skin wellness
DERMATOLOGY

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

New Patient Information

Patient Title ◯ Dr. ◯ Mr. ◯ Mrs. ◯ Ms. ◯ Miss

Last Name _____ First Name _____ M.I. _____

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

Date of Birth _____/_____/_____ Age: _____ ◯ Male ◯ Female

Home Phone _____ Cell Phone: _____

Is it okay to leave a detailed message? Yes ◯ No ◯

Social Security # _____ Email: _____

Preferred Language _____ Race: _____ Ethnic Group: _____

Marital Status ◯ S ◯ M ◯ D ◯ W

Primary Care Doctor: Name _____ Phone: _____ Fax _____

◯ No Current Primary Care Doctor

Occupation/Employer _____

Emergency Contact Name/Relation _____ Phone Number: _____

Would you like to receive emails on the latest advances in skin care treatments? Yes ◯ No ◯

How did you hear about us? _____

Insurance Coverage – Primary Carrier _____

Contract #: _____ Group #: _____

Policy Holder (insured) Name: _____ Date of Birth: _____

Insurance Coverage – Secondary _____

Contract #: _____ Group #: _____

Policy Holder (insured) Name: _____ Date of Birth: _____

Homewood
T: 205.871.7332
F: 205.871.7336
3415 Independence Dr. Suite 200
Birmingham, AL 35209

Chelsea
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F: 205.677.2079
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Patient History and Intake Form

Past Medical History: *(Please check 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 check 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 _____

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Patient History and Intake Form (continued)

Skin Disease History: *(Please check 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 list all current medications and dosage.)*

_____

_____

_____

Allergies: *(Please list all allergies.)*

_____

_____

_____

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Patient History and Intake Form (continued)

Social History: *(**Please do not leave blank**. Check 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

If you are 65+, have you ever received the Pneumonia Vaccine: *(Please circle one.)* Yes or No

Have you received the Influenza (flu) Vaccine? *(Please circle one.)* Yes or No

Preferred Pharmacy

Name _____

Phone _____

City or Zip Code _____

Special Alerts *(Please check 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
___ Breast feeding
___ Defibrillator
___ MRSA
___ Pacemaker
___ Require antibiotics prior to surgical procedure
___ Rapid heartbeat with epinephrine

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Statement of Patient Financial Responsibility

*Please Initial

____ 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 that all cosmetic procedures are not covered by insurance and 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.

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 $105 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. Additionally, the patient will be responsible for the cost of any medications prescribed at the visit. 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

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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 _____

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: _____

Cancellation/ No Show/ Late Arrival Appointment 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.

Our office asks for a 48-hour notice of cancellation for surgical appointments. Failure to show up to the scheduled appointment without 48-hour advance notification will be subjected to a $150 administrative fee. The fee is not reimbursable by insurance and are 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: _____/_____

Billing Zip Code: _____ CVV _____

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

_____	_____	_____
Patient or Legal Guardian Full Name	Patient or Legal Guardian Signature	Date

HIPAA Patient Consent Form

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 (HIPAA). 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.

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 NOT disclose my medical information to anyone.
___ I wish to GIVE permission to disclose my medical information.

You may disclose my information to the following family members and physicians:

_____

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Patient Signature: _____ Date_____

Witness Signature: _____ Date_____

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 $1 per page for the first 25 pages, and 50¢ for each additional page. 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):

Homewood
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_____ _____

_____ _____

E-mail: _____

Patient Signature: _____ Date: _____

Photography Consent Form

I authorize Dr. Corey L. Hartman of Skin Wellness Dermatology/and or his staff to take photographs of me before, during and after any procedures I may enter into while under the doctor's care. I further agree that the doctor and/or his staff may use the negatives or prints made from such photographs for such purposes and in such manner as he may deem appropriate. My name will not be used unless I specifically agree that it may be used. I understand that these photos may be used for purposes including, but not limited to, educating future patients and in possible publications and promotions and that such use may be accomplished in any manner the doctor wishes, with the exception of the following:

I have entered into this agreement willingly and hereby waive any right to compensation for such uses as the doctor may determine. I also state that I and my successors or assigns hereby Dr. Corey L. Hartman of Skin Wellness Dermatology/and or his staff harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

The term "photograph" or "photo" as used in this agreement shall mean motion picture or still photography in any format, as well as videotape, video disc, and any other mechanical or digital means of reproducing images.

