Date:_________________

**Name:** ____________________________________ **Nick Name:** __________________ **DOB** ___/___ /_____

**Address:** ________________________________________ **City:** _________________ **State:** _____ **Zip:**_________

**Gender:** ❑ **Female** ❑ **Male** ❑ **Other** **Marital Status:** __________________ **Birth State:** _________________

**Race:** ____________________ **Ethnicity:** ❑ **Hispanic** ❑ **Non-Hispanic** ❑ **Other:** ___________________ ❑ **Decline**

**Preferred Language** ***(Specify)***________________________ **Military Service:** _________________ **SS#:** _______________

**Best Phone#:** _________________________ ☐ **Cell** ☐ **Home** **Best Email:** ______________________________

**Do we have your permission to leave a voicemail regarding test results?** ❑ **Yes** ❑ **No**

**Is there anyone else we can speak with on your behalf?** ❑ **Yes** ❑ **No**

**Contact:** _______________________ **Relationship:** _________________________ **Phone:** ______________________

**Primary Care Physician:** _____________________________________ **Phone:** _________________________________

**ACTIVE CONDITIONS: Are you CURRENTLY receiving treatment for any condition(s) listed below? Check Y or N**

| | Y | N | | Y | N |
|---|---|---|---|---|---|
| Alzheimer's disease | ❑ | ❑ | Hepatitis: ***Please circle type: A B C*** | ❑ | ❑ |
| Anxiety | ❑ | ❑ | HIV (Human Immunodeficiency Virus) | ❑ | ❑ |
| Arthritis | ❑ | ❑ | High Cholesterol (Hypercholesterolemia) | ❑ | ❑ |
| Asthma | ❑ | ❑ | Hyperthyroidism | ❑ | ❑ |
| Atrial Fibrillation | ❑ | ❑ | Hypothyroidism | ❑ | ❑ |
| Benign Prostatic Hyperplasia (BPH) | ❑ | ❑ | Leukemia | ❑ | ❑ |
| Chronic Obstructive Lung Disease (COPD) | ❑ | ❑ | Malignant Lymphoma | ❑ | ❑ |
| Coronary Arteriosclerosis (Coronary Artery Disease) | ❑ | ❑ | Malignant tumor of lung (Lung Cancer) | ❑ | ❑ |
| Depressive Disorder | ❑ | ❑ | Malignant tumor of Colon (Colon Cancer) | ❑ | ❑ |
| Diabetes Mellitus | ❑ | ❑ | Malignant tumor of Prostate (Prostate Cancer) | ❑ | ❑ |
| End-Stage Renal Disease (ESRD) | ❑ | ❑ | Parkinson's Disease | ❑ | ❑ |
| Epilepsy | ❑ | ❑ | Radiation Therapy Treatment | ❑ | ❑ |
| Gastroesophageal Reflux Disease (GERD) | ❑ | ❑ | Rheumatoid Arthritis | ❑ | ❑ |
| Hypertension | ❑ | ❑ | **Are you pregnant or breast feeding** | ❑ | ❑ |
| Hearing Loss | ❑ | ❑ | **Other:** | | |

**PAST SURGICAL HISTORY: Have you ever had any of the following surgeries? Check Y or N**

| | Y | N | | Y | N |
|---|---|---|---|---|---|
| Coronary Artery Bypass Graft (CABG) | ❑ | ❑ | Hysterectomy | ❑ | ❑ |
| Excision of Basal Cell Carcinoma | ❑ | ❑ | Mechanical heart valve replacement | ❑ | ❑ |
| Excision of Malignant Melanoma | ❑ | ❑ | Prostatectomy (prostate removed) | ❑ | ❑ |
| Excision of Squamous Cell Carcinoma | ❑ | ❑ | Splenectomy (spleen removed) | ❑ | ❑ |
| History of tubal ligation | ❑ | ❑ | Total nephrectomy (kidney removed) | ❑ | ❑ |
| History of Appendectomy (appendix removed) | ❑ | ❑ | Total Replacement of Knee: (Left, Right, Both) | ❑ | ❑ |
| History of Cholecystectomy (gallbladder removed) | ❑ | ❑ | **Transplant History: check all that apply** | | |
| History of Mastectomy: (Left, Right, Both) | ❑ | ❑ | ❑ Kidney ❑ Heart ❑ Liver ❑ Pancreas | | |
| (Hx) Total Replacement of Hip: (Left, Right, Both) | ❑ | ❑ | | | |

