HIPAA & Financial Consent Notice of Receipt - Patient/Parent/Legal Guardian

I am the patient, or the parent or legal guardian of the patient listed below, of Sheftel & Associates Dermatology, LLP dba HealthySkin Medical & Cosmetic Dermatology. I hereby acknowledge receipt of HealthySkin Medical & Cosmetic Dermatology's Notice of Privacy Practices (Privacy Practices & HIPAA Consent, V2, 05.15.2015) and Financial Consent (Financial Consent, V2, 05.15.2015).

By acknowledgement of receipt of the financial consent, I hereby authorize direct payment of surgical/medical benefits to HealthySkin Medical & Cosmetic Dermatology for services rendered by any providers of such group. Patient agrees to pay for all medical services not paid for by insurance coverage.

It is practice policy to charge a $25 "no show" fee for all general dermatology appointments, a $100 "no show" fee for surgical procedures in the general dermatology department, and a $100 "no show" fee for surgeries in the Mohs department. There will be a $50 "no show" fee applied to any services in our cosmetic department. "No Show" is defined as an appointment not kept (missed) or cancelled or rescheduled with less than 24 hours' notice.

I understand that by accepting a patient appointment, I am agreeing to the cancellation/"no-show" policy.

_____ _____

Name of Patient (please print) Date of Birth

_____ _____

Signature of Patient or Personal Representative Date

HEALTHY SKIN DERMATOLOGY MEDICAL & COSMETIC

Consent to Treatment of Minors

We cannot legally treat a minor child, anyone under the age of 18 years of age, without a signed consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Patient Name: _____Date of Birth (DOB): _____

To allow for treatment of patients who are considered minors, it is necessary for a parent or legal guardian to give consent for treatment. You must be present at your child's **initial visit** sign the parental consent below. In the event that a minor child presents for a non-urgent appointment without a parent, legal guardian, or signed consent, treatment may be denied.

I am the

____Parent
____Guardian
____Other person having legal custody _____ of the above listed minor.

(Describe legal relationship, please print)

Special Permissions: This agreement is required in order for the minor child to be seen and treated without the parent/legal guardian present.

_____(Initials) **Unaccompanied**: I grant permission to treat and provide any healthcare services to my child that the

provider deems necessary for treatment, if my child arrives at the office unaccompanied. I understand that minors cannot make decisions without the parent or agent being present and that any new medical decisions that need to be made cannot be done at any appointment where my child is unaccompanied and will require a follow-up visit with myself, or an appointed guardian, present with my child. **This shall be in effect until: _____ (Date) or _____ expires 1 year from date of signature.**

_____ (Initials) **Accompanied by Others**: If I am unable to accompany my child to the appointment, the below listed

individuals have my permission to accompany my child and make medical decisions regarding my child. I understand that this authorization is given in advance of any specific diagnosis, treatment, or care being required, but is given to provide authority to the below-named agent to give consent to any and all such diagnosis, treatment, or hospital care which a licensed doctor or physician assistant recommends.

I hereby authorize the following individual(s) to act as my agent (please print):

Name: _____ Phone: _____ Relationship to Patient: _____

Name: _____ Phone: _____ Relationship to Patient: _____

These authorizations shall remain in effect until I revoke it in writing and present this document to the practice or the minor reaches the age of 18 years. By signing below, I certify that I have read the above information and have had any questions answered. My signature also certifies my understanding and agreement with the above information.

Signature: _____ Date/Time: _____

Print Name: _____

Witness to Signature: _____ Date/Time: _____

Print Name: _____

_____/_____ Received by Office
Date/Initials

Authorization to Release Health Information

The confidentiality of your health information is very important to us. We recognize that you may want certain family, close friends or caregivers to have access to your medical records. Please list the names, relationship to you, and phone numbers of anyone who has your permission to have access to your medical records. This information is not limited to but includes appointments, billing information, test results, medication, problem and allergy lists. If you have a durable health care power of attorney, please provide a copy of this document to our office as well.

