Intake Form

Coastal Dermatology

Name: _____

Date of Birth:_____ Sex ☐ Female ☐ Male Date: _____

Email: _____ Occupation:_____

Phone: _____ Okay to leave detailed messages at this number? ☐ Yes ☐ No

Referred By: _____ Primary Physician: _____

Preferred Pharmacy (Name and Location): _____

Reason for today's visit: _____

_____

HEALTH HISTORY

Past Medical History:

Anxiety ☐
Arthritis ☐
Asthma ☐
Atrial Fibrillation (Irregular Heartbeat) ☐
Benign Prostate Hypertrophy (BPH) ☐
Bone Marrow Transplant ☐
Breast Cancer ☐
Colon Cancer ☐
COPD ☐
Coronary Artery Disease ☐
Depression ☐
Diabetes ☐
End Stage Renal Disease ☐
GERD (Gastric Reflux) ☐
Hearing Loss ☐
Hepatitis B or C ☐
Hypertension (High Blood Pressure) ☐
HIV/AIDS ☐
Hypercholesterolemia (High Cholesterol) ☐
Hyperthyroidism ☐
Hypothyroidism ☐
Leukemia ☐
Lung Cancer ☐
Lymphoma ☐
Prostate Cancer ☐
Radiation Treatment ☐
Seizures ☐
Stroke ☐
Transplant of an organ ☐
*If yes, type*_____

List all other medical conditions: _____

Surgeries: Please list all surgeries you've had in the past 12 months. _____

_____

Past Skin Disease History

Acne ☐
Actinic Keratoses (Pre-Cancers) ☐
Basal Cell Skin Cancer (BCC) ☐
Blistering sunburns ☐
Dry Skin ☐
Eczema ☐
Flaking or Itchy Scalp ☐
Hay Fever/Allergies ☐
Melanoma ☐
Poison Ivy ☐
Precancerous Moles ☐
Psoriasis ☐
Squamous Cell Skin Cancer (SCC) ☐
Shingles ☐
Shingles Vaccine ☐
If yes, year _____

Family History of Non-Melanoma Skin Cancer
(Basal Cell Cancer, Squamous Cell Cancer)
_____
_____
_____

Family History of Melanoma ☐ Yes ☐ No
If yes, which relatives?
_____
_____
_____
_____

Other: _____

None ☐

Do you wear sunscreen? ☐ Yes ☐ No If yes, what SPF? _____ Do you tan in a tanning salon? ☐ Yes ☐ No

In accordance with the Federal Health Policy, please answer the following questions:

1. Have you EVER received a pneumonia vaccine? ☐ Yes ☐ No
2. Do you use tobacco products? ☐ Yes ☐ Formerly ☐ Never
3. Do you consume alcohol? ☐ Yes If Yes, # ____of drinks per_____
4. Do you have a surrogate Decision Maker ☐ Yes ☐ No
   If yes, please provide contact info: Name: _____ Phone:_____
5. Do you have a living will? ☐ Yes ☐ No
6. In the event you experience a cardiac event, which best describes your plan below:
   ☐ Do Not Intubate ☐ Do Not Resuscitate ☐ Full Cardiopulmonary Resuscitation

Current Medication List:

By **SIGNING BELOW** you hereby certify that you are allowing Coastal Dermatology, PLC to request your prescription history information from Surescripts for the purpose of providing direct health care services to you, the patient.

_____ _____

Signature of Patient or Legal Representative Witness Date

Are you **allergic** to any medications?

Name	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

SECTION II: REVIEW OF SYSTEMS

Check below any that apply:

- ☐ Allergy to adhesives
- ☐ Allergy to latex
- ☐ Allergy to topical antibiotic ointments
- ☐ Artificial heart valve
- ☐ Defibrillator
- ☐ Pacemaker
- ☐ Blood thinners
- ☐ HIV
- ☐ Artificial joints
- ☐ Hepatitis C
- ☐ Problems with local anesthesia
- ☐ Immunosuppression
- ☐ Fever or chills
- ☐ Night sweats
- ☐ Unknown weight loss or gain
- ☐ Sore throat
- ☐ Blurry vision
- ☐ Abdominal pain
- ☐ Bloody stool
- ☐ Bloody urine or kidney problems
- ☐ Anemia
- ☐ Blood clots
- ☐ Leg swelling
- ☐ Problems with bleeding
- ☐ Incontinence
- ☐ Problems with healing
- ☐ Problems with scarring (hypertrophic or keloid)
- ☐ Joint aches
- ☐ Muscle weakness
- ☐ Headaches
- ☐ Pregnancy or planning a pregnancy
- ☐ Fainting
- ☐ HSV
- ☐ Cough
- ☐ Shortness of breath

