skin wellness
DERMATOLOGY

Corey L. Hartman, MD, FAAD
Rayna M. Dyck, MD, FAAD
Deborah H. Youhn, MD, FAAD
Brittany Rigsby, CRNP

Patient Update Information

Patient Name: Last _____ First _____ D.O.B _____

If your info has not changed since your last visit, please sign the bottom of this page and all the consents for our yearly update. If any of the following has changed since your last visit, please fill out the following information:

Address _____ Apt/Ste # ____ City _____ State ____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Marital Status ◯ S ◯ M ◯ D ◯ W Spouse's Name _____

Primary Care Doctor: Name _____

Primary Care Doctor: Phone _____ Fax _____

Occupation _____ Student ◯ Full-time ◯ Part-time

Patient's Employer _____ Work Phone _____

Address _____ Apt/Ste # ____ City _____ State ____ Zip _____

Insurance Information:

Policy Member's Name _____ Relationship to Patient _____

Insurance Co. Name _____ Co-Payment Amount $ _____

Policy # _____ Group # _____

Patient Signature _____ Date _____

Please present your insurance card(s) and photo ID to the receptionist along with this completed form. Thank you.

Homewood
T: 205.871.7332
F: 205.871.7336
1920 Huntington Rd
Homewood, AL 35209

Chelsea
T: 205.678.7518
F: 205.677.2079
398 Chesser Dr, Suite 6
Chelsea AL 35043

info@skinwellness.com
skinwellness.com

skin wellness
DERMATOLOGY

Corey L. Hartman, MD, FAAD
Rayna M. Dyck, MD, FAAD
Deborah H. Youhn, MD, FAAD
Brittany Rigsby, CRNP

Statement of Patient Financial Responsibility

____ I understand that if I am uninsured or have an insurance that is not accepted at the practice, I will be responsible for payment in FULL at the time of service.

____ I understand all insurance copays must be paid in full at time of appointment and all deductibles must be current to be seen. Failure to make payments when requested could result in legal action. The undersigned agrees to pay all cost for collections, including a reasonable fee, and hereby waives his/her rights of exemption under the laws of the State.

____ I understand that I will be responsible for payment of any deductible and co-payment/ coinsurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

____ I authorize the release of medical information to my primary care or referring physician, to consultations if needed and as necessary to process insurance claims, insurance applications and prescriptions.

____ I am aware that the practice has a Notice of Privacy Policies that contains a section of Patient Rights. I have been given the opportunity to review this notice and the option to obtain a personal copy.

____ By initialing here, you give SWD consent to send automated text messages and/ or emails that will include information about promotions, events and other marketing information.

Patient Signature _____ Date _____

Self-Pay

In the event you do not have insurance coverage, we are pleased to offer a self-pay option for our patients. Effective January 1st, 2017 Skin Wellness Dermatology will charge $150 for a new self-pay patient appointment and $85 per follow-up self-pay appointment. The self-pay charge covers your visit with the provider, however, if additional services (i.e. biopsies, freezing, in office application of medication, etc.) are needed, they will hold individual charges. Please let us know when you make your appointment if you would like to utilize our self pay option.

I do not have health insurance and will be responsible for services rendered here at Skin Wellness Dermatology. I agree to pay the practice the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature _____ Date _____

Homewood
T: 205.871.7332
F: 205.871.7336
1920 Huntington Rd
Homewood, AL 35209

Chelsea
T: 205.678.7518
F: 205.677.2079
398 Chesser Dr, Suite 6
Chelsea AL 35043

info@skinwellness.com
skinwellness.com

skin wellness
DERMATOLOGY

Corey L. Hartman, MD, FAAD
Rayna M. Dyck, MD, FAAD
Deborah H. Youhn, MD, FAAD
Brittany Rigsby, CRNP

Appointment Policy

In an effort to keep appointments running smoothly and in a timely manner, the following policies have been implemented. Please completely read the policy before signing. If you have any questions, they may be directed to our office staff.

- For first office visits, please arrive 15-20 minutes early. New Patient forms must be completed prior to seeing the doctor. These forms are also available on our website at www.skinwellness.com under "Patient Resources" if you wish to complete prior to your office visit.

- Each time a patient misses an appointment without providing notification (no-shows), another patient is prevented from receiving care. A failure to be present at the time of your scheduled appointment will be recorded in the medical record, and an administrative fee of $50 will be charged to you (not your insurance company). If an individual has three (3) no-shows within a three (3) year period, they may be discharged from the practice.

