

WELCOME TO FREDERICK DERMATOLOGY ASSOCIATES

Thank you for choosing Frederick Dermatology Associates and entrusting your dermatology care to us. We are a full-service dermatology practice with the goal to provide the best dermatological care possible in an atmosphere that takes customer service seriously. We are honored to have you as our patient and will strive to combine the expertise of a university dermatology division with a warm and friendly environment. In our practice we take care of a variety of skin conditions, ranging from acne, moles, and warts, to psoriasis and skin cancer. In addition, we possess expertise in surgical and cosmetic dermatology. If you haven't visited our website, please visit us at www.frederickdermatology.com.

We want your experience at our office to be smooth from the day you make your appointment. In order to make your initial visit pleasant and effortless, please help us by filling out the patient information form that we have included. Additionally, after your appointment, please feel free to provide your feedback through an anonymous survey at www.drscore.com. This way we can listen to your constructive comments and make any necessary changes to achieve the highest level of satisfaction.

We accept patients with all types of insurance and it is our commitment to provide shorter wait times for appointments and better customer service. We have contracted with Medicare, Blue Cross Blue Shield Federal, CareFirst Blue Cross Blue Shield PPO & POS, NCPPO, United Healthcare, PHCS, Tricare and InforMed. What this means is that if you *do not* have one of these insurances, you will be responsible for the cost of the appointment upfront (an average medical appointment ranges for \$110-\$160 for a new patient and \$65-\$100 for return patients). Surgical and other procedures may increase the charge for the visit. We will provide you with the forms to obtain reimbursement from your insurance company, which may reimburse you if the policy has an out-of-network option. Payment at the time of the visit may be paid by check or major credit cards. You can also use a flexible spending account or health savings account to pay for your visit.

Again, we are privileged to take care of all your skin care needs. We look forward to seeing you at your appointment. If you have any questions or concerns about our practice, please do not hesitate to contact us.

Kevin Hogan, M.D.

Kathleen Moe, M.D.

& Staff of Frederick Dermatology Associates

45 Thomas Johnson Drive, Suite 209, Frederick, MD 21702 - 301.662.6755

FREDERICK DERMATOLOGY ASSOCIATES, LLC

Today's Date ____/____/____

NAME: Last _____ First _____ MI _____

Date of Birth: ____/____/____ Social Security ____/____/____ Male Female

Marital Status: Single Married Divorced Widowed Separated Partnered

Address: _____

City _____ State _____ Zip _____

Home # (____) _____ Work # (____) _____ Cell # (____) _____

E-Mail _____

Preference of communication: Home Work Cell

How did you hear about us? _____

Your Primary Care Doctor: _____

PRIMARY INSURANCE

Insurance Company _____

Policy Holder Name: _____ DOB: ____/____/____

Relationship to patient: _____

SECONDARY INSURANCE

Insurance Company _____

Policy Holder Name: _____ DOB: ____/____/____

Relationship to patient: _____

GUARANTOR (Person responsible for bill) Self or

Name _____ Relationship _____

DOB _____ SS# _____

Address: _____ City _____

State _____ Zip _____ Contact # (____) _____

EMERGENCY CONTACT INFORMATION

In case of Emergency, who should be notified? _____

Phone: (_____) _____ Relationship _____

Do you give our office permission to discuss your medical information with family members?

YES NO If yes, please provide their name and phone number below.

Name: _____ Phone (_____) _____

Name: _____ Phone (_____) _____

May we leave personal medical on your voice mail? YES NO

May we e-mail personal medical information to you? YES NO

Notice of Privacy Practices/HIPPA

A notice of Privacy Practice is attached at the end of this document. My signature below indicates that I have received and/or reviewed a copy of the offices Notices of Uses and Disclosure of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature _____ **Date** _____

Financial Policy

Frederick Dermatology Associates, LLC participates with Medicare, Blue Cross Blue Shield PPO, POS & FEP, Informed, NCPPO & PHCS, United Healthcare and Tricare. I agree to pay FDA for all services deemed not covered by my insurance. I also understand it is my responsibility to verify any "Out-of-Network" coverage for insurances that FDA does not participate with. For those insurances that FDA participates with, I agree to pay balances that my insurance indicates are my responsibility. **For those insurances that FDA does NOT participate with, I understand that I am responsible for the balance at the time of service.** If I have a biopsy, I understand that there are two components that will be billed. **1.** Professional component (Pathologist reading.) (*Professional components are billed through FDA.*) **2.** Technical component (Preparation of the specimen). (*Technical components are billed through Dianon/LabCorp.*) I agree to pay for any professional fees related to any pathology services that are not covered by my insurance. I understand that I will be billed for these services at a later date.