Educate yourself! **We are experts in Cosmetic Dermatology procedures! Please help us maintain the highest level of customer service by circling all that apply/interest you!**

☐ Hydrafacials	☐ Botox	☐ Dermal Fillers	☐ Chemical Peels
☐ Sclerotherapy	☐ Frown Lines	☐ Smile Lines	☐ Nasal Folds
☐ Fuller Lips	☐ Acne	☐ Brown Spots	☐ Aging Skin
☐ Spider Veins	☐ Loss of Firmness	☐ Loss of Elasticity	☐ Lack of Vibrancy
☐ Poor Skin Texture	☐ Oily Skin	☐ Clogged/Enlarged Pores	☐ Eye Puffiness
☐ Dark Circles	☐ Sun Protection	☐ Hair Restorative Health	☐ Neck Wrinkles

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.
- I acknowledge I understand how to obtain a copy of this.

_____ _____

Signature of Patient or Legal Representative Witness Date

Patient Name: _____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Coastal Dermatology (the Practice) to use and disclose my protected health information (PHI) to perform Treatment, Payment and health care Operations (TPO).

With this consent, Coastal Dermatology may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results. Person(s) you may release this information to:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked “Personal and Confidential.”

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

Patient Name: _____

Note: *This document is a template only. It does not reflect the requirements of your state’s laws. You should consult with advisors (your state or local medical or specialty society, or legal or other counsel) familiar with your state’s privacy laws prior to using this document.*

Consent for Minor Surgery, Biopsy & Cryotherapy

During your visit, the dermatologist may need to perform cryotherapy or a skin biopsy to treat or evaluate your skin condition. Please review and sign the consent form below. You will be given ample time to discuss the procedure if the doctor determines cryotherapy or a biopsy is necessary. This will serve as a standing consent for this and any and all future treatments, however verbal consent will always be obtained prior to any treatment.

PURPOSE:
A biopsy is a surgical procedure used to obtain a sample of tissue for microscopic examination to aid the physician in diagnosis. The entire lesion may not be removed in this procedure. Further medical or surgical treatment may be needed when the diagnosis is made.

cryotherapy is the use of liquid nitrogen to freeze the skin lesions that respond well to sub-zero temperatures. The process freezes potential skin cancers known as actinic keratosis or solar keratosis. The treatment is also used to freeze the virus infections that cause many common warts.

PROPOSED TREATMENT:
I understand that a biopsy requires obtaining a sample of tissue and is a surgical procedure. As in any surgical procedure, there are certain risks including bleeding, post-operative pain, nerve damage, infection, reactions to sutures, anesthetics or topical antibiotics, and scarring. Although all reasonable efforts will be made to minimize the possibility of these potential complications, no guarantees can be made since many factors beyond the control of the physician(such as the degree of sun damage or patient compliance with post-operative instructions) affect the ultimate healing.
A pathologist will examine the tissue obtained in this biopsy procedure. I understand I may receive a separate bill from the pathologist or laboratory for this microscopic examination.
Complications of applying liquid nitrogen to the skin may include:

- Irritation
- Redness
- Temporary discomfort
- Blistering
- Infection
- Permanent loss of pigmentation
- Hyperpigmentation

After the lesion has been treated, most patients develop a blister or scab that lasts for 1-2 weeks.

OTHER ACKNOWLEDGEMENT DISCLOSURE:
I am able to read and understand English. I understand that I will have the opportunity to discuss my procedure with the physician or other professional who is to perform the procedure and have all of my questions answered to my satisfaction.

PHOTOGRAPHIC CONSENT:
I AUTHORIZED AND CONSENT TO THE TAKING OF A SERIES OF PHOTOGRAPHS OF THE SURGICAL AREAS FOR THE USE OF Dr. Cahill, MD FOR DOCUMENTATION OR EDUCATIONAL PURPOSES.

I agree to not personally photograph or record any part of my procedure during my visit today. This includes by camera, tablet, or cellular device.

_____ _____
Patient Name: Patient Date of Birth

_____ _____
Patient Signature Date Agent / Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

This information is made available to all patients

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY HAVE ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY THE PRACTICE, WHETHER MADE BY THE PRACTICE OR AN ASSOCIATED FACILITY.

This notice describes our practices policies, which extend to:

Any health care professional authorized to enter information into your chart (including physicians, assistants, nurses, etc.);
All areas of the practice (front desk, administration, billing and collection, etc.);
All employees, staff and other personnel that work for or with our practice;
Our business associates (including a billing service, or facilities to which we refer patients), on-call physicians, and so on.
The Practice provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR THOUGHTS ABOUT YOUR PROTECTED HEALTH INFORMATION:
We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements. We are required by law to:

make sure that the protected health information about you is kept private;
provide you with ***Notice of our Privacy Practices*** and your legal rights with respect to protected health information about you; and
follow the conditions of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.
The following categories describe different ways that we use and disclose protected health information that we have and share with others. Each category of uses or disclosures provides a general explanation and provides some examples of uses. Not every use or disclosure in a category is either listed or actually in place. The explanation is provided for your general information only.

