KNOXVILLE INSTITUTE OF DERMATOLOGY

Pt #: ___________
*(Internal use only)*

## PATIENT INFORMATION

Social Security #: ____________________________________

First Name: ______________________________ MI: _______

Last Name: ________________________________________

Sex: ____________ Date of Birth: _____________________

Address: ___________________________________________

____________________________________________________

City: ______________________ State: _____ Zip: __________

Primary Phone #: (_______)____________________________

Cell Phone #: (_______)_______________________________

Email Address: _______________________________________

Marital Status *(circle one)*: Single Married Divorced Widowed

Race/Ethnicity: Asian Native American White Black/African American Hispanic/Latino Non-Hispanic/Latino Other

Language: English Spanish Other

Employment: Full-time Part-time Retired Student Other

Employer: _____________________________________

Primary Care Physician: ___________________________

Referring Physician: ______________________________

How did you hear about us? _________________________

## PRIMARY INSURANCE

Card Holder's Name: _________________________________ Date of Birth: ______________________

Relationship: _______________________________________ Employer: __________________________

## SECONDARY INSURANCE

Card Holder's Name: _________________________________ Date of Birth: ______________________

Relationship: _______________________________________ Employer: __________________________

## EMERGENCY CONTACT

First Name: ______________________________________ Last Name: ______________________________

Relationship: _____________________________________ Phone #: (_________)______________________

## GUARANTOR INFORMATION

*(If patient is disabled or a minor.)*

First Name: ____________________________ MI: ______ Last Name: _____________________________

Relationship: _________________________________ Phone#: (________)______________________________

Social Security #: ______________________________ Sex: ______________ Date of Birth: ____________________

## RELEASE

*Signature Required*

Authorization to release information and pay benefits to physician: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to the physician or the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described, responsible to pay non-covered services.

X_____________________________________________________________________________________

*Patient Signature (parent signature if minor)* *Date*

PATIENT NAME: ______________________________ DOB: ____________________

## HIPAA CONSENT: AUTHORIZATION TO REVEAL MEDICAL AND BILLING INFORMATION

I authorize Knoxville Institute of Dermatology, PLLC and staff to reveal to the following individuals, as needed, information regarding my protected health information and billing information. I understand that once this information is disclosed to these individuals, Knoxville Institute of Dermatology, PLLC will not have responsibility over to whom these individuals reveal this information. I may revoke this authorization by giving written notice to Knoxville Institute of Dermatology, PLLC.

Name: ______________________________ Relationship: ____________________

Name: ______________________________ Relationship: ____________________

Name: ______________________________ Relationship: ____________________

**LAB/BIOPSY RESULTS:** I authorize the staff of Knoxville Institute of Dermatology, PLLC to notify me of my **normal** and/or **benign labs and/or biopsy results** via:

Voicemail of primary phone number

**NO SHOW POLICY**: Our physicians and staff work very hard to meet the needs of our patients. We kindly ask that you give **24-hour notice** if you need to cancel your appointment. As a courtesy, we attempt to make confirmation calls 48 hours in advance of your scheduled appointment, and we will attempt to leave a reminder message on your answering machine if there is no answer. However, you are responsible for notifying us if you will not be able to make it. A one-time consideration will be made for failure to show up for your appointment. Any no shows thereafter will be charged as follows:

- Routine office appointments: $20
- Cosmetic appointments: $75
- Surgeries: $100

Payment must be made before another appointment may be scheduled. Thank you for your understanding in this matter.

**FINANCIAL POLICY**: We have contracts with many insurance companies to accept assignment of benefits for our services, but we must have a valid insurance card on file in order to do this. If you cannot present a valid insurance card at the time of the visit, you will be charged as a private-pay patient You are responsible for knowing your insurance. **Your co-pay is expected at the time of your visit**. As a service to you we will file your insurance claim following your visit. You will be billed for any amount not covered by the insurance company, including deductibles, surgical/pathology deductibles, and co-insurance. Payment is due upon receipt of your statement.

I understand that each time I am seen in the office for evaluation and/or treatment, an office visit can be charged in addition to any other charges. We accept cash, check, Visa, MasterCard, and Discover. I request that payment of Medicare or other insurance company benefits be made to Knoxville Institute of Dermatology, PLLC for services provided. I authorize the release of any information needed for processing of this or and related claim(s). I will permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. I understand that all outside laboratory testing will be billed from the specific laboratories to me and/or my insurance company. I accept payment responsibilities if my insurance denies payment.

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**: I acknowledge that I have been given the Notice of Privacy Practices for Knoxville Institute of Dermatology, PLLC and understand the policies. I am aware that I may request a copy at any time.

