PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

PATIENT INFORMATION: **Today's Date** ___/___/___

Patient Name _____ Date of Birth ___/___/___ Age: ____
Last First M.I.

Social Security # (REQUIRED for Billing) _____ Sex: ☐ Male ☐ Female

Mailing Address: _____
Street Address City State Zip

Home Phone: (_____) _____ Emergency Contact _____

Cell Phone: (_____) _____ Emergency Contact # (_____) _____

Email: _____
Please note: When an email is provided, promotional material from J Woodson Dermatology may be sent; unless otherwise specified.

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow/er Preferred method of contact: ☐ Email ☐ Text ☐ Voicemail

Race: _____ Ethnicity: _____ Language: _____

RESPONSIBLE PARTY (IF DIFFERENT FROM THE PATIENT): ☐ Check if not applicable

Name _____ Date of Birth ___/___/___
Last First M.I.

Mailing Address _____
Street Address City State Zip

Home (____) _____ Cell (___) _____ Relationship _____

REFERING PHYSICIAN (PRIMARY CARE PROVIDER):

Name _____ Office (____) _____
Last First

INSURANCE COVERAGE- PRIMARY:

Name of Policy Holder _____ SSN_____Date of Birth___/___/___

Insurance Company Name: _____ Policy ID # _____

Relationship of Patient to Policy Holder: _____

INSURANCE COVERAGE- SECONDARY:

Name of Policy Holder _____ SSN_____Date of Birth___/___/___

Insurance Company Name: _____ Policy ID # _____

Relationship of Patient to Policy Holder: _____

PATIENT MEDICAL HISTORY

Patient: _____ Date ____/____/____

Medication Allergies ☐ None ☐ Yes (Please List) _____

Are you sensitive to: ☐ Foods ☐ Dust/Pollen/Pets ☐ Bandages ☐ Topical Neosporin

Have you ever had "Numbing Medicine" (Novocain, Lidocaine)? ☐ Yes ☐ No Any reaction? ☐ No ☐ Yes

Current medications (including over the counter) 1) _____

2) _____ 3) _____ 4) _____

5) _____ 6) _____ 7) _____

Are you required to take antibiotics prior to dental or surgical procedures? ☐ No ☐ Yes

Do you have or have you ever had the following conditions? Denote a family condition checking where indicated:

Lungs:	No	Yes	Family History	Other Systemic	No	Yes	Family History
Bronchitis				Diabetes			
Emphysema				Thyroid			
Asthma				Kidney			
Chronic Cough				Dialysis			
Morning Cough				Excessive Urination			
Shortness of bre				Burning While Urinating			
Wheezing				Gastrointestinal			
Allergies				Nausea, Vomiting			
Cardiovascular:				Diarrhea			
High Blood Pressure				Arthritis			
Chest pain				Convulsions/Seizures			
Heart attack				Fainting			
Heart Murmur				Polycystic Ovaries			
Irregular Heartbeat				Yeast Infection			
Phlebitis				Infectious Disease			
Blood Clots				Hepatitis			
Pacemaker				HIV			
Hematology Oncology				MRSA			
Bleeding Disorde				Syphilis			
Cancer							

If yes what type of Cancer? _____ **Skin:** Have you ever had Skin Cancer? Yes ___ No____ What Type_____.

Has anyone in your family had skin Cancer? Yes___ No___ What type_____
Do you have a history of any specific skin diseases? Yes___ No ___ what type_____
Do you have problems with wounds healing? Yes ___ No ___
Do you develop large scars (keloids) after surgery? Yes___ No ___
List any other diseases or conditions: _____
List any surgical procedures in the last six months _____
(Women) Are you currently pregnant? Yes___ No ____ Due Date? _____

Social History:

Do you drink alcohol? Yes____ No __ How many drinks per day? __ _____
Do you use recreational drugs? Yes___ No___ What kind? _____
Do you smoke? Yes____ No_____ How often? _____ How much? _____
What is your occupation? _____
Completed by ____ Patient ___ Parent/Guardian ___ Medical Assistant _____ (Initials)

J. Woodson
DERMATOLOGY & ASSOCIATES

J. Woodson Dermatology & Associates

J. Woodson Dermatology and Associate's goal is to provide each patient with the highest quality care. We do our part by employing a highly trained, specialized and motivated staff. This is only part of the equation. Much of what we can do is in the hands of you, our patient. Please read the following guidelines and sign below.

