Dermatology Associates of Macomb-Oakland, PC

Today's Date: _____/_____/_____
MRN: _____

PLEASE PRINT

PATIENT INFORMATION

Patient Name: _____ **Date of Birth**: _____/_____/_____
First Middle Last

Preferred Prefix: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. **SEX:** ☐ Male ☐ Female **Social Security Number:** _____-_____-_____

Preferred Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced **Preferred Spoken/Written Language:** ☐ English ☐ Other: _____

Address: _____
Street Address City State Zip

Preferred Contact Number: (_____)-_____-_____ ☐ Home ☐ Work ☐ Cell

Alternate Contact Number: (_____)-_____-_____ ☐ Home ☐ Work ☐ Cell

Email Address: _____

I authorize my provider and/or clerical and clinical staff to leave a message on my given contact method regarding:
- ☐ **Non-Medical Information**
- ☐ **Medical Information**
- ☐ **All of the Above**

Dermatology Associates of Macomb-Oakland, PC utilizes an automated appointment reminder system utilizing email, telephone, and text messaging, that is automatically initiated when an appointment is created. You will be solely responsible for any text message or data rates associated with text messaging. You have the option to opt out of text messaging at any time. Access information to your patient portal will automatically be sent to the email provided.

PRIMARY INSURANCE		SECONDARY INSURANCE	
Name of Insurance Policy		Name of Insurance Policy	
Policy Holder Name		Policy Holder Name	
Policy Holder Date of Birth		Policy Holder Date of Birth	
Relationship to Patient		Relationship to Patient	

FINANCIALLY RESPONSIBLITY ☐ **Patient (Self)**

Name of Financially Responsible Party: _____ Relationship to Patient: _____

Financially Responsible Party Date of Birth: _____ Financially Responsible Phone Number: (_____) -_____-_____

EMERGENCY CONTACT ☐ Same As Financially Responsible Party

NAME: _____ Relationship to Patient: _____ Phone Number: (_____) -_____-_____

PRIMARY CARE PROVIDER AND PREFERRED PHARMACY

PCP: Primary Care Physician (Family Doctor or Provider): _____ Phone: (_____) _____-_____

Preferred Pharmacy Name: _____ Phone: (_____) _____-_____

Pharmacy City and Crossroads: _____

How did you hear about us? ☐ PCP Referral ☐ Family/Friend ☐ Google/Internet Search ☐ Facebook/Instagram ☐ Other_____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my provider and/or clerical and clinical staff to disclose my protected health information to:

☐ Myself Only ☐ My Parent(s) (Specify Name(s)) _____

☐ My Spouse or Significant Other (Specify Name) _____

☐ Other (Specify Name and Relationship to Patient) _____

Type of protected health Information to be disclosed: ☐ **All Information** ☐ Lab or Pathology Results ☐ Diagnosis ☐ Medications

By signing below and/or by receiving services from Dermatology Associates of Macomb-Oakland, PC (DAMO) you agree to and acknowledge the following: I acknowledge that the provided information on this form is current and accurate, I agree to receive treatment from DAMO, I understand that the information above and these authorizations shall be in force and effective until they are updated or revoked by me in writing, at which time these authorizations will expire. I understand that I have the right to revoke these authorizations at any time by submitting written notification to DAMO. I acknowledge that I have received or reviewed the following documents and agree to abide by all policies and procedures of DAMO: Notice of Privacy Practices and Patient Financial Responsibility Statement. I acknowledge that these documents can be found online at dermatologistnoviwarren.com/patient-information or I may request a paper copy in the office.

Signature: _____ **Date:** _____/_____/_____

Relationship to Patient:

☐ Self ☐ Parent, Printed Name: _____ ☐ Legal Guardian, Printed Name: _____

DERMATOLOGY ASSOCIATES OF MACOMB-OAKLAND, PC

MEDICAL HISTORY FORM

Today's Date: _____/_____/_____

Patient Name: _____ **DOB:** _____ /_____ /_____ **HEIGHT:** _____ **WEIGHT:** _____

MEDICAL HISTORY

Check any of the following medical conditions that you have/had or are currently being treated for: ☐ **None**

- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Cancer: _____
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ Hearing Loss
- ☐ Heart Attack / Stroke YEAR: _____
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hypertension (High Blood Pressure)
- ☐ Hyperthyroidism (Overactive Thyroid)
- ☐ Hypothyroidism (Underactive Thyroid)
- ☐ Pacemaker or Implanted Heart Device
- ☐ Radiation Treatment, Body Location: _____
- ☐ Renal Disease
- ☐ Seizures/Epilepsy
- ☐ Other: _____

SURGICAL HISTORY *(Check all that apply)*

- ☐ None
- ☐ Pacemaker or Implanted Heart Device
- ☐ Artificial Valve Replacement (Mechanical or Biological)
- ☐ Organ Transplant: _____ (List organ and year)

Joint Replacement:

- ☐ Right or Left Knee (circle one or both) Year: _____
- ☐ Right or Left Hip (circle one or both) Year: _____
- ☐ Other: (List joint, right or left, and year): _____

SKIN HISTORY *(Check all that apply)*

- ☐ Actinic Keratosis (AK)
- ☐ Precancerous Moles
- ☐ Basal Cell Skin Cancer
- ☐ Squamous Cell Skin Cancer
- ☐ Melanoma Skin Cancer

Do you wear sunscreen?

