DERM PATIENT REGISTRATION

THE SKIN WELLNESS CENTER

Date _____ Who are you seeing today? _____

Patient's Full Name (legal) _____ Patient # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work _____Cell Phone _____ Email _____

Preferred Primary Phone Number? Home ☐ Work ☐ Cell ☐ Where may we leave messages? Home ☐ Work ☐ Cell ☐

Birth Date _____Age _____SS# _____ Sex: M F Marital Status _____ Full Time Student _____

All minors must be accompanied by a parent or legal guardian

Occupation _____ Employer/School _____ Phone _____

Spouse Name _____ Employer_____Phone _____

Spouse Birthdate_____ SS# _____

Race _____ Preferred Language_____ Ethnicity (Hispanic/Not Hispanic)_____

Notify in Emergency _____ Phone_____ Relationship _____

Referring Doctor_____ Primary Care Physician_____

FINANCIAL RESPONSIBILITY (if different than above)

Name _____ Birthdate _____ Phone _____ SS# _____

Address _____ City _____ State _____ Zip_____

Employer _____ Phone _____ Relationship to Patient _____

INSURANCE – PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

Primary Insurance Carrier _____ Effective Date _____

Subscriber's Name _____ SS# _____ Birthdate _____ Relation _____

Secondary Insurance Carrier _____ Effective Date _____

Subscriber's Name _____ SS# _____ Birthdate _____ Relation _____

INITIAL

_____ I consent to treatment necessary for the care of the above named patient.

_____ I authorize the release of all medical records to the referring or treating physicians and to my insurance company, if applicable.

_____ I allow fax transmittal of my medical records if necessary.

_____ I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.

_____ If this account becomes past due, I agree to pay all reasonable collection costs. If legal action is required to collect this account, I agree to pay all attorney fee and court costs.

_____ I further authorize and request that insurance payments be made directly to The Skin Wellness Center, should they elect to receive such payment.

_____ I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

_____ I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices.

Please note:

Photos of you may be taken before and after each procedure to capture treatment outcomes. Any photos taken will become part of your medical record only and will not be shared or used in any other way without your express written permission.

Is there anyone you would like to give us permission to speak to? _____Relation_____

Signature: _____ Date: _____

DERM MEDICAL HISTORY

THE SKIN WELLNESS CENTER

Patient Name: _____ Date: _____ Patient Acct #: _____

Reason for today's visit: _____ Referring Physician (if any): _____

MY PHARMACY: Name: _____ Location _____ Phone _____

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list:

_____

List all medications, vitamins, and herbals you are currently taking:

_____

_____

_____

Do you have now, or have you ever had diseases or conditions of:

	Yes	No
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heart Beat	☐	☐
Pacemaker	☐	☐
Phlebitis	☐	☐
Have you had or have you been exposed to HIV (AIDS)?	☐	☐
Depression/Anxiety	☐	☐
Mood or Behavioral Disorder	☐	☐

If yes, please specify: _____

Other Systemic:

	Yes	No	If yes, please specify:
Diabetes: please specify type 1 or 2	☐	☐	_____
Thyroid: please specify hypo or hyper	☐	☐	_____
Kidney	☐	☐	_____
Bladder	☐	☐	_____
Bowel	☐	☐	_____
Hepatitis	☐	☐	_____
Glaucoma	☐	☐	_____
Arthritis / Joint Deformity	☐	☐	_____
Convulsions, Epilepsy or Seizures	☐	☐	
Fainting	☐	☐	
Herpes (fever blisters)	☐	☐	

Other medical conditions not listed: _____

How often do you use a tanning bed? ☐ Never ☐ Occasionally ☐ Frequently ☐ Have used in the past

How often do you use sunscreen? ☐ Never ☐ Occasionally ☐ Frequently

Have you ever had skin cancer? ☐ Yes ☐ No If yes, what type? _____ How long ago? _____

Has an immediate family member had melanoma? ☐ Yes ☐ No If yes, who? _____

Do you have a history of any specific skin diseases? ☐ Yes ☐ No If yes, please list: _____

Do you have a history of MRSA? ☐ Yes ☐ No

Please list the last date of the following:

- Last flu vaccine _____
- Last pneumonia vaccine _____
- Last colonoscopy _____
- Pap smear _____
- Mammogram _____

Have you ever had local anesthesia? ☐ Yes ☐ No If yes, any bad reaction? ☐ Yes ☐ No

How tall are you? _____ ft. _____ in. How much do you weigh? _____ lbs.

