PATIENT REGISTRATION

Date: _____ Patient's Name: _____
(NAME AS IT APPEARS ON YOUR INSURANCE CARD)

Address: _____
(Street) (Apt. #) (City) (State) (Zip)

Home#_____ Cell#: _____ Work#: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Marital Status: M W D S (Please Circle One) Sex: Male or Female (Please Circle One)

Email Address:_____ Employer:_____
(If un-able to reach you by phone)

Race _____ Ethnicity: Hispanic □ Non-Hispanic□ Preferred Language: _____

Referred by: _____ How'd You Hear About Us? _____

Family Physician: _____

INSURANCE AND RESPONSIBLE PARTY INFORMATION

Primary Insurance Co: _____ID#: _____

Subscriber's Name:: _____ Subscriber's Date of Birth: _____

Subscriber's Address (if different from above): _____

Subscriber's Social Security # _____ Subscriber's Employer _____

Relationship to patient _____

Secondary Insurance Co: _____ID#: _____

Subscriber's Name:: _____ Subscriber's Date of Birth: _____

Subscriber's Address (if different from above): _____

Subscriber's Social Security # _____ Subscriber's Employer _____

Relationship to patient _____

Tertiary Insurance Co: _____ID#: _____

Subscriber's Name:: _____ Subscriber's Date of Birth: _____

Subscriber's Address (if different from above): _____

Subscriber's Social Security # _____ Subscriber's Employer _____

Relationship to patient _____

Patient's Name: _____ **DOB**: _____

Reason for Visit: _____ Duration of symptoms: _____

(Please be Specific)

Pharmacy: _____**Pharmacy Phone and address**: _____

Referring Doctor: _____ Family Doctor:_____

PLEASE CHECK ALL THE PROBLEMS THAT APPLY TO YOU:

PERSONAL HISTORY:

Occupation: _____

__ Smoke _____ Amount _____

__ Blood Transfusion Year _____

__ Tested for HIV Year and Result: _____

MEDICATIONS NOW TAKING (Include over The counter medications and aspirin)

Type: Dose:

_____

_____

_____

I have ALLERGIES to the following MEDICATIONS:

_____

_____

_____

PAST HISTORY:

MEDICAL PROBLEMS:

___ Diabetes

___ Cancer Types: _____

___ Anemia

___ Arthritis

___ Stomach/Bowel Problems

___ High Blood Pressure

___ Heart Problems

___ Thyroid Problems

___ Urinary Problems

___ Hepatitis

___ Liver Problems

___ Neurologic Disorders Type: _____

___ Asthma

___ Lupus or other collagen vascular disease

___ High Cholesterol

___ Other: _____

Have you been diagnosed with:

___ Malignant Melanoma

___ Other Skin Cancer

Has anyone in your family been diagnosed with:

___ Malignant Melanoma

___ Other Skin Cancer

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE… I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or the party who accepts assignment.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE… I authorize payment of medical benefits to the physician or supplier for services rendered.

AGREEMENT TO BE FINANCIALLY RESPONSIBLE: I/We, _____ (guarantor) agree to be financially responsible for the cost of all medical services rendered to the patient by Coastal Dermatology. If payment for these services is not made when requested, I agree to pay, in addition to the physician's fee, all costs of collecting the amount due. I understand there is a $40 return check fee. I understand that my insurance will be filed for me as a courtesy and that I will be responsible for payment of any amount not paid by the insurance company because of deductible, co-insurance, lapse of coverage or cancellation of coverage. If you have insurance coverage with a company with whom we do participate, you will be asked to pay for the cost of the office visit on the day of service.

I understand that Coastal Dermatology will charge my account $35.00 for any "No Show" appointments or Cancellations within 24 hours.

_____ _____

(Signature) (Date)

Office use only:_____

Patient Consent for Use and Disclosure of Protected Health Information

I HAVE BEEN OFFERED A COPY OF PRIVACY PRACTICES

With my consent, Coastal Dermatology/Dr Kimberly Soderberg may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

(Please refer to Coastal Dermatology's Notice of Privacy Practices for a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Coastal Dermatology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Coastal Dermatology's Privacy Officer at 3176 Holland Rd, Suite 103, Virginia Beach, VA 23453.

With my consent, Coastal Dermatology **may call my home or other designated location and leave a message on voice mail**, **in person or by e-mail** in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory/biopsy results among others.

With my consent, Coastal Dermatology may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointments reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Coastal Dermatology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions. If the practice agrees to the requested restrictions, it is bound by this agreement.

By signing this form, I am consenting to Coastal Dermatology's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Coastal Dermatology may decline to provide treatment to me.

☐ *Please check here to request that verbal information regarding diagnostic and/or recommendations for treatment is discussed directly with* ***you and you alone****.*

If you do choose to give permission for your PHI to be discussed with a spouse, family member, care giver, etc.; list them below:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Print Name: _____ Date of Birth: _____

Email Address: _____

Signature: _____ Date: _____

Notice of Consent to HIV Blood Testing

A law was enacted in Virginia in 1989 which authorized health care providers to test their Patients for HIV antibodies when the health care provider is *ACCIDENTALLY EXPOSED* to blood or body fluids in a manner which may transmit the human immunodeficiency virus (HIV). However, you would be informed before any of your blood would be tested for HIV antibodies. The testing would be explained and you would be given the opportunity to ask any questions you might have.

In the event of one of our health care providers is exposed to potentially infectious body fluids; permission is hereby granted to test my blood.

The expense is covered by Coastal Dermatology.

Patient's Signature_____ **Date**_____

Coastal Dermatology, P.C.
3176 Holland Road, Suite 103 Virginia Beach, Virginia 23453
Office: 757-368-SKIN* (7546) *Fax: 757-368-DERM (3376)

Referral Letter of Understanding

*To Be Completed By HMO Policy Holders Only

If you have a PPO Policy you do NOT need to sign this form.

- ☐ I understand that I am being seen ***without*** benefit of a valid referral form as required under my insurance policy. I understand that I may be responsible for full payment of any charges resulting from this and/or any diagnostic testing that may occur. I understand that retroactive referrals might not be allowed under the referral policy of my plan.

- ☐ Understanding all the above, I hereby accept the foregoing responsibility and still want to complete the visit.

Signature: _____ Date of Appointment: _____

Witnessed by: _____ Date: _____

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Patient Privacy Policy

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should be unafraid to provide information to our practice and its physicians and staff for purposes of treatment, payment, and healthcare operations (TPO). To that end, our practice and its physicians and staff will:

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorization, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, authorization from the patient.
- Use and disclose PHI to remind patients of their appointments only within their consent.
- Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice and its physicians and staff respect and patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential.
- Consequently, our practice and its physicians and staff will:
    - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.

- Not disclose PHI data unless the patient (or his or her authorized representative) has properly consented to or authorized the release or the release is otherwise authorized by law.

- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believe his/her information is inaccurate or incomplete. Our practice and its physicians and staff will:

    - Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review those patients' appeals.

Patient Privacy Policy Continued

    - Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.

- All physicians and staff of our practice will maintain a list of all disclosures of PHI for purposes other than TPO for each patient. We will provide this list to patients upon request, so long as their requests are in writing.

- All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have been requested and have been approved by our practice.

- All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

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