- Please be aware that Monday appointments must be canceled by noon on the previous Friday. If you are scheduled for surgery, a procedure for Accutane follow-up and you cancel or no show, we may not be able to reschedule another appointment in a timely manner.

- Any time that you will be late for an appointment, please call to inform us. If you are running more than 15 minutes late, you may be asked to reschedule if our schedule is tight. This may also result in a Late Cancellation Fee of $50 charged to you (not your insurance company). We will always try to accommodate as we all run late sometimes.

Appointment times reflect the health issues provided to the receptionist at the time the appointment is scheduled (i.e. is the visit for acne, a mole check, a surgical procedure or a consultation regarding a specific skin and/or cosmetic concerns?). Lengthy delays result from patients asking for additional time to address issues other than those originally scheduled. Please be considerate of those waiting.

Skin Wellness Dermatology is committed to timely appointments, so we appreciate your cooperation and understanding on these matters.

Patient's Name _____ Date _____
(please print)

Signature of Patient or Legal Guardian _____

Homewood
T: 205.871.7332
F: 205.871.7336
1920 Huntington Rd
Homewood, AL 35209

Chelsea
T: 205.678.7518
F: 205.677.2079
398 Chesser Dr, Suite 6
Chelsea AL 35043

info@skinwellness.com
skinwellness.com

skin wellness
DERMATOLOGY

Corey L. Hartman, MD, FAAD
Rayna M. Dyck, MD, FAAD
Deborah H. Youhn, MD, FAAD
Brittany Rigsby, CRNP

Credit Card on File Policy

Skin Wellness Dermatology is committed to providing you with excellent care and timely appointments.

No shows, late arrivals (15-minutes or more), and/or appointments cancelled with less than 24-hour advance notification inhibit us from treating you and others; and are subject to a $50 administrative fee. This fee is not reimbursable by insurance and is the sole responsibility of the patient. A valid credit card must be provided/maintained for appointment scheduling. If you are running more than 15-minutes late, please contact us. We will always do our best to accommodate and get you in whenever we can.

When scheduling, please communicate to reception the primary reason(s) for your visit so that we may allot the appropriate amount of time to address your concerns during your visit. We truly appreciate your cooperation and thank you in advance for helping us to serve you better.

Please indicate your preferred method of payment below:

Card Type: Mastercard, Visa, American Express, Discover

Credit Card #:
Expiration Date:
CVN:
Billing Zip:

_____

My signature confirms that I understand and accept the Skin Wellness Dermatology appointment policy.

Homewood
T: 205.871.7332
F: 205.871.7336
1920 Huntington Rd
Homewood, AL 35209

Chelsea
T: 205.678.7518
F: 205.677.2079
398 Chesser Dr, Suite 6
Chelsea AL 35043

info@skinwellness.com
skinwellness.com

skin wellness
DERMATOLOGY

Corey L. Hartman, MD, FAAD
Rayna M. Dyck, MD, FAAD
Deborah H. Youhn, MD, FAAD
Brittany Rigsby, CRNP

HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____
Printed Name – Patient or Representative

_____ _____/_____/_____
Signature Date

Relationship to Patient
(if other than patient): _____

Witness: _____
Printed Name – Patient or Representative

_____ _____/_____/_____
Signature Date

Homewood
T: 205.871.7332
F: 205.871.7336
1920 Huntington Rd
Homewood, AL 35209

Chelsea
T: 205.678.7518
F: 205.677.2079
398 Chesser Dr, Suite 6
Chelsea AL 35043

info@skinwellness.com
skinwellness.com

skin wellness
DERMATOLOGY

Corey L. Hartman, MD, FAAD
Rayna M. Dyck, MD, FAAD
Deborah H. Youhn, MD, FAAD
Brittany Rigsby, CRNP

HIPAA Patient Consent Form (continued)

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

I wish to have the following restrictions to the use or the disclosure of my health information:

_____

_____

_____

_____

You may release my records to the following family members and physicians:

_____

_____

_____

_____

Patient Signature _____ Date _____

Homewood
T: 205.871.7332
F: 205.871.7336
1920 Huntington Rd
Homewood, AL 35209

Chelsea
T: 205.678.7518
F: 205.677.2079
398 Chesser Dr, Suite 6
Chelsea AL 35043

info@skinwellness.com
skinwellness.com

skin wellness
DERMATOLOGY

Corey L. Hartman, MD, FAAD
Rayna M. Dyck, MD, FAAD
Deborah H. Youhn, MD, FAAD
Brittany Rigsby, CRNP