Do you smoke? ☐ Yes ☐ No If yes, how much? _____ If no, have you ever smoked? ☐ Yes ☐ No

Do you bleed easily? ☐ Yes ☐ No

Are you pregnant or breast feeding? ☐ Yes ☐ No If pregnant, what is your due date? _____

Do you have artificial joint(s)? ☐ Yes ☐ No

What is your occupation? _____

What are your hobbies? _____

Our Dermatologists provide a wide range of skin rejuvenation products and services. Please let our staff know if you are interested in learning about these.

_____ _____

Signature of Patient or Patient's Representative **Date**

PRACTICE INFORMATION

THE SKIN WELLNESS CENTER

Patient Name _____ Date _____ Patient # _____

Your Appointment

Your time is important to us. Your appointment time was scheduled based on the **reason you gave us** when you scheduled your appointment. If you have additional problems or need to discuss additional concerns with your provider, we may have to schedule another appointment to address these problems/concerns. This will allow us to be considerate of all our patients' time. **Please bring your insurance card and be prepared to preset it at ***every*** appointment

Cancellation/No-show Policy

We respectfully ask for 24 hours' notice if you will be unable to keep an appointment. Multiple no-shows in a row may result in discharge from the practice.

Not showing for a cosmetic service appointment may incur a no-show fee or loss of deposit.

Late Arrivals

Out of respect for other patients arriving on time, if you arrive late, with or without notice, you may be asked to reschedule. It is at the discretion of your care provider whether you can be worked back into the schedule. Being worked back into the schedule will result in a longer wait time.

Co-pays and Fees for Service

All out-of-pocket charges, co-payments and charges for cosmetic procedures are expected at time of visit.

Your Prescriptions

Unless you request a written prescription to take with you after your visit, prescriptions are sent electronically to your pharmacy. We suggest you call your pharmacy to make sure your prescriptions are ready before going to pick them up.

Insurance companies often change their list of "preferred drugs". We try very hard to keep current with these changes. If your prescription is rejected by your insurance because it is not on their "preferred list", additional time will be required for approval of a substitute medication.

Lab

We participate only with Dermatopathology Partners for all biopsy samples. Your insurance will be billed by Dermatopathology Partners, and you are responsible to Dermatopathology Partners for any balance due after insurance.

For all other labs (blood work, urine samples) we use PathGroup which participates with most insurances. If your insurance plan requires you to use a different lab, please notify us at the time of your visit.

Consent to Treat Minors

Minors, persons under the age of 18, must be accompanied by a parent or legal guardian for all appointments. If it is necessary for a minor to come to appointments alone or with a friend or family member, we must have a statement ***in writing*** from a parent or legal guardian giving us permission to treat your child without the parents' presence.

__First visit__: A parent or legal guardian ***must accompany a minor patient to the first visit in our office. We have a form for consent to treat a minor that we can provide upon request for future appointments. The parent that brings the child in for the initial appointment will automatically be the guarantor for the account and must be able to present a photo ID and the patient's insurance card.

I acknowledge that I have read and understand the above statements and all questions have been answered to my satisfaction.

_____ _____

Signature of Patient or Patient's Representative Date

Please tell the receptionist if you would like a copy of this form for your own files.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. • We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information at the bottom of this notice. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

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 the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory. **we do not create or manage a hospital directory* *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 unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes **we do not create or maintain psychotherapy notes at this practice*
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

To treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Example: We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	*Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we 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 have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Other Uses and Disclosures

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 • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can 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 an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • 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 health information about you in response to a court order or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Who will follow this notice?