- ☐ Yes, SPF _____
- ☐ No

Do you tan in a tanning bed?

- ☐ Yes
- ☐ No

Has anyone in your family had a melanoma skin cancer?

- ☐ Yes, Their relationship to you: _____
- ☐ No

CURRENT MEDICATIONS AND ALLERGIES

List All Current Medications: (If you have a list please give that to reception and we will make a copy)

☐ None

List: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES ***(Check all that apply and list reaction)***

- ☐ None
- ☐ Penicillin _____
- ☐ Sulfa _____
- ☐ Keflex _____
- ☐ Codeine _____
- ☐ Erythromycin _____
- ☐ Tetracycline _____
- ☐ Other allergies:

_____

_____

_____

_____

FEMALE PATIENTS:

Are you currently using oral contraceptives, a contraceptive patch, or a contraceptive implant? (Birth Control)

- ☐ YES
- ☐ NO

Is there any chance that you are pregnant at this time?

- ☐ YES
- ☐ NO

IMMUNIZATIONS

Do you get your flu shot annually?

- ☐ YES
- ☐ NO

Adults 65 and older: Did you get your pneumonia vaccine?

- ☐ YES
- ☐ NO

Did you get your COVID vaccine?

- ☐ YES, (Month/Year): _____
- ☐ NO

SOCIAL HISTORY

Alcohol intake:

- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

Smoking status:

- ☐ Never
- ☐ Former
- ☐ Current
- ☐ If current or former, how many cigarettes do/did you smoke per day? _____

Recreational Drug Use Status:

- ☐ Never
- ☐ Former
- ☐ Current
- ☐ If current or former, what drug and how often do you use? _____

Signature of Patient, Parent, or Legal Guardian: _____ **Date:** _____/_____/_____

Dermatology Associates of Macomb-Oakland, PC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.
We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and receive a copy your PHI. A fee may be applied for resources associated with copy requests.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of November 2017 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer Suzanne Somers, (Phone: 248-380-8900) for more information, in person or in writing. If you would like a printed copy of the Notice of Privacy Practices for your records, please ask.

DERMATOLOGY ASSOCIATES OF MACOMB-OAKLAND, PC

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing Dermatology Associates of Macomb-Oakland, PC (DAMO) for your dermatology needs. The medical services you seek imply a financial responsibility on your part which obligates you to ensure payment in full for the services and or products you receive. To assist in your understanding of that financial responsibility, we ask that you read this statement regarding our billing and insurance policies carefully and reach out to our staff or billing team with any questions. Our billing department is available Monday – Friday and we make every effort to assist you in reconciliation of any insurance or billing issues. To reach the billing department please call the main office number and press option 2 for the billing department.

1. You are ultimately responsible for all payment obligations arising out of services received or products provided by DAMO. You are responsible for deductibles, co-payments, coinsurance amounts, or any other patient responsibility indicated by your insurance carrier or our financial policies, which are not otherwise covered by supplemental insurance. Any outstanding account balances must be settled prior to being seen for your next appointment.
2. You are responsible for knowing your insurance policy. You are also responsible for knowing if your health plan requires prior authorization or referral by a Primary Care Provider (PCP) before receiving services at DAMO (we are specialists). If you are not familiar with your plan coverage, we recommend you contact your insurance carrier or plan provider directly.
3. You will be required to follow all registration procedures, which may include updating or verifying personal information and presenting verification of identification and current insurance policies.
4. Payment is required at the time of service, in full, for all of the following reasons, but not limited to; your insurance requires a prior authorization and you have not obtained one, DAMO does not participate with your insurance carrier and is considered “out of network”, you insurance carrier has deemed the services being received not medically necessary and/or not covered, you do not have or are unable to provide DAMO with proof of your health insurance plan, you do not have a health insurance plan. If you are not prepared to pay for services in full your visit may be re-scheduled by DAMO.
5. Your balance owed will be billed to the financially responsible party at the address provided during the registration process, payment remittance is due within 30 days of receipt of your billing statement.
6. Any balance over 90 days past due will be referred to our collection agency and your account will be charged an additional fee, which is 30% of the total balance past due.
7. **A fee will be charged for missed or canceled appointments without 24 hours’ notice** at the discretion of the practice. The fee is $50.00 for 15-minute appointments, and $75.00 for 30(plus) minute appointments or procedure/surgery appointments.
8. If any payment is made directly to you for services billed by us, you agree to promptly submit payment to DAMO until your patient account is paid in full.
9. If you make a payment that results in a surplus on your account, you authorize DAMO to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family’s, or dependent’s account. Any remaining surplus in the amount of $10.00 or more will be returned to the payor.
10. We accept online, cash, check, or credit card payment. If payment by check is returned or declined for any reason your account will be charged a fee of $25.00. Online payment may be made at dermatologistnoviwarren.com by clicking the “Pay My Bill” link.

