patient or Responsible Party refusal to sign any of the above acknowledgements:
Information presented on (date) _____ Time _____

Staff Name _____ Signature_____

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Informed Consent for Biopsy

Patient_____

I hereby authorize my Vanguard Dermatology Provider to perform the following procedure on me:

Biopsy

I recognize that, during the course of the biopsy, unforeseen conditions may necessitate additional or different procedures than those set forth above. I further authorize that my Vanguard Dermatology Provider or their assistant perform such procedures that are, in their professional judgment, necessary and desirable.

I consent to administration of local anesthesia to be given by or under the direction of the above doctor. I am aware of the risks of this procedure include the following:

- bleeding, infection, scarring (including keloid formation)
- darkening or lightening of pigmentation which can be temporary or permanent
- temporary (rarely permanent) loss of sensation / numbness to the area
- pain or discomfort
- possible need for additional procedures

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of the operation of procedure.

After this procedure, I agree to cooperate with the above doctor in my own care until completely discharged.

By signing below, I understand and agree that laboratory and pathology services are covered by Vanguard Dermatology's INSURANCE INFORMATION AND FINANCIAL POLICY and that I am entitled to a copy of this policy upon request.

Patient Signature _____ Date: _____

Staff Signature_____

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Notice of Privacy Practices

This notice describes how medical information about you may be used disclosed and how you can get access to this information. Please READ this carefully in its entirety.

Treatment

Your health information may be used by staff members or disclosed to other health care professions for the purpose of evaluating your health, diagnosis medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professions who may provide treatment or who may be consulted by staff members.

Payment

Your health information may be used to seek payment from your health plan. For example, your health plan may request and receive information on the dates of service, the services provided, and the medical condition being treated. You are required to provide Vanguard Dermatology with your health insurance coverage information, automobile and workers compensation (if applicable). If you do not want us to share your health information, you must provide Vanguard Dermatology with an alternative method for payment for services rendered (cash, check or credit card only).

Law Enforcement

Your health information may be requested by and disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Health Care Operations of Vanguard Dermatology

Your health information may be used to inform, evaluate and insure the quality of health care in the day-to-day operations of this medical practice.

Public Health Reporting

Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's health department.

Other Uses and Disclosures Require Your Authorization

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing use of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not retroactively affect any disclosure of information that occurred prior to your written revocation.

Additional uses of information

Your health information may be used by the Vanguard Dermatology staff to send you appointment reminders. Your health information may be also used to send you information on the treatment and management of your medical condition that you may find to be of interest.

Individual Rights

You have rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your protected health information.
2. The right to receive confidential communications concerning your medical condition and treatment.
3. The right to inspect and copy your protected health information.
4. The right to amend or submit corrections of your protected health information.
5. The right to receive an accounting of how and to whom your protected health information has been disclosed.
6. The right to receive a printed copy of this notice.

This medical practice, known as **Vanguard Dermatology,** is required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice. As permitted by law, we reserve the right to amend or modify our policies and practices. These changes in our policies and practices may be required by changes in federal and state law and regulations. Whatever the reason for the revision, we will provide you with a revise notice on your next office visit. Revised policies and practices will be applied to all protected health information that we maintain in our files.

Request to inspect information

As permitted by federal law, we require that requests to inspect or copy protected information be submitted in writing.

Complaints

If you would like to submit a comment or complaint about our privacy notices, or suspect violation, you may do so by outlining your concerns in writing. Please address this correspondence to the main branch of Vanguard Dermatology.

EFFECTIVE DATE OF THIS NOTICE IS JULY 1, 2005

IF YOU WOULD LIKE A COPY OF OUR PRIVACY PRACTICES, PLEASE ASK OUR RECEPTIONIST.