PATIENT INFORMATION

DATE:_____

REFERRED BY:_____

NAME:_____
(LAST) (FIRST) (M)

SEX: M___ F___ AGE:___ DOB:_____/_____/_____ MARITAL STATUS: M___ S___ W___ D___

SS#_____/_____/_____ FULL TIME STUDENT: Y___ N___ EMPLOYMENT STATUS: F___ P___ N___

ADDRESS:_____ HOME PH#_____

CITY:_____ STATE:_____ ZIP:_____

PATIENT'S EMPLOYER:_____ WK#:_____

OCCUPATION:_____ CELL#:_____

SPOUSE'S NAME:_____
(LAST) (FIRST) (M)

SPOUSE'S EMPLOYER:_____ WK#:_____

OCCUPATION:_____

EMERGENCY CONTACT:_____ PH#:_____

RESPONSIBLE PARTY

ONLY TO BE FILLED OUT IF PATIENT IS A MINOR

NAME:_____
(LAST) (FIRST) (M)

RELATIONSHIP:_____ SS#_____/_____/_____

ADDRESS:_____ HM#:_____

CITY:_____ STATE:_____ ZIP:_____

EMPLOYER:_____ WK#:_____

INSURANCE INFORMATION

OUR CLINIC ONLY FILES PRIMARY AND SECONDARY INSURANCE

PRIMARY:	**SECONDARY:**
INSURANCE NAME:_____	_____
ADDRESS:_____	_____
CITY,STATE,ZIP:_____	_____
POLICY HOLDER:_____	_____
ID#:_____	_____
GROUP#:_____	_____
RELATIONSHIP TO POLICY HOLDER:_____	RELATIONSHIP TO POLICY HOLDER:
POLICY HOLDER DOB:_____/_____/_____	SELF:___ SPOUSE:___ CHILD:___ OTHER:___

Name_____ Date_____

Referred by (physician)_____
Preferred pharmacy_____

Reason for visit_____
_____

Current diseases_____
_____

Surgeries_____
_____

Previous skin problems_____
_____

Allergies to medication_____
_____

Current medications (if you have a written medication list, you do not need to fill this out):
_____
_____
_____
_____

Do you smoke? yes no Drink alcohol? yes no
Occupation_____

ALERTS: PLEASE CIRCLE ANY THAT APPLY TO YOU

Pregnant
Defibrillator
Premedication recommended prior to procedures
Latex allergy Describe_____
Blood thinners What type?_____

Breast-feeding
Lidocaine (Xylocaine) allergy
Epinephrine allergy
Organ transplant

Blaine Lehr, M.D. Zann McMahan, M.D.

Notice of Privacy Practices

Dermatology Clinic Inc.

2743 NW Expressway

Oklahoma City, OK 73112

405-951-4949

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation. Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery. Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards. The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible. We may also create and distribute de-identified health information by removing all reference to individually identifiable information. We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us. The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you: Most uses and disclosure of psychotherapy notes; Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations; Disclosures that constitute a sale of PHI under HIPAA; and Other uses and disclosures not described in this notice. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization. You may have the following rights with respect to your PHI: The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it. The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations. The right to inspect and copy your PHI. The right to amend your PHI. The right to receive an accounting of disclosures of your PHI. The right to obtain a paper copy of this notice from us upon request. The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed. If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure. We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI. This notice if effective as of September 6, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office. You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint. Feel free to contact the Practice Compliance Officer Dr. Blaine Lehr 405-951-4949 for more information, in person or in writing.

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

THE DERMATOLOGY CLINIC

I am a patient of Dr Lehr's or Dr Mcmahan's. I hereby acknowledge receipt of

The Dermatology Clinic's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of The Dermatology Clinic's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name:_____ Today's Date____/____/____

In case of an emergency, who should be notified?_____Phone(_____)_____

RELEASE OF INFORMATION:

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

PAYMENT POLICY:

Notice to all patients: In the event that your account must be turned over to collections, a collection fee will be added to your account.

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% copayment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

Note: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

HMO, PPO or other mananged care patients: You will be responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 35% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

MEDICARE PATIENTS:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically " crosses over ", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Patient or Responsible Party Signature_____**Date**____/____/____