DERMATOLOGY & LASER CENTER at Harvard Park

REGISTRATION FORM

PATIENT INFORMATION

□ Mr. □Miss □Mrs. □Ms. □ Dr.

Last Name: ______________________ First: ______________________ M.I.: ________

Address: ______________________________________ Apt. /Ste. #: ____________

City: ____________________ State: __________ Zip: __________

Marital Status: □ Single □ Married □ Divorced □ Legally Separated □ Widowed □ Unknown

Sex: □ M □ F DOB: ________________ SSN: ______________________

Phone Numbers: Home: ________________ E-mail: ______________________

Work: ________________ Ext.: ____________

Cell: ________________

□ None □ Primary Care Physician: ______________________________

Employer: ____

Employment Status: □ Full Time □ Part Time □ Unemployed □ Self Employed □ Retired □ Homemaker □ Student

Preferred Language: □English □ Spanish □ Other: ______________

Ethnicity & Race: □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ White □ Hispanic or Latino □ Unknown □ Other Race: ______________

RESPONSIBLE PARTY

Fill this section out only if information is different from above

Person Responsible for bill: ____________________ Is this person a patient here? □ Yes □ No

Address: ______________________________________ Apt. /Ste. #: ________

City: ____________________ State: __________ Zip: __________

Phone Numbers: Home: ______________ E-mail: ______________________

Work: ______________ Ext.: __________

Cell: ______________

INSURANCE INFORMATION

Primary Insurance Plan: ____________________ Subscriber ID: ____________ Group # ____________

Subscriber Name: ______________ Relationship to Subscriber: ______________ Subscriber's DOB: ______________

Copay: $ __________

Medical Claims Address

Address: ____________________________ City: ____________ State: ______ Zip: ________

Secondary Insurance Plan: ____________________ Subscriber ID: ____________ Group # ____________

Subscriber Name: ______________ Relationship to Subscriber: ______________ Subscriber's DOB: ______________

Copay: $ __________

Medical Claims Address

Address: ____________________________ City: ____________ State: ______ Zip: ________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize the Dermatology & Laser Center at Harvard Park, PLLC, or my insurance company to release any information required to process my claims.

____

Patient/Guardian Signature **Date**

DERMATOLOGY & LASER CENTER at Harvard Park

950 E. Harvard Ave, Ste. 440 • Denver, CO 80210 • Phone 303.744.2704 • Fax 303.744.3244 • www.DLCderm.com

Patient Name: ______________________________ **Date of Birth:** ______________

History and Intake Form

Current/Past Medical History: (please check all that apply)

☐ **None**
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Irregular Heartbeat
☐ BPH (Enlarged Prostate)
☐ Bone Marrow Transplant
☐ Breast Cancer
☐ Colon Cancer
☐ COPD (Pulmonary Disease)
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ End Stage Renal Disease
☐ GERD (Reflux)
☐ Hearing Loss
☐ Hepatitis
☐ Hypertension
☐ HIV/AIDS
☐ Hypercholesterolemia
☐ Hyperthyroidism (High)
☐ Hypothyroidism (Low)
☐ Leukemia
☐ Lung Cancer
☐ Lymphoma
☐ Prostate Cancer
☐ Radiation Treatment
☐ Seizures
☐ Stroke

Other ____

Skin Disease History: (please circle all that apply)

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

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 ones prescribed by our office)

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

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Drug Allergies: (please enter all allergies)

______________________________ ______________________________

______________________________ ______________________________

______________________________ ☐ No known allergies

Social History: (Please check all that apply)

☐ Drug Use
☐ Currently Smokes - Daily
☐ Currently Smokes – Other than Daily
☐ Has smoked in the past
☐ Has never smoked

Review of Systems: (please mark 'Yes' or 'No' for all of the following that apply)

	Yes	No
Pacemaker		
Defibrillator		
Artificial joints in past two years		
Artificial heart valve		
Premedication need prior to procedure		
Allergy to adhesive		
Allergy to topical antibiotic ointments		
Blood thinners (other than aspirin)		
Currently pregnant or planning a pregnancy (Women)		
Allergy to lidocaine		
Problems with scarring (hypertrophic or keloid)		

Other Symptoms: ______________________________

Pharmacy:

Pharmacy Name: ______________________________

Address: ______________________________

Phone number: ______________________________

EMERGENCY CONTACT INFO., NOTICE OF PRIVACY PRACTICES & PAYMENT POLICY

Patient Name: ________________________________ Today's Date: ______/______/______

EMERGENCY CONTACT INFORMATION:

In case of emergency, who should be notified? ______________________ Phone: (   ) ____________

May we leave personal medical information on your answering machine at home? ☐ Yes ☐ No

May we leave personal medical information on your cell phone? ☐ Yes ☐ No

Do you give our office permission to discuss your medical information with family members?

☐ Yes ☐ No If yes, please provide their names and phone numbers below.

Name: ________________________________ Relationship: ________________________

Primary Phone #: (   ) ____________________ Secondary Phone #: (   ) ____________________

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my provider's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature: ________________________ Date: ______/______/______

PAYMENT POLICY:

Insured Patients: You will be responsible for paying your annual deductible, co-insurance and copayment. All co-payments are due at the time of service. We accept cash, check, and money orders, as well as, MasterCard, Visa and Discover. Please remember that although we bill insurance claims, you are ultimately responsible for payment of all services rendered.

Self-Pay and Cosmetic Patients: Please note that payment for all self-pay and cosmetic services and procedures are due in full at the time of service.

Patient or Responsible Party Signature: ________________________ Date: ______/______/______

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Sharon Kluk. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, *(12.00 for first ten pages and 25 cents for every page after ten)* for each page and the staff time charged will be
$ *(25.00)* per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: Dermatology and Laser Center at Harvard Park, PLLC

Privacy Officer: Sharon Kluk

Phone: 303-744-2704 Fax: 303-744-3244

Address: 950 E Harvard Ave, Suite 440, Denver CO 80210