Patient/Representative may revoke or modify this specific authorization at any time, and that revocation or modification must be in writing.

I, _____, hereby give my permission for my physician's office, Sheftel & Associates Dermatology, LLP dba HealthySkin Medical & Cosmetic Dermatology, to disclose my Protected Health Information for purposes of communicating my medical condition, to communicate results, findings and care decisions, medication, problem, and allergy lists, appointments, billing information, and/or any other relevant information to (*please print*):

Name: _____ Relationship:_____
Phone:_____

Name: _____ Relationship:_____
Phone:_____

Name: _____ Relationship:_____
Phone:_____

Please note: we cannot share your Protected Health Information with any family, friends, or caregivers unless their name is listed on this sheet. Please be sure to list all persons you would like to give permission for us to disclose your Protected Health Information to above.

By signing below, I am giving my permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the person(s) listed above. *I am also acknowledging it is my responsibility to notify HealthySkin Medical and Cosmetic Dermatology of* ***any*** *changes to the communication permissions I have given in this document, in writing, as soon as possible.*

_____ _____
Patient Name (Please Print) Date of Birth

_____ _____
Patient Signature Today's Date

_____ _____
If patient is a minor, parent or legal guardian's signature Today's Date

---

To be completed by HealthySkin Medical & Cosmetic Dermatology Staff:

_____ Note entered in chart
(staff initials)

HealthySkin History and Intake Form

Name: _____ Date of Birth: _____ Height: _____ Weight: _____

Occupation: _____ Hobbies: _____

If you are a new patient, how were you referred to us? _____

Past Medical History: *(Please circle all that apply)*

Atrial fibrillation	Hepatitis B	Hyperthyroidism	Pacemaker	Seizures
Anxiety	Hepatitis C	Hypothyroidism	Defibrillator	Radiation Treatment
Diabetes	HIV/AIDS	Heart Attack	COPD	Rheumatoid Arthritis
End Stage Renal Disease	Hypertension	Stroke	Hearing Loss	GERD
Depression	Asthma	High Cholesterol	BPH	Coronary Artery Disease

History of Cancer (Other Than Skin Cancer): _____ None

Do you have any issues with: *(Please circle all that apply)* Healing Bleeding Scarring Immunosuppression

Do you have any allergies/sensitivities to the following? : Adhesives Latex Lidocaine Epinephrine Neosporin/Bacitracin

YOUR Skin Disease History: *(Please circle all that apply)*

Basal Cell Skin Cancer
Squamous Cell Skin Cancer
Precancerous Spots/Moles
Actinic Keratoses
Melanoma - Location: _____ Year: _____

YOUR FAMILY History of Skin Disease: *(Please circle all that apply)*

Basal Cell Skin Cancer Squamous Cell Skin Cancer Melanoma Yes, skin cancer type unknown

If you do have family history, which family member? _____

Do you wear sunscreen? Yes No Do you tan in a tanning salon? Yes No Not anymore

If yes, what SPF? _____

Past Surgical History: *(Please circle all that apply)*

Heart Valve Replacement
Coronary Artery Bypass
Joint Replacement - Site and year: _____
Organ or Bone Marrow Transplant: _____

Please list additional surgeries and their approximate date: _____

_____

Females Only, Are You: Pregnant Breastfeeding

Medications: *Please list all current medications/vitamins/herbs, including the dosage, how often you take them, and how (ex: by mouth, etc). If more space is required, please see our Front Desk for a separate Medication Form.*

_____

_____

_____

Allergies: *Please list all allergies and the reaction you experience to each.*

_____

_____

Cigarette Smoking:	Alcohol Use:		Substance Abuse:
Never smoked	Yes	# of Drinks Per Day: _____	Yes
Quit: former smoker	No		No
Smokes less than daily			
Smokes daily			

Is it ok to leave a detailed message with anyone else? No Yes If so, with whom? _____

Pharmacy: _____ Cross Streets: _____

Zip code: _____ _____