I understand that Frederick Dermatology Associates, LLC will provide me with all forms required to submit to my insurance company to facilitate reimbursement if my plan has out-of-network benefits. I understand that Frederick Dermatology Associates, LLC is not responsible for securing my reimbursement from my insurance company.

Cancellation Policy

Frederick Dermatology Associates, LLC requires 24 hour notice when canceling any appointment. I understand that I may be liable for a charge of \$40.00 if I fail to give 24 hours notice to cancel an appointment.

Return Check Policy

Frederick Dermatology Associates, LLC charges \$35.00 for all returned checks.

I have read and understand the previous statements.

Signature _____ **Date** _____

MEDICAL HISTORY FORM

Patient Name: _____ **DOB:** _____

Why are we seeing you today? _____

What is name and location of you preferred pharmacy? _____

Please list any allergies and the type of reaction you have:

Medications You Are Currently Taking: *Including Over-The Counter, Vitamins, Herbal & Topical Medications*

Are you experiencing any of the following symptoms?

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Heat Intolerance | <input type="checkbox"/> Swollen Lymph Nodes |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Hair Loss/Growth | |

What is your height: _____

Most recent sun exposure: _____

Weight: _____

Date of last menstrual cycle: _____

Have you taken Accutane before? Y N **Dates:** _____

Family History

Relationship

- | | |
|---|-------|
| <input type="checkbox"/> Asthma | _____ |
| <input type="checkbox"/> Lupus | _____ |
| <input type="checkbox"/> Atopic Dermatitis | _____ |
| <input type="checkbox"/> Psoriasis | _____ |
| <input type="checkbox"/> Basal Cell Carcinoma | _____ |

- | | |
|--|-------|
| <input type="checkbox"/> Skin Cancer | _____ |
| <input type="checkbox"/> Malignant Melanoma | _____ |
| <input type="checkbox"/> Squamous Cell Carcinoma | _____ |
| <input type="checkbox"/> No Significant Family History | |

Past Medical History

- | | | |
|---|---|--|
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Malignant Lymphoma | <input type="checkbox"/> Systemic Lupus Erythematosus |
| <input type="checkbox"/> Diabetes Type I | <input type="checkbox"/> Malignant Melanoma | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Diabetes Type II | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> No Significant Past Medical History |
| <input type="checkbox"/> High Cholesterol | (Location) _____ | History |
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Squamous Cell Carcinoma | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Hypothyroidism | (Location) _____ | _____ |
| <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Non-Melanoma Skin Cancer | |
| <input type="checkbox"/> Keloid | <input type="checkbox"/> Scleroderma | |

Social History

- | | |
|---|---|
| <input type="checkbox"/> History of Blistering Sunburns | <input type="checkbox"/> Alcohol Use Frequency: _____ |
| <input type="checkbox"/> Non-Smoker | <input type="checkbox"/> History of Tanning Salon Use |
| <input type="checkbox"/> No Alcohol Use | <input type="checkbox"/> Tobacco Use Pack(s) per day: _____ |

COSMETIC QUESTIONNAIRE

Please check any areas you would like to discuss or receive more information about:

- | | | |
|--|--|---|
| <input type="checkbox"/> Freckles / Brown Spots | <input type="checkbox"/> Excessive Hair Growth | <input type="checkbox"/> Skin Care Regimen |
| <input type="checkbox"/> Removing Facial Blood Vessels | <input type="checkbox"/> Lip Augmentation | <input type="checkbox"/> Wrinkles |
| <input type="checkbox"/> Mouth Lines | <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Botox |
| <input type="checkbox"/> Acne/Acne Scarring | <input type="checkbox"/> Facial Redness | <input type="checkbox"/> Skin Care Products |
| <input type="checkbox"/> Leg Spider Veins | <input type="checkbox"/> Large Pores | <input type="checkbox"/> Dermal Filler |
| <input type="checkbox"/> Lower Face Folds | <input type="checkbox"/> Frown Lines | <input type="checkbox"/> Laser Treatments |
| <input type="checkbox"/> Sun Damage | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Skin Tightening |
| <input type="checkbox"/> Scar Reduction | <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Other _____
_____ |

Have you had any cosmetic surgery or procedures in the past five years? YES NO

If so, please describe:

Would you like to receive information of any specials or events that we are having? Yes No

Contact Preference: Phone Mail Email: _____

Print Name: _____

Signature: _____

HIPPA

INTRODUCTION

Frederick Dermatology Associates, LLC is required by law to maintain the privacy of "protected health information." "Protected health information" includes any identifiable information that we obtain from you or others that relate to your physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a copy of our most current privacy notice from our Privacy Officer.

