HIPAA
Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

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 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.

Acknowledgement of Notice of Privacy Practices

My signature below verifies that I, _____, have received
(Print Name)
a copy of the Notice of Privacy Practices from Romagosa Dermatology Group, LLC

Signature of Recipient _____ Date: _____/_____/_____

Protected Health Information Authorization

My signature below indicates that I □ **DO** / □ **DO NOT** (please check one) authorize Romagosa Dermatology Group, LLC to discuss my PHI with my spouse or personal representative.

If yes, please provide their name and phone number.
Name: _____ Phone #: _____-_____-_____
Relationship : _____

Signature of Patient _____ Date: _____/_____/_____

MINOR PATIENT REGISTRATION FORM

Child's Name: _____ SS#: _____/_____/_____

Date of Birth: _____/_____/_____ Age: _____ Sex: □ Male □ Female

Who Referred You? _____

Home Address: _____

_____

Home #: (_____) _____Work #: (_____) _____Cell #: (_____) _____

Legal Guardian or Parent Name: _____

Parent Name: _____ SS#: _____/_____/_____

Employer: _____

Should statements of your account be sent to the above address? □ Yes □ No

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. **PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE.** Your signature below indicates that you understand and accept this policy. Further, your signature authorizes Romagosa Dermatology Group, LLC to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to Romagosa Dermatology Group, LLC when an assigned claim is filed.

_____ _____/_____/_____
Parent/Legal Guardian Signature Date

Name of policy owner if other than patient: _____

Patient relationship to policy owner: □ Self □ Child □ Other: _____

Do we have your permission to?

Leave a message on your answering machine at home? □ Yes □ No
Leave a message at your place of employment? □ Yes □ No
Discuss your medical condition with any member of your household? □ Yes □ No

If yes, whom: _____ Relationship: _____

_____ _____/_____/_____
Parent/Legal Guardian Signature Date

TREATMENT TO MINORS

Many times parents find themselves unable to accompany their children to their appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I hereby grant to Romagosa Dermatology Group, LLC permission to treat my child, _____, for any dermatologic condition or procedure when they arrive at the office unaccompanied.

Signature of Parent: _____ Date: _____/_____/_____

AUTHORIZATION TO CHARGE SERVICES TO MAJOR CREDIT CARD

My minor child will be coming to the office for regular treatment of his/her dermatological condition unaccompanied, I authorize the above physician to charge my credit card (listed below) under the following circumstances:

(Initials) _____ I understand that I am responsible for payment of my account at the time of service for deductibles, non-covered services, medically unnecessary services, co-payments and balance after primary insurance has paid, should my primary insurance be with a company with which the physician(s) are contracted.

☐ Visa ☐ MasterCard

Credit Card #: _____ Expiration Date: _____/_____

Name as it appears on the credit card: _____

Signature: _____ Date: _____/_____/_____

Romagosa Dermatology Group, LLC
Medical History and Intake Form

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

Past Medical History: (please circle 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
Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
NONE

Other :_____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
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 (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

Other:_____

Skin Disease History: (please circle 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:_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Romagosa Dermatology Group, LLC
Medical History and Intake Form

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 enter all current medications)
_____
_____
_____

Allergies: (Please enter all allergies)
_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Other:_____

Family History (Only first degree relatives)
_____
_____
_____
_____

Preferred Language: _____

Race:_____ Ethnic Group:_____

Preferred pharmacy Name: _____ Pharmacy Phone#: _____

Pharmacy City or Zip code:_____

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heartbeat with epinephrine
Pregnant or currently trying to get pregnant?

PLEASE COMPLETE BOTH SIDES OF THIS FORM

To Our Patients:

As you know if you have ever checked into a hotel or rental car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At the time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This will not compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays due at the time of the visit will, of course, still be due at the time of the visit.

If you have any questions about this payment method, do not hesitate to ask.

Sincerely yours,

Romagosa Dermatology Group, LLC

I authorize Romagosa Dermatology Group, LLC to charge outstanding balances on my account to the following credit card:

Visa MasterCard American Express Discover Other: _____

Account number: _____ Expiration Date: _____

Name on card (please print):_____

Signature: _____ Date: _____

optional