This Notice of Privacy Practices applies to The Skin Wellness Center and any of its workforce members authorized to create medical information which may be used for purposes such as treatment, payment, and healthcare operations. These workforce members may include:

- All departments and units of The Skin Wellness Center
- Any member of a volunteer group
- All employees, staff and other personnel
- Any entity providing services under The Skin Wellness Center's direction and control will follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment, or healthcare operational purposes described in this notice

If you have any questions about this Notice of Privacy Practices, please contact:

Privacy Officer: Crystal Myers
Phone Number: (865)584-8580
Email: cmyers.swc@gmail.com

The Skin Wellness Center
10215 Kingston Pike, Suite 200
Knoxville, TN 37922
www.theskinwellnesscenter.net

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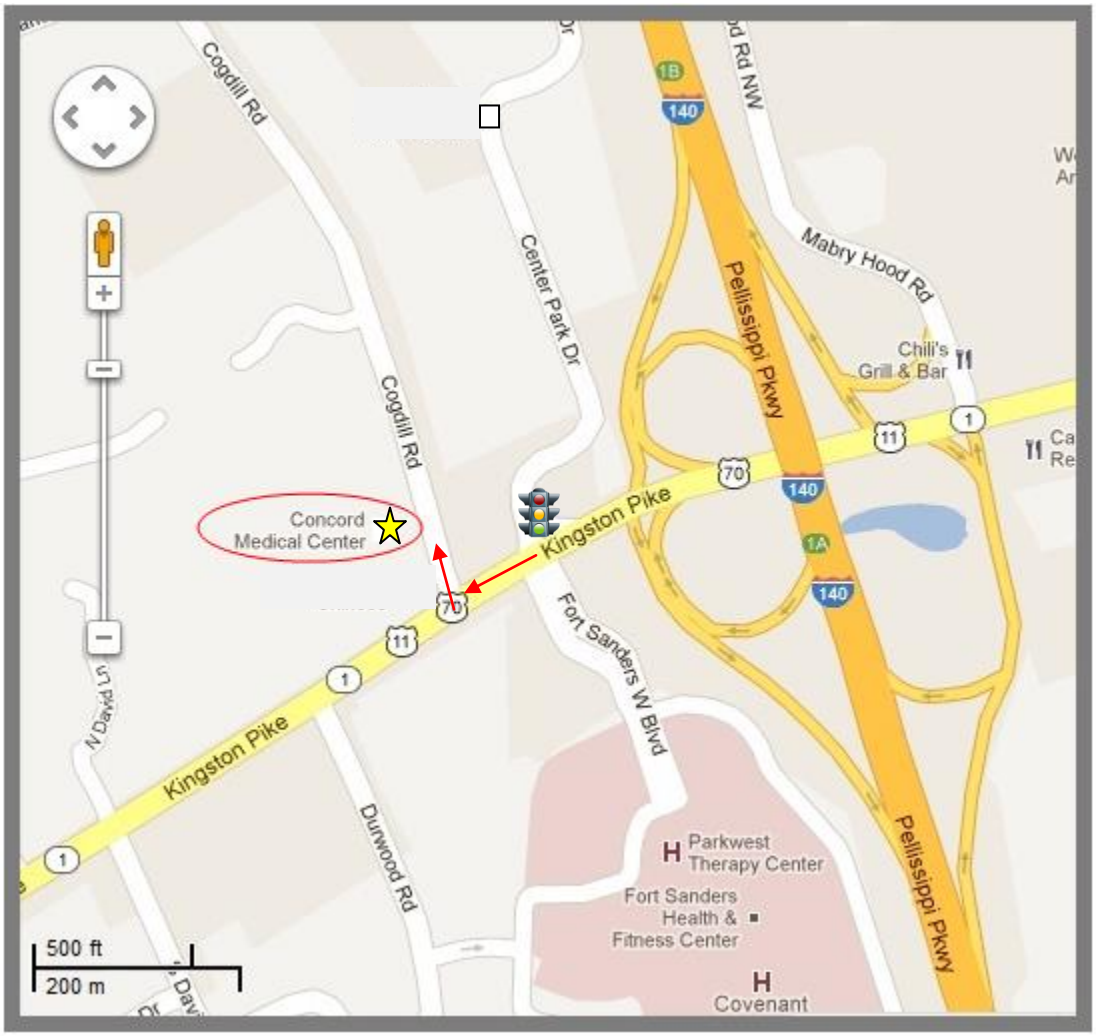

Our office is located at

10215 Kingston Pike, Suite 200, Knoxville, TN 37922

From **I-40** both East and West

Take **Exit 376B South** toward Maryville

Then take **Exit 1B West** onto Kingston Pike

Go through the red light at Center Park Drive

Turn right on **Cogdill Road**

Our office is located on the left at **Concord Medical Center**

We are on the **2nd floor**