SIGNATURE: ______________________________ DATE: ____________________
(patient or guardian)

KNOXVILLE INSTITUTE OF DERMATOLOGY

Date: ______________________________

## REVIEW OF SYSTEMS

PATIENT NAME: ____________________________________________ DOB: ______________________

Email: ____________________________________________________ SSN#: ______________________

Primary Care Physician: ____________________________________________________________

### CURRENT CONDITION *(check all that apply)*

- ☐ Problems with Bleeding
- ☐ Problems with Healing
- ☐ Problems with Scarring
- ☐ Rash
- ☐ Immunosuppression
- ☐ Hay Fever
- ☐ Chest Pain
- ☐ Fever or Chills
- ☐ Night Sweats
- ☐ Unintentional Weight Loss
- ☐ Thyroid Condition
- ☐ Sore Throat
- ☐ Blurred Vision
- ☐ Abdominal Pain
- ☐ Bloody Stool
- ☐ Bloody Urine
- ☐ Joint Aches
- ☐ Muscle Weakness
- ☐ Neck Stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Anxiety
- ☐ Depression

### CURRENT MEDICATIONS

______________________________________

______________________________________

______________________________________

______________________________________

______________________________________

### ALERTS

- ☐ Adhesive Allergy
- ☐ Lidocaine Allergy
- ☐ Topical Antibiotic Allergy
- ☐ Latex Allergy
- ☐ Artificial Heart Valve
- ☐ Artificial Joints (in the past 2 years)
- ☐ Blood Thinners
- ☐ Pacemaker/Defibrillator
- ☐ MRSA Staph Infection
- ☐ Pre-Procedure Medications
- ☐ Rapid Heartbeat w/ Epinephrine
- ☐ Pregnant or Planning a Pregnancy
- ☐ Breastfeeding
- ☐ Vagal Episodes
- ☐ Travel to West Africa (in the last 21 days)
- ☐ Contact with Ebola Virus
- ☐ HIV/AIDS
- ☐ Hepatitis

### OTHER ALLERGIES

______________________________________

______________________________________

______________________________________

______________________________________

______________________________________

### PREFERRED PHARMACY

Name: ________________________________

Address: ______________________________

City: ______________ State: _____ Zip: _________

KNOXVILLE INSTITUTE OF DERMATOLOGY

Date: ______________________

# HISTORY AND INTAKE

PATIENT NAME: ______________________________________ DOB: __________________________

## PAST MEDICAL HISTORY *(check all that apply)*

- ☐ None
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Emphysema (COPD)
- ☐ Depression
- ☐ Diabetes ☐ Type 1 ☐ Type 2
  Select Most Recent Hemoglobin A1C:
  ☐<7 ☐ 7 - 9 ☐ >9
- ☐ Acid Reflux (GERD)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Seizures
- ☐ Stroke
- ☐ Other: ________________________________
  ________________________________

## PAST SURGICAL HISTORY

- ☐ NONE
- ☐ Breast Surgery (R, L, Bilateral)
  Type: ____________________________
- ☐ Heart Bypass
- ☐ Heart Transplant
- ☐ Heart Valve Replacement
- ☐ Joint Replacement
  Type: ____________________________
- ☐ Kidney Biopsy
- ☐ Ovarian
- ☐ Uterine
- ☐ Other: ____________________________

## HISTORY OF SKIN DISEASE

- ☐ None
- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Carcinoma
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaky or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
- ☐ Other: ________________________________
  ________________________________

## RISK ASSESMENT

Family history of **melanoma**? ☐ Yes ☐ No
If so, which relatives? ____________________
____________________________________

Do you wear **sunscreen**? ☐ Yes ☐ No
If so, what SPF? ______________________

Do you tan in a **tanning salon**? ☐ Yes ☐ No

## SOCIAL HISTORY

**Smoking**:

- ☐ Never
- ☐ Previously, but I've quit.
- ☐ Sometimes (less frequent than daily)
- ☐ Often (daily)

**Alcohol Use**:

- ☐ No
- ☐ Yes – number of drinks per day: ____________

**Vaccinations:**

Current Flu Vaccination ☐ Yes ☐ No
Current Pneumonia Vaccination ☐ Yes ☐ No

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 personal 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 this 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 would include referring you to a retina specialist.
- 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.
- Heath 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 disclose your PHI for law enforcement and other legitimate reasons although 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.

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 across relying on your 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 communication of Protected Health Information by alternative locations.
- The right to inspect and copy your PHI.
- 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 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.

This notice is effective as of September 24, 2014 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPPA 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 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 office 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, in person or in writing, for more information at 6516 Kingston Pike, Knoxville, TN 37919.