Medical Treatment. We use previously given medical information about you to provide you with current or prospective medical treatment or services. Therefore we may, and most likely will, disclose medical information about you to doctors, nurses, technicians, medical students, or hospital personnel who are involved in taking care of you. For example, a doctor to whom we refer you for ongoing or further care may need your medical record. Different areas of the Practice also may share medical information about you including your record(s), prescriptions, requests of lab work and x-rays. We may also discuss your medical information with you to recommend possible treatment options or alternatives that may be of interest to you. We also may disclose medical information about you to people outside the Practice who may be involved in your medical care after you leave the Practice; this may include your family members, or others we use or to whom we refer you to provide services that are part of your care. Unless clearly instructed to the contrary, we may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps to pay or pays for your care.
Payment. We may use and disclose medical information about you for services and procedures so they may be billed and collected from you, an insurance company, or any other third party. For example, we may need to give your health care information, about treatment you received at the Practice, to obtain payment or reimbursement for the care. We may also tell your health plan and/or referring physician about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment, to facilitate payment of a referring physician, or the like.

Operational Uses. We may use and disclose medical information about you so that we can run our Practice more efficiently and make sure that all of our patients receive quality care. These uses may include reviewing our treatment and services to evaluate the performance of our staff, deciding what additional services to offer and where, deciding what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Practices to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.
We may also use or disclose information about you for internal or external utilization review and/or quality assurance, to business associates for purposes of helping us to comply with our legal requirements, to auditors to verify our records, to billing companies to aid us in this process and the like. We shall endeavor, in all times when business associates are used, to advise them of their continued obligation to maintain the privacy of your medical records.

Appointment and Patient Recall Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with the Practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, e-mail, or otherwise and may involve the leaving an e-mail, a message on an answering machines, or otherwise which could (potentially) be picked up by others.
Others Involved in Your Care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes regarding medications, efficiency of treatment protocols and the like. All research projects are subject to an approval process, which evaluates a proposed research project and its use of medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the Practice. We will attempt to make the information non-identifiable to a specific patient but we cannot guarantee that we can always do this. We will endeavor to (but cannot guarantee we will) seek your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care with the Practice; provided, however that we will obtain your specific authorization if required by law.

Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.
To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Public Health Risks. Law or public policy may require us to disclose medical information about you for public health activities. These activities generally include the following:
to prevent or control disease, injury or disability;
to report births and deaths;
to report child abuse or neglect;
to report reactions to medications or problems with products;
to notify people of recalls of products they may be using;
to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
Investigation and Government Activities. We may disclose medical information to a local, state or federal agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the payor, the government and other regulatory agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. This is particularly true if you make your health an issue. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information requested if you so desire. We may also use such information to defend ourselves or any member of our practice in any actual or threatened action.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:
In response to a court order, subpoena, warrant, summons or similar process;
To identify or locate a suspect, fugitive, material witness, or missing person;
About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
About a death we believe may be the result of criminal conduct;
About criminal conduct at the Practice; and
In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Practice to funeral directors as necessary to carry out their duties.
Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

CHANGES TO THIS NOTICE
We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the Practice. The notice will contain on the first page, in the top right-hand corner, the date of last revision and effective date. In addition, each time you visit the Practice for treatment or health care services you may request a copy of the current notice in effect.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager, who will direct you on how to file an office complaint. All complaints must be submitted in writing, and all complaints shall be investigated, without repercussion to you.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.
Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission, unless those uses can be reasonably inferred from the intended uses above. If you have provided us with your permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

PATIENT RIGHTS
THIS SECTION DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THIS PRACTICE REGARDING THE USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION.
You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records, but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.To inspect and copy your medical record, you must submit your request in writing to our HIPAA Compliance Officer. Ask the front desk person for the name of the HIPAA Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies (tapes, disks, etc.) associated with your request.We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that our Compliance Committee review the denial. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome and recommendations from that review.

Right to Amend. If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the Practice maintains your medical record.To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to

amend. The amendment must be dated and signed by you and notarized.We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
Is not part of the medical information kept by or for the Practice;
Is not part of the information which you would be permitted to inspect and copy; or
Is inaccurate and incomplete.