Patient History and Intake Form

Past Medical History: *(Please circle all that apply.)*

___ Anxiety
___ Arthritis
___ Asthma
___ Atrial fibrillation
___ Bone Marrow Transplantation
___ Breast Cancer
___ Colon Cancer
___ COPD
___ Coronary Artery
___ Disease
___ Depression
___ Diabetes
___ End Stage Renal Disease
___ GERD
___ Hearing Loss
___ Hepatitis
___ High Blood Pressure
___ HIV/AIDS
___ High Cholesterol
___ Hyperthyroid
___ Hypothyroid
___ Leukemia
___ Lung Cancer
___ Lymphoma
___ Prostate Cancer
___ Radiation Treatment
___ Seizures
___ Stroke
___ NONE

Other _____

Past Surgical History: *(Please circle all that apply.)*

___ Appendix Removed
___ Biological Valve Replacement
___ Bladder Removed
___ Breast Biopsy (Right, Left, Bilateral)
___ Breast Reduction
___ Breast Implants
___ Colectomy: Colon Cancer Resection
___ Colectomy: Diverticulitis
___ Colectomy: IBD
___ Coronary Artery Bypass
___ Gallbladder Removed
___ Heart Transplant
___ Hysterectomy
___ Hysterectomy: Fibroids
___ Hysterectomy: Uterine Cancer
___ Joint Replacement, Hip (Right, Left, Bilateral)
___ Joint Replacement, Knee (Right, Left, Bilateral)
___ Joint Replacement within last 2 years
___ Kidney Biopsy (Nephrectomy)
___ Kidney Removed (Right, Left)
___ Kidney Stone Removal
___ Kidney Transplant
___ Lumpectomy (Right, Left, Bilateral)
___ Mechanical Valve Replacement
___ Mastectomy (Right, Left, Bilateral)
___ Ovaries Removed: Endometriosis
___ Ovaries Removed: Cyst
___ Ovaries Removed: Ovarian Cancer
___ Prostate Biopsy
___ Prostate Removed: Prostate Cancer
___ Spleen Removed
___ TURP (Prostate Removal)
___ Testicles Removed (Right, Left, Bilateral)
___ Tonsillectomy
___ NONE

Other _____

Homewood
T: 205.871.7332
F: 205.871.7336
1920 Huntington Rd
Homewood, AL 35209

Chelsea
T: 205.678.7518
F: 205.677.2079
398 Chesser Dr, Suite 6
Chelsea AL 35043

info@skinwellness.com
skinwellness.com

skin wellness
DERMATOLOGY

Corey L. Hartman, MD, FAAD
Rayna M. Dyck, MD, FAAD
Deborah H. Youhn, MD, FAAD
Brittany Rigsby, CRNP

Patient History and Intake Form (continued)

Social History: *(Please circle all that apply.)*

Cigarette Smoking:
___ Currently smokes
___ Has smoked in the past
___ Never smoked

Alcohol Use:
___ Less than 1 drink per day
___ 1-2 drinks per day
___ 3 or more drinks per day
___ None

Other _____

65+ Pneumonia Vaccine: *(Please circle one.)* Yes or No

Family Medical History: *(Only first degree relatives.)*

_____

_____

_____

_____

Preferred Language _____

Race _____ Ethnic Group _____

Preferred Pharmacy

Name _____

Phone _____

City or Zip Code _____

Homewood
T: 205.871.7332
F: 205.871.7336
1920 Huntington Rd
Homewood, AL 35209

Chelsea
T: 205.678.7518
F: 205.677.2079
398 Chesser Dr, Suite 6
Chelsea AL 35043

info@skinwellness.com
skinwellness.com

skin wellness
DERMATOLOGY

Corey L. Hartman, MD, FAAD
Rayna M. Dyck, MD, FAAD
Deborah H. Youhn, MD, FAAD
Brittany Rigsby, CRNP

Patient History and Intake Form (continued)

Skin Disease History: *(Please circle all that apply.)*

___ Acne
___ Actinic Keratoses
___ Asthma
___ 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
___ NONE

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.)*

_____

_____

_____

Allergies: *(Please enter all allergies.)*

_____

_____

_____

Homewood
T: 205.871.7332
F: 205.871.7336
1920 Huntington Rd
Homewood, AL 35209

Chelsea
T: 205.678.7518
F: 205.677.2079
398 Chesser Dr, Suite 6
Chelsea AL 35043

info@skinwellness.com
skinwellness.com

skin wellness
DERMATOLOGY

Corey L. Hartman, MD, FAAD
Rayna M. Dyck, MD, FAAD
Deborah H. Youhn, MD, FAAD
Brittany Rigsby, CRNP

Patient History and Intake Form (continued)

Review of Symptoms

Are you currently experiencing any symptoms?