- **All co-payments and deductibles are due at the time of service and will be collected at check in or prior to procedures.**
- We will be happy to provide a receipt to every patient. Please be sure to ask for a receipt if one is not provided at the time of payment.
- Visits or procedures that are not covered by insurance will be paid at the time of that visit. We cash, credit and debit cards for payment. No exceptions will be made.
- **Cancellations of an appointment must be made with at least 24 hours' notice or a $25 fee will be assessed for the office visit and $100 will be charged for a procedure. (Surgery). A $25 fee will be assessed for cosmetic procedure.**
- Please be aware that we do not perform procedures on the same day as the scheduled office visit. If a surgical procedure is determined necessary by the physician or physician assistant you will be scheduled for an appointment on the next available day.
- All refill requests will be addressed within 48 hours of receipt of a fax from the pharmacy. This allows time to review your chart and respond in an informed manner. Please be aware of the laboratory that your insurance plan uses for blood and tissue samples. If you do not know, please contact your insurance plan and ask them.
- **All forms must be filled out neatly and completely at visit. Please inform us of any changes to address, phone, emergency contact or insurance.**
- **Cell phones and electronic devices must be turned off once you enter the examination room or surgery areas.**
- Providers will address a maximum of two different skin complaints per appointment. Additional concerns will be addressed in an additional appointment.
- Some benign diagnosis is not covered by insurance. These include but are not limited to skin tags, DPNs (Dermatosis Papulosis Nigra) sebborrheic keratosis and sebaceous hyperplasia, and Alopecia. These are considered non-covered conditions and must be paid at time of service. Insurance will not be billed for these non-covered procedures.

We thank you for helping us make J. Woodson Dermatology & Associates the best possible choice for your skin care needs in the Las Vegas Valley.

Patient Signature_____ Date ____/____/_____

FINANCIAL AGREEMENT

I have been informed that it is the policy of J.Woodson Dermatology & Associates to confirm medical eligibility, benefits and coverage for all patients and all new insurance for established patients. Evidence of coverage must be obtained prior to services being provided.

I have been informed by the staff of J. Woodson Dermatology prior to receiving services, that although I may have medical insurance, I will accept responsibility for payment for any balances that are not paid by my insurance plan. I have also been informed that any insurance contracted with J. Woodson Dermatology will be billed as a courtesy to me.

I have been informed that if this office receives **no payment within sixty days**, my signature acknowledges that I will be responsible for the entire unpaid balance, even if the charge should be denied for any reason.

I clearly understand that my insurance may consider that charges in excess of their fee schedule, consider a service(s) medically unnecessary, bundle certain services or apply benefits to your annual deductible. If the balance of the above charges is not covered in full, I understand that I am financially responsible for the entire outstanding balance, regardless of the reason for any reductions in payment made by my insurance.

I also agree to make this payment within ten (10) days of the receipt of my statement with J. Woodson Dermatology after my insurance has made its determination or if no payment has been received in the aforementioned sixty (60) day period. I accept this notification and understand that **a 40% collection fee** will be added to my account balance if payment is not received in full as outlined. I am aware that my account will proceed to a collection agency and additional charges for collection and interest (1.5% monthly or 18% annually) will be added by the agency for the collection efforts of my account. If I do not present verification of my insurance (valid insurance card with coverage in force) at the time of service, I have 72 hours to produce such verification of insurance or I will become responsible for all charges.

I have also been informed of J. Woodson Dermatology & Associate's policy regarding the required 24 hour notice for canceling an appointment and the fee for not keeping your appointments without notifying the office. I accept there is a $25 fee for any no show and cancelations on the same day. I further understand that there is $100 fee if the appointment was a surgical procedure.

_____ Date ____/____/_____

Patient Name (Print)

_____

Responsible Party (Print)

_____

Patient or Responsible Party Signature

J. Woodson
DERMATOLOGY & ASSOCIATES

229 N. Pecos # 100 Henderson, NV 89074

702-485-5300 Fax 702-433-4297

NOTICE OF PRIVACY PRACTICES

This practice adheres to any and all governmental regulations regarding patient privacy and accessibility of their records in accordance with HIPAA.

In the course of treatment it may become necessary to share information with outside providers for treatment, payment and operations.

