Arizona Dermatology Specialists, PLLC
contactus@azdermatologyspecialists.com

14800 W. Mountain View Blvd., Suite 160
Surprise, AZ 85374
(623) 584-3376
Fax: (623) 584-3375

13090 N. 94th Drive, Suite 101
Peoria, AZ 85381
(623) 584-3376
Fax: (623) 584-3375

PATIENT REGISTRATION (Please Print)

SS#: _____ - _____ - _____ PATIENT'S NAME: _____
(Last Name) (First Name) (Middle Initial)

DATE OF BIRTH: _____/_____/_____ SEX: (M / F) MARITAL STATUS: (S / M / W / D)
(Month) (Day) (Year)

RACE/ETHNICITY: _____ PRIMARY LANGUAGE: _____

PERMANENT ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIP: _____

LOCAL ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: (_____) _____–_____ CELL PHONE #: (_____) _____–_____

WORK PHONE #: (_____) _____–_____ EMAIL ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____ PCP PHONE #: (_____) _____–_____

HOW DID YOU HEAR ABOUT US?: _____

PRIMARY INSURANCE

Ins. Co. Name: _____

Policy #: _____ Group #: _____

SECONDARY INSURANCE

Ins. Co. Name: _____

Policy #: _____ Group #: _____

★ **EMERGENCY CONTACT**

- NAME: _____ DATE OF BIRTH: _____/_____/_____

RELATIONSHIP TO YOU: _____ CONTACT PHONE #: (_____) _____–_____

PARENT/GUARDIAN NAME(IF PATIENT IS MINOR): _____ DATE OF BIRTH: _____/_____/_____

★ **WHO MAY RECEIVE INFORMATION REGARDING YOUR PROTECTED HEALTH INFORMATION?**

- NAME: _____ DATE OF BIRTH: _____/_____/_____

RELATIONSHIP TO YOU: _____ CONTACT PHONE #: (_____) _____–_____

May we leave messages regarding test results and appointments on your answering machine or other voice mail?

(Check One) ☐ YES ☐NO

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

DATE:_____ **SIGNATURE:** _____
Circle One (PATIENT / PARENT / GUARDIAN)

IF YOU HAVE TWO INSURANCE COMPANIES PLEASE PRESENT BOTH CARDS SO THAT WE MAY FILE WITH YOUR SECONDARY CARRIER FOR ANY BENEFITS DUE TO YOU.

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Name: _____

DOB: _____/_____/_____

Date: _____/_____/_____

New Patient History & Intake Form

Past Medical History: (please circle all that apply)

Anxiety	Hepatitis
Arthritis	Hypertension
Artificial Joints	HIV/AIDS
Asthma	Hypercholesterolemia
Atrial Fibrillation	Hyperthyroidism
BPH (Benign Prostatic Hyperplasia)	Hypothyroidism
Bone Marrow Transplantation	Leukemia
Colon Cancer	Lung Cancer
COPD (Emphysema)	Pacemaker
Coronary Artery Disease	Radiation Treatment
Depression	Seizures
End Stage Renal Disease	Stroke
GERD (Acid Reflux)	Valve Replacement
Hearing Loss	None

Other (Including any other type of cancer or any other problems you see a doctor for): _____

_____

Past Surgical History: (please circle all that apply)

Appendix Removed	Kidney Biopsy
Bladder Removed	Kidney Removed (left or right)
Mastectomy (Left, Right, Bilateral)	Kidney Stone Removal
Lumpectomy (Left, Right, Bilateral)	Kidney Transplant
Breast Biopsy (Left, Right, Bilateral)	Ovaries Removed: Endometriosis
Breast Reduction	Ovaries Removed: Cyst
Breast Implants	Ovaries Removed: Ovarian Cyst
Colectomy: Colon Cancer Resection	Prostate Removed: Prostate Cancer
Colectomy: Diverticulitis	Prostate Biopsy
Colectomy: IBD	TURP
Gallbladder Removed	Skin Biopsy
Coronary Artery Bypass	Basal Cell Carcinoma Surgery
PTCA	Squamous Cell Carcinoma Surgery
Mechanical Valve Replacement	Melanoma Surgery
Biological Valve Replacement	Spleen Removed
Heart Transplant	Testicles Removed (Left, Right, Bilateral)
Joint Replacement, Knee (Left, Right, Bilateral)	Hysterectomy (Fibroids)
Joint Replacement, Hip (Left, Right, Bilateral)	Hysterectomy (Uterine Cancer)
Joint Replacement within the last 2 years	None

Other: _____

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Name: _____

DOB: _____/_____/_____

Date: _____/_____/_____

Skin Disease History: (please circle all that apply)

Acne	Hay Fever/Allergies
Actinic Keratoses	Melanoma
Asthma	Poison Ivy
Basal Cell Carcinoma	Precancerous Moles
Blistering Sunburns	Psoriasis
Dry Skin	Squamous Cell Carcinoma
Flaking or Itchy Scalp	None

Other: _____

Do you wear Sunscreen? Yes No

If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)?_____

Medications: (Please enter all current medications, including the dose, if you know)

_____

_____

_____

_____

_____

Allergies: (please enter all medical allergies)

_____

_____

_____

_____

_____

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Name: _____

DOB: _____/_____/_____

Date: _____/_____/_____

Social History: (please circle one)

Cigarette Smoking

Never Smoked
Quit: Former Smoker
Smokes less than daily
Smokes daily

Alcohol Use Per Day

0-1
1-2
3+

How often do you exercise?