| SKIN DISEASE HISTORY: Have you ever had any of the following conditions? Check Y or N | | | | | |
|---|---|---|---|---|---|
| | Y | N | | Y | N |
| Acne | ❑ | ❑ | Psoriasis | ❑ | ❑ |
| Actinic Keratosis | ❑ | ❑ | Rosacea | ❑ | ❑ |
| Basal Cell Cancer : year/site: ________ | ❑ | ❑ | Scalp itchy | ❑ | ❑ |
| Dry Skin | ❑ | ❑ | Seasonal Allergies | ❑ | ❑ |
| Eczema | ❑ | ❑ | Squamous Cell Cancer: year/site: _______ | ❑ | ❑ |
| History of Melanoma: year/site: ________ | ❑ | ❑ | Any immediate family history of melanoma? | ❑ | ❑ |
| Do you wear sunscreen? *What SPF level:* | ❑ | ❑ | ❑ Mother ❑ Father ❑ Brother ❑ Sister | | |
| Do you tan in a tanning salon? | ❑ | ❑ | Other: | ❑ | ❑ |

## SOCIAL AND VACCINATION HISTORY

1. Are you an active tobacco user?
   ❑ Yes ❑ No ❑ Former
2. How many times in the past year have you had 4 or more alcoholic drinks in one day?
   ❑ Never ❑ No alcohol use
   ❑ 1-2 days ❑ 3 or more days
3. Did you have a Pneumonia Vaccination?
   ❑ Yes, *when* _______ (year) ❑ No
4. Are you allergic to adhesive? ❑ Yes ❑ No
5. Are you allergic to latex? ❑ Yes ❑ No
6. Do you have an advance directive, a living will or designated decision maker with a healthcare provider?
   ❑ No/unsure ❑ Yes (please specify) ___________________________________

## PLEASE LIST ALL ACTIVE SUPPLEMENTS/MEDICATIONS BELOW:

| *Example: aspirin 81 mg 1/day* | |
|---|---|
| | |
| | |
| | |

**PLEASE LIST ANY MEDICATION ALLERGIES** ____________________________________________________________

## PREFERRED PHARMACY INFORMATION

Pharmacy Name: __________________________________________ Phone: _____________________________________

Address/ City/Zip: _________________________________________________________________________________

Primary Insurance Carrier: ___________________________ Name of Insured (Subscriber): _________________________

Subscriber DOB: ___/___/___ Subscriber Gender: ❑ Male ❑ Female Relationship to patient: _____________________

## PAYMENT OF BENEFITS/ AUTHORIZATION OF TREATMENT

Our Practice teaches dermatology residents from Orange Park Medical Center and they may be involved in your care under the supervision of your physician. However, your physician will direct your care and treatment plan during each visit. I hereby authorize treatment from any licensed medical professional within Parks Dermatology Center, LLC.

I understand that this authorization may be used now or in the future. PAYMENT IS EXPECTED AT THE TIME OF SERVICE FOR "YOUR PART" OF THE CHARGES. We accept VISA, MasterCard, AMEX, DISCOVER and Care Credit for your convenience. Your signature below indicates that you understand and accept this policy. I request the direct payment of all authorized medical benefits to be made to Parks Dermatology Center for any services I received by the physicians or laboratory of Parks Dermatology Center. I authorize any holder of medical information about me to release this information to process my claims or meet legal requirements. I permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked, in writing. I understand that because these services were performed for me or my legal dependent, I am financially responsible for all charges incurred. Parks Dermatology Center, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Signature:_____________________________________________________________ Date: _________________

# PARKS DERMATOLOGY

## PATIENT CONSENT FOR USE, DISCLOSURE OR REQUEST OF HEALTH INFORMATION FOR TREATMENT OR PAYMENT

Patient Name:_______________________________________________________________________________

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for services information. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals who contribute to your healthcare
- Submit your diagnosis and treatment information for payment from insurance companies or others

**"ONLY AS PERMITTED BY STATE OR FEDERAL LAW", you are giving this practice CONSENT to do the following:**

- **To disclose, as may be necessary, your protected health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified psychiatric notes) to other healthcare providers (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) for your treatment and/or healthcare.**

- **To request from other healthcare entities (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.**

- **To submit diagnosis and treatment information to insurance company(s), other agencies and/or individual(s) for payment of our services.**

- **Leave appointment reminders or information we believe necessary for your treatment or payment on an answering machine or with a member of your household. We may also send a text message or email if requested by you or by an authorized person on your behalf. The information will be the minimum necessary in our professional judgment.**

- **Discuss your health information (only as necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.**

- **Please list by name and relationship persons with whom we may share your healthcare or payment information**_______________________________________________________________________
  _______________________________________________________________________________

You may request a copy of or as a new patient, have been given a copy of our ***"Notice of Patient Privacy Practices"*** that provides a more complete description of health information uses and disclosures as required by the HIPAA standard. You have read and understand or have had the right to read the ***"Patient Health Information Privacy Practices"*** prior to signing this consent.