- Staff personnel will have the minimum necessary access to medical, demographic and billing information to accomplish the intended purposes of handling of your care.
- J. Woodson Dermatology & Associates refers all biopsies and excisions to an outside laboratory. Be advised that insurance information as well as a diagnosis and request for a pathology opinion of any and all biopsies obtained in the office will be sent to a laboratory. Please be advised that you will receive a separate bill from this laboratory.
- All insurance claims will be forwarded with the information necessary to obtain payment for all appropriate insurance carriers.
- Our staff may at some point in the course of your treatment telephone other physicians to discuss your treatment or to make an appointment on your behalf.
- We take all precaution to keep your medical records secure and out of sight. We utilize sign-in sheets and will call your name from our lobby.
- All examination rooms remain close for your privacy
- You have the right at any time to examine your medical records and to amend, as you deem necessary.

****AS A COURTESY TO OUR PATIENTS WE WILL TRY TO GIVE A COURTESY REMINDER OF YOUR APPOINTMENT 24 HOURS IN ADVANCE. ****

Patient Signature:_____

Date:_____

HIPAA PATIENT CONSENT AND PERMISSION FORM

Patient Name: _____
Last First M.I.

Other Family Members that are Patients

_____

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

☐ Yes ☐ No If yes, please specify names:

Name	Relationship	Phone
Name	Relationship	Phone

May we leave personal medical information on your answering machine at home? ☐ Yes ☐ No

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Right's section describing your rights under the law. You have the right to review our Notice before signing the 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 your 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).

This Consent signed by: _____
Print Name of Patient or Representative

_____
Signature Date

_____
Relationship to Patient

Witness: _____
Printed Name – Practice Representative

_____
Signature of Practice Representative Date

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operation and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present, future physical or mental health condition and related health care services. We are required by law to: (i) maintain the privacy of your Protected Health Information; (ii) give you this notice of our legal duties and privacy practices regarding health information about you; and (iii) follow the terms of our notice that is currently in effect.

We reserve the right to change the terms of this notice and to make the new provisions effective for all Protected Health Information that we maintain. Any revisions made to this notice will be immediately posted in our front office lobby area. We will also inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. You may be asked to sign a revised version at the time of your next appointment.

1. Uses and Disclosure of Protected Health Information

The following describes the ways we may use and disclose your Protected Health Information.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your Protected Health Information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: We may use or disclose your Protected Health Information to obtain payment for your health care services. For example, we may give your health plan information about you so that they will pay for your treatment.

Healthcare Operations: We may use or disclose your Protected Health Information in order to support the business activities of our practice. These uses and disclosures are necessary to ensure that all of our patients receive quality care and to operate and manage our office. For example, we may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information.

Appointment Reminders: We may use and disclose your Protected Health Information to contact you to remind you of your appointment or to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As Required by Law: We may use or disclose your Protected Health Information if state or Federal law requires it, including in the following situations pursuant to applicable laws and regulations: Public Health issues; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Medical Examiners and Funeral Directors; Organ Donation; Threats to Health and Safety; Military Activity and National Security; Workers' Compensation; and with respect to Inmates. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

Research: We may disclose your Protected Health Information for research when such research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your Protected Health Information. We may also share your Protected Health Information with people preparing to conduct a research project.

Fundraising: Under certain circumstances, we may contact you regarding fundraising efforts. At this time, you will also be provided an option for you to elect not to receive further fundraising communications.

Family Members/Certain Third Parties: You have the right and choice to tell us to share your Protected Health Information with a person who is involved in you medical care or payment for your care, such as your family or a close friend, or in the event of a disaster relief effort. If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest.

2. Uses and Disclosures Where Authorization is Required

Psychotherapy Notes: Unless otherwise required by law, most disclosures of psychotherapy notes (if recorded by us) will require your authorization.

Sale of Protected Health Information: Other than the transition provisions in 45 C.F.R. 164.532, we will obtain your authorization for any disclosure of your Protected Health Information for sale. Such authorization will state whether the disclosure will result in remuneration.

Marketing: Except in limited situations permitted under 45 C.F.R. 164.508(a)(3), we will obtain your authorization for any use or disclosure of your Protected Health Information for marketing purposes. Such authorization will state whether remuneration was involved.

Other Permitted and Required Uses and Disclosures: Other disclosures not described in this notice will be made only with your individual written authorization, unless required by law. You may revoke such authorization, at any time, in writing to our Privacy Officer identified below, except to the extent we have taken an action in reliance on the use or disclosure indicated in the authorization.