Once a day
A few times a week
A few times a month
Never

What is your caffeine use?

Once a day
A few times a week
A few times a month
Never

Patient Data: (please circle one)

Race:

White
Black/African American
Asian
American Indian/Pacific Islander
Other

Ethnicity:

Hispanic/Latino
Non-Hispanic/Latino
Other:_____

Preferred Language:

English
Spanish
Other:_____

Pharmacy:

Name: _____

Cross Streets: _____

Zip code/City: _____

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OFFICE POLICIES

In effort to make your visit with us as easy as possible we ask that you make note of the following office policies. We thank you in advance for your cooperation.

- Please notify us of any changes to the following at the time of your visit:
    1. Address
    2. Insurance Information
    3. Medical illness, injury, or surgery since your last visit
    4. Medications added or discontinued since the last visit
    5. Telephone number and cell phone number

- Please notify us of any appointment cancellation at least 48 hours in advance. We realize that circumstances may change and we are happy to accommodate your changing schedule. However, if you miss any appointments without contacting us prior to the missed appointment(s) we may assess you a missed appointment charge of fifty dollars ($50.00) for any routine appointments or a charge of one hundred dollars ($100.00) for any missed surgery appointments. Multiple no-shows, last minute cancellations, or reschedules may result in termination from our practice.

- We make every effort to minimize your wait time in the office and keep our providers on schedule. To that effect, we make courtesy calls to confirm your upcoming appointment in the days prior. The purpose of these confirmation calls is for us to have a better idea of our patient load for the day. Failure to confirm your appointment with us may result in your appointment slot being double-booked in anticipation of you possibly not showing up for your appointment. This could result in a longer wait time for you to see the doctor.

- Please allow 48 hours for prescription refill requests to be completed. Please note that we will not fill or refill any prescriptions for narcotic medications.

- All co-pays and deductibles are due at time of the visit. There will be a $30.00 returned check charge.

- There is a $25.00 fee for the completion of additional paperwork (cancer/disability policies, etc.).

- Assignment of Insurance Benefits: I hereby give authorization for payment of insurance benefit to be made directly to Arizona Dermatology Specialists, PLLC for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize my healthcare provider to release all information necessary to secure payment of benefits.

Sincerely,

The Staff
Arizona Dermatology Specialists, PLLC

Patient Acknowledged

Date: _____/_____/_____ Print Name: _____

Signature: _____

Notice of Privacy Practices

Effective: April 14, 2003

Contact: Privacy Officer (Operations Manager)

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.

Arizona a Dermatology Specialists, PLLC is required by law to maintain the privacy of protected health information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.

Assigning Privacy and Security Responsibilities: It is the policy of this medical practice that the Privacy Officer is assigned the responsibility of implementing and maintaining the Health Insurance Portability & Accountability Act (HIPAA) Privacy and Security Rule's requirements. Furthermore, it is the policy of this medical practice that this individual will be provided sufficient resources and authority to fulfill their responsibilities.

Minimum Necessary Use and Disclosure of Protected Health Information for Treatment, Payment and Health Operations: It is the policy of this medical practice that for all routine and recurring uses and disclosures of PHI except for uses or disclosures made 1) for treatment purposes, 2) to or as authorized by the patient or 3) for payment, 4) for health care operations, 5) as required by law and for HIPAA compliance such uses and disclosures of protected health information must be limited to the minimum amount of information needed to accomplish the purpose of the use or disclosure. It is also the policy of this medical practice that non-routine uses and disclosures will be handled pursuant to established criteria. It is also the policy of this organization that all requests for protected health information (except as specified above) must be limited to the minimum amount of information needed to accomplish the purpose of the request.

We will use your health information for treatment: For example: Information obtained by your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment: For example: A bill may be sent to you or a third-party payer. This information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedure and supplies used. We will use your health information for regular health operations. Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Appointment Reminders: We may use and disclose medical information to contact and remind you about appointments, if you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone. Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Judicial and Administrative Proceedings: We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

Specialized government functions: We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

Coroners/Funeral Directors: We may disclose health information to funeral directors/coroners consistent with applicable law to carry out their duties. Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing and controlling disease, injury, or disability.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Arizona a Dermatology Specialists, PLLC will abide by the following policies regarding patient privacy practices: We will have the most current notice of privacy practices available for distribution at our reception desk.

