DERMATOLOGY CENTER OF
SOUTHERN INDIANA

DCSI

Leading skin care for over 30 years

Dear Patient,

We are pleased that you have chosen the Dermatology Center of Southern Indiana for your dermatological needs.

Our goal is to ensure that all of our patients have a comfortable and positive experience, while in our care.

In order to expedite your check-in process, please complete the registration forms and bring them with you to your appointment along with your insurance card(s) and a picture ID.

Some insurance companies require a referral from your primary care provider before we can see you so please make sure this is in order before your visit. If you do not have your insurance card(s) or referral at the time of your appointment, insurance regulations require that you sign a financial waiver. All co-pays are to be paid at the time of service. We file all insurance claims for medical services and bill you any remaining balance, which is to be paid promptly. If insurance is not responsible or available, full payment must be paid at the time of service.

We look forward to being of service to you. If you need to cancel your appointment, please notify us within 24 hours of your visit.

If you have any questions, please feel free to call our office at 1-812-339-6434.

Sincerely,

Dermatology Center of Southern Indiana

Dermatology Center of
Southern Indiana

Today's Date:_____

Demographics

Patient Name:_____

Nickname:_____

Date of Birth:_____Age:_____

Social Security #:_____

Marital Status: ☐ Married ☐ Divorced ☐ Single
☐ Widow ☐ Partner

Sex: ☐ Male ☐ Female

Address:_____

City:_____

State:_____ Zip:_____

Cell Phone:_____

Home Phone:_____

Preferred Phone: ☐ Cell Phone ☐ Home Phone

Is it okay to send you text messages ☐ Yes ☐ No

What is your preferred method of contact?
☐ Phone ☐ Mail ☐ Email

Do you authorize us to leave medical information on your voicemail or answering machine? ☐ Yes ☐ No

Email:_____

Would you like to receive email notifications?
☐ Yes ☐ No

Guarantor Information (for Patient's under the age of 18)

Name: _____

DOB: _____

Social Security #: _____

Preferred Language: ☐ English ☐ Other _____

Ethnicity: ☐ Hispanic ☐Non-Hispanic ☐ Decline

Primary Insurance Information

Insurance Name:_____

Policy Number:_____

Policyholder Name:_____

Group #:_____

Policyholder's Date of Birth:_____

Policyholder's Soc. Sec #:_____

Relation to Patient:☐ Self ☐ Spouse ☐ Child ☐ Other

Employer:_____ ☐ Retired

Secondary Insurance Information

Insurance Name:_____

Policy Number:_____

Policyholder Name:_____

Group #:_____

Policyholder's Date of Birth:_____

Policyholder's Soc. Sec #:_____

Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer:_____ ☐ Retired

Primary Care Physician:_____

Preferred Pharmacy:_____

Emergency Contact Information

Name:_____

Relation to Patient:_____

Phone:_____

Patient Name:_____ **Date of Birth:**_____

Acknowledgement of Office Policies

Cancellation/No-Show Policy: It is the patient's responsibility to contact the office at least 24 hours in advance to cancel regularly scheduled visits. If the patient fails to notify the office or fails to appear 3 or more times, the patient may be assessed a fee of $50 for regularly scheduled visits. There will be a $100 fee for any surgery or patch testing appointments that are not canceled within 24 hours or if the patient fails to appear. If the patient continues to cancel less than 24 hours or no-show their appointment they may be dismissed from the practice.

Consent to Treatment: I consent to the performance of diagnostic exams and procedures provided by the medical provider and/or their staff as deemed necessary. I also understand that photographs may be taken in the course of treatment. If photographs are selected for commercial use I will be contacted for consent.

The staff of this office pledges to give the finest care our capacities allow. Complications are seldom seen in the many procedures performed, however, it should be understood that even small procedures can scar, occasionally bleed, and rarely become infected or incite allergic response.

I authorize the transfer of medical information to my other healthcare providers, pharmacies and consultants, if needed and as necessary to process insurance claims, applications, and prescriptions.

I understand if I have a surgical procedure or biopsy performed there will be at least two charges. The first is for the provider collecting the biopsy and the second is for the examination of the specimen. It is possible that a specimen could be sent out for a second opinion if needed. In the event that my biopsy is sent to an outside laboratory such as Indiana University Health a separate bill may be sent to me from this outside laboratory for their pathology charges. DCSI will provide the outside laboratory with billing/insurance information in order for the outside laboratory to process these charges.

Acknowledgement of Financial Policies

Consent for Filing Insurance Claims: I understand that, in order to file claims and release medical information to any insurance company(s) I have listed in my financial record; DCSI is required to keep my signature on file. I hereby authorize DCSI to receive benefits directly from my insurance company/Centers for Medicare and Medicaid Services and its agents when an assigned claim is filed. I also authorize DCSI to appeal any denial to my insurance company on my behalf and authorize the release of any medical information to my insurance company(s) that is necessary for the processing of claims. I also authorize payment of any Medigap benefits on my behalf to DCSI for services furnished to me.

As a courtesy DCSI will file claims to all insurance carriers for medical services. I understand that it is my responsibility to determine if DCSI is a network provider for my insurance carrier. I understand it is my responsibility to contact the insurance carrier to determine insurance benefits, as we cannot guarantee your insurance coverage for our services. I acknowledge that it is my responsibility to notify DCSI of any insurance changes. I also understand that it is my responsibility to obtain any and all necessary referrals if my plan requires one. All necessary copay's are due and collected at the time of service.

I understand that if my account has not been paid in full within 90 days from the time my insurance responds, the account may be referred to our collection agency. I understand I will be responsible for all costs including fees, attorney fees, and court fees.