3. Notice to Patients Regarding the Destruction of Health Care Records

In accordance with Nevada law, J. Woodson Dermatology & Associates hereby advises all patients of our company's commitment to comply with Nevada law regarding the destruction of health care records as follows:

1.) The health care records of a person who is less than 23 years of age may not be destroyed; and
2.) The health care records of a person who has attained the age of 23 years may be destroyed for those records which have been retained for at least 5 years or for any longer period provided by federal law; and
3.) Except as otherwise provided in subsection 7 of NRS 629.051 and unless a longer period is provided by federal law or pursuant to your insurance plan, the health care records of a patient who is 23 years of age or older may be destroyed after 5 years pursuant to subsection 1 of NRS 629.051.

Please be advised your medical records may be requested from our company by filing a "Medical Records Release Form" located in the front office. We will process the request in a reasonable period of time (not to exceed 1-2 weeks) and reserve the right to charge $0.60 per page for filing such request.

4. Your Rights

The following is a statement of your rights with respect to your Protected Health Information.

You have the right to inspect, access and request a copy of your Protected Health Information: You have the right to inspect, access and request a copy of your Protected Health Information, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, civil, criminal, or administrative action or proceeding, and Protected Health Information that is now subject to law that prohibits access to Protected Health Information. You may elect to receive your Protected Health Information in which ever requested form you choose. For example, you may receive your Protected Health Information by an electronic format, by mail, by email or request a hard copy. If you elect to receive your Protected Health Information electronically, we will provide your Protected Health Information in a readily producible format per your request. Please note, if you wish to have your Protected Health Information by email, we may use an encrypted email to avoid risks associated with unencrypted emails, such as viruses or theft. You have the right to request an unencrypted email, but understand and agree to accept the risks associated with unencrypted emails. You have the right to request your Protected Health Information be transmitted to a third party. All request, must be submitted in writing to our Privacy Officer and will be timely processed from the date received in accordance with law. We reserve the right to charge $0.60 per page for a hard copy of your information and a reasonable cost for copies of X-ray photographs and other healthcare records produced by similar processes.

You have the right to request a restriction of your Protected Health Information: This means you may ask us not to use or disclose any part of your Protected Health Information for the purposes of treatment, payment or healthcare operations. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your Protected Health Information, your Protected Health Information will not be restricted. You then have the right to use another healthcare professional. In addition, J. Woodson Dermatology & Associates may decide to deny access to medical records in limited circumstances, please contact our Privacy Officer for further details.

You have a right to be told of a breach: We will timely notify you in writing following any breach of your unsecured Protected Health Information, as required by law.

You have the right to restrict certain health plan disclosures: You have the right to restrict certain disclosure of your Protected Health Information to a health plan with respect to payment of health care items or services for which you have paid out-of pocket and in full for a health care item or service, unless required by law. All request for restrictions, must be submitted in writing to our Privacy Officer and will be timely processed from the date received in accordance with law.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location: All requests to receive confidential communications by alternative means or at an alternate location must be authorized by you in writing. Your request will be timely processed from the date received in accordance with law.

You have the right to obtain a paper copy of this notice from us: You may request a paper of this notice on or after the effective date of this notice revision, even if you have agreed to this notice alternatively, i.e., electronically.

You have the right to have your physician amend your Protected Health Information: If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your Protected Health Information: You have the right to an accounting of disclosures except for those related to treatment, payment and healthcare operations, and certain other disclosures (such as any you asked us to make).

5. Complaints

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated by our office. You may file a complaint to the U.S. Department of Health and Human Services Office for Civil Rights. Complaints may be in writing, either **electronically via the OCR Complaint Portal**, or on paper by mail, fax, or **e-mail**; please see the following contact information:

Email: OCRComplaint@hhs.gov
Region IX - San Francisco (American Samoa, Arizona, California, Guam, Hawaii, Nevada)
Michael Leoz, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Voice Phone (800) 368-1019
FAX (415) 437-8329
TDD (800) 537-7697

To file a written complaint to our office, please see the following contact information:

J. Woodson Dermatology & Associates
Attention: HIPAA Privacy Officer
229 N. Pecos Rd Ste 100 Henderson, NV 89074
Voice Phone (702) 485-5300
FAX (702) 433-4297

We will not retaliate against you for filing a complaint.

This notice was published and is effective on **September 23, 2013.**

For further information about matters covered by this notice or if you have any objections to this notice, you may ask to speak with our HIPAA Privacy Officer (Lori Haynie/Administrator) in person or by phone at : (702) 485-5300.

Your signature below acknowledges that you have received and fully understand this Notice of our Privacy Practices:

Print Name: _____
Signature_____ Date_____