Business Associates must be contractually bound to protect health information to the same degree as set forth in the policy. It is also the policy of this organization that business associates who violate their agreement will be dealt with first by an attempt to correct the problem, and if that fails by termination of the agreement and discontinuation of services by the business associate.

Prohibited Activities: No Retaliation or Intimidation—no employee or contractor may engage in any intimidating or retaliatory acts against persons who file complaints or otherwise exercise their rights under HIPAA regulations. It is also the policy of this organization that no employee or contractor may condition treatment or payment on the provision of an authorization to disclose protected health information except as expressly authorized under the regulations.

Certification of Identity of all persons who request access to protected health information will be verified before such access is granted.

Deceased Individuals: privacy protections extend to information concerning deceased individuals.

Mitigation: effects on any unauthorized use or disclosure of protected health information will be mitigated to the extent possible.

Safeguards will be in place to reasonably safeguard protected health information from any intentional or unintentional use or disclosure that is in violation of the HIPAA Privacy Rule. These safeguards will include physical protection on premises of PHI, technical protection of PHI maintained electronically and administrative protection. These safeguards will extend to the oral communication of PHI. These safeguards will extend to PHI that is removed from this organization.

Training and Awareness: all employees have been trained on the policies and procedures governing protected health information and how this medical practice complies with the HIPAA Privacy and Security Rules.

Retention of Records: The HIPAA Privacy Rule which requires records retention of at least six years will be strictly adhered to.

Regulatory Currency: we remain current in our compliances program with HIPAA regulations.

Cooperation with Health/Privacy Oversight Authorities: Agencies such as the Office for Civil Rights of the Department of Health and Human Services will be given full support and cooperation in their efforts to ensure the protection of health information within this organization. It is also the policy of this organization that all personnel must cooperate fully with all privacy compliance review and investigations.

Understanding Your Health Record/Information: Each time you visit Arizona a Dermatology Specialists, PLLC, a record of your visit is made. Typically, this record contains your symptoms, examination and procedure results. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment by your physician.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you receive.
- Means by which you or a third-party can verify that services billed were actually provided.
- A tool for educating health professionals.
- A source of information for public health officials charged with improving the health of this state and nation.
- A tool with which we can assess and continually work to improve the care we render.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

Your Health Information Rights: Although your record is the physical property of Arizona a Dermatology Specialists, PLLC, this information belongs to you. You have the right to: Obtain paper copy of this notice of information practices upon request. Inspect and copy your health records as provided for in 45 CFR 164.524. Amend your health record as provided in 45 CFR 164.528.

- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528.
- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522.

It is a requirement that the above requests be in writing. You may request a change in your record; however, we are not required to agree with your requests.

It is the policy of this medical practice that we will adopt, maintain and comply with our Notice of Privacy Practices, which shall be consistent with HIPAA and Arizona law.

Our Responsibilities: Arizona a Dermatology Specialists, PLLC is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,

Abide by the terms of this notice,

- Notify you if we are unable to agree to requested restrictions, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change we will notify you on your next visit.

We will not use or disclose your health information without your written authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received written revocation of the authorization according to the procedures included in the authorization.

Arizona a Dermatology Specialists, PLLC will utilize every reasonable means to protect your health information; however charts may occasionally be visible in the office or transferred from one internal facility to another. Also, patient information may be visible on computer screens, and although we exercise great care in fax and email transmissions, we cannot guarantee that it will not go to an incorrect recipient.

Complaints: Complaints about this notice or how this medical practice handles your health information should be directed to the Privacy Officer listed in the front of this notice.

If you are not satisfied with the manner in which this office handles complaints, you may submit a formal complaint to:

Department of Health and Human Services Office of Civil Rights
Hubert H. Humphrey Bldg. 200 Independence Ave., SW Room 509f HI-IN Building
Washington, DC 20201

You will not be penalized for filing a complaint.

Received and Read:

Date: _____/_____/_____

Patient Name: _____

Signature: _____

Arizona Dermatology Specialists, PLLC

PHOTOGRAPHY PERMIT/CONSENT

I hereby authorize Arizona Dermatology Specialists, Dr. James O. Barlow, Dr. Jesse M. Olmedo, and/or their designate(s) to take photographs and/or video images of my skin condition before, during, and after treatment. I understand that these photographs are important to document and follow my progress throughout the treatment process. These photographs may be used for research, educational, scientific purposes, including publication. In such an event, I will not be identified by name.

I further state that at the time of the execution of consent, that I am fully aware of the pictures to be taken and the uses, as above described, to which they are to be put, and that all questions with respect to the taking of the pictures and the use thereof have been fully explained to me and to my complete satisfaction by personnel of Arizona Dermatology Specialists, PLLC.

Date: _____/_____/_____

Print Name: _____

Signature: _____