_____

_____

_____

_____

Special Alerts *(Please circle all that apply.)*

Are you pregnant or currently trying to get pregnant? Yes ◯ No ◯

___ Allergy to adhesive
___ Allergy to lidocaine
___ Allergy to topical antibiotics
___ Artificial heart valve
___ Artificial joint replacement
___ Blood thinners
___ Defibrillator
___ MRSA
___ Pacemaker
___ Require antibiotics prior to surgical procedure
___ Rapid heartbeat with epinephrine

Homewood
T: 205.871.7332
F: 205.871.7336
1920 Huntington Rd
Homewood, AL 35209

Chelsea
T: 205.678.7518
F: 205.677.2079
398 Chesser Dr, Suite 6
Chelsea AL 35043

info@skinwellness.com
skinwellness.com

skin wellness
DERMATOLOGY

Corey L. Hartman, MD, FAAD
Rayna M. Dyck, MD, FAAD
Deborah H. Youhn, MD, FAAD
Brittany Rigsby, CRNP

No Recording Policy

Skin Wellness Dermatology prohibits the use of any recording devices in the waiting area or the exam rooms. Any unauthorized recording or photography may result in dismissal from the practice.

Patient Signature: _____

Date: _____

Homewood
T: 205.871.7332
F: 205.871.7336
1920 Huntington Rd
Homewood, AL 35209

Chelsea
T: 205.678.7518
F: 205.677.2079
398 Chesser Dr, Suite 6
Chelsea AL 35043

info@skinwellness.com
skinwellness.com

skin wellness
DERMATOLOGY

Corey L. Hartman, MD, FAAD
Rayna M. Dyck, MD, FAAD
Deborah H. Youhn, MD, FAAD
Brittany Rigsby, CRNP

Office Procedures

The following information will help you understand our office procedures. These procedures are in place so that our staff can give the best care to all our patients. Thank you for allowing us to take care of you!

MEDICATION REFILLS
Please allow up to 48 hours on all prescription requests. We try to do them the **SAME DAY** you call if possible, but **DO NOT** wait until last minute. We ask that you submit your request via the patient portal, as this can result in a quicker response time. You can also leave a voicemail on the office **NURSE** line to request a refill. Please leave your **full name, DOB, name of medication requested, pharmacy name and pharmacy phone number.** Please contact the office that you are seen in, either Homewood or Chelsea.

LAB AND TEST RESULTS
Some test and lab results can take up to 10-14 days. Your abnormal results will be called to you. Your normal results will be available on the patient portal. You may request a copy of your records.

REFERRALS
You are responsible for insurance authorizations. You will need to know if a referral is needed from your insurance company for your visit. If your doctor wants to refer you for a test, or to another specialist, please allow 5 days for the medical staff to process your referral.

MEDICAL RECORDS
Medical records require a 72-hour notice and are subject to a fee. A **medical records release** form must be on file for records to be released. Records can be faxed to another provider free of charge.

PHONE CALLS AND APPOINTMENTS
- The appointment line voicemail is checked every hour. If you have a more urgent matter that needs to be handled, you may send an email to info@skinwellness.com.
- Please do not leave multiple messages on the nurse line. You can also submit request or questions through the patient portal or info@skinwellness.com.
- Three “No Show” appointments or recurrent cancellations will result in DISMISSAL FROM THE CLINIC. Please call as soon as you know you will not be able to make your appointment. Please see **APPOINTMENT POLICY** for further detail on fees that can be associated with same day cancellations and no-show appointments.

I authorize the staff of Skin Wellness Dermatology to leave message(s) concerning my care on the voicemail of the following phone number(s):

_____ _____

_____ _____

E-mail: _____

Patient Signature: _____ Date: _____

Homewood
T: 205.871.7332
F: 205.871.7336
1920 Huntington Rd
Homewood, AL 35209

Chelsea
T: 205.678.7518
F: 205.677.2079
398 Chesser Dr, Suite 6
Chelsea AL 35043

info@skinwellness.com
skinwellness.com