I understand that if I do not have health insurance, $160 deposit is due at time of service unless other arrangements have been made. I understand that I will be billed or refunded the difference between the deposit and any occurred charges at each visit.

I understand that returned checks will incur a $25 insufficient funds fee. Balances must be handled by cash or credit card.

X_____ _____

Signature of Patient or Personal Representative Date

The Dermatology Center of Southern Indiana, P.C. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. DCSI offers Language assistance services, if needed, free of charge. 812-339-6434.

El Centro de Dermatología del Sur de Indiana, P.C. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. DCSI ofrece servicios de asistencia lingüística, si es necesario, sin cargo. 812-339-6434.

南印第安纳州皮肤病中心，P.C. 符合适用的联邦民权法，不因种族，肤色，国籍，年龄，残疾或性别而受到歧视。 如有需要，DCSI免费提供语言协助服务。812-339-6434。

History and Intake Form

Name:_____ **Date of Birth:**_____ **Date**_____

Primary Care Physician:_____ **Preferred Pharmacy:** _____

Past Medical History: (Please check mark all that applies. Please mark "**None**" if nothing applies.)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atrial fibrillation (Irregular heartbeat)
- ☐ BPH (Enlarged Prostate)
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (Emphysema)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease (Kidney disease)
- ☐ GERD (Acid reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension (High Blood Pressure)
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia (High Cholesterol)
- ☐ Hyperthyroidism (Thyroid Disease - Fast)
- ☐ Hypothyroidism (Thyroid Disease - Slow)
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement (Heart)
- ☐ None

Other:_____

Past Surgical History: (Please check mark all that applies. Please mark "**None**" if nothing applies)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Both)
- ☐ Lumpectomy (Right, Left, Both)
- ☐ Breast Biopsy (Right, Left, Both)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD (Inflammatory Bowel Disease)
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA (Balloon angioplasty)
- ☐ Mechanical Valve Replacement (Heart)
- ☐ Biological Valve Replacement (Heart)
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee (Right, Left, Both)
- ☐ Joint Replacement, Hip (Right, Left, Both)
- ☐ Joint Replacement within last 2 years
- ☐ Kidney Biopsy
- ☐ Kidney Removed (Right, Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP (Resection of prostate)
- ☐ Skin Biopsy
- ☐ Basal Cell Carcinoma Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Both)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ None

Other:_____

Skin Disease History: (Please check mark all that applies. Please mark "**None**" if nothing applies.)

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ 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
- ☐ Lupus
- ☐ 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 skin cancer?

- ☐ Basal Cell Carcinoma ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
- ☐ Squamous Cell Carcinoma ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
- ☐ Melanoma ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
- ☐ No

Please list any other family history of diseases:

Mother:_____
Father:_____
Sister:_____
Brother:_____
Daughter:_____
Son:_____

Do you have any allergies **(including drug allergies)** ☐ Yes ☐ No

Please list:

Social History: (Please check mark all that applies.)

Cigarette Smoking:
- ☐ Never smoked
- ☐ Former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily

Alcohol use:
- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more per day

IV Drug Use:
- ☐ Yes
- ☐ No

How often do you exercise:
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never

Caffeine use:
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never

Have you ever been diagnosed or exposed to HIV or AIDS? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No
Do you have artificial joints? ☐ Yes ☐ No
Are you required to take antibiotics before minor surgery? ☐ Yes ☐ No
Do you have hearing aids or are hearing impaired? ☐ Yes ☐ No
Do you have Alzheimer's or Dementia? ☐ Yes ☐ No

Dermatology Center of Southern Indiana, P.C.

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

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is legally required to maintain the confidentiality of your PHI, and to follow specific rules when using or disclosing this information. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules when using or disclosing your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required by law to follow the terms of this Notice. We reserve the right to change the terms of the Notice, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a copy of our current Notice if you call our office and request that a copy be sent to you in the mail, or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure - This means we will only use or disclose your PHI as described in this notice, unless you authorize other use or disclosure in writing. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI* - This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. We are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the expected date when the request will be fulfilled.

You have the right to request a restriction of your PHI* - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information* - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability* - You may submit a written request for a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

* If you have questions regarding your privacy rights, or would like to submit any type of written request described above, please feel free to contact our Privacy Manager. Contact information is provided at the bottom of the following page.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

You may ask questions about your privacy rights, file a complaint or submit a written request (for access, restriction, or amendment of your PHI or to obtain a disclosure accountability) by notifying our Privacy Manager at:

Phone: 812-339-6434, ext. 242 or
Fax: Attn: Privacy Officer at 812-331-0196 or
Mail: Attn: Privacy Officer, 1200 S. Rogers Street, Bloomington, IN 47403

Patient Signature: _____ **Date:** _____

Effective Date 02/12/2018 Publication Date 02/12/2018

DERMATOLOGY CENTER OF
SOUTHERN INDIANA

DCSI

Leading skin care for over 30 years

Patient Authorization for Personal Representative

Form 7.30

Please print all information, then sign and date form at bottom.

Name of Practice: Dermatology Center of Southern Indiana, P.C.

Patient Name: _____

Social Security Number: _____ **Date of Birth:** _____

Purpose of request: I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

Name of Personal Representative | Relationship to Patient

Address

City, State, Zip | Phone Number

- **Description of information to be disclosed:** I authorize the practice to disclose all of my protected health information to my designated personal representative.
- **Expirations or termination of authorization:** This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.
- **Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

  Dermatology Center of Southern Indiana, P.C.
  1200 S. Rogers St.
  Bloomington, IN 47403
  Attn: Privacy Manager

Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

Patient signature | Date

Copies of signed authorizations are available upon request.