PERMITTED USES AND DISCLOSURES

We can use or disclose your protected health information for purposes of *treatment, payment and health care operations*. For each category we will explain what we mean and give some examples. However, not every use or disclosure will be listed.

Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Therefore, the doctor may review your medical records to assess whether you have potentially complicating conditions like diabetes.

Payment means activities we undertake to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we may need to provide to your health plan information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill your health plan for the services rendered to you, we can provide them with information regarding your care if necessary to obtain payment.

Health care operations means the support functions of our practice related to *treatment and payment*, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff when caring for you. We may also combine medical information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. In addition, we may remove information that identifies you from your health information so that others can use this de-identified information to study healthcare delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

We may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the protected health information that is directly relevant to their involvement in your care.

When permitted by law, we may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.

We will allow your family and friends to act on your behalf to pick up, medical supplies, X-rays, and similar forms of protected health information, when we determine, in our professional judgment that it is in your best interest to make such disclosures.

We may contact you as part of our marketing efforts as permitted by applicable law.

SPECIAL SITUATIONS

Except for the special situations set forth below and the general uses and disclosures described above, we will not use or disclose your protected health information for any other purposes unless you provide a written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Worker's Compensation. We may release medical information about you for programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:

to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of product, recalls, repairs or replacements; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose medical information to federal or state agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. We may disclose protected health information to persons under the Food and Drug Administration's jurisdiction to track products or to conduct post-marketing surveillance.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

In response to a court order, subpoena, warrant, summons or similar process

To identify or locate a suspect, fugitive, material witness, or missing person

About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement

About a death we believe may be the result of criminal conduct

About criminal conduct on our premises

And in emergency circumstances to report a crime, the location of the crime or victims or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, or other national security activities authorized by law.

Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Right to request restrictions. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request. To request a restriction, you must make your request in writing to the Frederick Dermatology Privacy Officer.

Right to request confidential information. You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations. Your request must be submitted in writing to the Frederick Dermatology Privacy Officer. Your request must specify how or where you wish to be contacted.

Right to inspect and copy. You have the right to inspect and copy the protected health information contained in your medical and billing records and in any other Practice records used by us to make decisions about you (you must submit your request in writing to the Frederick Dermatology Privacy Officer. We may charge you for the costs of copying and mailing your records as well as any other costs associated with your request), except for: psychotherapy notes, which are notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; protected health information involving laboratory tests when your access is required by law; if you are a prison inmate and obtaining such information would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you; if we obtained or created protected health information as part of a research study for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research; your protected health information is contained in records kept by a federal agency or contractor when your access is required by law; and if the protected health information was obtained from someone other than us under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information. We may also deny a request for access to protected health information if: A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person; The protected health information makes reference to another person (unless

such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or Health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person.

If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.

Right to amend. You have the right to request an amendment to your protected health information, but we may deny your request for amendment, if we determine that the protected health information or record that is the subject of the request: was not created by us, unless you provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment; is not part of your medical or billing records; is not available for inspection as set forth above; or is accurate and complete.

In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records. A request for amendment must be submitted in writing to the Frederick Dermatology Privacy Officer and contain a reason that supports your request for amendment.

Right to an accounting of disclosures. You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you, except for disclosures: to carry out treatment, payment and health care operations as provided above; to persons involved in your care or for other notification purposes as provided by law; for national security or intelligence purposes as provided by law to correctional institutions or law enforcement officials as provided by law; or that occurred prior to April 14, 2003.

Right to a paper copy of this notice. You have the right to request and receive a paper copy of this notice from us. Submit your request to the Frederick Dermatology Privacy Officer or obtain a copy from our website, www.frederickdermatology.com.

COMPLAINTS

If you believe that your privacy rights have been violated, you should immediately contact our Privacy Officer. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

CONTACT PERSON

If you have any questions or would like further information about this notice, please contact us at (301)-662-6755.

This notice is effective as of April 14, 2003.