Please initial consent (yes) and no (non-consent) for each specified use:

____ For medical research, education, or science.

____ For use during in-office patient consultations.

____ For use on Skin Wellness Dermatology website.

____ For external marketing, public relations use (including referral websites, print/television/social media that provides information about the physician, practice, or specific procedure).

____ For my name to be used as a reference to future patients.

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Patient Signature: _____ Date: _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and about how you can get access to this information. Please review it carefully.

The policy of Skin Wellness Dermatology is to protect the confidentiality, integrity and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use or disclosure of such information. We are required by law to maintain the privacy of your health information and provide you with this notice of our duties and obligations. This policy applies to patients who are current or former patients of Skin Wellness Dermatology.

Individually identifiable health and personal information are any information obtained by Skin Wellness Dermatology in connection with providing healthcare treatment, obtaining payment and related health care operations. This relates to past, present or future information that Skin Wellness Dermatology receives from you as our patient.

Skin Wellness Dermatology collects personal information in order to learn about your medical history and medical conditions to render treatment and collect payment for our services. We gather this information from your patient forms, health questionnaires and other forms you will be asked to complete from time-to-time. In addition, we will assemble information based on our discussions and conversations with you, your personal representative and your family members. Your healthcare plan or insurance carrier may provide information to our office.

We will use this information to provide caring and quality medical care to you. Examples include diagnosis, treatment and communications such as follow up and appointment reminders, as well as treatment alternatives or other health-related benefits. As part of our standard treatment and healthcare operations, we may share information with a facility such as a hospital, laboratory, diagnostic service or healthcare provider to efficiently coordinate your treatment plan. For contracted insurers, your information will be used for claims management and to obtain payment from your insurance carrier. As required by your insurance contractor, we will exchange paper and electronic data with your insurance carrier for activities such as eligibility, benefit and coverage determinations, precertification, utilization review and related activities. For worker's compensation, information about work-related condition can be exchanged with the employer.

Your information is maintained in our office in our practice management computer system. We also maintain information about you in your medical chart Skin Wellness Dermatology limits the access to your protected health information to those employees and business associates who need to know that information. With some limitations, you have the right to inspect, amend, copy and receive an accounting of disclosures of your medical and billing records.

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We do not disclose personal information to third parties unless one of the following exceptions applies:

- We receive explicit authorization from you to release individually identifiable information. This authorization must be in writing and give exact details regarding to whom the disclosure applies, the nature of the data to be released, the applicable dates and signed by the patient (or guardian). You may revoke this authorization by providing a written statement to the Skin Wellness Dermatology Privacy Officer.

- Federal, state or other applicable law requires us to share protected information or records.

We are obligated to abide by the terms of this notice. If, at any time in the future, it is necessary to disclose any of your personal information in a way that is materially different from this policy, Skin Wellness Dermatology will give you notice of the change through a mailed announcement or on your visit following the change.

With some exceptions, you have the right to review and obtain a copy of your health information. This request must be in writing and there may be a reasonable charge to provide you with a copy of your information. You also have the rights to request your records be amended, to request special accommodations and restrictions of your health information and to receive an accounting of the disclosures of your information. You have the right to request to receive confidential communications of your information Skin Wellness Dermatology is not obligated to agree to a requested restriction. We must receive a written request from you to administer these rights. Please speak to the receptionist for further information or to begin the process to exercise any of these rights.

If you have a complaint about the management of your health information or believe your privacy rights have been violated, contact **Vickie Miles at (205) 871-7332**. You have the right to file a complaint with the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. There will be no retaliation for filing a complaint.

Other uses of PHI:

- Your medical information may be reviewed by our medical staff for possible inclusion and referral in research studies. You will be contacted prior to the use of your information in a research study.

- We may leave a message on your answering machine, voice mail, or email to contact you about appointments or to have you call our office.

- We may send emails about new services or promotional events for new cosmetic services.

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