DERMATOLOGY ASSOCIATES OF MACOMB-OAKLAND, PC

THE PATIENT-SPECIALIST PROVIDER PARTNERSHIP AGREEMENT

As specialty providers our mission is to improve our patients' dermatologic health by providing high quality patient-centered care with excellence. This can be achieved when we work with both you, the patient, and your Primary Care Provider, your Patient Centered Medical Home, to maintain your health and wellness. Thank you for choosing to partner with Dermatology Associates of Macomb-Oakland for your dermatologic needs, below you will find your responsibilities as our patient as well as our responsibilities as your specialty provider.

Patient's Responsibilities:

- Make and keep all appointments recommended by our office. If you must cancel an appointment, make every attempt to reschedule it as soon as possible.
- Ask questions, share your feelings, and be part of your care.
- Be honest about your history, symptoms, and other important information about your health.
- Make healthy decisions about your daily habits and lifestyle.
- Follow through with recommended testing and contact the office if you cannot get these tests completed.
- Participate and commit to the treatment plan developed by you and your provider or other health professionals.
- Be sure you understand the treatment plan. If you do not understand, ask questions until you feel comfortable with the agreed upon treatment plan.
- Tell us immediately if you are not able to follow the treatment plan for any reason so we can assist you in adjusting the plan, so you get the best results.
- Follow up with your Primary Care Provider for your overall healthcare needs.

Specialty Provider's Responsibilities:

- Our office will strive to schedule your appointment as soon as possible, keeping in mind the goals and recommendations of your Primary Care Provider.
- Explain diseases, treatments, and results in an easy-to-understand way.
- Provide instruction on how to self-manage your condition and assist you with establishing goals for this condition.
- Keep treatments, discussions and records private.
- Provide 24-hour access to medical care and same day appointments, whenever possible.
- Provide instruction on how to meet your health care needs when the office is not open.
- Communicate regularly with your Primary Care Physician, making sure that we receive and provide information to coordinate your care.
- To care for you to the best of our abilities based on our understanding of current medical methods available.
- When necessary, direct and coordinate your care through referrals to appropriate community resources.
- End every visit with clear instructions about your diagnosis, expectations, treatment goals, and future plans.

Hours of Operation:

Novi Office Location:	**Warren Office Location:**
M: 9:00 – 5:00pm	M: 9:00 – 4:15pm
T: 7:30 – 4:00pm	T: 7:30 – 3:30pm
W: 7:30 – 3:15pm	W: 7:30 -3:00pm
TH: 7:30 – 3:15pm	TH: 9:30 – 5:00pm
F: 7:00 – 2:30pm	F: 7:30 – 11:30am

All hours of operation may fluctuate depending on holidays and changes in the providers schedules.
The Novi office location is open select Saturdays each month.

If you have an urgent medical matter after business hours, that cannot wait until the next business day, you may reach the provider on call through our provider directory on our closed telephone recording until 9:30pm daily. If you have a non-emergent issue that can be treated within an Urgent Care Setting and it is after 9:30 PM, I will refer you to:

PrimeCare Urgent Care of Novi	**Or**	**Warren Urgent Care**
39555 W 10 Mile Rd #301, Novi, MI 48375		31700 Van Dyke, Warren, MI 48093
8am – 6pm M-F, Sat 9am – 2pm		10am – 8pm Daily

Or you may choose to go to an urgent care facility closer to your home.

Community Services Available to you:

NEED HELP? 2-1-1 is now available. Dial 211 from any phone and you will be connected to a referral hotline that can connect you with non-profit agencies in your area that can help with human health and social needs. (Ex: utilities, housing, health insurance, food, diapers, etc.) A listing of the area resources can also be found at mi211.org

Ask us about our patient portal.

Our web-based patient portal supports two-way, secure and compliant communication between patient and provider.

Thank you,
Dermatology Associates of Macomb-Oakland, PC