Right to an Accounting of Disclosures. You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of medical information about you, to others for purposes other than treatment, payment or healthcare operations.To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) years back and may not include dates before April 14, 2004 (or the actual implementation date of the HIPAA Privacy Regulations). Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or friend). For example, you could ask that we not use or disclose information about treatment you received.We are not required to agree to your request and we may not be able to comply with your request. If we do agree, we will comply with your request except that we shall not comply, even with a written request, if the information is needed to provide emergency treatment to you.To request restrictions, you must make your request in writing. In your request, you indicate:
what information you want to limit;
whether you want to limit our use, disclosure or both; and
to whom you want the limits to apply, (e.g., disclosures to your children, parents, spouse, etc.)

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail or e-mail, or the like.To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests. Your request must specify how or where you wish us to contact you.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

I CERTIFY THAT I HAVE READ THIS FORM AND UNDERSTAND THE CONTENTS OF THIS FORM. I acknowledge that I have been informed how to obtain a copy of HIPAA policies and procedures.

_____ Patient Name _____

Patient Signature

_____ Date

Financial Responsibility Form

Thank you for choosing Coastal Dermatology. We are committed to providing you with the best quality healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed a payment policy to assist you. Please read it, ask us any questions that you may have and sign in the space provided. We will be happy to provide you a copy upon request.

We participate in most insurance plans. We will inform you of our participation with your insurance company, but knowing your insurance benefits will be your responsibility. We will assist you to the best of our abilities. Please contact your insurance company with any questions you may have regarding your coverage. If you are insured by a plan that we do not participate with, payment will be your responsibility.

All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Concerning non-covered services, insurers determine what services are non-covered. Please check with your insurance company. If your insurance company does not cover a service, you will be responsible to pay for the services in full at the time of visit. If coverage for a service is unknown and that service is provided, you will be billed and responsible for payments.

All patients must fill out our patient information form before seeing the doctor. We will need a copy of your drivers license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information, you will be responsible for the balance. Please, take time to make sure that all information is up-to-date and accurate.
We will assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please understand that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company, we are not a party to that contract.
If you have a change in insurance companies, please notify us within two weeks of your next visit so that we can make the appropriate changes to help you receive your maximum benefits. If you do not notify us within two weeks of the time of your visit or if the information you give us is inaccurate, you will be responsible for the charges of services rendered at the time of your visit. If your insurance company does not pay your claim within a 60 day window, the balance will automatically be billed to you.

It is vital that you keep us informed of changed addresses, phone numbers and insurance companies. If the responsible party/policy holder is someone other than the patient, by signing below, you give Coastal Dermatology permission to contact said individual to collect balances. If your account goes over 90 days past due, it will automatically go to a collection agency and be out of our hands. Please, take time to ask your insurance company any questions you may have.

Our goal is to provide you the most comprehensive healthcare available.
We have patients that are eager to get into our schedule. If you are scheduled for an appointment and find that you cannot make it, you must call us within 24 hours of your appointment to give us a chance to offer that appointment slot to someone in need of care. Failure to show up for an appointment and failure to call us within 24 hours of your appointment could result in a $35 fee.

We at Coastal Dermatology believe that we can partner with you and provide you with the best healthcare possible. Thank you for placing your trust in us.

CTA PATHOLOGY

If you have had a biopsy that was sent to pathology for evaluation, you will receive a separate bill from the pathology lab.

For questions related to this or your bill, please contact CTA lab directly at 503-906-7300.

_____ Patient Name _____

Patient Signature

_____ Date

Authorization for Use or Disclosure of Protected Health Information

Name of Patient_____Date of Birth _____

Address_____

City_____State_____Zip Code _____

Request Records From:		Send Records To:	
Clinic Name		Coastal Dermatology Clinic Name or Patient Name	
Street Address	City, State, Zip	954 Business Park Drive, Ste. 5 Street Address	Traverse City, MI 49686 City, State, Zip
Phone #	Fax #	231-252-3200 Phone #	231-252-3206 Fax #

Information to be released:

From & To Dates _____

- ☐ History and physical exams_____
- ☐ Lab report_____
- ☐ Biopsy report_____
- ☐ Other_____

Purpose of Disclosure:

- ☐ Changing physicians / Relocation
- ☐ Other _____

1. I understand that this authorization will expire one year from the day this form is signed. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying medical records at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipi ent and no longer be protected by Federal privacy regulations. However, other state or federal laws may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS – related information, and psychiatric /mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that I will get a copy of this form after I sign it, if requested.

By signing below, I acknowledge that I have read and understand this authorization.

_____ _____ **OR** _____ _____

Signature of Patient | Date | Parent/Legal Guardian/Authorized Person | Date

_____ _____ _____

Records Received By | Date | Relationship to Patient

For Office Use Only