**I fully understand and agree to this consent and acknowledge the above rights and disclosures.**

| _______________________________ | _______________________________ | _______________ |
|---|---|---|
| Signature | Print name of person signing | Date |

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have Power of Attorney for treatment and/or payment for this patient. Yes [ ] No [ ] RELATIONSHIP___________________________. If you are not the parent, please provide a copy of your legal authority for this patient.

**FOR OFFICE USE ONLY**

Patient refused to sign the consent form. Reason:_______________________________________ Date:______________

# PARKS DERMATOLOGY
# Notice of Patient Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
This Notice is effective March 1, 2013 and applies to all protected health information as defined by federal and state regulations. (Rev. 3/2013)

**Understanding your health record/information:**
What is in your healthcare record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and for you to make better informed decisions when authorizing disclosure to others.

Each time you visit our office a record of your visit is made. This record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, referred to as your health or medical record may be used by our practice as follows:

- A basis for planning your care and treatment
- A means of communication among health professionals who contribute to your care. We may need to transmit PHI over an unsecured medium, such as the internet, or text message when deemed necessary by the healthcare provider.
- A legal document describing the care we provided to you
- A record that you or a third-party payer can verify services billed were actually provided
- A tool in educating heath professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this county, state and the nation
- A tool which we can assess and continually work to improve the care we render and the outcomes we achieve
- To provide you with information on additional treatment alternatives and other health related benefits
- We may use your information for appointment reminders as defined by the "Consent" page

**Your Health Information Rights:**
Although your health record is the physical property of this practice, the information belongs to you. You have the right to:
- Obtain a copy of this "Notice of Patient Information Privacy Practices"
- Inspect and/or receive a copy your health record electronically as provided for in 45 CFR 164.512 and 45 CFR 164.524 (HIPAA)
- Amend your health record as provided in 45 CFR 164.524 (HIPAA)
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information to health plans, if you fully paid for these services out of pocket
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken
- You have a right to opt out of communications for fund raising activities of this practice

**Our Responsibilities, we are required to:**
- Maintain the privacy of your health information as defined by federal/state laws
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Notify you of a breach of your protected healthcare information
- Notify you if we are unable to agree to a requested restriction

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the changes in our reception area. At your request, we will provide you a revised "Notice of Patient Privacy Practices".

**To Report a Problem**
If you have questions, would like additional information or wish to report a problem, please contact the practice's Privacy Officer.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

**Treatment, Payment and Health Operations:**

**Treatment:** Information obtained by a member of our healthcare team will be recorded in your record and will be used to determine the course of treatment we believe is best for you. We may also share with others involved with your treatment copies of your healthcare information to assist them in treating you.

**Payment**: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

**Healthcare Operations:** Members of the medical staff may use information in your health record to assess the care and outcomes in your case and others like it. This information maybe used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

**Business Associates:** There are some services provided to our organization through contracts with business associates. When these services are contracted, we may need to disclose your health information to our business associate/s so they can perform the job we've hired them to do. HIPAA now requires the business associate to protect your health information just as we do. Therefore, this practice requires the business associate, their agents, subcontractors and representatives to sign a "Business Associate Agreement" protecting and securing your health information as required by Federal and State law.

**Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. (As governed by federal/state law and the "Consent" page)

**Communication with family:** Our healthcare professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care as governed by federal/state law.

**Research:** We may disclose information to researchers, when an institutional review board having reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research. This information will be de-identified.

**Food and Drug Administration (FDA):** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**Workers Compensation:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

**Public health:** As required by law we may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**Correctional institution:** Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

**Law enforcement:** We may use or disclose your PHI as required by law or required by a court ordered subpoena.

**Abuse and Domestic Violence:** As provided by federal and state law, we may, at our professional discretion, disclose to proper federal or state authorities healthcare information related to possible or known abuse or domestic violence.

**Authorization:** We will not use or disclose your health information without written authorization from you or your legal representative for: psychotherapy notes, HIV+/AIDS status, drug/alcohol abuse records, marketing purposes, disclosures that constitute the sale of your PHI, or other uses and disclosures not described in this notice.